UNODC
United Nations Office on Drugs and Crime

HIV in prisons

Situation and needs assessment toolkit

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European Monitoring Centre
for Drugs and Drug Addiction

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Abbreviations

ABC	Assisting Bioethics Committee
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BBV	Blood Borne Viruses
CCM	Country Coordinating Mechanism
CDC	Center for Diseases Control and Prevention
CDRI	Central Drug Research Institute
CIOMS	Council for International Organisation of Medical Sciences
CPT	Cotrimoxazol Preventive Therapy
CSO	Civil Society Organisation
DOTS	Directly Observed Therapy
EIA	Enzyme Immunoassay
ELISA	Enzyme Linked Immunosorbent Assay
GAP	Global Assessment of Drug Abuse Programme
HAART	Highly Active Antiretroviral Treatment
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
IDU(s)	Injecting Drug User(s)
KABP	Knowledge, Attitudes, Behaviour, Practices
MoI	Ministry of Interior
MoH	Ministry of Health
MoJ	Ministry of Justice
MMT	Methadone Maintenance Treatment
MDR TB	Multi-drug resistant tuberculosis
MSM	Men having sex with men
NAP	National AIDS Programme
NCPI	(UNGASS) National Composite Policy Index
NGO	Non Governmental Organisation
NSP	Needle and Syringe Programme
NTP	National TB Programme
OST	Opioid Substitution Treatment
PEP	Post Exposition Prophylaxis
PI	Principal Investigator
PLWH	People living with HIV infection
PMTCT	Prevention of Mother to Child transmission (PMTCT)
PSI	Population Services International

SIDA	Swedish International Development Cooperation Agency
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
UNAIDS	Joint programme of the United Nations on HIV/AIDS
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
UNGASS	United Nations General Assembly Special Session on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

About this toolkit

This toolkit aims to provide information and guidance, primarily, to national governments.

It is written with low and middle-income countries in mind, but it will also be a useful resource for high-income countries. Its focus is on HIV, but it recognizes that other diseases linked to HIV, in particular hepatitis and tuberculosis, also represent serious problems in prisons.

The toolkit is divided into two sections. The first section provides a description of the characteristics of HIV in prisons, prisoners' unique requirements and principles of assessments. This section is aimed mainly at national government decision makers, prison administration and steering committee members. The second part provides the substantive 'tools' for a multidisciplinary approach to situation and needs assessments.

It is based on the requirements of international law and standards and ethics, scientific evidence and best practice experience. It complements a series of other documents produced by United Nations agencies and refers to them and to other documents, for additional information on HIV in prisons.

A note about terminology and scope

In some jurisdictions different terms are used to denote whether places of detention hold people who are awaiting trial, who have been convicted or who are subject to different conditions of security. Similarly, different words are being used for various groups of people who are detained.

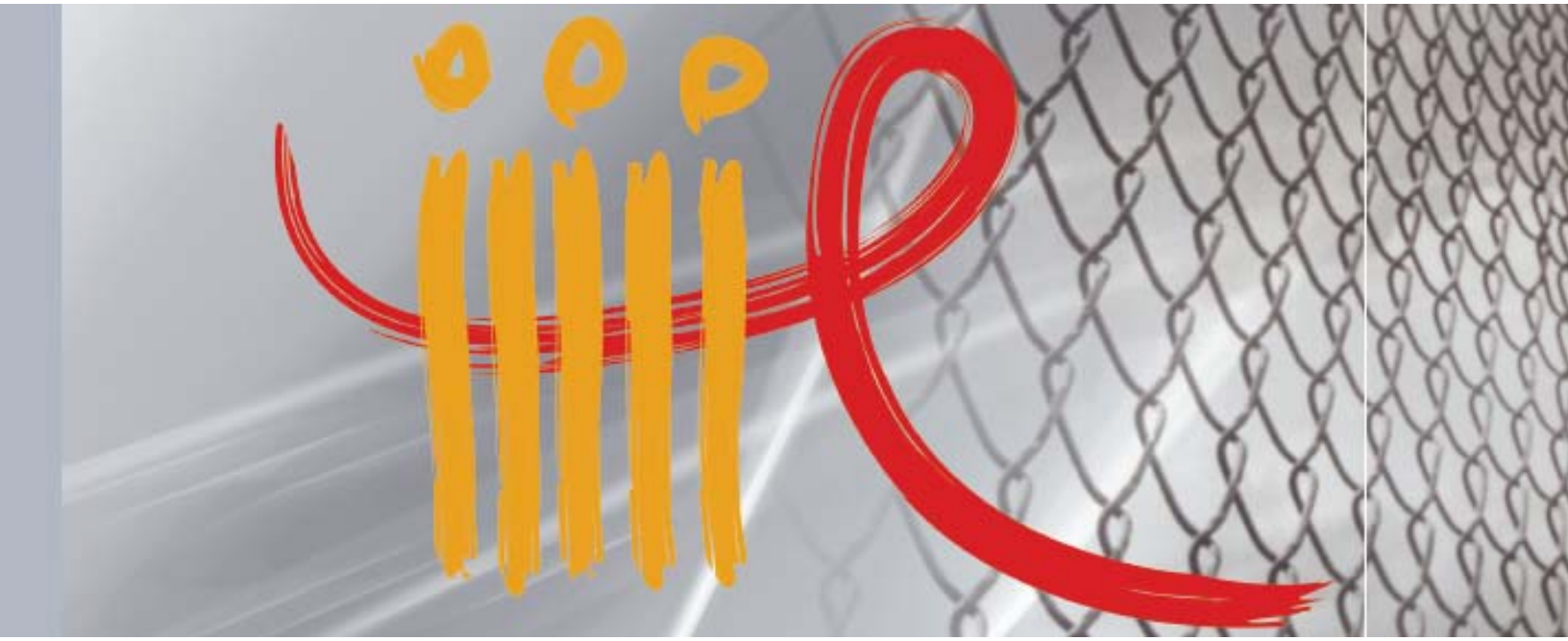
In this toolkit, the term **"prison"** has been used for all places of detention and the term "prisoner" has been used to describe all who are held in such places, including adult and juvenile males and females detained in criminal justice and correctional facilities during the investigation of a crime; while awaiting trial; after conviction and before sentencing; and after sentencing. Although the term does not formally cover persons detained for reasons relating to immigration or refugee status, those detained without charge, and those sentenced to compulsory treatment and rehabilitation centres as they exist in some countries, most of the considerations in this paper apply to them as well.

How does the toolkit relate to other United Nations Documents on HIV in prisons?

This toolkit is part of a set of documents produced by United Nations agencies aimed at providing up-to-date evidence-informed guidance on HIV in prisons. These include:

- **HIV/AIDS Prevention, Care, Treatment and Support in Prisons: A Framework for an Effective National Response.** This document provides a framework for mounting an effective national response to HIV in prisons, based on the evidence reviewed in the *Evidence for Action Technical Papers* and on accepted international standards and guidelines, and reflecting principles of good prison management. It sets out 11 principles and 100 actions. *Available at www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf*
- **HIV and AIDS in places of detention:** A training toolkit for policymakers, programme managers, prison officers and health care providers in prisons. This document provides information and guidance primarily to individuals and institutions with responsibilities for prisons and prisoners, and to people who work in and with prisons. In addition, it will assist everyone who has anything to do with prisons. *Available in English and Russian at http://www.unodc.org/unodc/en/hiv-aids/publications.html?ref=menuside*
- **HIV testing and counselling in prisons and other closed settings.** This policy brief provides guidelines for ensuring access to voluntary counselling and HIV testing for prisoners. *Available in English at http://www.unodc.org/unodc/en/hiv-aids/publications.html?ref=menuside*
- **Women and HIV in prisons.** This information note describes the HIV characteristics of women in prison and lists recommended responses. *Available in English, Spanish, Russian and Bahasa Indonesian at http://www.unodc.org/unodc/en/hiv-aids/publications.html?ref=menuside*
- **Policy Brief: Reduction of HIV Transmission in Prisons.** This document provides a two-page summary of the evidence related to HIV prevention programmes in prisons. *Available in English and Russian via www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html*
- **Evidence for Action Technical Papers on Effectiveness of Interventions to Address HIV in Prisons.** These papers provide a comprehensive review of the effectiveness of interventions to address HIV in prisons. They contain the most detailed and rigorous analysis of the evidence related to HIV in prisons undertaken to date, with hundreds of references. They comprise 'Dependence Treatments'; 'Needle and Syringe Programmes and Decontamination Strategies'; 'HIV Care, Treatment and Support' and 'Prevention of Sexual Transmission'. Available in English and Russian at *http://www. unodc.org/unodc/en/hiv-aids/publications.html?ref=menuside*
- **Policy guidelines for collaborative TB and HIV services for injecting and other drug users - an integrated approach** (pdf) . *Available at http://whqlibdoc.who.int/publications/2008/9789241596930_eng.pdf*
- **Guidelines for Control of Tuberculosis in Prisons.** This document provides general guiding principles for the implementation of the STOP TB Strategy in prisons to accelerate case detection and treatment targets and to cure and prevent the emergence of drug resistance. Available at http://www.tbcta.org//Uploaded_files/Zelf/GuidelineTBPrisons1252321251.pdf

Another document (HIV/AIDS and HCV in Prisons: A Select Annotated Bibliography) was prepared for the Third International Policy Dialogue on HIV/AIDS in Prisons, hosted by the Government of Canada and UNAIDS. It contains the references and short summaries of hundreds of documents dealing with issues related to HIV in prisons. It aims to increase knowledge of and access to the literature on issues related to HIV and HCV in prisons; and to increase the capacity of governments, prison systems, non-governmental organizations, and researchers to respond effectively to the challenges posed by HIV and HCV in prisons. It was updated in 2007 and is available in English and French.



I. Introduction

I. Introduction[1] [2] [3]

In 2000, Heads of State and Government representatives from 189 countries made an unprecedented commitment in the United Nations Millennium Declaration[4] to halt and reverse the HIV epidemic by 2015. At the 2005 World Summit[5] and at the 2006 UN High Level Meeting on AIDS, world leaders committed "to pursuing all necessary efforts … towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010".[6] Achieving this objective requires the inclusion of all sectors in these efforts, including prisons.

At the end of 2008 an estimated 33.4 million people were living with HIV and in that year, 2.7 million new HIV infections occurred throughout the world. This figure of new HIV infections was approximately 30% lower than at the epidemic's peak reported in 1996. Sub-Saharan Africa remains the hardest-hit region accounting for more than 67% of people living with HIV and with 70% of the new infections reported in 2008. While globally the epidemic is generally stable, in Eastern Europe and Asia epidemics continue to grow.[7]

At any given time there are over 10 million people[8] held in detention centres worldwide, and more than half are in pre-trial detention. Considering the high turnover in the prison population, over 30 million people are imprisoned annually.

The rates of HIV, TB and hepatitis C and B infections among prisoners in most countries are significantly higher than those in the general population. HIV/AIDS, hepatitis, tuberculosis (TB) and sexually-transmitted infections (STIs) are significant health threats to prisoners, prison staff and their families. Outbreaks of HIV infection have occurred in a number of prison systems, demonstrating how rapidly HIV can spread in prison unless effective action is taken to prevent transmission.

These diseases present significant challenges for prison and public health authorities and governments. Among prisoners, the burden of HIV infection, viral hepatitis, tuberculosis (TB) and sexually-transmitted infections (STIs) is high due to risk behaviours prior to and during incarceration. Risk behaviours can include sexual coercion, continuation and initiation of injecting drug use, unsafe medical practices, and in the case of tuberculosis, environmental factors include overcrowding and poor ventilation.

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1 United Nations Office on Drugs and Crime, Vienna. *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings A Framework for an Effective National Response*. Co published with the World Health Organisation and the Joint United nations Programme on SIDS. http://www.unodc.org/documents/hiv-aids/HIV-AIDS_prisons_Oct06.pdf. accessed 28 may 2009

2 Wilson D, Halperin DT. "Know your epidemic, know your response": a useful approach, if we get it right. *The Lancet*, Volume 372, Issue 9637, Pages 423 - 426, 9 August 2008.

3 Halperin DT, Potts M. Public Health: Reassessing HIV Prevention. *Science* 9 May 2008: Vol. 320. no. 5877, pp. 749 – 750.

4 United Nations. 2000. United Nations Millienium Declaration, Resolution 55/2. 8 September 2000. http://www.un.org/millennium/declaration/ares552e.htm, accessed 22 June 2010

5 United Nations. 2005. World Summit Outcome. Resolution 60/1. 16 September 2005. http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement, accessed 22 June 2010

6 United Nations. Political Declaration on HIV/AIDS; UN Resolution 60/62, 25 June 2006 http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf, accessed 22 June 2010

7 UNAIDS. *2008 Global Report*. http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp, accessed 22 June 2010

8 King's College. 2008. *World Prison Population List* (seventh edition). http://www.kcl.ac.uk/depsta/law/research/icps/downloads/world-prison-pop-seventh.pdf, accessed 22 June 2010.

The high degree of mobility between prison and community means that communicable diseases and related illnesses transmitted or exacerbated in prison do not remain there. When people living with HIV are released from incarceration and return to their sexual and/or needle-sharing partners in the community, their partners face increased risk of HIV infection and may not be aware that they are at risk.

Despite this situation, HIV and other infectious diseases prevention, treatment and care services are rarely adequate or are not provided at all in prison settings. In many countries, and in particular in Africa, available data on HIV prevalence have been collected erratically, mostly through studies conducted in individual prisons and often only among prisoners who have been diagnosed with HIV or AIDS. Existing data are not recent or accurate enough to provide a reliable picture of the current situation.[9]

A. Scope and Purpose

This toolkit is intended to guide national and regional or provincial governments to conduct situational and needs assessments for the design and implementation of effective HIV intervention programmes - tailored to the risk behaviours and HIV seroprevalence among prisoners and staff. Furthermore, this toolkit provides technical assistance for researchers to carry out assessments. It is designed to enhance health promotion and harm prevention programmes for prisoners and prison staff, their families and their social networks.

It is specific to HIV and TB related HIV, but it has relevance to other communicable diseases, such as viral hepatitis and STIs. It is a guide to review all factors which contribute to HIV risk in prisons, including the prevalence of HIV infection and behavioural risk factors for transmission of HIV among prisoners; access to health care; the availability of HIV programmes; and HIV-related policies. It is not designed as a research instrument and results of each assessment cannot be generalised to other countries. The toolkit provides guidance on using multiple sources and multiple methods to collect data to provide a profile of needs and opportunities for prison systems.

It should be noted that the assessment process described below is not a conditio sine qua non for the implementation of evidence-based intervention strategies in prison systems relevant to HIV, but it will assist prison authorities in tailoring their policies, strategies and interventions according to their specific needs. Timely action must be initiated or continue to be provided (as applicable). Action, newly initiated or continuing, can be enhanced if situation and needs assessments are carried out. They will serve to complement existing information, engage and inform relevant stakeholders and help tailor necessary interventions to local circumstances. Undertaking a situation and needs assessment, however, should never delay implementation of needed programmes, but rather, it should be a tool to accelerate implementation.

Policy briefs and technical papers on effective and evidence-based HIV and AIDS strategies have been published by the World Health Organisation[10] and the United Nations Office on Drugs and Crime.[11] A compendium of companion resources is attached at Annex 1.

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[9] UNODC. *HIV and prisons in sub-Saharan Africa: Opportunities for Action, page 1*. http://www.unodc.org/documents/hiv-aids/publications/UNODC_UNAIDS_WB_2007_HIV_and_prisons_in_Africa-EN.pdf, accessed 22 June 2010

[10] WHO *Evidence for Action series*, http://www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html, accessed 21 March 2009

[11] UNODC. *HIV/AIDS in places of detention: a toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*, http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf, accessed 21 March 2009

B. Audience

This toolkit is primarily targeted to national governments to enable them to lead and direct situation and needs assessments for the development and implementation of comprehensive prevention and treatment of HIV infection and TB programmes in prisons.[12] It is designed for use by governmental bodies, Civil Society Organisations (CSOs) and other groups which wish to plan an assessment of the prevalence, related risk-behaviours, environmental factors and the dynamics of communicable diseases, in particular, HIV infections, in prisons.

C. Characteristics of Prisons

It is estimated that there is over ten million people held in prisons at any given time. But, annually, considering the high turnover in the prison population, over 30 million people are imprisoned. Prison populations have particular characteristics relative to HIV, TB, viral hepatitis, and STIs: [13, 14]

- The rates of HIV infection in prisons are significantly higher than those in the general population;
- The groups most vulnerable to HIV are those at increased risk for incarceration. Many of the same social and economic conditions and human rights violations which increase vulnerability to HIV also increase susceptibility to imprisonment. As a result, the populations with the highest rates of HIV infection are also disproportionately represented within prisons. For example, in countries where the prevalence of injecting drug use is high in the community, the prevalence of injecting drug users in prisons will be high. While more prisoners contract their infections before detention, the risks of being infected in prisons remains important;
- HIV can be transmitted in prisons through unsafe sexual activities (including men having sex with men), rape, unsafe medical practices, unsafe tattooing, blood sharing rituals, sharing of injection equipment and other sharp instruments; and from mother to child;
- Prison conditions in many countries do not meet the minimum requirements set out in the UN Standard and Minimum Rules for the Treatment of Prisoners, as well as other international and regional standards and norms. Lack of adequate space, drinking water and nutrition, poor sanitation, lack of natural light and fresh air are characteristic features of many prisons worldwide. Many of these factors increase both the chances of someone being infected with HIV and TB;
- Prevalence rate of tuberculosis in prisons are also always higher than in the general population. As mentioned above, the poor living condition play a major role in the risk for transmissions and this situation places prisoners living with HIV at particular risk. Co-infection with HIV and TB requires special attention,

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[12] In countries where federal constitutions apply and criminal justice authority resides with state/territory/ province/regional governments, significant involvement of these governments is required, however leadership, in line with national and international HIV/AIDS responsibilites, for example, the Three Ones, should come from the *National* Governments. http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes/default.asp, accessed 29 June 2010

[13] WHO. *Health in prisons. A WHO guide to the essentials in prison health*. 2007. http://www.euro.who.int/document/e90174.pdf ,accessed 13 March 2009

[14] WHO Regional Office for Europe (2003). *Declaration on Prison Health as a Part of Public Health*. Copenhagen, WHO Regional Office for Europe 2003. (http://www.euro.who.int/Document/HIPP/moscow_declaration_eng04.pdf), accessed 13 March 2009

especially with the increasing prevalence of multi-drug resistant (MDR-TB) and extensively drug resistant (XDR-TB) strains of tuberculosis;

- Health services in prison settings, where they exist, are generally substandard and under-funded, characterised by shortage of staff and of essential medications. Often health care in prison settings works in complete isolation from the general health care system, hampering the quality of health care and continuum of care following release;

- Effective policies to prevent HIV and hepatitis infections inside prisons are often hampered by the denial of the existence of the factors that contribute to their spread such as the illicit drugs availability, sexual activities, the lack of protection for the youngest, female and weakest prisoners, corruption and poor prison management;

- Prison staff are also at risk of HIV and hepatitis infection through blood and body fluid exposure, for example accidental puncture with contaminated tools;

- Inside prisons, drug users and people living with HIV are often stigmatised population. Stigma for drug users and fear of AIDS often places affected prisoners at increased risk of social isolation, violence, and human rights violations from both prisoners and prison staff.

- The legal framework often also hampers the delivery of HIV preventive services, such as condoms or harm reduction;

- The lack of HIV and TB prevention programmes jeopardises not solely the health of prisoners and prison staff, but also the health of the wider community.

D. Principles and Standards

Situation and needs assessments and targeted interventions must meet human rights principles and minimum rules for prisoners.[15] These include impartiality, non-discrimination and respect for religious beliefs and moral precepts. In the area of health, standards are mandated for education, nutrition, sanitation and timely access to appropriate medical services. The latter includes the prevention of transmission of communicable diseases. Health interventions must be evidence-informed, in line with international and national guidelines.

This toolkit is based on UNODC and WHO-published standards and guidelines,[16,17,18,19] which, among other things, recommend that services be based upon the assessed needs of prisoners. Preventive interventions should be based on the specific risk behaviours in individual prisons, most notably needle-sharing among people

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15 *Standard Minimum Rules for the Treatment of Prisoners*. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. http://www2.ohchr.org/english/law/treatmentprisoners.htm, accessed March 12, 2009.

16 WHO *Guidelines on HIV infection and AIDS in prisons* http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf, accessed February 9, 2009

17 UNODC. *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response. Op. cit.*

18 UNODC. *HIV/AIDS in places of detention: A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*, op. cit.

19 Tuberculosis Coalition for Technical Assistance and International Committee of the Red Cross. *Guidelines for Control of Tuberculosis in Prisons*. January 2009, op.cit.

who inject drugs and unprotected sexual intercourse. Information and education provided to prisoners should aim for realistically achievable changes in attitudes and risk behaviours while incarcerated and after release. A key element of prevention and treatment processes is consultation with prisoners, allowing them to take responsibility for planning their treatment and care.[20]

The general principles for HIV/AIDS prevention and care in prisons comprise:

- **Good prison health is good public health**

  Reducing the transmission of HIV in prisons is an important element in reducing the spread of infection in society outside of prisons.

- **Good prisoner health is good custodial management**

  Protecting and promoting the health of prisoners benefits not only the prisoners, but also increases workplace health and safety for prison staff.

- **Respect for human rights and international law**

  States have an obligation to develop and implement prison legislation, policies, and programmes consistent with international human rights norms.

- **Adherence to international standards and health guidelines**

  The standards and norms outlined in established international human rights instruments and public health guidelines should guide the development of responses to HIV/AIDS in prisons.

- **Equivalence in prison health care**

  Prisoners are entitled, without discrimination, to a standard of health care equivalent to that available in the outside community, including preventive measures.

- **Holistic approach to health**

  HIV/AIDS is only one of many complex – and often related – health care challenges facing prison officials and prisoners. Therefore, efforts to reduce the transmission of HIV in prisons, and to care for those living with HIV, must be holistic and integrated with broader measures to tackle inadequacies in general prison conditions and health care.

- **Evidence-based intervention**

  The development of prison policy, legislation, and programmes should be based upon empirical evidence of their effectiveness at reducing the risks of HIV transmission, and improving the health of prisoners.

[20] WHO *Guidelines on HIV infection and AIDS in prisons*, op. cit., General principle 5

- **Addressing vulnerability, stigma and discrimination**

  HIV programmes and services must be responsive to the unique needs of vulnerable or minority populations within the prison system, as well as combat related stigma and discrimination.

- **Collaborative, inclusive and intersectoral cooperation and action**

  While prison authorities have a central role in implementing effective measures and strategies to address HIV and AIDS, this task also requires cooperation and collaborative action that integrates the mandates and responsibilities of various local, national, and international stakeholders.

- **Monitoring and quality control**

  Regular reviews and quality control assessments, including independent monitoring of prison conditions and prison health services, should be encouraged as an integral component of efforts to prevent the transmission of HIV, hepatitis and TB in prisons and to provide care for prisoners living with HIV/AIDS.

- **Reducing prison populations**

  Overcrowded prison conditions are detrimental to efforts to improve prison living standards and prison health care services, and to preventing the spread of HIV infection among prisoners. Therefore, action to reduce prison populations and prison overcrowding should accompany, and be seen as an integral component of a comprehensive prison HIV/TB strategy.

- **HIV and TB services should be available to all prisoners and staff.** These include:

  - Targeted information, education and communication (IEC)
  - Voluntary Counselling and Testing (VCT)
  - Drug dependence treatment including opioid substitution therapy (OST)
  - Condom Programming
  - Needle and syringe programmes (NSP)
  - Anti-retroviral treatment (ART)
  - Sexually transmitted infections (STIs) prevention and treatment
  - Prevention of mother to child transmission
  - Hepatitis diagnosis, treatment (A,B,C) and vaccination (A,B)
  - Tuberculosis (TB) prevention, diagnosis and treatment
  - Universal precautions

  Because of their unique health care needs, special attention should be paid to women's health issues, among other things, the prevention of the transmission of HIV to the child of pregnant and nursing mothers, and specialised reproductive health care.[21] Similarly access to comprehensive TB prevention,

[21] UNAIDS. *Women and HIV in Prisons*. http://www.unodc.org/documents/hivaids/Women%20and%20HIV%20in%20prison%20settings.pdf. Accessed 3 April 2010

diagnosis and treatment services should be guaranteed for prisoners and staff regardless of HIV status. The greatly increased risk of TB for HIV infected prisoners should be recognized and responded to.

Post-exposure prophylaxis should be widely available for prisoners and staff who have high-risk blood or sexual exposures. TB infection control measures should be implemented to protect staff and prisoners alike.

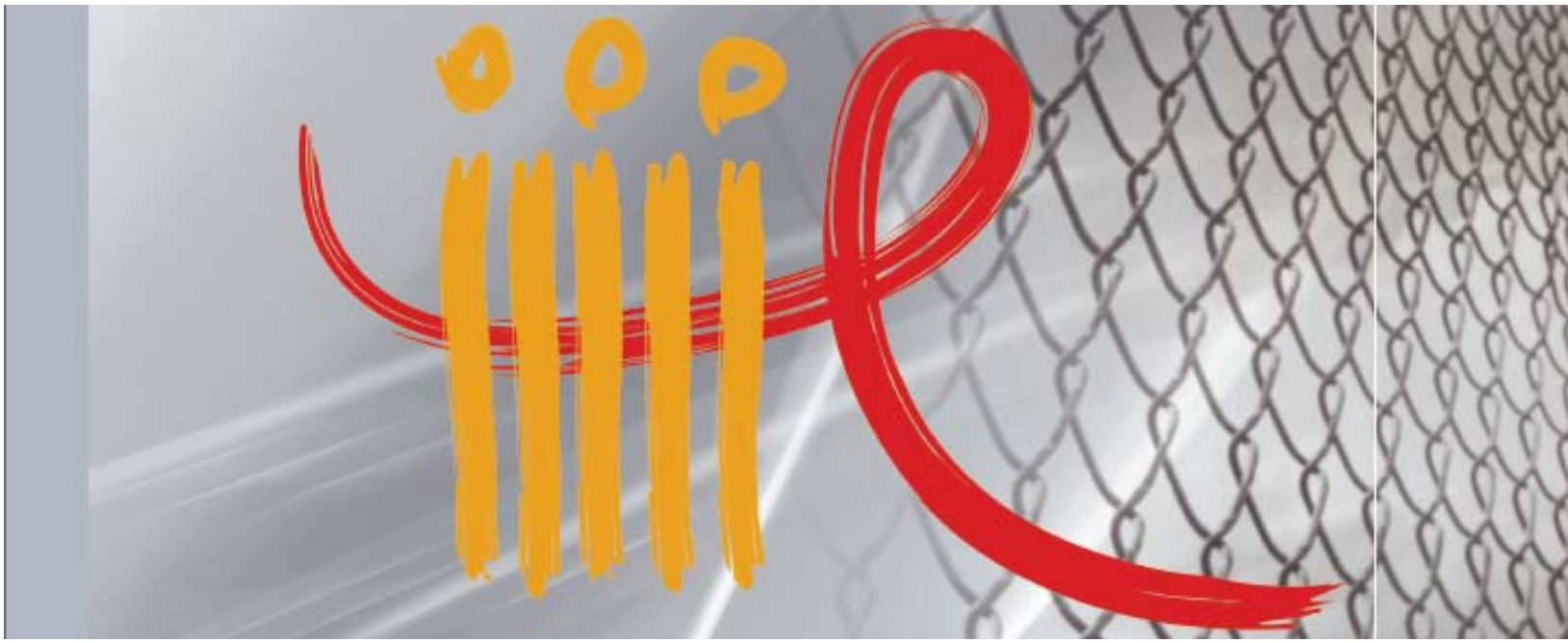
Concerning situation and needs assessments conducted in prisons, the over-riding principles are: voluntary participation; informed consent; anonymity and confidentiality of the information collected. Each participant in a situation and needs assessment should be assured that population-based test results will be unlinked to any individual identifier.

What is a situation and needs assessment?

As the name suggests, there are two components: a situation assessment and a needs assessment, conducted sequentially, but with a concurrent purpose.

A situation assessment measures the status quo, while a needs assessment identifies gaps between the status quo and an accepted standard or pre-existing goal. The concurrent purpose is to design, resource, implement and monitor and evaluate interventions to bridge the identified gaps.

As it applies to HIV/AIDS, the pre-existing goal might be, for example, consistency with the National AIDS Action Plan.



II. A multidisciplinary approach to a stepwise situation and needs assessment

II. A multidisciplinary approach to a stepwise situation and needs assessment [22]

A. Goal and Objectives

The goal of the situation and needs assessment is to complement existing information in the country (or state or province) with regard to HIV and other communicable diseases. The gathering of additional information will allow national governments to set more specific targets for achieving universal access for prisoners to comprehensive and evidence-based HIV prevention, treatment, care and support interventions.

The specific objectives of the stepwise approach are to:

- Assess the HIV prevalence (and the prevalence of TB, hepatitis B and hepatitis C, and STIs, where possible) in the prison population generally, and in sub-groups such as women, people who use drugs, remand and convicted prisoners, and unauthorised immigrants (refer to steps 4 and 7);
- Identify specific risk factors which may be associated with the transmission of bloodborne pathogens and airborne infections, including TB, among prisoners, visitors, and staff (refer to steps 4,5,6 and 7);
- Assess the level of knowledge, attitudes, behaviours and practices (KABP) on HIV/TB/hepatitis/ STIs in all target groups within the prison, including prison staff (refer to step 7);
- Determine the availability of and quality of health services, prison conditions, associated infrastructure and national policies and legal framework to identify feasible and appropriate opportunities for improvement (refer to steps 4 and 5);
- Strengthen the information and training for prisoners and prison staff (refer to step 10); and
- Provide a baseline for ongoing monitoring and evaluation of the resulting intervention programmes.

B. General Parameters

Effective intervention programmes operate through a realistic assessment of current needs, which should be tracked over time as conditions evolve.

A needs assessment should:

- Describe needs and available resources;
- Document lessons learned;
- Be feasible, timely, acceptable and applicable;

[22] Centers for Disease Control and Prevention and Health Resources and Services Administration. *Integrated Guidelines for Developing Epidemiologic Profiles:* HIV Prevention and Ryan White CARE Act Community Planning. 2004. http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/, accessed 2 April 2010

- Have limited costs and use of resources;
- Be accurate enough to provide decision-makers with information to take appropriate actions;
- Have a dynamic plan of action which can be revised on an as-needed basis;
- Use multiple sources of information and methods to help ensure validity and reliability; and
- Be sustainable and able to be monitored.

C. Establish a National Steering Committee

The main voices for a joint undertaking should be the Health and Justice/Interior Ministries, with substantial input from the National AIDS Coordinating authority and the National TB Programme. Leadership and direction should come from the responsible national[23] party; for example, the National Minister of Justice/Interior or the National Minister of Health. It is important to explain to decision-makers (most importantly the Ministry or Ministries responsible for places of detention, the Ministry of Health and the National AIDS coordinating body) why a situation and needs assessment should be undertaken; how it should be initiated; and how its findings should guide future action.

Involving other stakeholders is critical to the success of situation and needs assessments. These stakeholders include representatives from the prison staff (wardens, custodial staff, health service members, and treatment and prevention delivery staff), prison governors and management boards, as well as from the prisoners themselves. These stakeholders might differ depending on the individual country.

Potential Members of a National Steering Committee

- Ministries of Justice, Interior, Health;[a]
- Mental Health Secretariat;[a]
- Prison Authorities ;
- National HIV and TB Control Programmes;
- National Drug Control Authorities;
- National Central Statistics Office;
- Relevant civil society organisations, for example, former prisoner associations, NGOs dealing with the highest risk populations such as injecting drug users, sex workers, unauthorised immigrants, faith-based organisations implementing HIV/AIDS programmes in prisons, and persons living with HIV);
- Prison management;
- Staff associations/Unions;
- Former and current prisoners ;
- Judiciary;
- National Bar Association;
- Human rights organizations;
- Technical assistance partners, e.g. United Nations bodies; and
- Principal investigator as adviser.

Notes: a. In countries with federal constitutions, state/provincial/regional counterparts as well.

[23] The Three Ones obligations of national governments comprise: One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad-based multisectoral mandate; and One agreed country-level Monitoring and Evaluation System.

Accordingly, the very first activity, prior to conducting a situation and needs assessment, should be the establishment of a National Steering Committee, defining its role, tasks and responsibilities.

The role of the National Steering Committee is to guide and monitor the design and implementation of a situation and needs assessment for HIV which will guide policy and programming on HIV prevention, treatment, care and support, in consideration of related conditions such as TB, viral hepatitis, and STIs.

The involvement of a National Steering Committee will facilitate the implementation of programme interventions because of the strong interest among the key institutions and partners. To the extent possible, consensus among members of the Steering Committee should be obtained.

The primary tasks of the National Steering Committee are to:

- Select an independent Principal Investigator OR Identify the most capable national institutions for designing and conducting the assessment process (if the assessment team has not yet been nominated);
- Facilitate the work of the Principal Investigator with advice and guidance, source funding, and provide access to prisons;
- Identify and engage an appropriate ethics committee;
- Prioritise recommendations derived from the needs assessment and disseminate the recommendations strategically, to provide maximum support for implementation of the recommendations;
- Provide overall policy direction of the assessment and ensure advocacy;
- Discuss the draft of the assessment protocol and the methodological agreement, before submitting it to the Ethics Committee for approval;
- Agree on a budget, allocate assessment funding and ensure fiscal accountability ;
- Select the prisons to be covered by the assessment to ensure representativeness of the country's prison population;
- Determine data collection needs; and
- Plan and coordinate national and regional activities.

D. Ethical considerations

All assessments and research involving human participants must be conducted in an ethical manner which respects the dignity, safety and rights of participants, and recognises the safety, security and responsibilities of assessment team members.[24]

The guiding ethical consideration in serological and behavioural situation and needs assessments is to ensure that the basic human rights of individuals are not violated in the course of the assessment. Respondents need to know the objectives of the assessment; how the assessment will be carried out; any possible risks of participation; the benefits of participation to themselves, the community and science; and how confidentiality will be maintained. Moreover, participation in the assessment should be completely voluntary, without coercion. Each assessment team member must acknowledge the participant's right to give or withhold consent at any stage of the assessment. It is important to note that throughout the assessment, investigators should not raise false expectations. A signed informed consent form is recommended for all participants of the KABP survey and focus groups. Templates of informed consent forms for survey and focus group participants are attached at Annex 2 and 3.

Anonymity and confidentiality are crucial during the assessment. Moreover, arrangements should be made to ensure that respondents are not endangered in any way by disclosure of information. In addition to the safety of the respondents, field worker safety should also be taken into account, considering the particular setting. All members of the assessment team should sign a confidentiality agreement. A template of a confidentiality agreement for assessment team members is attached at Annex 4.

To respect the anonymity of the serological and behavioural surveys, test results will not be provided to individual participants who might be interested in their results. If participating prisoners want to know their HIV/TB/HBV/HBC serological status, they should be offered an independent and nominative (non-anonymous) test. A voluntary testing and counselling programme can be linked to the assessment activities in participating prisons. Principal Investigators should consider integrating VCT activity into their assessment protocol.

Further details on ethical considerations are provided in the UNODC Global Assessment of Drug Abuse (GAP) Toolkit, Module 7, Ethical challenges in drug epidemiology: issues, principles and guidelines.[25]

E. Step by Step Assessment

As the goal of the assessment is similar in all countries, the general principles, guidelines and core indicators for an assessment should also be similar. However, country-specific applications of the assessment methodology can be tailored to the unique conditions in each country.

[24] See for example, WHO http://www.who.int/rpc/research_ethics/en/, accessed January 26, 2009.

[25] UNODC, http://www.unodc.org/documents/GAP/GAP%20toolkit%20module%207%20ENGLISH%2003-89740_ebook.pdf accessed 13 March 2009

The Ten Steps

Step 1: **Select a qualified team**

Step 2: **Develop a protocol, budget and workplan**

Step 3: **Obtain ethics committee approval**

Step 4: **Train an assessment team and collect and analyse available information (secondary data)**

Step 5: **Collect and analyse the national framework and prison conditions (primary and secondary data)**

Step 6: **Interview staff and prisoners (primary qualitative data)**

Step 7: **Survey prison risk behaviour and ascertain HIV seroprevalence and other related communicable diseases (primary quantitative data)**

Step 8: **Analyse and interpret data**

Step 9: **Prepare a final report**

Step 10: **Focus interventions**

Step 1: Select a qualified team

For the success of the assessment, it is essential for the Principal Investigator and the entire assessment team to be independent of the involved ministries, prison administrations and medical and social services. This can be achieved through an open and transparent selection process by a sub-committee which includes representation from independent organisations with prisoner advocacy interests. The Principal Investigator should be well-qualified with assessment skills.[26]

Assessment team members should be recruited by the Principal Investigator based on their capacity to understand the project and HIV-related issues, and to work well as team members.

[26] For example:

- An advanced degree in public health, medical or social sciences and a proven track record in HIV/AIDS programming and behavioural research
- Experience and/or knowledge of current best practice in the area of HIV in prisons
- Skills in qualitative and quantitative data collection and analysis
- Excellent facilitation, communication and report writing skills
- Prior experience working in prisons settings not required, but may be helpful
- Completed training in medical ethics

Team members will also have to have special skills tailored to their individual tasks, for example:

- Ability to do field work;
- Interviewing skills;
- Data recording and management skills;
- Ability to communicate in a relevant local language;
- Non-judgmental attitudes; and
- All involved personnel are pledged to maintain strict confidentiality regarding any information they may acquire.

Step 2: Development of a protocol, budget and workplan

The Principal Investigator will develop a comprehensive draft protocol for the assessment. Ethics committees will require a protocol in order to assess the merits and desirability of granting authority to proceed.[27] When completing the draft protocol the Principal Investigator should consult the World Health Organisation[28] ethical standards and procedures for research with human beings and the "International Ethical Guidelines for Epidemiological Studies.[29] In addition, national guidelines for ethical research must be met. Once the draft protocol is approved by the National Steering Committee, it should be submitted to the ethics committee for consideration and approval. It is important to recognize that this process might take a significant amount of time and therefore taken into account when developing a work plan. (See step 3).

In addition, a comprehensive budget and costed work plan should be developed by the Principal Investigator to track implementation and resource needs and availability. The budget will include the cost of each of the ten steps of the study process. It will also include items such as personnel time, procurement of materials, cost of sample analysis, transport and any other resources necessary to conduct assessment. The budget should also reflect all in-kind contribution such as cost of rapid tests provided by Ministry of Health, human resources provided by other partners (e.g.. drivers, nurses, etc) and transport for the team, etc. A template for an assessment cost plan is attached at Annex 5.

Step 3: Obtain ethics committee approval

Prior to initiating the assessment, an authorisation to proceed should be obtained from a national research ethics committee. Most countries have ethics committees at national and local levels. In addition, national guidelines for ethical research must be met. If there is no national ethics committee, the National Steering Committee and the Principal Investigator should consider using an established committee at a local teaching hospital or University. If these resources are not available, the Steering Committee should consider an international organization, such as WHO, or develop an independent body to serve as an ethics committee. If the latter is chosen, the committee should comprise lay and scientific members with backgrounds in research and protection of human subjects.

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[27] See for example, WHO, *Recommended format for a research Protocol*, http://www.who.int/rpc/research_ethics/format_rp/en/index.html, accessed 29 June 2010

[28] WHO, http://www.who.int/ethics/research/en/index.html, accessed 13 March 2009

[29] CIOMS, http://www.cioms.ch/080221feb_2008.pdf, accessed 13 March 2009

The composition of the committee should be equally balanced by gender and race (as it would apply locally) and have at least one member who would represent prisoners' interests. Guidance on how to establish independent, multidisciplinary and pluralist ethics committees at national, regional, local or institutional levels is provided by the Assisting Bioethics Committees (ABC).[30]

The decision of the ethics committee should not be a "rubber stamp," but rather, a serious consideration of the methodology, and to ensure confidentiality, anonymity and protection from harm.

Step 4: Train an assessment team and collect and analyse available information (secondary data)

Prior to the beginning of any data collection, all assessment team members should be trained by the Principal Investigator. This training should include an overview of the assessment and its objectives; techniques of interviewing; field procedures; a detailed description of all the sections of the questionnaires and the other data collection instruments; standard operating procedures regarding the removal and handling of biological specimens; and confidentiality agreements. If applicable, the trainees might be divided according to the local languages spoken to practice interviewing using the questionnaire in their local languages.

This fourth step of the assessment is designed to determine what information is available from secondary sources and to determine the validity and reliability of those sources. The gaps which are identified become the targets for the primary data collection, described below in Step 5.

In all countries, useful information related to HIV and other communicable diseases in prisons will already exist. It is crucial to collect and synthesize existing data before undertaking further steps of the assessment. The assessment should start with a review of existing studies and data sources in the country; a desk analysis of risk behaviours based on available information; mapping where the risks are and the population at risk; and formative qualitative work to identify opportunities, barriers, and appropriate approaches to promote behaviour change. An analysis of the information is an essential step in the process as it will orient all future steps of data collection. The information is important to collate and analyse in depth. Secondary (existing) data are available in many forms, including reported statistics and documents routinely collected. In particular, country progress reports towards achievement of UNGASS goals might be the first sources to be consulted.[31]

UNGASS country reports contain 25 Core Indicators which address four key areas of the HIV response: National Commitment and Action (2); National Programme (9); Knowledge and Behaviour (10); and Impact (4). They provide an overview of the HIV situation for the general community and among most-at-risk populations (injecting drug users, sex workers and men who have sex with men), groups over-represented in prison settings. However, none specifically address prison populations.

A National Composite Policy Index (NCPI) is appended to the core indicator results. The NCPI includes twelve specific prison population indicators across strategic planning, prevention activities and human rights approaches. Three additional sections cover civil society involvement (including prison organisations), prevention programmes (including for prisoners and prison staff), and treatment care and support programmes

[30] UNESCO, http://portal.unesco.org/shs/en/ev.php-URL_ID=11280&URL_DO=DO_TOPIC&URL_SECTION=201.html, accessed 13.March 2009

[31] UNAIDS, 2010. Guidelines on construction of core indicators: 2010 reporting. http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090331_UNGASS2010.asp, accessed 29 June 2010

(including for prisoners and prison staff). An abbreviated list of prisoner and prison staff NCPI indicators is attached at Annex 6.

In addition to UNGASS progress reports a non-exhaustive list of other potential secondary data sources would include:

- Policy documents regarding drug use, HIV/AIDS and TB prevention and treatment;
- Ministry of Justice or Ministry of Interior reports;
- Penal system reports;
- National human rights reports;
- Reports by prison inspection bodies (national or international);
- Civil Society Organisation reports;
- Arrest data on sex workers and people using drugs;
- Records of training and qualifications of staff;
- Data/information/records from the medical departments of prisons (e.g. urine test records, HIV, HBV, HCV, and TB screening and/or surveillance data, treatment records);
- National reports and strategies on HIV, TB, viral hepatitis, STIs and risk behaviour in the general population; and
- National guidelines for prevention and treatment of HIV, TB, viral hepatitis, and STIs.

The Principal Investigator should understand the limitations of applying secondary data sources (particularly data which only address the population as a whole) to an individual prison.

Analysis of the available information builds the foundation for the next steps of the assessment. When focussing on actual prison conditions, all information should be triangulated with, in particular, the data obtained in later steps of the assessment. All secondary data should be cross-validated and cross-checked, using different sources, to assess whether national policies, regulations, recommendations and guidelines are actually followed and implemented at the prison level.

Step 5: Collect and analyse the national framework and prison conditions and prison HIV and TB programme (primary and secondary data)

Data collection and analysis of the national framework and prison conditions is important for the development of individualised national (or regional) programme interventions. This customisation helps ensure that appropriate behaviours are targeted.

Data collection components

- Desk analysis (mainly national legal and policy framework, and incidence/prevalence reports);
- Key informant interviews and focus group discussions (providing insight on prison realities - living conditions, food/nutrition, hygienic conditions, sanitation, access to care and risk behaviours, such as violence and drug use in prisons); and
- Prison inspections, including interviews with key prison staff and prisoners (all aspects listed on the checklist, including the information gathered by desk top analysis).

Each element of the data collection should be related to the purpose of the situation and needs assessment, keeping its objectives in mind. The data should be collected to identify gaps for the purpose of designing and implementing appropriate evidence-based interventions to improve the prevention, treatment, care and support for HIV infection, TB, viral hepatitis, and STIs.

In developing an action plan aimed to control communicable diseases in prisons, it is crucial to understand not only the national framework, but also the demographics and conditions in the respective regions and in the prisons being studied. The assessment team should precede the analysis process with an assessment of key variables of the prison conditions and an assessment of the designs of available intervention programmes. Accurate baseline data is an essential prerequisite for policy formulation and designing effective intervention strategies. Some elements of the UNODC Criminal Justice Assessment toolkit[32] can be used in guiding this analysis. A checklist for an analysis of the national framework and the prison conditions at national and regional levels is attached at Annex 7

In many countries, there is little, if any, information available about many of the issues related to the broader prison conditions which have an impact on the capacity to respond to HIV, TB, hepatitis and STIs in prisons. Therefore, it is essential to gather information from a variety of sources, to clearly specify those sources and to identify gaps in information. Hence, a multi-method approach is essential. For each indicator, determine the respective methodology used for the data collection, describe the geographical coverage of information provided, and if possible, comment on the reliability of reported data and conclusions.

Data and information gathered through secondary sources need to be cross-validated and cross-checked from several sources. The assessment team should validate whether national policies, regulations, recommendations and guidelines are actually followed and implemented at prison levels. It should collect information on the actual living conditions and health services and their respective determinants. Prison setting conditions may vary substantially across a country (or region). When describing prison conditions, local peculiarities and strong distinctions between conditions for specific subgroups, for example, women, IDUs, PLWH and TB patients, should be highlighted.

[32] UNODC. 2006. *Custodial and non-custodial measures: The Prison System*,. http://www.unodc.org/unodc/en/justice-and-prison-reform/Criminal-Justice-Toolkit.html, accessed 13 March 2009

General considerations for reviewing data and data sources which may be used for the interpretation of findings

- *Completeness of the data*: How well does the number of reported HIV or AIDS cases reflect the true number of persons who have HIV infection or AIDS and are thus eligible to be reported?
- *Representativeness of the data*: How well do the characteristics from a data source correspond to the characteristics of the prison population for the nation?
- *Age of the data:* Is the data sufficiently up-to-date for current prevention activities?
- *Limitations of the data source or variable of interest*: Does the data sources or variables have any considerable limitations?

Based on the important association of TB and HIV, particularly in prisons, it is recommended to include a detailed assessment of the TB situation in every HIV situation and needs assessment. The WHO status paper on prisons and tuberculosis provides an overview of elements of a sound TB control programme which need to be assessed.[33] The WHO guidelines for NTP managers also provide a list of indicators in the framework of an evaluation check list for "Quality Criteria for Tuberculosis Control Programmes".[34] A template for the assessment of TB and TB control in prisons, adapted with permission from the international Guidelines on Tuberculosis Control in Prisons[35] is attached at Annex 8. Refer also to 'TB considerations', Step 7c below.

Assessing the levels of HIV stigma and discrimination centres on four domains: fear of casual transmission and refusal of contact with PLWH; values, shame, blame and judgement; enacted stigma; and disclosure.[36] Indicators are measured at community and provider (institution) level. As they relate to prisons, the community of reference is fellow prisoners and the provider is all levels of the criminal justice system, but most importantly, prison management and prison service providers (e.g. health). In brief, the indicators measure attitudes and practices. For the purposes of the recommended situational and needs assessment, the indicators are spread across all elements of the project, rather than contained in a dedicated instrument. A checklist of core indicators, extracted from the elements, is attached at Annex 9.

Step 6: Interview staff and prisoners (primary qualitative data)

Following the secondary data collection and assessment, as an intermediate step between the desk- analysis and the implementation of a prison survey, it may be important to undertake some additional qualitative interviews with prison staff, prisoners and/or conduct focus group discussions to further validate the information

[33] WHO, Status Paper on Prisons and Tuberculosis 2007. http://www.euro.who.int/document/e89906.pdf, accessed 25 March 2009

[34] WHO. Tuberculosis control in prisons 2001. http://www.who.int/tb/publications/prisons_tb_control_manual/en/index.html, accessed 21 March 2009

[35] Coalition Against TB and International Committee of Red Cross TBCTA and ICRC, Guidelines for Control of Tuberculosis in Prisons, op.cit.

[36] USAID, 2007. Can we measure HIV/AIDS-RELATED Stigma and Discrimination? Current Knowledge about Quantifying Stigma in Developing Countries; http://www.policyproject.com/pubs/generalreport/Measure%20HIV%20Stigma.pdf; accessed 30 June 2010

gathered thus far. Depending on the size of the target population and the type and nature of the information sought, the data collection might rely on a purposive sampling of this population. Inside the prison, stakeholders to interview would include the prison staff (wardens, custodial staff, health service members, and treatment and prevention delivery staff), the prison governor and management board, as well as the prisoners themselves.

For qualitative data collection, the two main forms are focus group discussions and key informant interviews. The aim of qualitative data collection is to generate descriptive data; plan pre-test questionnaires; identify possible risks which were not envisioned by the investigators; monitor effectiveness of programmes in operation; provide explanations of attitudes and behaviour; and generate hypotheses for quantitative collection. These interviews require special qualifications and special training for the data collector.

Through in-depth interviews and group discussions, the assessment team should seek to provide explanations of attitudes and behaviours, rather than to quantify their extent in the population. This major difference between qualitative and quantitative research necessitates a specific type of sample design. It is neither necessary nor desirable for qualitative samples to be as large as survey samples or to be statistically representative. It is essential, however, that qualitative samples be selected purposely to encompass the range and diversity present in the target population. For example, if the target population is people who inject drugs and have experience with the criminal justice system, one should try to include males, females and ethnic minorities, and former and current prisoners, of different ages, who have injected drugs.

Focus group discussions and key informant interviews do not necessarily have to be conducted in each of the facilities involved in the assessment process; however interviews with prison staff and prisoner representatives are useful when they are carried out in each facility where the assessment is being conducted.

Qualitative Data Collection

Focus group discussions are usually conducted with a group of six to ten people, selected for a common experience or common access to information. Examples of common experience might include health care personnel within the prison with different expertise/training; prisoners and prison staff; and former and current drug users. Focus group discussions allow participants to express their experiences with the criminal justice system and to share their views on the services provided and the respective gaps.

Key informant interviews represent one of the most frequently used techniques in assessment studies. They are conducted, one-to-one with individuals who hold key information by virtue of their position or life experience, using on an open-ended (and semi-structured) questionnaire. The technique of data collection as well as the analysis of information is similar to the focus group discussion.

Methodological details on focus group discussions and key informant interviews are provided in a separate toolkit for this purpose: *UNODC Global Assessment Programme on Drug Abuse*.

Step 7: Survey prison risk behaviour and ascertain HIV seroprevalence and other related communicable diseases (primary quantitative data)

The following paragraphs describe the methodology for a prison survey to assess the prevalence of blood-borne and air-borne viruses (HIV, TB, HBV and HCV) in prisons, combined with a KABP study of both prisoners and prison staff on HIV, TB, HBV and HCV and related risk behaviours. These include sensitive topics like violence, sexual activity involving people of the same sex, tattooing, injecting drug use and blood-sharing rituals, in order to assess:

- knowledge of transmission risks (especially hidden risks) and means of prevention;
- attitudes towards drug use and sexual behaviour and towards prevention strategies and interventions;
- behaviour towards other prisoners' and personal health behaviours; and
- practices of prisoners and prison staff regarding communicable disease and the means of prevention.

The design is a cross-sectional study across prison systems, nationally and regionally; one which might be repeated after one or two years in the same settings to assess trends. Studies of individual prisons may not yield information which is representative of the entire prison system. With careful planning and preparation, including adequate staffing, the data collection can be carried out within one day per prison.

a) Cross-sectional voluntary anonymous survey on communicable disease and related risk-behaviour among prisoners

The aim of the prisoner survey is to determine the prevalence of HIV; HIV related TB, other related infections and the prevalence of self-reported HIV related knowledge, attitudes, behaviours and practices (KABP) in a representative sample of the prison population. The survey examines the association between the prevalence of these infections and related factors, such as incarceration history and risk behaviours. It can compare self-reported prevalence of blood-borne viral infections with the actual prevalence.

Field preparation

The success of data collection is highly dependent on careful and sensitive preparation. The assessment team has to carefully prepare with the prison administration, representatives of the prison staff and with representatives of prisoners. In particular, collaboration with the prison administration is an essential and a necessary condition for the project's success.

All involved parties, including prison managers, the target prison population, administrative staff, health professionals and social workers should be thoroughly informed about the aims and objectives of the assessment. Any objections to the survey as a whole or to specific components must be discussed and resolved in advance.

Questionnaire

The questionnaire should be self-administered to respect anonymity and to be feasible. Each questionnaire should be coded to preclude identification of any individual prisoner. The questionnaire should be as simple as possible, brief and in the prison population's most frequently used languages. The questionnaire must also ensure that a question of the sum of the some questions do not allow for the identification of the respondents. A template questionnaire and standard information for the recruitment of possible survey participants are attached at Annex 10 and 11.

It should be noted that the questions in the template are core questions; a minimum set of items to be kept in any national adaptation of the instrument. However, it might be necessary to include further questions which relate to national (or regional) characteristics. The total number of additional questions should be restricted to a maximum of five to keep the instrument short and feasible.

In some jurisdictions, some of the behavioural risk factors mentioned in the template questionnaire might be particularly sensitive. It is absolutely necessary and worthwhile to address these sensitive topics, including men who have sex with men and injecting drug use, in the data collection instruments.

Some sections of the template questionnaire may need to be adapted to the terminology used locally (e.g., the type of drugs and their names), the prevalence of communicable diseases, and the peculiarities of risk behaviours in prisons (like body modification practices or drug use patterns). These questions are marked with footnotes.

Since the literacy rate among prisoners is usually lower that in the general population, some members of the assessment team should be available to do private, face–to-face interviews, based on the written questionnaires with those prisoners. When face-to-face interviews are conducted, interviewer safety and security must be addressed.[37] The prison space for interviews should be separated, but in close proximity to, an available custodial staff, should their intervention be required.

The different chapters of the questionnaire deal with:

- Socio-demographics;
- Penal information;
- HIV related risk behaviour before and during incarceration (drug use, injecting behaviour, sexual behaviour, violence, tattooing, etc.);
- Knowledge and attitudes towards HIV, TB and hepatitis;
- Self-reported status (HIV, TB and hepatitis);
- Access to information and means of prevention; and
- Access to and quality of health care

[37] See for example http://www.ncjrs.gov/pdffiles1/nij/grants/202947.pdf, accessed 2 April 2010

Pretesting

Before going into the field, all versions of the questionnaire (if different language versions are used) have to be pretested to assess each question on functional difficulty and to determine problems which may arise during the field operations.

The most widely used pretesting tool is a cognitive interview, where a selected number of each cluster of the target population is asked to report directly on the internal cognitive processes used to answer the survey questions. This means that respondents are asked to think aloud and describe their thought processes as they answer the survey questions. In addition, interviewers might probe the meaning of specific terms or the intent of specific questions throughout the interview. The following possible problems should be explored during this process:

- Does the respondent have any difficulty understanding the meaning of the question or the meaning of particular words or concepts?
- Does the respondent have different understandings of what the question refers to?
- Does the respondent have any difficulty recalling, formulating, or reporting an answer?
- Individuals selected for pretesting should be as diverse as possible. The number of pre-tests carried out should be at least ten for each subgroup of the target population (i.e. men, women, ethnic/language group).

Sampling

The assessment team may wish to know the prevalence of HIV and related risk behaviours in a given prison population, but it might be impractical to measure the HIV status of each prisoner. In this case, investigators should collect data on a carefully chosen sample or subset of the population. The sample should be sufficiently large to yield an acceptable degree of precision (often defined as a confidence interval of 95%) and the sample should represent the full study population. Strategies to achieve representativeness should reflect each country's unique situation. Sampling methodologies, sample size calculations and considerations related to the selection of facilities and prisoners are described in detail at Annex 12.

Inclusion criteria

The following inclusion and exclusion criteria are suggestive and might be modified, at the discretion of each country.

Inclusion criteria: All prisoners incarcerated on a given day who speak the languages of the provided instruments.

Exclusion criteria: Prisoners incarcerated in segregation housing or who are rarely in contact with other prisoners and where access is a logistical challenge (for example, prisoners who, in the judgement of custodial staff, represent too great a risk for harm to themselves or interviewers); juveniles under 18 (because of difficulties in getting consent and challenges to getting ethics committee approvals for research on juveniles)[38]; prisoners who are not competent at the time of the assessment; prisoners who do not speak the provided languages of the instrument; and those with a too short duration of stay in prison.[39]

[38] Collection of secondary data on this cohort should still be undertaken

[39] The 'duration' is at the discretion of National Steering Committees, but in general, < 3 months might be taken as a guide as 'too short'.

Recruitment of prisoners

Prisoners should be informed that this study is about HIV and AIDS (and TB, viral hepatitis and health care in prisons) and that it will provide information about the needs for prevention, treatment, care and support services during imprisonment. The study is carried out with the agreement with the prison administration, but not on behalf of it. The information about HIV/HBV/HCV/TB/STI status and behaviours is strictly anonymous and no one, including prison administration and assessment team members, will be able to connect collected information to individual prisoners.

A high participation rate is critical. Through participation in the survey, all prisoners can personally contribute to improvement of knowledge and information on HIV in prison and thus, the improvement of services for the entire prison population.

It might be useful to offer the survey participants a small incentive like condoms, chocolate bars or soft drinks. These incentives should not be excessively valuable, since those who decide not to participate (or who are not selected) might feel disadvantaged by not receiving the item.[40]

Approaches for specific subgroups of prisoners

Illiterate prisoners: A large proportion of prisoners are functionally illiterate. Prisoners who are not able to read and write should be invited to sit in privacy with a member of the assessment team who will read the questions to them and tick the respective answers on the questionnaire. The recommendations on interviewer safety and security, and prisoner exclusion criteria discussed above, should be addressed beforehand.

Ethnic minorities: Questionnaires have to be provided in those languages mainly spoken in the respective prison, including, where possible, migrant groups, to the extent that they represent a significant proportion of the prison population. Where there is no translation service for the questionnaires and the interviews, the study will be substantially limited by potential bias. For example, the assessment may miss the highest drug-using population. Translators should be qualified and translations should be checked by assessment team members who speak and write the relevant languages.[41] All survey instruments in other languages should be field tested to ensure that the questions are clear and meet the intent of the survey.

Data collection and organisation

Prisoners must be informed about the survey, its aims and its benefits, prior to the beginning of the actual data collection. It is essential that appropriate means of information are explored and possibly discussed with opinion leaders among the prison population. For instance, prisoners might be invited by letter to participate in a study on prevention of communicable diseases and access to health care. Furthermore, global information (prison radio or TV, newsletter, poster, or other media) might be used. In settings where these media are not available and/or there is a high prevalence of illiteracy among prisoners, oral information for small groups of prisoners is a feasible way of informing prisoners. A short-form template for standard oral information for prisoners is attached at Annex 13.

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[40] It is sometimes useful to identify, with the assistance of custodial staff, an influential prisoner, whose participation would encourage other prisoners to participate.

[41] A technique of double translation is sometimes employed: firstly from the original language to the target language, and secondly, from the translation back to the original language, using two independent translators. The two original language versions are then compared and any inconsistencies corrected.

The place of the survey depends on the specific circumstances in the individual prison. However, general conditions must be similar: Prisoners must be invited to a place with acceptable conditions to fill out a questionnaire and to give a biological sample, while maintaining as much privacy and confidentiality for prisoners, and safety and security for interviewers, as possible. Where sputum samples are collected, safety measures, for example, collection outdoors or in a ventilated, well lit space, must be adhered to. While security needs to be maintained, prisoners should have full assurance that there will be no negative repercussions for participating in the survey.

The assessment team must be independent from prison administration and health care staff. Explanations about the project must be easy to understand. Confidentiality and anonymity have to be stressed.

Services provided to prisoners during the survey including VCT

During the project, special attention should be paid to offer prevention messages about risks of HIV, TB, viral hepatitis and STI transmission and means of prevention. Prevention education materials should form part of the incentive package previously mentioned.

If some prisoners want to know their serological status of HIV/HBV/HCV and/or TB status, they must be offered an independent and nominative (non-anonymous) test and relevant clinical examination. In this case, an appointment should be made with a health professional from the prison medical department which will then do the pre-test counselling, take a blood sample or an oral fluid sample (depending on the testing methodology selected) and give the result and the respective post-test counselling. In case of TB, clinical examination, sputum exam and chest radiography may be required. During the survey, each prisoner might be given a request-for-test form where they can indicate their identification number or name, to be invited by the medical office for individual testing.

Keeping data anonymous

Anonymity is an essential and critical element of seroprevalence studies and in particular, those which deal with illegal and punishable behaviours. Anonymity can be maintained by a simple technique which allows matching the information gained through behavioural risk factor questionnaires and biological samples, without using a personal identifier or any other information which might identify individual prisoners. Two identical bar code labels per prisoner (available without any printed figures and thus only readable with a bar code reader) can be used. One will be stuck on the questionnaire and the other on the biological sample. These bar code labels have to be prepared in advance of the survey and can be ordered though specialised companies. When ordering the bar code labels, care should be exercised with respect to the material of the labels, which should be water-resistant and insensitive to temperatures necessary for the storage of the biological samples. Where matched bar-code labelling is not available, a simple numbering system can be used to match individual questionnaires with the biological samples.

b) HIV testing methodology[42]

There are a variety of methods for initial screening for HIV infection. Diagnostic testing is a two-step process, beginning with an initial screening and a subsequent confirmatory test; for example an initial test of whole blood using ELISA, followed by a Western-blot confirmatory test. Confirmatory testing is not necessary for a rapid assessment seroprevalence study, as the results are not applied to an individual patient and there is no clinical

[42] Greenwald JL, Burstein GR, et al. A Rapid Review of Rapid HIV Antibody Tests. *Current Infectious Disease Reports* 2006, 8**:**125–131.

risk for any individual. Confirmatory testing is required for voluntary testing when the results will be given to the prisoner.

The assessment team should carefully consider whether to use conventional testing or rapid testing. The considerations are logistical and economic. For the purposes of a situation and needs assessment seroprevalence testing is anonymous. Rapid testing in a prison, with a large volume of tests, can be challenging because of the need to conduct the testing and keep track of times, so that the results are read in the appropriate time interval. With rapid testing, there is also a concern about confidentiality and anonymity, as test results are read just 10-30 minutes later. With a conventional testing option, the logistics might be much easier because only phlebotomy staff is required to do all of the blood draws. The specimens can be refrigerated (a critical component of conventional testing) and processed in a distant laboratory with conventional EIA. Conventional testing is less expensive than rapid testing.

For the purposes of assessing seroprevalence in a prison, rapid HIV testing is certainly an option to be considered. There are several types available that can be performed on-site by unlicensed personnel. Various tests have been approved in various countries for use on-site, without a laboratory. Some can be used with either oral fluids (saliva) or blood. Rapid tests can be read, typically, in 10 – 15 minutes. Though each of these rapid HIV tests has unique characteristics, they share many common features. All the tests are interpreted visually and require no instrumentation. The sensitivity and specificity of each of the tests exceeds 99%. The tests can be performed on-the-spot or at the end of the day, with no special handling in the interim.

All rapid HIV tests require the periodic use of external controls (known HIV-positive and -negative specimens). External controls must be run 1) by each new operator prior to performing a test on patients, 2) when a new lot of test kits is used, 3) upon receipt of a new shipment of test kits, 4) when the temperature of the storage or testing area falls outside the recommended range, and 5) at periodic intervals determined by the testing facility, usually based on their volume of testing.

The Steering Committee and Principal Investigator should give strong consideration to concurrent testing for markers for viral hepatitis B and C. This information would extremely valuable, especially in countries where there is a low seroprevalence of HIV infection, but a high rate of infection with viral hepatitis that is transmitted in the same manner as HIV.

A Comparison of HIV Testing Technologies: Enzyme Immunoassays (EIA) and Rapid Tests:[43]

HIV Testing Technology	Specimens	Advantages	Limitations	Cost[44]	Complexity[45]
EIA	Serum Plasma Dried blood spots Oral fluids Urine	• Can be batched: good for >100 specimens at a time • Can be automated • QA/QC done at national and regional laboratories: easier to control • May cost per test less than cost per rapid test • Identifies seroconverters earlier: highly sensitive, which reduces non-reactive period • Fewer staff required	• Not flexible in testing (need minimum numbers filled for maximum efficiency) • Requires skilled, trained technicians to perform and read results • Requires >2 hours for results (if need to run two EIAs, >5 hours) • Requires special equipment • Requires maintenance of equipment • Reagents must be refrigerated	1-2 USD	4
Rapid Test	Serum Plasma Whole blood Oral fluids[46]	• Good for testing 1 to 100 specimens at a time • Requires minimal equipment and reagents • Can be performed in a clinic (on-site testing) • Highly skilled staff not required • Very easy to interpret test results • Results in < 45 minutes • Test kits can be stored at room temperature (increased stability)	• Not good for testing >100 specimens at a time • The QA/QC is performed at multiple sites: requires more control • May cost more per individual test than EIA • Choice of testing strategy may require multiple specimens • Inter-reader variability may provide inconsistent results with some assay formats (e.g., particle agglutination) • Possible breaches in anonymity/confidentiality • More staff required • Possible false positives[47]	1-3	For tests based on Immunochro-matography — 1 Dipstick and membrane flow-through technology — 2 Agglutination — 3

c) Tuberculosis considerations

Prison authorities should carefully consider surveillance, prevention, diagnosis, containment, and treatment of tuberculosis for the benefit of individual prisoners, staff and the community to which the prisoners return. TB is a particular problem for IDUs because of the co-infection of TB and HIV and other associated factors including poor living conditions.

Inaccurate beliefs about TB transmission and treatment among prisoners and prison staff may hinder timely detection and effective treatment. Therefore it is advantageous to consider aspects related to TB while developing the questionnaires on HIV Knowledge, Attitudes, Practices and Behaviours. In order to capitalize on resources, it would be useful to include TB aspects, to the extent possible, at the same time as the anonymous HIV survey.

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43 World Health Organization and Joint United Nations Programme on HIV/AIDS, 2001 . http://data.unaids.org/Publications/IRC-pub02/jc602-hivsurvguidel_en.pdf, accessed 13 March 2009.

44 The cost of a testing technology will be affected by the direct and indirect costs.

45 UNAIDS/WHO's four categories of complexity for HIV antibody tests: (1) No additional equipment or laboratory experience is required; (2) Reagent preparation or a multistep process is required; (3) Specific skills

46 Rapid tests using oral fluids are under evaluation in field settings. EIA, enzyme immunoassay; QA/QC, quality assurance/quality control.

47 Reported in New York City, summer 2008. The cause has not been reported.

Undiagnosed and untreated TB is frequently found among persons living with HIV. Survey data in high TB burden settings show that up to 10 percent of people living with HIV may have undiagnosed TB at the time of undergoing voluntary counselling and testing (VCT). TB is the most common opportunistic infection in people living with HIV. It is a leading cause of death in this group. Only one in ten persons infected with TB who are HIV negative will develop active TB in their lifetime. By contrast, among persons infected with both TB and HIV, one out of ten will develop active TB each year.[48] In high-burdened TB settings 30 to 40 percent of people living with HIV will develop TB in their lifetime, in the absence of isoniazid preventive therapy (IPT) or antiretroviral therapy (ART).[49]

In some prisons, accurate data on TB prevalence may not exist and Principal Investigators may opt for a TB prevalence survey. Although TB prevalence surveys can shed light on the extent of TB in prisons, the critical value of such a survey needs to be balanced against its cost and the potential implication in changing screening and treatment policies. Having clear objectives of a study will help to focus on essentials and avoid collection of information that will not be used.[50]

WHO guidelines recommend the following quantitative and qualitative elements be assessed.

- Government structures supporting TB programmes in both the civil-sector and prison systems;
- Written agreement on collaboration and coordination between prison and civil-sector TB programmes;
- Prevention through early detection, respiratory isolation, and treatment of TB and TB/HIV cases; avoidance of overcrowding; good nutrition, ventilation; clear definition of infectious zones with clear policies on how to reduce transmission; and the use of surgical masks for patients and personal respirators for staff;
- Complete access to TB diagnosis and treatment for all prisoners entering the prison system;
- Adequate treatment in line with national TB programme guidelines, including those for prisoners with MDR-TB and TB-HIV co-infection, using Directly Observed Treatment (DOT) and an uninterrupted supply of drugs of guaranteed quality;
- A guarantee by prison and civil medical personnel of continued treatment for infected individuals following their release from prison;
- Continuing human resource development that ensures an adequate number of staff with satisfactory background education and continuous training;
- A mechanism in place for timely investigation of TB suspects and early detection of individuals with active TB and their treatment;
- A network of laboratories carrying our quality-assured smear microscopy;
- Drug susceptibility testing in a centralized laboratory of ensured quality, either in the civil sector or in the prison;

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48 Tuberculosis Coalition for Technical Assistance and International Committee of the Red Cross. *Guidelines for Control of Tuberculosis in Prisons*. January 2009, http://www.tbcta.org//Uploaded_files/Zelf/GuidelineTBPrisons1252321251.pdf, accessed 2 April 2010

49 L. Mtei, M. Matee, O. Herfort, et al. 2005. High Rates of Clinical and Subclinical Tuberculosis among HIV-Infected Ambulatory Subjects in Tanzania. *Clinical Infectious Diseases* 40: 1500–07.

50 WHO. Assessing tuberculosis prevalence through population-based surveys. 2007. http://www.wpro.who.int/NR/rdonlyres/F49273CB-4CAB-4C38-B1E3-500108BA4A97/0/AssessingTBprevalence.pdf, accessed 2 April 2010

- A supply of quality second-line drugs for prisoners suffering from MDR-TB once the capacity to test prisoners for drug resistance is in place; and
- Recording and reporting in close coordination with the civil sector.

d) Cross-sectional voluntary anonymous survey of HIV and related risk-behaviour among prison staff

The aim of a survey among prison staff is to examine their knowledge, attitudes and behaviours regarding communicable diseases; drug use and people who use drugs; people living with HIV and/or hepatitis; and potential preventive measures; and to design and implement interventions for staff which will address their needs and fears and remove potential barriers to the introduction of comprehensive and evidence-based programmes. The results can also be used to compare results of different professional groups working in prisons and to compare the staff's knowledge of communicable disease with the information gathered from the prisoner survey.

As with prisoners, a self-administered questionnaire can be used to collect information among prison staff. The questionnaire should be distributed to all members of the staff in the selected institutions. A specific sampling procedure is not necessary. The participation rate might be increased significantly if the survey is supported by the respective staff trade unions. A template for such a questionnaire and an information sheet for possible participants are attached at Annex 14 and 15.

The questionnaire should also be pretested, as described for the prisoner survey above (Pretesting, Section of Step 7). It might also be useful to combine the staff survey with an offer for voluntary HIV testing and counselling and an information campaign on prevention of HIV and other health related issues.

Step 8: Analyse and interpret data

This element has the ultimate aim of subsequently designing custom interventions to prevent the transmission of bloodborne (and airborne TB) infections. Collecting and presenting HIV and AIDS data are only part of the task. To be useful to planning groups and others, the data must be analyzed and interpreted. Analysis is the application of logic to understand and find meaning in the data. It involves identifying consistent patterns and summarizing the relevant details.

The purposes of the analysis are to:

- Identify populations that are infected with HIV and describe their key characteristics;
- Understand the trends and the impact of HIV/AIDS in a prison system;
- Identify groups or populations at risk of acquiring or transmitting HIV and identify prevention needs;
- Determine the characteristics of HIV-infected persons and persons engaged in high-risk behaviours;
- Determine the indicators of risk in the prison population;
- Describe the distribution of the disease (geographically and by population); and
- Identify trends over time, if any.

Step 9: Prepare a final report

The final report for the HIV situation and needs assessment is essential from several points of view. It should be self-critical and answer the question as to whether the project accomplished its objectives. Though the report format might differ from one country to the next, based on the local context and the required emphasis in that country, there are minimum chapter contents for a report to ensure, to the extent possible, a uniformity of content which could facilitate exchange of expertise.

The report documents the process, including the soundness of the methodology and the reliability of the findings. The report should include the history of the project, including the contextual assessment of the prison (facility descriptions, offence/conviction types, demographics, etc.) and a health care resource assessment. The report should describe the development of the team, the data, and the quantitative and qualitative findings. The report should also include a section on the recognized limitations of the study and a gap analysis with identification of needs. Finally, recommendations for action, based on the findings, to limit the transmission of communicable diseases, especially HIV, in the nation's prisons should be developed. The report should also address findings to help prepare for early detection and treatment, including the provision of antiretroviral treatment. These recommendations could include required changes in public policy, legislative amendment and reviews, prison policy, allocation of resources and targeted interventions for staff and prisoners. Performance targets should be set.

Among other tasks, the assessment team should identify "champions" such as opinion leaders and policy makers who can influence prison policy to improve the likelihood that the project's recommendations are followed. These key players will be in government, the prison systems, the news media and the community. Dissemination of the final report can be crafted so as to impact the direction of public policy toward improved attention to effective public health programmes.[51]

The report needs to be discussed and affirmed through a consensus meeting of the National Steering Committee and other counterparts which have a stake in the HIV programmes in prisons, led by the Principal Investigator who drafted the report. Importantly, feedback on the findings and on decisions of the national Steering Committee should be provided to all participants, including prisoners and prison staff. The report should be made available to the general public and should be widely disseminated.

Recommended report chapters

- Executive summary with key results, findings and recommendations for further action;
- Contextual assessment of prisons;
- Methodology of data collection;
- Health care resource assessment;
- Intervention and policy assessment;
- HIV prevalence and knowledge, attitude and behaviour assessment in both prisoners and prison staff;
- Gap analysis and identification of needs;
- Discussion of the results (obstacles faced, recommendations for improvement of collection);
- Conclusions;
- Recommendations.

[51] UNODC, WHO, & Joint UN Programme on HIV/AIDS. *HIV/AIDS Prevention, Care, Treatment and Support in Prisons: A Framework for an Effective National Response*. op. cit.

Step 10: Focus Interventions

The assessment team can consider setting-related interventions and interventions for individuals. Some of the interventions are universally needed. Others will depend on the local situation. Results of the assessment will allow for tailoring the response to the situation and needs.

On-site interventions for HIV prevention should include the following:[52, 53]

Providing information and education to prisoners and prison staff

Prisoners and prison staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release. The information should be coordinated and consistent with that disseminated in the general community, but tailored to the needs and situation in prisons. Information intended for the general public (through posters, leaflets, and the mass media) should also be available to prisoners. All written materials distributed to prisoners should be appropriate for the educational level in the prison population. Information should be made available in a language and form which prisoners can understand and presented in an attractive and clear format. Prison staff should receive HIV/AIDS prevention information during their initial training and thereafter on a regular basis.

Prisoners should receive HIV/AIDS education on entry, during their detention and in pre-release programmes. All prisoners should have an opportunity to discuss the related information with qualified instructors. Face-to-face communication, both in groups and on an individual basis, is an important element in education and information.

Consultation with and participation of prisoners and staff in the development of educational materials should be encouraged to help ensure that the information leads to changed behaviour. In view of the importance of peer education, both prison staff and prisoners themselves should be involved in disseminating information.

Information on drugs and alcohol: Psychoactive substances, some of which are used to a considerable extent in different prisons worldwide, may increase the likelihood of HIV transmission by impairing judgement and hindering the adoption of preventive measures. Users of psychoactive drugs should be made aware of this, as well as of other possible harmful effects and consequences of these substances. Injecting drug users should receive information on risks linked to injecting and the way to reduce these risks.

Information should also cover, where relevant, hepatitis B and C and tuberculosis. But information is not enough to prevent the transmission of HIV. Both prisoners and staff should be provided with the means to protect themselves.

Addressing stigma and discrimination

HIV-related stigma and discrimination are violations of human rights and barriers to effective prevention, treatment, care and support. Fear of discrimination leads to greater reluctance to be tested or to reveal an HIV-infected status and lower adherence to treatment regimes. HIV-infected prisoners should not be segregated

[52] *WHO Guidelines on HIV Infection in Prisons. 1993*, electronic version 1999

[53] UNODC/WHO/UNAIDS *HIV/AIDS in places of detention A toolkit for policymakers, programme managers, prison officers and health care providers in prisons*, op. cit.

from other prisoners and they should be involved in the planning, implementation and evaluation of HIV interventions. UNAIDS provides a 'best practice' guide to effective anti-stigma and discrimination programmes.[54]

Voluntary HIV counselling and testing (VCT)

Prison systems should offer voluntary HIV counselling and testing (VCT) to all prisoners upon entry. In addition, because entry is a stressful time and many prisoners may not want to have an HIV test at that time, HIV testing should be available to prisoners at any time during incarceration, so that prisoners can learn their HIV status and prisoners with HIV can benefit from access to treatment (including antiretroviral treatment), care and support. Counselling is an important component of VCT, for both HIV-infected and non-infected persons. HIV testing should never be mandatory.

Providing condoms and preventing rape, sexual violence and coercion

Clear information should be available to prisoners on the types of sexual behaviour which can lead to HIV transmission. The role of condoms in preventing HIV transmission should also be explained. Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms and lubricants should be made available to prisoners throughout their period of detention. They should also be made available prior to any form of leave or release. In prisons where conjugal visits are available, condoms and lubricants should be provided to prisoners and sex partner visitors at the time of visits and be available in the visiting space.

Prison authorities are responsible for combating aggressive sexual behaviour such as rape, exploitation of vulnerable prisoners (e.g., transgender or men having sex with other men, young people or mentally disabled prisoners) and all forms of prisoner victimization, by providing adequate staffing, effective surveillance, disciplinary sanctions, and education, work and leisure programmes. These measures should he applied regardless of the HIV status of the individuals concerned.

Providing needle and syringe programmes and bleach or other disinfectants

Prevention of transmission by injection: As part of overall general HIV education programmes, prisoners should be informed of the dangers of drug use. The risks of sharing injecting equipment, compared with less dangerous methods of drug taking, should be explained. In countries where clean syringes and needles are made available to people who inject drugs in the community, clean injecting equipment during detention and on release to prisoners who request them, should be provided. Considering their poor efficacy, especially in prisons, disinfectants to sterilise syringes should be provided only in places where there is no access for injecting drug users (IDUs) to sterile needles and syringes. Diluted bleach (e.g. sodium hypochlorite solution) or another effective viricidal agent, together with specific information on their limitations should be provided and detailed instructions on cleaning injecting equipment should be emphasised. It should also be made available for disinfection of tattooing or skin piercing equipment.

[54] UNAIDS. *HIV-related Stigma, Discrimination and Human Rights Violations. Case studies of successful programmes*. http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf. accessed 3 April 2010.

Drug dependence treatments

Drug-dependent prisoners should be encouraged to enrol in drug treatment programmes while in prisons, with adequate protection of their confidentiality. Good quality, evidence informed, appropriate, and accessible treatment can improve the health and social functioning of prisoners as long as it meets the individual needs of prisoners.

All types of evidence-based treatment available in the community should be accessible in prisons, especially opioid substitution therapy (OST) for opiate dependent people. In countries in which methadone or buprenorphine maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons. Prisoners on methadone or buprenorphine maintenance prior to imprisonment should be able to continue this treatment while in prisons and new treatments should be initiated for drug dependent inmates who may not have had access to treatment in the community.

The enrolment in drug treatment, especially OST, increases adherence to antiretroviral therapy as well as to treatment for tuberculosis.

Universal precautions

Prison authorities must ensure the implementation of Universal Precaution measures to prevent the transmission to prisoners, staff and visitors and to ensure the safety of medical care. Prison health services must have adequate material and resources available to ensure that HIV transmission through the use of non-sterile equipment during medical, dental procedures and transfusions does not occur.

Post-exposure prophylaxis (PEP)

If a prison staff member or a prisoner has a significant HIV exposure, post-exposure procedures should be followed (if such procedures do not exist, prison management should develop them).

Providing antiretroviral therapy and other treatment for prisoners with HIV or AIDS

In addition to providing comprehensive prevention programmes, prisons have a responsibility to provide prisoners with treatment, care and support equivalent to that available in the outside community. The right to medical care in prisons includes an appropriate follow-up of persons living with HIV (PLWH), provision of antiretroviral therapy (ART) in the context of comprehensive HIV and AIDS care and prevention; treatment of opportunistic infections; access to nutritional supplements; and access to palliative care and compassionate release. The national guidelines on the treatment of PLWH should be implemented in prisons.

On admission, prison health officers should determine whether prisoners require treatment for any HIV/AIDS-related illness or opportunistic infection, such as TB. “Symptomatic management” usually requires treating and preventing the more common opportunistic infections associated with HIV. The WHO and UNAIDS

recommendation of providing Cotrimoxazole Preventive Therapy (CPT) to prevent opportunistic bacterial and parasitic infections should be followed.[55]

Prevention of Mother to Child transmission (PMTCT)

For HIV-infected pregnant and breastfeeding prisoners, prisons must offer preventive measures for the transmission of HIV from HIV infected mothers to their infants during pregnancy, labour, delivery and breastfeeding, all of which are linked to access to comprehensive reproductive health services.

Prevention and treatment for Hepatitis C and B

Most of the measures to prevent HIV, described above, also contribute to reducing the risk of hepatitis C virus (HCV) transmission. However, HCV is much more easily spread than HIV, including through sharing of shaving equipement and toothbrushes, as well as through tattooing and body piercing. It is therefore important that all prisoners and staff receive information about the risks of HCV transmission in prisons and that they are educated about the ways to reduce that risk. Shaving equipement and toothbrushes should be made available to prisoners and replaced as necessary, so that they do not have to share them with fellow prisoners. Prisons should also consider implementing measures to reduce the spread of HCV through tattooing and body piercing, such as making sterile tattooing equipment available to prisoners.

Hepatitis A-B Vaccination: All staff and prisoners should have easy access to free hepatitis A and B vaccination. Prisoners should have voluntary and easy testing for hepatitis B and hepatitis C, with proper follow-up of hepatitis patients and their treatment.

Collaborative HIV-TB activities

Tuberculosis prevention and control should be prioritised in any prison HIV prevention program. The three pillars of collaborative TB/HIV activities are: 1 - existence of a mechanism of collaboration, 2) decreasing the burden of TB among people living with HIV and 3) decreasing the burden of HIV among TB patients. An adequate mechanism should exist for collaboration between TB and HIV programs at national, provincial, district public health and prison services. Prison health authorities should play an active role in planning and strategizing meetings of the coordinating TB/HIV body.

In order to decrease the burden of TB among people living with HIV, the “three Is” strategy should be implemented (Infection Control, Intensive TB case finding and Isoniazid prophylactic therapy). [56]

Considering the high risk of transmission of tuberculosis in prisons and the important links between HIV and tuberculosis, both staff and prisoners should be informed on the risks, symptoms and prevention measures and tuberculosis should be addressed in information and education activities.

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[55] See for example, WHO. Tuberculosis Care with TB-HIV co-management. 2007. http://www.who.int/hiv/pub/imai/TB_HIVModule23.05.07.pdf. accessed 2 April 2010

[56] WHO.The three Is. http://www.who.int/hiv/topics/tb/3is/en/, accessed 2 April 2010

Management of prisons should implement infection control measure to reduce the risks of airborne transmission including TB. These measures include managerial activities, including training, infection control planning and surveillance of TB among health care staff. Administrative measures include separation of TB patients, separate entrances for patients and staff and encouraging patients to use masks. Importantly, paper masks only prevent patients from developing aerosols. Specially fitted hepafilter masks are required to protect staff and other patients from breathing in infected particles. Environmental measures include ensuring adequate ventilation, filtration and ultraviolet germicidal irradiation and providing staff with appropriate respirators.[57] Treatment under direct observation (DOT) and patient support remain cornerstones to ensure treatment adherence.

Continuity of care upon admission and release

Prison health staff should ensure that there is a continuity of medical care for released prisoners. In the case of drug dependence treatments, such as OST, or in the case of antiretroviral or tuberculosis therapy, about to be released prisoners, together with their confidential medical records, should be referred to the appropriate community health services. Contacts with these providers, if they are not present in prisons, must be made in advance of release.

Continuity of care also applies to those being admitted to prison. Linkages and collaborations with community health services, community organisations and social services will facilitate a smooth continuation for those who are already receiving some form of treatment and care in the community.

Other levels of interventions: policy, legal and environmental measures

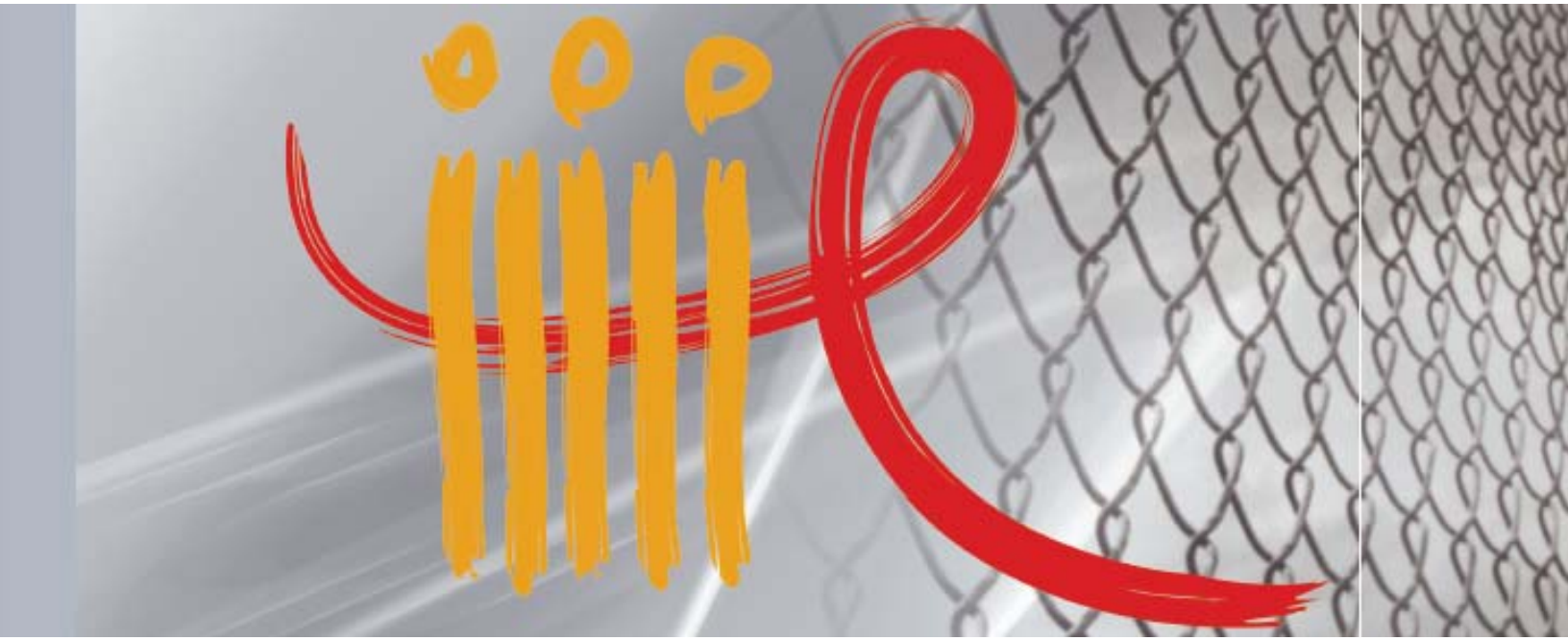
Policy measures: Prison policies, regulations and procedures should be reviewed to ensure the respect of the rights of prisoners, particularly to an equivalent level of healthcare, freedom from discrimination and stigmatization, and protection of patient confidentiality. Prisons should also implement effective protection against sexual violence.

Integration within national health programme: Prison health programmes should ideally be under the authority of the National Ministry of Health. Where this is not the case, and in federal constitutional systems, prison health authorities should ensure that national health programmes such as AIDS and tuberculosis are fully implemented in prisons, including monitoring and evaluation components. In addition, prisons should be represented within the national AIDS coordinating bodies, such as the National AIDS Committee and Country Coordinating Mechanisms (CCM).

Living conditions should be adapted to ensure the promotion of both good physical and mental health, through the provision of a healthy living environment.

Legal reforms in order to ensure (1) that the principle of equivalence of health care in prisons is clearly established; (2) that the legal status of comprehensive HIV prevention, treatment, care and support services in prisons, including condom distribution, needle and syringe programmes and opioid substitution therapy; (3) that there is no involuntary HIV testing or segregation of prisoners living with HIV or AIDS; (4) that health decisions in prisons are made by health professionals; (5) that laws allow for provisions to reduce imprisonment and pre-trial detention; (6) that laws allow for early release of terminally ill prisoners and (7) that laws are supportive of an effective HIV programme.

[57] WHO. *Policy on TB infection control in health-care facilities, congregate settings and households*. 2009, http://whqlibdoc.who.int/publications/2009/9789241598323_eng.pdf, accessed 2 April 2010



Annexes

List of Annexes

Annex 1. Complementary Resources[58]

Title	Publisher	URL
A Guide to Developing Knowledge, Attitude and Practice Surveys	WHO, co-published with StopTB Partnership	http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM_KAP%20GUIDE.pdf,
Assessing tuberculosis prevalence through population-based surveys	WHO	http://www.wpro.who.int/NR/rdonlyres/F49273CB-4CAB-4C38-B1E3-500108BA4A97/0/AssessingTBprevalence.pdf
Criminal Justice Assessment tool: Custodial and non-custodial measures: The Prison System	UNODC	http://www.unodc.org/documents/justice-and-prison-reform/cjat_eng/1_Prison_%20System.pdf
Declaration on Prison Health as a Part of Public Health	WHO	http://www.euro.who.int/__data/assets/pdf_file/0007/98971/moscow_declaration_eng04.pdf
Establishing a bioethics committee	ABC	http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/SHS/pdf/Checklist.pdf
Ethical challenges in drug epidemiology: issues, principles and guidelines	UNODC	http://www.unodc.org/documents/GAP/GAP%20toolkit%20module%207%20ENGLISH%2003-89740_ebook.pdf
Evidence for Action Technical Papers on Effectiveness of Interventions to Address HIV in Prisons	WHO, co-published with UNODC, UNAIDS	http://www. unodc.org/unodc/en/hiv aids/publications.html?ref=menuside
Focus Assessment Studies: A qualitative approach to Data Collection	UNODC	http://www.unodc.org/pdf/iran/links/UNODC/gap_toolkit_module6.pdf
Guidelines for Control of Tuberculosis in Prisons	Tuberculosis Coalition for Technical Assistance and International Committee of the Red Cross	http://www.tbcta.org//Uploaded_files/Zelf/GuidelineTBPrisons1252321251.pdf
Guidelines for Using HIV Testing Technologies in Surveillance: Selection, Evaluation and Implementation	UNAIDS	http://data.unaids.org/Publications/IRC-pub02/jc602-hivsurvguidel_en.pdf
Health in prisons. A WHO guide to the essentials in prison health.	WHO	http://www.euro.who.int/document/e90174.pdf
HIV and AIDS in places of detention	UNODC, co-published with WHO, UNAIDS	http://www. unodc.org/unodc/en/hiv-aids/publications.html?ref=menuside
HIV testing and counselling in prisons and other closed settings	UNODC, co-published with WHO, UNAIDS	http://www. unodc.org/unodc/en/hiv-aids/publications.html?ref=menuside
HIV/AIDS and HCV in Prisons: A Select Annotated Bibliography	Taylor &Francis	http://www.informaworld.com/smpp/content~content=a758014225&db=all
HIV/AIDS Prevention, Care, Treatment and Support in Prisons: A Framework for an Effective National Response	UNODC, co-published with WHO, UNAIDS	www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf

[58] All urls were accessible as of 8 June 2010

Title	Publisher	URL
HIV-related Stigma, Discrimination and Human Rights Violations. Case studies of successful programmes	UNAIDS	http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf
Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning	CDC	http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/
International Ethical Guidelines for Epidemiological studies	CIOMS	http://www.cioms.ch/frame_ethical_guidelines_2009.htm
Policy Brief: Reduction of HIV Transmission in Prisons.	WHO, co-published with UNODC, UNAIDS	www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html
Policy on TB infection control in health-care facilities, congregate settings and households	WHO	http://whqlibdoc.who.int/publications/2009/9789241598323_eng.pdf
Standard Minimum Rules for the Treatment of Prisoners	UNODC	http://www.unodc.org/unodc/search.html?q=Standard+Minimum+Rules+for+the+Treatment+of+Prisoners
The three Is	WHO	http://www.who.int/hiv/topics/tb/3is/en/
Tuberculosis Care with TB-HIV co-management	WHO	http://www.who.int/hiv/pub/imai/TB_HIVModule23.05.07.pdf
Tuberculosis control in prisons	WHO	http://www.who.int/tb/publications/prisons_tb_control_manual/en/index.html
Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants	WHO	http://www.who.int/hiv/pub/mtct/rapid_advice_mtct.pdf
WHO 2009 ART Guidelines for Adults and Adolescents	WHO	http://www.who.int/hiv/topics/treatment/evidence/en/index.html

Annex 2: Template for informed consent form for prisoner survey

Title of Research: _____

Investigator: _____ *(name, contact details)*

You are invited to participate in a study on health in prison**.** We hope to learn more about HIV and AIDS, health care provisions and prevention in prison. The study will provide information about the needs for prevention, care, treatment and support services during imprisonment. This study is carried out with the agreement of the prison administration but not on behalf of it. The information about your HIV (Hepatitis, TB) status and behaviours is strictly anonymous and no one, including the prison administration, is able to connect given information to individual prisoners. Any information that is obtained in connection with this study which can be identified with you will remain confidential and will not be disclosed.

Through participation in the survey, all prisoners can contribute to improvement of knowledge and information on HIV in prisons and thus personally account for the improvement of services for the entire prison population. You were selected as a possible participant in this study because you are currently detained in prison ***(name)***.

If you decide to participate, we will ***(Describe the procedures to be followed, including their purposes, how long they take. Describe the discomforts and inconveniences reasonably to be expected and estimate the total time required. Describe the risks reasonably to be expected and any benefits reasonably to be expected.)***

Your decision whether or not to participate will not prejudice your future relations with ***(Name of Prison)*** or any other part of the criminal justice system. If you decide to participate, you are free to discontinue participation at any time without prejudice.

If you have any questions, please do not hesitate to contact us. If you have any additional questions later, please contact **(*name of principal investigator)*** at ***(contact information)*** who will be happy to answer them.

This project has been approved by the **(name of ethical committee)**. If you should have any complaints related to this project, please address them to **(address of ethical committee)**.

You will be offered a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time without penalty or loss of benefits after signing this form should you choose to discontinue participation in this study.

_____	_____
Signature of Subject	Date
_____	_____
Signature of Researcher	Date

Annex 3: Template for informed consent form for focus groups

Title of Research: _____

Investigator: _____ ***(name, contact details)***

Before agreeing to participate in this discussion, it is important that you read the following explanation. This statement describes the purpose, procedures, benefits, risks, discomforts, and precautions of the interview. Also described are the alternative procedures available to you, as well as your right to withdraw from the study at any time.

Explanation of Procedures

You are being asked to participate in the research project to investigate the attitudes and perceptions of prisoners on the subject of HIV/AIDS and the needs for HIV prevention in prisons. The type of research is known as 'exploratory focus groups'. A focus group is a small group of people (about 8) who meet together and provide answers and opinions to some questions asked by a group leader. You will be asked some questions about what you think about HIV and health in prison. You will also complete a short survey that has questions about yourself. The focus group will be audio-taped, and transcribed. The focus group will last approximately (time).

Risks and Discomforts

You will not be at any physical or psychological risk and should experience no discomfort resulting from the research procedures.

Benefits

There are no direct personal benefits by participating in this focus group.

Confidentiality

All information gathered from the study will remain confidential. Your identity as a participant will not be disclosed to any persons. Only the researchers will have access to the research materials, which will be kept in a locked draw. Any references to your identity which would compromise your anonymity will be removed or disguised prior to the preparation of the research reports and publications. Audiotapes will be destroyed or erased at the completion of the study. Your name will not be used in the transcripts of the recording.

Withdrawal Without Prejudice

Participation in this study is voluntary; refusal to participate will involve no penalty. Each participant is free to withdraw consent and discontinue participation in this project at any time without prejudice from this institution.

Costs and/or Payments to Subject for Participation in Research

There will be no costs for participating in the research. Participants will not be paid to participate in this research project. (However, the researcher can include details such as complimentary refreshments provided during the focus group time.

Complaints

This project has been approved by the (name of ethical committee). If you should have any complaints related to this project, please address them to (address of ethical committee).

Agreement

This agreement states that you have received a copy of this informed consent information sheet. Your signature below indicates that you agree to participate in this study.

_____	_____
Signature of Subject	Date
_____	_____
Signature of Researcher	Date

Annex 4: Template for Confidentiality Agreement

Title of Research: _____

Investigator: _____ ***(name, contact details)***

The ***(name of project)*** assures confidentiality to all persons who provide information to us in this national assessment of HIV for correctional populations. As a **[*role and name of project – (e.g. interviewer for "project")]*** you may be exposed to information or materials that are of a confidential nature. This could include personal information which people choose to share with you, information that you learn in ***(edit as needed)*** meetings, trainings and workshops, and notes you take to document your involvement in the program (interviews, focus group sessions, etc.).

- Do not share any information at any time about past or present participants to anyone other than the staff involved in the project who have a need to know the information.

- Do not use the names of participants or any identifying information about participants unless you are behind closed doors and are disclosing information required as part of the project.

- Ensure that all data and notes collected for this project are not visible or accessible to persons not directly involved in the project.

- Keep all data and notes collected for this project in a secure location.

By signing this form you are agreeing to protect the confidentiality of all participants involved in the project.

I have read the above statement and agree to the terms of this confidentiality agreement.

_____	_____
Signature of Subject	Date
_____	_____
Signature of Researcher	Date

OVERALL BUDGET - OVERVIEW	
ITEM	**Total Cost in selected currency**
E1. Personnel	0.00
E2. Travel costs and subsistence allowances	
E3. Non-expendable	
E4. Consumables & supplies (or use overheads flat rate)	
E5. Sub-Contracts	
E6. Other related costs	
E7. Overheads / Administrative cost	
Total – Expenditures	(Sum of all above budget lines)

DETAILED BUDGET[59]

E1 PERSONNEL

Responsible Partner	Function	Name	Number of days	Cost - Daily rate (specify currency)	Total (Days X Cost)
MoH	Coordinator			0.00	0.00
	Researcher			0.00	0.00
	Secretary			0.00	0.00
	Administrator			0.00	0.00
	Laboratory technician			0.00	0.00
	ADD OTHERS			0.00	0.00
TOTAL STAFF COST					**0.00**

E2 TRAVEL COST AND SUBSISTENCE ALLOWANCES

A. TRAVEL

Responsible Partner	Purpose	Means of transport	Number of persons	Cost	Total (Days X Cost)
	Inception workshop in Northern Province	Flight		0.00	0.00
	Meeting with Prison services	Transport provided by X		0.00	0.00
	Field Trip to X			0.00	0.00
	ADD OTHERS			0.00	0.00
TOTAL TRAVEL COST					**0.00**

[59] More lines can be added to include items specific to the assessment and to the level of detail desired.

B. DAILY SUBSISTENCE ALLOWANCES (DSAs)					
Responsible Partner	**Purpose**	**Number of Days**	**Number of persons**	**Cost of the daily Subsistence Allowance**	**Total (Days X Persons X Cost)**
	Inception workshop in Northern Province	Flight		0.00	0.00
	Meeting with Prison services	Transport provided by X		0.00	0.00
	Field Trip to X			0.00	0.00
	ADD OTHERS			0.00	0.00
TOTAL DSAs COST					**0.00**
TOTAL FOR TRAVEL AND DSA					

E3 NON EXPENDABLE EQUIPMENT					
Responsible Partner	**Item**	**Details**	**Quantity**	**Cost**	**Total (Days X Cost)**
	Computer	Laptop for field work		0.00	0.00
	Computer	Desktop –Office		0.00	0.00
	Camera	Field work		0.00	0.00
	ADD OTHERS			0.00	0.00
TOTAL NON EXPENDABLE EQUIPMENT COST					**0.00**

E4 EXPENDABLE EQUIPMENT – SUPPLIES					
Responsible Partner	**Item**	**Details**	**Quantity**	**Cost**	**Total (Days X Cost)**
	Test kits	HIV		0.00	0.00
	Paper	Boxes of 1000		0.00	0.00
	Pens	Boxes of 50		0.00	0.00
	ADD OTHERS			0.00	0.00
TOTAL EXPENDABLE EQUIPMENT – SUPPLIES COST					**0.00**

E5 SUB-CONTRACTS					
Responsible Partner	**Type of contract**	**Details**	**Number of Days**	**Cost**	**Total (Days X Cost)**
				0.00	0.00
				0.00	0.00
	ADD OTHERS			0.00	0.00
TOTAL SUB-CONTRACT					**0.00**

E6 OTHER RELATED COST					
Responsible Partner	**Item**	**Details**	**Quantity**	**Cost**	**Total (Days X Cost)**
	Translation	Forms		0.00	0.00
	Printing			0.00	0.00
	Mailing			0.00	0.00
	Conference venues			0.00	0.00
	ADD OTHERS			0.00	0.00
TOTAL OTHER RELATED COST					**0.00**

TOTAL COST (Total E1 to E6)	**0.00**

Annex 6. Abbreviated UNGASS NCPI prison indicators

A/I/1.3	Does the [country's] multisectoral strategy address [prisoners and prisons]?
A/I/1.4	Were [prisoners] identified through a needs assessment? If yes, when was this needs assessment conducted?
A/I/1.8	Has the country ensured "full involvement and participation" of [prisoners] in the development of the multisectoral strategy? If active involvement, briefly explain how this was organised.
A/I/4.1	Which of the following programmes [among prison staff] have been implemented beyond the pilot stage to reach a significant proportion of [prison staff]? • Behavioural change communication • Condom provision • HIV testing and counselling • Sexually transmitted infection services • Antiretroviral treatment • Care and support • Others
A/I/5.1	Does the country have non-discrimination laws or regulations which specify protections for [prisoners]? If yes, briefly explain what mechanisms are in place to ensure these laws are implemented [and] briefly comment on the degree to which these laws are currently implemented
A/I/6.1	Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for [prisoners]? If yes, briefly describe the content of these laws, regulations or policies [and] briefly comment on the degree to which these laws are currently implemented
A/III/3.1	Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for [prisoners]? If yes, what elements are addressed? • Targeted information on risk reduction and HIV education • Stigma and discrimination reduction • Condom promotion • HIV testing and counselling • Reproductive health, including sexually transmitted infections prevention and treatment
A/III/5	Is there a mechanism to record, document and address cases of discrimination experienced by [prisoners]? If yes, briefly describe this mechanism.
A/III/6	Has the Government, through political and financial support, involved [prisoners] in governmental HIV-policy design and programme implementation? If yes, describe some examples.
A/III/9	Does the country have a policy to ensure equal access for [prisoners] to HIV prevention, treatment, care and support? If yes, briefly describe the content of this policy.
A/III/9.1	If yes, does this policy include different types of approaches to ensure equal access for [prisoners]? If yes, briefly explain the different types of approaches to ensure equal access for [prisoners].
B/I/2.1	Does the country have non-discrimination laws or regulations which specify protections for [prisoners]? If yes, briefly describe the content of these laws, regulations or policies: [and] briefly comment on the degree to which these laws are currently implemented
B/II *in toto*	Civil society [including prisoners] participation in HIV strategies
B/III *in toto*	Prevention Programmes [for prisoners]
B/IV *in toto*	Treatment care and support programmes [for prisoners]

Annex 7: Checklist for analysis of the national framework and the prison conditions

A. National legal and policy framework[60]

1. Which national body is responsible for the prison administration/ health care in prison?
2. Which national body pays for health care in prison?
3. Is the use of drugs illicit in the country? If yes, specify drugs?
4. Is sex-work illicit in the country a punishable offence?
5. Is sodomy illicit in the country a punishable offence?
6. Are alternatives to imprisonment available and regulated by law?
7. Are compassionate releases available and regulated by law?
8. Is the equivalence of health care in the community and in prisons regulated by law?
9. Are there legal regulations for pre-release programmes?
10. Are treatment and prevention of communicable diseases in prisons regulated by law?
11. Are treatment and prevention of drug / alcohol use in prisons regulated by law?

B. The prison system, population and living conditions

1. What is the total prison population of the country?
2. What is the prison population rate per 100,000?
3. How many prisons are there in the country/region and how are they distributed geographically?
4. How many pre-trial detention facilities are there?
5. How many young offender institutions (boys/girls) are there?
6. How many prisons are there for women?
7. What is the capacity of the prisons system and the actual occupation rate (in total and by institution for men, women, boys/girls (minors under 18), migrants/foreign nationals?
8. What are the maximum and minimum capacities of each type of prison and what are the actual occupation levels (by men/women/boys/girls)?
9. What is the percentage of prisoners on remand/awaiting trial (by men/women/boys/girls)?
10. Among sentenced persons, what is the percentage of those sentenced to less than 2 years and those sentenced to more than 5 years?
11. What is the annual prisoner turnover rate of the facility, i.e. admissions per year divided by the average census?[61]
12. Among sentenced persons, what are the percentages of all sentenced women and as a sub-set, women with accompanying children?

[60] Where possible, include the name of the legislation, or other identifier
[61] The count of prisoners on a given day

13. What are the percentages of child prisoners awaiting trial and sentenced children (minors under 18), as proportions of total prison population?[62]
14. What are the percentages of male and all female prisoners awaiting trial and sentenced male/female prisoners, as proportions of total prison population?
15. What are the percentages of all foreign nationals and all members of ethnic minority groups and sentenced foreign nationals/ethnic minorities?
16. Among sentenced persons, what is the percentage of those convicted of drug related offences?
17. What is the percentage of prisoners diagnosed as mentally ill (indicate who defines the diagnosis)?
18. Are sentenced prisoners separated from prisoners awaiting trial?
19. Are men and women separated?
20. Are children (minors under 18) separated from adults?
21. What type of accommodation is provided (individual cells, rooms for up to 6-12 people or larger dormitories)? What is the size (in square metres) of each accommodation type?
22. What is the official capacity for each cell or dormitory? How many people are there in each cell or dormitory in practice?
23. Are there windows that can be opened by prisoners? Is there adequate ventilation?
24. Is there regular running water in prisons? If not, what arrangements have been made to supply prisoners with water?
25. Do prisoners have access to clean drinking water? To what extent? Is the tap water drinkable?
26. Do toilets and washing space exist in or close to every dormitory/cell? What is the ratio of prisoners to toilets, hand-washing facilities?
27. To what extent are prisoners provided with articles necessary for personal hygiene (like soap, toothbrushes, shaving equipment)?
28. Do prisoners rely on their families or other external sources for food? Are they allowed to receive food from outside prison? What happens if a prisoner's family (or other source) is not able to provide food?
29. Is the required nutritional value of prisoners' diet determined by national law reflected in prison regulations, standing orders, etc. To what extent are the requirements met? How many calories per day do the prisoners receive?
30. Do prisoners with medical needs have access to special diets (e.g. supplementary food for HIV infected patients)? Are feeding times and medication times appropriate?
31. Are gangs an influence on prison culture? Explain.
32. What is the level of violence in the prisons (prisoner on prisoner; staff on prisoner)?
33. What is known about sexual assault?
34. What is known about sex bartering?
35. Do the conditions in the prison comply with international human rights acts, specifically the United Nations International Covenant on Civil and Political Rights?[63]

[62] E.G. Total prison population (minors and adults combined) awaiting trial and sentenced) = 100 persons; of whom 15 children are awaiting trial (=15%) and a further 25 sentenced children (=25%); a total therefore of 40% of all persons in prison of being children.

C. Health services, personnel and prevention

1. Are CSOs, Ministry of Health, National AIDS and TB agencies involved in prison health care? If so, how are they involved?
2. What diseases must be reported to the Ministry of Health?
3. Do prisons have health care quality assurance programmes? Describe.
4. Do prisons have a health surveillance system? Describe.
5. What provisions are made for continuity of care and medication on transition between community and prison and vice versa?
6. Is there an infection control plan that addresses blood-borne and airborne pathogens?
7. Are there guidelines on prevention of diseases and health care in prisons? specify
8. What is the nature of and access to medical care and what is the scope of services?
    - Intake screening
    - Treatment for drug intoxication, drug dependency and withdrawal
    - Acute medical care
    - Chronic disease care
    - Oral health care
    - Mental health care
    - Diagnostics and specialty care
    - Hospital care
9. Are there functional medical records?
10. How are the health professionals credentialed?
11. What is the complement of health care professionals (physicians, nurses, dentists, technicians, mental health professionals, others)? Is the staffing adequate to address the burden of illness among the prisoners?
12. Are staff members educated on the transmission of diseases, especially TB and HIV, and forms of protection?
13. What are the physical facilities of the prison health department?
14. What medical equipment is available? Is it adequate?
15. Are hygienic items available (syringes, sanitary napkins etc.)?
16. What preventive services are available and how are they accessible?
    - Vaccinations?
    - Voluntary HIV counselling and testing (VCT)?
    - Screening and treatment for viral hepatitis?
    - Screening and treatment for tuberculosis?
    - Isoniazid preventive therapy to prevent TB disease?

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[63] International Covenant on Civil and Political Rights, G.A. res 2299A (XXI), 21 U.N. GAOR Supp. (no. 16) at 52, Un> Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force Mar. 23, 1976. Accessed January 16, 2009 at http://www.hrweb.org/legal/cpr.html.

- Screening and treatment for STIs?
- Screening and treatment for malaria?
- Screening for chronic disease, such as asthma, diabetes, hypertension?
- Are health services provided so as to avoid transmission of bloodborne pathogens, e.g., clean needles and syringes, safe blood transfusions, safe dental care, and use of universal precautions?
- Are condoms and lubricants available? If yes, are they free of charge? (number of condoms available per prisoner/month)
- Are clean needles and syringes available to prisoners? If yes, how are needles and syringes made available?
- Are disinfectants available?
- Are conjugal visits (or intimate visits) possible?
- Do prison staff have access to HIV post exposure prevention, information HIV risk, protective equipment, training? If yes, under what circumstances?
- Is CD4 counting possible?
- Are TB patients offered HIV testing?
- Are HIV patients screened for TB?

17. Is opioid substitution treatment available where there is opioids use or where opioid dependent persons are detained? Which prisoners are eligible for treatment?
18. Are there CSOs involved in assisting with prisoners' health care?
19. Are there CSOs involved in assisting with prisoners' preparation for release?
20. Are national guidelines for diagnosis and treatment of HIV, TB, and other opportunistic infections implemented in prisons?
21. Do HIV-infected prisoners have access to antiretroviral treatment?
22. Are HIV-infected prisoners segregated from other prisoners?
23. Are HIV-infected prisoners excluded from any kind of activities?
24. Are TB-infected and contagious prisoners segregated from other prisoners?
25. Are TB-infected and contagious prisoners excluded from any kind of activities?
26. Is psychosocial support available and accessible for patients with HIV infection and AIDS?
27. Is there access to HIV drug treatment in the prison? What type of treatment (e.g. antiretroviral drugs)? What guidelines are followed?
28. Are TB management programmes (including DOTS) implemented in prisons? Describe
29. Female prisoners:
    - Do prisons offer care for pregnancy, including prenatal care, labour and delivery, and post-partum care?
    - Is prevention for mother to child transmission of HIV available and accessible?
    - Do HIV infected nursing mothers have access to powdered milk?
    - Is reproductive health care available and accessible?
    - Is follow-up treatment offered for HIV infected babies and accompanying children?

Annex 8: Template for Assessment of TB Situation and TB Control in Prison Settings

Prison: _____

Location: _____

Date: _____

Respondent (Name, Position) _____

I. Structural and administrative aspects of detention:

- Type of prison (state, county etc.)
- Type of prisoners (sentenced, remand etc.)
- Average daily prison population (number)
- Approximate number of admissions per year
- Approximate number of releases per year
- Official prisoner capacity
- Number and size of rooms (prisoner accommodation, average size in square metres)
- Number of security staff per shift
- Funding sources
- Prison resources and limitations (as viewed by respondent)
- Salaries (Mean wage per staff member and total annual salary budget)
- Infrastructure (include recreational, medical, occupational, educational facilities)
- Provision of essential needs and supplies (include Food, medicines, health services and staff, medical supplies)
- Prison conditions (as observed by interviewer) (Include overcrowding, nutrition status of prisoners, hygiene, security
- Penal reform efforts (e.g. amnesties in the last 12 months; compassionate releases etc.)

II. Aspects of Health Care

- Treatment facilities (yes/no) (If yes, describe) (If no, reasons why as offered by prison health)
- Diagnostic facilities (yes/no) (If yes, describe) (If no, reasons why as offered by prison health)
- Treatment referral facilities (yes/no) (If yes, describe) (If no, reasons why as offered by prison health)
- Collaborative TB/HIV activities (yes/no) (If yes, describe) (If no, reasons why as offered by prison health)
- Measures to decrease the burden of TB among people living with HIV
- Measures to decrease the burden of HIV among TB patients
- Availability of transportation to referral facilities (yes/no) (If yes, describe) (If no, reasons why as offered by prison health
- Health Staff
    - ✓ Number
    - ✓ Training (Doctor, professional nurse, auxiliary nurse, nurse assistant, etc.)
    - ✓ Salaries (mean annual salary per health staff member and total annual salary across each professional classification)

- Availability of supplies (yes/no)
    - ✓ Anti-TB drugs, describe.
    - ✓ Lab materials, describe.
    - ✓ Storage facilities and capacity, describe.
    - ✓ Adequate stock management, describe.
    - ✓ Sources of supplies.

III. TB specific data

a) ***TB morbidity among prisoners in the last year*****:** (Ask medical staff, check treatment cards)

TB morbidity among prisoners in the last year													
Pulmonary Tuberculosis									New extra pulmonary		TOTAL		
Smear Positive							New Smear Negative						
NEW			Relapse		Others								
M	F	Total	M	F	M	F	M	F	M	F	M	F	Total

- TB mortality in the current year (number of deaths)
- Number of prison staff with TB disease (and number of years working in prison)
- Number and percentage of HIV-positives among a) prisoner TB patients and b) prison staff
- Number of MDR-TB and XDR-TB cases detected in the last reporting period (quarterly/annual)

b) TB case finding and diagnosis

- Screening upon entry (yes/no), If yes, method for screening (physical, X-ray exam., etc.) / If no, reason(s) why as offered by prison health.
- Passive case finding (yes/no), If yes, method(s) for finding cases (physical, X-ray, sputum analysis) / If no, reason(s) why as offered by prison health.
- Other (active case finding) (yes/no) / Describe.
- If screening activities performed, either upon entry or subsequently, % and number of cases found by active versus passive case finding.
- TB Lab services in prison (Smear/culture/DST/molecular diagnosis/etc) (yes/no), If yes, describe. If no, reason(s) why as offered by prison health
- Radiology services in prison (yes/no), If yes, describe. If no, reason(s) why as offered by prison health.
- Diagnostic referral facilities for TB services (yes/no), If yes, describe. If no, reason(s) why as offered by prison health.
- Average delay in days of diagnosis.
- If screening activities performed, % and number of cases are found by active versus passive case finding

c) TB treatment

- Average delay in days between diagnosis and treatment initiation
- Chemotherapy regimens in accordance with NTP/WHO (yes/no), If yes, describe the regimen. If no, reason(s) why as offered by prison health
- Methods of ensuring treatment adherence (DOT, incentives):
- Source of anti-TB drug (funder, supplier etc)
- Are they free of charge? (yes/no), If no, reason(s) why as offered by prison health
- Has there been any drug interruption in the past 2 years? (yes/no)
- If YES, when, why, how was it resolved (or not yet resolved)? If not yet resolved, reason(s) why from prison management.

Total No. of smear-positive patients reported last year	Regimen	Treatment Outcomes						Total number evaluated
		Cured	Treatment completed	Died	Failure	Defaulter	Transfer out	
	Smear-positive new cases (1)							
	Smear-positive relapses (2)							
	Other smear-positive cases (3)							
	Total smear-positive retreatment cases (2+3)							

d) TB prevention and infection control policies:

- Isolation wards for TB patients (yes/no) If yes, describe. If no, reason(s) why as offered by prison health.
- Availability of referral for TB treatment (yes/no). If yes, where (e.g. another prison, hospital (under guard) etc.). If no, reason(s) why as offered by prison health.
- Infection control measures (managerial, administrative, environmental and respiratory protective equipment (describe)

e) Registration, recording and reporting system

- Recording and reporting of cases (National/regional): (yes/no). If YES, by whom (e.g. NTP/MOH?), If no, reason(s) why as offered by prison health.
- Registries are NTP/MOH formats? (Yes/no). If no, describe actual formats and reason(s) why not NTP/MOH format (as offered by prison health).
- Are cases reported (specified) as prison cases? (Yes/no)
- Are they included in civilian registries by the NTP? (Yes/no)
- Are referrals to appropriate services given every time when TB patients are transferred or released? (Yes/no). If yes, describe mechanism. If no, reason(s) why as offered by prison health

f) Training and Education

- Training of prison health staff (yes/no). If yes:

  - ✓ Number of Trainers
  - ✓ Type of training
  - ✓ Frequency of training
  - ✓ Date of last training

- Training to administrative staff (yes/no). If yes, describe type of training. If no, reasons why as offered by prison health.
- Information, education to prisoners (yes/no). If yes, describe type of education, information. If no, reasons why as offered by prison health

g) Program management

- Supervision/evaluation of tuberculosis control program in prison: (yes/no). If yes, describe mechanism, and by whom (e.g. NTP/MOH/MoJ/MoI).
- Frequency supervision/evaluation (e.g. annually etc)

h) Other relevant comments from observation by interviewer

Annex 9: Checklist of core indicators of stigma and discrimination

- ☐ Mandatory testing
- ☐ Segregation of prisoners with HIV
- ☐ Exclusion of infected prisoners from any kind of activity
- ☐ Failure to provide equivalence of health care
- ☐ Failure to provide supplementary food for infected prisoners
- ☐ Unwillingness of prisoners to work, eat, continue to meet or share a cell with infected prisoners
- ☐ Unwillingness of staff to provide services to infected prisoners
- ☐ Unwillingness of staff to work, eat, continue to meet or share cutlery with infected fellow staff
- ☐ Staff disagreeing with propositions that infected prisoners should be able to
    - Participate in sport
    - Cook in the prison
    - Work in the prison
- ☐ Staff agreeing that infected prisoners should be segregated
- ☐ Staff agreeing that they should be informed about prisoners' infection status
- ☐ Publicly identifiable infection status markers (e.g. different clothing, different coloured health cards etc).

Annex 10: Template questionnaire for prisoners

[Insert logos of all involved organizations, institutions and governmental bodies]

Date: Name of prison:

BAR CODE OR NUMBER	

Anonymous Study on Health in Prison Questionnaire for prisoners

(Name of organisation) is implementing a study on health in prisons, to help plan better care and prevention in prison. This study is strictly anonymous and voluntary. An independent scientific institute will analyse the information. Your personal results will not be transmitted to any one, in particular not to the prison.

1	**Are you**	Male	❑1
		Female	❑2
		Transgender	❑3
2	**How old are you / Age Group**	Younger than 19 years	❑1
		19-24 years	❑2
		25-29 years	❑3
		30-34 years	❑4
		35-39 years	❑5
		Older than 39 years	❑6
3	**Are you currently**	Remand/awaiting trial	❑1
		Sentenced /convicted	❑2
		Other	❑3
4	**Are you a**	Citizen of …..[name of the country of the study]	❑1
		Not citizen of …..[name of the country of the study]	❑2

5	**How long have you been in prison on this sentence/remand – awaiting trial?**	Less than 1 month	❑1
		1 month to less than 3 months	❑2
		3 months to less than 12 months	❑3
		1 year to less than 3 years	❑4
		More than 3 years	❑5

6	**In the last 10 years (up to today) approximately how much time have you spent in prison?**	Less than 3 month	❑1
		3 months to less than 12 months	❑2
		1 year to less than 3 years	❑3
		More than 3 years	❑4

7	**How many times have you been in prison <u>before</u> the present time?**	Never	❑1
		One time	❑2
		2 times or more	❑3

			Yes	**No**
8	**How long have you been in prison on this sentence/ remand – awaiting trial?**	HIV/AIDS	❑1	❑2
		Syphilis, other sexually transmitted infections	❑1	❑2
		Tuberculosis	❑1	❑2
		Hepatitis B	❑1	❑2
		Hepatitis C	❑1	❑2

			High risk	**Low risk**	**No risk**	**Don't know**
9	**Do you think that you are at risk of contracting the following, while in prison?**	HIV	❑1	❑2	❑3	❑4
		Syphilis and other STIs	❑1	❑2	❑3	❑4
		tuberculosis	❑1	❑2	❑3	❑4
		hepatitis B	❑1	❑2	❑3	❑4
		hepatitis C	❑1	❑2	❑3	❑4

			Yes	No	Don't know
10	**Do you think that HIV (AIDS virus) can be transmitted from an HIV infected person?**	by vaginal sexual intercourse without a condom	❑1	❑2	❑3
		by anal sexual intercourse without a condom	❑1	❑2	❑3
		by oral sex	❑1	❑2	❑3
		by contact with the toilet seat	❑1	❑2	❑3
		by drinking from the glass of an HIV infected person	❑1	❑2	❑3
		by kissing	❑1	❑2	❑3
		by a mosquito bite	❑1	❑2	❑3
		by an injection with used needles (medical and injecting drugs use)	❑1	❑2	❑3
		by common use of razor blades or tooth brushes	❑1	❑2	❑3
		by tattooing	❑1	❑2	❑3
		by sharing blood in brotherhood rituals	❑1	❑2	❑3
		by shaking hands	❑1	❑2	❑3
		by breastfeeding	❑1	❑2	❑3
		from mother to child during pregnancy and child birth	❑1	❑2	❑3

			Yes	No	Don't know
11	**If you knew that someone is HIV infected, would you accept?**	eating with him/her	❑1	❑2	❑3
		by anal sexual intercourse without a condom	❑1	❑2	❑3
		continuing to meet or associate with him/her	❑1	❑2	❑3
		sharing a cell with him/her	❑1	❑2	❑3

12	**Do you think that <u>hepatitis B</u> can be transmitted from an infected person?**		**Yes**	**No**	**Don't know**
		by vaginal sexual intercourse without a condom	❑1	❑2	❑3
		by anal sexual intercourse without a condom	❑1	❑2	❑3
		by oral sex	❑1	❑2	❑3
		by contact with the toilet seat	❑1	❑2	❑3
		by drinking from the glass of an HIV infected person	❑1	❑2	❑3
		by kissing	❑1	❑2	❑3
		by a mosquito bite	❑1	❑2	❑3
		by an injection with used needles (medical and injecting drugs use)	❑1	❑2	❑3
		by common use of razor blades or tooth brushes	❑1	❑2	❑3
		by tattooing	❑1	❑2	❑3
		by sharing blood in brotherhood rituals	❑1	❑2	❑3
		by shaking hands	❑1	❑2	❑3
		by breastfeeding	❑1	❑2	❑3
		from mother to child during pregnancy and child birth	❑1	❑2	❑3

13	**Do you think that <u>hepatitis B</u> can be transmitted from an infected person?**		**Yes**	**No**	**Don't know**
		by vaginal sexual intercourse without a condom	❑1	❑2	❑3
		by anal sexual intercourse without a condom	❑1	❑2	❑3
		by oral sex	❑1	❑2	❑3
		by contact with the toilet seat	❑1	❑2	❑3
		by drinking from the glass of an hepatitis C infected person	❑1	❑2	❑3
		by kissing	❑1	❑2	❑3
		by a mosquito bite	❑1	❑2	❑3
		by an injection with used needles (medical and injecting drugs use)	❑1	❑2	❑3
		by common use of razor blades or tooth brushes	❑1	❑2	❑3
		by tattooing, piercing	❑1	❑2	❑3
		by sharing blood in brotherhood rituals	❑1	❑2	❑3
		by shaking hands	❑1	❑2	❑3
		by breastfeeding	❑1	❑2	❑3
		from mother to child during pregnancy and child birth	❑1	❑2	❑3

			None	Some	Many	Most	Don't know
14	**According to you, how many prisoners are using one or more of the following drugs in this prison**[64]	cannabis	❑1	❑2	❑3	❑4	❑5
		alcohol (all forms of alcohol incl. self brewed alcohol liquids)	❑1	❑2	❑3	❑4	❑5
		heroin /opioids	❑1	❑2	❑3	❑4	❑5
		opiates	❑1	❑2	❑3	❑4	❑5
		cocaine	❑1	❑2	❑3	❑4	❑5
		amphetamines	❑1	❑2	❑3	❑4	❑5
		tablets without prescription	❑1	❑2	❑3	❑4	❑5
		other	❑1	❑2	❑3	❑4	❑5

			inside and outside prison	only outside prison	only inside prison	never used
15	**Which, if any, of the following have you used…?**[65]	cannabis	❑1	❑2	❑3	❑4
		alcohol (all forms of alcohol incl. self brewed alcohol liquids)	❑1	❑2	❑3	❑4
		heroin / opioid	❑1	❑2	❑3	❑4
		cocaine	❑1	❑2	❑3	❑4
		amphetamines	❑1	❑2	❑3	❑4
		tablets without prescription	❑1	❑2	❑3	❑4

16	**According to you, how many prisoners are INJECTING DRUGS in this prison?**	None	❑1
		Few	❑2
		Many	❑3
		Most	❑4
		Don't Know	❑5

17	**Have you EVER INJECTED drugs?**	Yes, inside and outside prison	❑1
		Yes, only outside prison	❑2
		Yes, only inside prison	❑3
		No, never	❑4

[64] Choose categories according to predominantly used drugs in population and use the local language name of the substances.
[65] Choose categories according to predominantly used drugs in population and use the local language name of the substances

18	**How many times have you injected in the last month?**	Number of times	
		Does not apply to me	❑99
19	**How old were you when you <u>first</u> injected drugs? (in years)**	Age	
		Does not apply to me	❑99
20	**The FIRST time you ever injected drugs, was that inside prison?**	Yes	❑1
		No	❑2
		Does not apply to me	❑99
21	**BEFORE getting arrested, when was the last time you injected?**	on the day you were arrested	❑1
		in the week before	❑2
		in the month before	❑3
		in the year before	❑4
		more than 1 year before	❑5
		does not apply to me	❑99

22	**BEFORE coming into prison, have you shared any of these injection items / tools with someone else?**		**Always**	**Sometimes**	**Never**	**Does not apply to me**
		Needles (spikes) or syringes (barrels)?	❑1	❑2	❑3	❑99
		Other (filters, spoons water etc.)?	❑1	❑2	❑3	❑99
23	**While IN PRISON, have you ever shared any of these injection items / tools with someone else?**		**Always**	**Sometimes**	**Never**	**Does not apply to me**
		Needles (spikes) or syringes (barrels)?	❑1	❑2	❑3	❑99
		Other (filters, spoons water etc.)?	❑1	❑2	❑3	❑99

24	**Do you think that <u>tuberculosis (TB)</u> can be spread from an infected person**		**Some-times**	**Never**	**Does not apply to me**
		By breathing the air around a person who is sick with TB	❑1	❑2	❑3
		By sharing eating/drinking utensils	❑1	❑2	❑3
		Through semen or vaginal secretions shared during sexual intercourse	❑1	❑2	❑3
		From smoking	❑1	❑2	❑3
		From mosquito or other insect bites	❑1	❑2	❑3

			True	False	Don't know
25	**Based on your knowledge please indicate for each of the following sentence related to tuberculosis (TB) if is true or false**	The risks for TB transmission are higher in prison than in the community	❑1	❑2	❑3
		A person who is coughing for more than 2-3 weeks should be suspected for tuberculosis	❑1	❑2	❑3
		Tuberculosis can be cured with appropriate medications	❑1	❑2	❑3
		To prevent the spread of tuberculosis in a prison, one should keep doors and windows of the cells closed	❑1	❑2	❑3
		Cloth or paper mask (surgical mask) for contagious TB patients is effective to prevent tuberculosis transmission	❑1	❑2	❑3
		TB patients remain contagious during the entire duration of the treatment	❑1	❑2	❑3
		The risks for TB transmission are higher in prison than in the community	❑1	❑2	❑3

			True	False	Don't know
26	**In this prison, have you…, any of the following: ?**	heard about or witnessed sexual violence (sex against somebody's will)	❑1	❑2	❑3
		heard about or witnessed other physical violence (fist fights, attacks with weapons)	❑1	❑2	❑3
		heard about or witnessed psychological violence (threats, bullying, intimidation)	❑1	❑2	❑3
		been forced into sex	❑1	❑2	❑3
		forced someone else into sex	❑1	❑2	❑3
		been involved in consensual sex with another prisoner	❑1	❑2	❑3
		been involved in consensual sex with staff member	❑1	❑2	❑3
		been involved in consensual sex with visitors	❑1	❑2	❑3
		been involved in sexual violence	❑1	❑2	❑3

			No one	Few	Many	Almost all
27	**To what extent are prisoners in this prison involved in the following behaviours?**	Consensual sex between prisoners	❑1	❑2	❑3	❑4
		Consensual sex between prisoners and staff?	❑1	❑2	❑3	❑4
		Consensual sex between prisoners and visitors (excluding conjugal visits)?	❑1	❑2	❑3	❑4

			Yes, regu-larly	Yes, occasio nally	No	Don't know
28	**Do some prisoners provide sex to others for money, goods or services?**	Do some prisoners provide sex to others for money, goods or services?	❑1	❑2	❑3	❑4
		Have some prisoners been "tricked" by unknowingly offered goods or services for sex?	❑1	❑2	❑3	❑4

29	**Have you ever paid/accepted money/goods for sex in prison?**	Yes	❑1
		No	❑2

			Yes	No	Don't know
30	**Has a health professional ever told you that you are infected with:**	HIV	❑1	❑2	❑3
		Other STI's	❑1	❑2	❑3
		Tuberculosis	❑1	❑2	❑3
		Hepatitis B	❑1	❑2	❑3
		Hepatitis C	❑1	❑2	❑3

			Yes	No	Does not apply
31	**Was your treatment for any of the following interrupted <u>upon</u> your arrest?**	HIV	❑1	❑2	❑3
		Tuberculosis	❑1	❑2	❑3
		Hepatitis C	❑1	❑2	❑3
		Drug dependence (except substitution therapy)	❑1	❑2	❑3
		Substitution therapy (Methadone or buprenorphine)	❑1	❑2	❑3

			Yes	No	Does not apply
32	**Was your treatment for any of the following interrupted <u>during</u> your stay in prison?**	HIV	❑1	❑2	❑3
		Tuberculosis	❑1	❑2	❑3
		Hepatitis C	❑1	❑2	❑3
		Drug dependence (except substitution therapy)	❑1	❑2	❑3
		Substitution therapy (Methadone or buprenorphine)	❑1	❑2	❑3

33	Inside prison, have you ever …[66]		Yes	No
		shared a razor blade (shaving or hair cut)	❑1	❑2
		shared a toothbrush	❑1	❑2
		been tattooed	❑1	❑2
		been pierced (e.g. for earring)	❑1	❑2
		been involved in a blood sharing ritual	❑1	❑2

34	While in this prison, have you been given :		Yes	No
		information on HIV	❑1	❑2
		Information on hepatitis C and B	❑1	❑2
		Information on condoms	❑1	❑2
		Information on lubricants	❑1	❑2
		Information on tuberculosis (TB)	❑1	❑2
		Information on cough hygiene	❑1	❑2
		Information on Anti Retroviral Therapy (ART)	❑1	❑2
		Information on Prevention of mother to child transmission (PMTCT)	❑1	❑2
		Information on alcohol and drugs	❑1	❑2
		Information on Sexual and Reproductive Health	❑1	❑2
		Information on clean needles and syringes	❑1	❑2
		Information on bleach (disinfectants)	❑1	❑2
		Information on voluntary HIV counselling and testing	❑1	❑2
		Information on Positive Living	❑1	❑2
		Information on Male Circumcision	❑1	❑2

[66] N.B.: Other country specific risk behavior should be listed here

			Yes	No
35	**In this prison, are the following available?**	HIV Voluntary counselling and testing?	❑1	❑2
		Screening for tuberculosis	❑1	❑2
		Treatment for tuberculosis	❑1	❑2
		Prevention of mother to child transmission treatment (PMTCT)	❑1	❑2
		Antiretroviral Therapy (ARV) for HIV	❑1	❑2
		Male circumcision	❑1	❑2
		Supplementary feeding for HIV or TB patients	❑1	❑2
		Sexual and reproductive health	❑1	❑2
		Condoms	❑1	❑2
		Lubricants	❑1	❑2
		Needles and syringes for injecting drug users	❑1	❑2
		Testing for hepatitis C and B	❑1	❑2
		Hepatitis A vaccination	❑1	❑2
		Hepatitis B vaccination	❑1	❑2
		Treatment for hepatitis C	❑1	❑2
		HIV Post-exposure prophylaxis (PEP)	❑1	❑2
		Drug treatment (other than methadone / buprenorphine)	❑1	❑2
		Opioid substitution therapy (methadone and/or buprenorphine)	❑1	❑2
		Masks for (suspected) tuberculosis patients as long as they are contagious	❑1	❑2

36	**Is the quality of health care in this prison… than in the community**	Better	❑1
		Equal	❑2
		Worse	❑3

QUESTIONS FOR FEMALE PRISONERS ONLY

37	**Do women in this prison have access to services**	Yes	❑1
		No	❑2
		Don't know	❑3

38	**Do women with babies in this prison have access to replacement feeding / powder milk?**	Yes	❑1
		No	❑2
		Don't know	❑3

Annex 11: Template for recruitment of prisoners for survey

Example of the information to be given to prisoners when recruiting for the survey [67] [68]

- We would like to inform you about a study which we will carry out today at (name of prison). We need your support for this study. This study is carried out by (name organisation of principal investigator) and will be conducted in other prisons in country.
- We will give you a detailed introduction about the purpose of our study. You will have enough time to discuss all points, to clear possible doubts, and to encourage you to raise any questions. The main objective of the study is to collect information to improve the health services care and in particular on HIV /TB for prisoners and reduce the risks of diseases for prisoners, staff and their families.
- We are conducting a study about (List the issues addressed by the study here, i.e. HIV and AIDS, TB, hepatitis and related risky behaviours in prison). We want to collect reliable data and information about the extent of (Include list of addressed infections here) among prisoners and behaviours and circumstances that are related to health, and the level and quality of preventive and curative health care you receive, so that we can better deal with these issues.
- Your participation in the study is absolutely voluntary; no one is obliged to take part. However, we do want to point out that this study can only be of high quality if we will have as many participants as possible. It is important for you to take part, even if you might be of the opinion that the questions do not concern you.
- Your participation in this study is strictly anonymous. Neither names nor any other attributable data, like dates of birth, need to be filled out in these questionnaires. Personal information is treated confidentially and under no circumstances will it be transmitted any person or organisation. The results of this survey will be evaluated and summarised by (name organisation) and a feedback of the results to the participants will be given by (name organisation and time).
- Are there any questions so far?
- We would like to ask you to fill out a short questionnaire, (show questionnaire) and to leave us 5 ml of your blood (or a saliva sample, as applicable). With these drops of blood (saliva sample) we can detect the AIDS virus (hepatitis infection).
- Sputum samples will be taken from a sample of prisoners[69]
- After you filled out the questionnaire, please pass it to (study team member)[70]. We will then take your blood (or saliva) sample. We will put an identical label on both the questionnaire and your blood (or

[67] This oral information can also be translated into a short written information sheet that might be displayed at the notice board of the respective departments/wings of the survey prisons. However, it is strongly recommended to inform the prisoners face to face about the survey, without giving written information in advance. Written information might be misunderstood and since rumours spread easily inside prisons it might be discussed in a way that can strongly bias the participation rates.

[68] Can be adapted in case that hepatitis and/or tuberculosis are also covered

[69] Optional, in case that TB screening is part of the assessment

[70] For settings where no self administered questionnaires will be used, this sentence has to be adopted respectively: “After we conducted the interview with you,…”

saliva) sample which help us to connect the information of the questionnaires with the blood drops (or saliva sample) without identifying you personally.

- Questionnaires are available in different languages (mention available languages).
- Introduce all study team members with name, title function and languages spoken.
- For those who have problems with reading, please let us know and a study team member will assist you with answering the questions while ensuring that your answers remain confidential.
- We would like to ask you to answer as many questions as possible. But of course you are free to answer only those questions you feel comfortable with (mention confidentiality).
- Since this as an anonymous study, we cannot inform you of the results of your individual tests. (Describe procedure how prisoners can get individual test results like: “However, you have the possibility to carry out an individual test in the medical department of this prison.”)
- On completion of the study, we will however provide you with feedback on the aggregated results.
- Do you have any more questions?

Annex 12: Sampling Methodology

It is important to take the following elements into consideration when designing and implementing the sampling strategy:

1) **The goal of the assessment:** this will assist in determining the sample population, how to sample and what facilities to include in the sampling frame.
2) **The data to be collected:** the prevalence of the event sought plays a role in determining the minimum sample size to be achieved.
3) **The desired degree** of accuracy that the investigators are willing to accept.
4) **Subpopulations of interest:** the study population may be divided into subpopulations of interest with varying behavioural or HIV prevalence. Different strategies and sample sizes may be needed for the subpopulations. Access to the subpopulations may be restricted by the prison authority.

Broadly speaking, there are two types of sampling strategies: random and convenience. Although random sampling is best for obtaining accurate estimates, convenience sampling may be more appropriate in some situations.

When the investigators wish to estimate the HIV prevalence in a heterogeneous prison system composed of multiple facilities or locations, the following particulars should be considered when developing a representative sampling strategy.

- Is the total number of persons in the correctional population known (i.e., average daily population (ADP)?
- Is there detailed information about the study population? If possible, obtain information on gender, estimated HIV prevalence, security classification and segregation, housing unit structure, geographic distribution of facilities, etc.
- Can a sample be selected from the entire prison system to assure representativeness? Where all prisons are not included in the sampling frame, give preference to prisons with more diversified populations.
- Are prisoners housed in special units depending on their classification? Each of these classes of prisoners may have quite varied risk factors and HIV prevalence, and consideration should be given to ensuring access to these prisoners. For example, a large prison may have special housing units for female prisoners, prisoners in treatment for substance abuse, prisoners who have a history of injection drug use, foreigners in remand awaiting trial and/or deportation, and juveniles.
- Does the correctional system include different pre-trial facilities and prisons for convicted persons? If so, the sampling frame should include subjects from both types of facilities.

The Principal Investigator should be as practical as possible, focusing on how representative the sample is to the overall population, and making adjustments where necessary, e.g., weighted sample based on gender, risk characteristics, etc. In situations where obtaining a representative sample of the country's prison population is challenging, the Steering Committee and the Principal Investigator may decide that a non-representative sample

would be required. Whether or not a representative sample is obtained, the Steering Committee and the Principal Investigator should address the limitations of the sampling design in reports and publications.

Selecting facilities

The number of target facilities selected depends on the number of facilities and access to the facilities. The first step is to obtain a list of all prisons, remand, and juvenile facilities in the national system. If it is logistically possible, all facilities should be included in the sampling frame. If there are a large number of facilities, consider selecting a subset of facilities. Facilities may be selected according to a simple random sample, with each facility having an equal probability of selection. Alternatively, facilities may be selected proportional to the size of the prison population, with larger facilities having a greater probability of selection. The characteristics of the prison population should also be considered when selecting the facilities. If national systems house prisoners with certain characteristics in specific institutions, consideration should be given to selecting these facilities. Such characteristics may include juvenile facilities, female facilities, or facilities that house injection drug users, or persons living with HIV/AIDS. The prisoners in these facilities may provide information significantly different from prisoners in other prisons, and therefore, should be included in the sample. Facilities may also be selected according to the regional distribution of HIV prevalence, or based on logistical issues (proximity to the capital city, warden granting permission to enter), although these criteria tend to limit generalizability.

Selecting prisoners for assessment and testing

Once facilities are selected, prisoner sampling is required to reach the target sample size. Prisoner sampling strategies may differ according to the design of facility and the availability of specific information. Prisoner sampling will likely differ for prisons and remand facilities (jails).

Prisons

In some countries a roster of prisoners will be available for prisoner selection. If a roster is unavailable, a rough estimate of the prisoner average daily population (ADP) can be used to select prisoners (see below). The ADP can be divided by the total number of prisoners needed to be approached to reach the target sample size. For example, if the ADP is over 100,000 prisoners, and it is estimated that 50% will participate in the assessment, and the target sample size is 383 prisoners, then you would need to approach 766 prisoners (383X2). One in every 130 prisoners should be selected, approached, and asked to participate (766/100,000=1/130). The design of the facility can be incorporated into the random selection. For example, if there are 10 different blocks or buildings with 250 cells each and approximately 1000 prisoners per block (4 per cell), and there are no differences between the blocks, then sampling could be restricted to fewer blocks within the facility (e.g., 2 blocks) and a lower sampling ratio (e.g., every 3rd prisoners approached and asked to participate). If blocks contain different types of populations (e.g., female prisoners, juvenile prisoners, prisoners on lock down) then consider if these populations should be included. If they are to be included, the investigator must determine the required sample size for each of the sub-populations and take this into consideration.

If the ADP is not known, then a rapid census to estimate the ADP could be conducted during times when prisoners are available, such as during meal times. A rapid census can be achieved through several systematic approaches. One relatively simple strategy would be to count the number of prisoners in one housing unit, cell, or structured activity (e.g., meal time). This number would then be multiplied by the total number of units, cells, or structured activities to determine the ADP. If the units or structures vary in size, accommodations will need to be made to take the variations into consideration. Following the rapid census, every n^{th} prisoner could be

selected during a subsequent meal time as above. The prisoners could be identified and approached a later time.

Pre-trial facilities

The selection of detainees in pre-trial facilities to participate may require additional methods because of the rapid turnover of prisoners. One method may be to select persons released from pre-trial facilities over several days. This method may tend to capture persons who are arrested and released in a relatively short period of time (less than 2 days) and less likely to have served a longer sentence. The design of the facility may also affect the selection of individual detainees to be approached and asked to participate. If all persons in the pre-trial facilities are eligible, then methods for selection within large holding cells may be needed. If only prisoners serving longer sentences are eligible, then methods used in prisons above may be sufficient if exclusionary criteria are included that requires participants to have been detained for a minimum period of time.

Alternative sample selection methods

To the extent that representative samples cannot be drawn, for logistical or political reasons, the Steering Committee and the Principal Investigator may decide to rely on other methods. Two examples of selecting potential subjects could include:

- a serial sample of discharging prisoners;
- a serial sample of prisoners entering or leaving a common area;

These alternative strategies will allow for a selection of participants who are likely to represent many of the prisoners, but will not represent those who are not being released or are detained in restricted locations.

A convenience sample of prisoners who are “recommended” by the correctional staff or other prisoners should **not** be used to conduct assessment activities, unless all other strategies have been exhausted. This could result in a biased sample and therefore, data collected may not be representative of the population. Conclusions and recommendations based on data from this design may not be valid.

Sample Size

An adequate sample size is necessary to ensure that the results are representative of the study population.

Determining the necessary sample size depends on:

1. Size of the population of interest: An estimate of the population size is adequate, and this is less important when the population is large. When the population size is small, an adjustment in the calculated sample size may be needed.
2. Prevalence of the variable of interest: When the variable of interest (risk behaviour or HIV prevalence) in the correctional population is unknown, use an estimated rate that is 1.5 to 2 times that of the estimated HIV prevalence in the non-incarcerated population of the region. If both rates are unknown, an estimate that will get you the most conservative sample size is 50% (the sample size in this situation will not be optimally efficient but will be conservative enough to cover the true population rate).
3. Precision: The degree of accuracy that the investigators are willing to accept between the true population prevalence and the estimated prevalence. Typically, a difference of 5 percent is an

acceptable benchmark. For example, if your survey finds that 25 percent of the sample has a certain characteristic, the actual rate in the population may be between 20 and 30 percent.

4. Confidence interval (CI): a range of values that you would expect the true value to fall between. A 95% CI would mean that the value would be within the range 95% of the time and outside the range 5% of the time.

5. Refusal rate: not all subjects that are invited to participate in the activity will accept. Based on prior experience or evidence from similar situations, an estimated refusal rate should be anticipated. The number of subjects to approach must be calculated based on the required sample size and the anticipated refusal rate. For example, if the required sample size is 224, and an anticipated refusal rate is 20%, then the projected number of subjects to approach would be 269.

When the investigators wish to estimate the prevalence of HIV infection in a single, relatively homogeneous study population, they may take a random sample of *n* persons (based on required sample size) from this population, and assess their HIV infection status. Suppose *x* individuals test positive and (*n* – *x*) individuals test negative. Then the proportion *p* = *x*/*n* estimates the proportion of HIV infected persons in the study population. For example, if n = 150, and x = 45, then p = 0.30. Therefore, the estimated prevalence is 30% (also referred to as point estimate).

Calculating the Confidence Interval around a point estimate

This point estimate is only a single observation that comes from a sample of the population. This estimate should be presented with a measure of uncertainty to describe where the true population proportion is assumed to lie. Typically, a 95% confidence interval is an acceptable confidence level to present on the values around which the true population proportion lies.

For a 95% confidence interval, the true population proportion lies within +/- 1.96 standard deviations from the point estimate. An approximate estimate for the standard deviation of the true population for large samples is p * (1-p) / n.

Where “p” is the point estimate and “n” the sample size. For large populations, one popular approximate formula for a 95% CI has the form:

lower p – 1.96*SE, upper = p + 1.96*SE.

Thus, if n = 150 and p = 0.30 (or 30%),

The SE = $\sqrt{[(0.30*0.70)/150]}$ = 0.0374,

The 95% CI is:

lower = 0.30 – 1.96*0.0374 = 0.227,

upper = 0.30 + 1.96*0.0374, = 0.373

Therefore, the prevalence would be written as 30% with a 95% CI (22.7% - 37.3%).

Determining the required sample size

Sample size calculators are available on the internet, including: Epi Info or http://www.raosoft.com/samplesize.html. Alternatively, sample sizes can be calculated using the following formula presented below:

$$n = (t^2pq)/d^2$$

Where:

n = first estimate of sample size (minimum sample size for large population)
t = confidence interval (if 95% use 1.96)
d = precision (0.05)
p = estimated prevalence (proportion) in target population
q = 1-p

Illustration:

Study population is over 500,000 (large population)
Desired Confidence Interval is 95%
Precision desired is 0.05
Estimated prevalence of HIV is 20% (proportion is 0.2)
Estimate of uninfected persons is 80% (proportion is 0.8)
Sample size estimate is "n"
n = (t2pq)/d2
n = (1.96 x 1.96 x 0.2 x 0.8) / (0.05 x 0.05)
n = 246

Therefore, you would need 246 people in your sample.

If you want to be able to have stratum-specific estimates where the population size and prevalence estimates are similar, you would need 246 in each stratum, e.g., 246 men, 246 women, etc. If the population size or the prevalence estimates differ by strata, the sample size for each stratum would vary.

In a similar case with an estimated HIV prevalence of 5%, the sample size for each stratum (for example, gender, age group, or range of time in custody) would be 73.

Adjusting the calculated sample size based on estimated population size

In smaller populations, a given sample size provides proportionately more information than it would for a large population. Therefore, as the size of the population of interest decreases, the investigator can reduce the required sample size. This is illustrated in Table and the formula to adjust the sample size is provided below. Usually, if n is greater than 10% of the total study population, the sample size should be adjusted using the formula below to reduce the required sample size to the final sample size n_f as shown in the formula below:

$$n_f = n/(1+n-1/N)$$ where n_f = is final sample size

Table 1: **Sample sizes required based on a 5% margin of error and 95% confidence interval by estimated population size.**

Population size	Estimated Prevalence in target population								
	50%	40%	30%	25%	15%	10%	5%	2%	1%
500,000	385	369	323	289	196	139	73	31	16
100,000	383	368	322	288	196	139	73	31	16
50,000	382	367	321	287	196	138	73	31	16
25,000	379	364	319	285	195	138	73	31	16
10,000	370	356	313	281	193	137	73	31	16
1,000	278	270	245	224	164	122	69	30	15
750	255	248	226	209	156	117	67	29	15
500	218	213	197	184	144	109	64	29	15
250	152	150	142	135	111	90	57	27	15

Note: Increase sample size based on estimated refusal rate

Annex 13: Template for standard oral information (short form)

We would like to inform you about a study which will be carried out today at (name of prison). We need your support for this study. This study is carried out by (name organisation of principal investigator) and will be conducted in other prisons in country.

We are conducting a study about HIV and AIDS, TB, hepatitis and related risky behaviours in prison. We want to collect reliable data and information about the extent of HIV and hepatitis (jaundice) infections among prisoners and behaviours and circumstances that are related to health, and the level and quality of preventive and curative health care you receive, so that we can better deal with these issues.

You have been randomly selected to take part. Participation in the study is absolutely voluntary; no one is obliged to take part. However, we do want to point out that this study can only be of high quality if we will have as many participants as possible. It is important, if you are selected for you to take part, even if you might be of the opinion that the questions do not concern you.

Participation in this study is strictly anonymous. Neither names nor any other attributable data, like dates of birth, need to be filled out in these questionnaires. Personal information is treated confidentially and under no circumstances will it be transmitted any person or organisation. The results of this survey will be evaluated and summarised by (name organisation) and a feedback of the results to the participants will be given by (name organisation and time).

Participants will fill out a short questionnaire (show questionnaire), and to leave us 5 ml of blood (or a saliva sample, as applicable). With these drops of blood (and/or saliva sample, as applicable) we can detect the AIDS virus (hepatitis infection).

Sputum samples will also be taken from a sample of prisoners[71]

Any questions?

We look forward to your participation

[71] Optional, in case that TB screening is part of the assessment

Annex 14: Template for standard information for prison staff

Anonymous Study on Health in Prison Survey among prison staff

The (name all involved organisations) plan to carry out a study on HIV infection and HIV/TB diseases in prisons to improve prevention, care and safety inside prisons in (country), for both prison officers and prisoners. We invite you to contribute to this study by sharing your experiences and your professional competence with us.

In (country) the study comprises an epidemiological investigation (HIV,TB, hepatitis B and C) of (number) prisoners as well as a survey/interviews among (number of) prisoners and a total of (number) prison staff in the same prisons in which the epidemiological investigation among prisoners takes place.

The survey of prison staff serves to explore the knowledge of practitioners and experts in the individual prison, to let this information flow into the investigation and to utilise this knowledge for the improvement of the health and safety of prison staff and prisoners in (country).

The study is an appraisal of general problems in prison and in particular, the impact of communicable disease, including the implications for prison staff. This includes the relevant risk behaviour of prisoners relative to drug consumption and sexual and other risky behaviours. The perception of this complex of problems from the view of the staff, and their opinion as to the appropriate handling of the situation stands in the centre of our interest.

Your participation in this study is voluntary and strictly anonymous. Neither names nor departments nor any other attributable data like dates of birth need to be filled out in these questionnaires. Personal results are treated confidentially and will, under no circumstances, be transmitted to any person or organisation. The results of this survey will be evaluated and summarised by (name organisation) and feedback of the results to the participants will be given by (name organisation) at the completion of the study, without any individual identifiers.

Annex 15: Template for prison staff questionnaire

[Insert logos of all involved organizations, institutions and governmental bodies]

Date: Name of prison:

BAR CODE OR NUMBER	

Anonymous Study on Health in Prison: Questionnaire for prison staff

(Name of organisation) is conducting a study about communicable diseases in prison to support preventive measures and services. Participation in this study is voluntary and strictly anonymous. Your personal results will not be transmitted to anyone. We invite you to contribute to this study by sharing your experiences and your professional competence with us.

Thank you in advance for your collaboration and honesty.

1	**How old are you / Age Group**	Years	
2	**Are you**	Male	❑1
		Female	❑2
		Transgender	❑3
3	**What is your highest educational level with regard to the task performed in prison?**	unskilled	❑1
		semi-skilled (small introduction)	❑2
		trained/skilled (for example having a certificate as warden)	❑3
		college/university degree (i.e. lawyer, doctor)	❑4
4	**How long have you been working in the prison service?**	Years	

5	**What is your actual professional rank?**	Administrative worker	❑1
		Prison officer	❑2
		Officer in charge	❑3
		Psychologist	❑4
		Social worker	❑5
		Nursing staff	❑6
		Physician	❑7
		Other	❑8

6	**In which section of the prison do you spend MOST of your working time?**	in administration	❑1
		in all sections / units	❑2
		in isolated quarters	❑3
		in medical service	❑4

7	**Do the following problems exist in your prison?**	**Yes**	**No**	**Does not apply**
	poor hygiene of the premises	❑1	❑2	❑3
	too few staff	❑1	❑2	❑3
	risk to staff safety	❑1	❑2	❑3
	lack of protective supplies (gloves, etc.)	❑1	❑2	❑3
	overcrowding	❑1	❑2	❑3
	lack of information on communicable diseases	❑1	❑2	❑3

8	**Have you ever heard of one of the following:**		**Yes**	**No**
		HIV	❑1	❑2
		Syphilis and other STI's	❑1	❑2
		tuberculosis	❑1	❑2
		hepatitis B	❑1	❑2
		hepatitis C	❑1	❑2

9	**How do you assess your knowledge on**		**Excellent**	**good**	**Poor**	**None**
		HIV	❑1	❑2	❑3	❑4
		Syphilis and other STI's	❑1	❑2	❑3	❑4
		hepatitis B	❑1	❑2	❑3	❑4
		hepatitis C	❑1	❑2	❑3	❑4

10	**How do you assess your knowledge on**		Exists and disturbs my work	Exists but does not disturb my work	Does not exist	Don't know
		drug use of prisoners	❑1	❑2	❑3	❑4
		drug trafficking in the prison	❑1	❑2	❑3	❑4
		prisoners hiding syringes in the cells	❑1	❑2	❑3	❑4
		Prisoner alcohol use	❑1	❑2	❑3	❑4
		Violence	❑1	❑2	❑3	❑4
		sexual contacts between prisoners	❑1	❑2	❑3	❑4
		Sexual contact between prisoners and staff	❑1	❑2	❑3	❑4
		Sexual contact between prisoners and members of the community (excepting conjugal visits)	❑1	❑2	❑3	❑4
		Conjugal visits between prisoners and their sexual partners	❑1	❑2	❑3	❑4
		HIV infection among prisoners	❑1	❑2	❑3	❑4
		tuberculosis infection among prisoners	❑1	❑2	❑3	❑4
		hepatitis (viral infection of the liver) among prisoners	❑1	❑2	❑3	❑4

11	**Do you think that because of your work you are at risk of contracting**		**High risk**	**Low risk**	**No risk**	**Don't know**
		HIV	❑1	❑2	❑3	❑4
		Syphilis and other STIs	❑1	❑2	❑3	❑4
		tuberculosis	❑1	❑2	❑3	❑4
		hepatitis B	❑1	❑2	❑3	❑4
		hepatitis C	❑1	❑2	❑3	❑4

12	**During your work in prison, have you ever been confronted with an event which made you fear you may become infected with**		**Yes**	**No**
		HIV	❑1	❑2
		Syphilis and other STI's	❑1	❑2
		tuberculosis	❑1	❑2
		hepatitis B	❑1	❑2
		hepatitis C	❑1	❑2

			Yes	No
13	**During your work in prison, have you ever experienced an injury with blood exposure?**	during a fight	❑1	❑2
		accidental puncture in medical service or with medical waste	❑1	❑2
		accidental puncture with hidden needles from injecting drug user (during a search)	❑1	❑2
		accidental puncture with needles used for tattooing or piercing (during a search)	❑1	❑2
		others	❑1	❑2

14	**Have you been trained on what to do in case of blood exposure?**	Yes, within the last 12 months	❑1
		Yes, more than one year ago	❑2
		No	❑3
15	**Have you received a written guideline on what to do in case of blood exposure?**	Yes	❑1
		No	❑2

			No one	Few	Many	Almost all	Don't know
16	**For each following, in your opinion, how many prisoners in this prison are infected with[72]:**	HIV	❑1	❑2	❑3	❑4	❑5
		Syphilis and other STIs	❑1	❑2	❑3	❑4	❑5
		tuberculosis	❑1	❑2	❑3	❑4	❑5
		hepatitis B	❑1	❑2	❑3	❑4	❑5
		hepatitis C	❑1	❑2	❑3	❑4	❑5

			Yes	No	Don't know
17	**Have you ever heard of/or experienced violence among prisoners in this prison?**	sexual violence (sexual abuse or sexual exploitation against somebody's will)	❑1	❑2	❑3
		other physical violence (fist fights, attacks with weapons)	❑1	❑2	❑3
		psychological violence (threats, bullying, intimidation)	❑1	❑2	❑3

[72] N.B.: Choose categories according to actual prevalence in the general population of your country or according to presumed prevalence in prisons

			Yes	No	Don't know
18	**Have you ever heard of / or experienced violence between prisoners and prison officers in this prison?**	sexual violence (sexual abuse or sexual exploitation against somebody's will)	❑1	❑2	❑3
		other physical violence (fist fights, attacks with weapons)	❑1	❑2	❑3
		psychological violence (threats, bullying, intimidation)	❑1	❑2	❑3

			Yes	No	Don't know
19	**What forms of sexual contacts occur within this prison?**	conjugal visits with wife/partner/girlfriend	❑1	❑2	❑3
		consensual sex between prisoners	❑1	❑2	❑3
		Unauthorised sexual contacts between prisoners and community (other than conjugal visits)	❑1	❑2	❑3
		rape (forced or non-consensual sex) between prisoners	❑1	❑2	❑3
		sexual intercourse between prisoners as a form of currency (i.e. to pay for goods, services, or favours)	❑1	❑2	❑3
		consensual sex between prisoners and prison staff	❑1	❑2	❑3
		Non-consensual sex between prisoners and prison staff	❑1	❑2	❑3

			Most	Many	Some	None	Don't know
20	**In your opinion, how many prisoners are using one or more of the following drugs in this prison?**[73]	cannabis	❑1	❑2	❑3	❑4	❑5
		alcohol (all forms of alcohol incl. self brewed alcohol liquids)	❑1	❑2	❑3	❑4	❑5
		heroin / opioids	❑1	❑2	❑3	❑4	❑5
		cocaine	❑1	❑2	❑3	❑4	❑5
		amphetamines	❑1	❑2	❑3	❑4	❑5
		other illicit drugs or medications					

21	**In your opinion, how many prisoners are INJECTING DRUGS in this prison?**	Most	❑1
		Many	❑2
		Some	❑3
		None	❑4
		Don't know	❑5

[73] N.B.: Choose categories according to prevalence of drugs used in your country and use the local language names of the substances!

			Agree	Disagree
22	**What do you think about injecting drug users in general?**	Has to be considered as ill (sick) and needs medical treatment	❑1	❑2
		Doesn't deserve support	❑1	❑2
	The injecting drug user in general:	Risks infecting others with HIV or hepatitis	❑1	❑2

			Yes	No	Don't know
23	**Do you think that the virus of HIV can be transmitted from an infected person**	by vaginal sexual intercourse without condom	❑1	❑2	❑3
		by anal sexual intercourse without condom	❑1	❑2	❑3
		by oral sex	❑1	❑2	❑3
		by contact with the toilet seat	❑1	❑2	❑3
		by drinking from the glass or cup of an HIV infected person	❑1	❑2	❑3
		by kissing	❑1	❑2	❑3
		by a mosquito bite	❑1	❑2	❑3
		by an injection with used needles (medical or injecting drugs use)	❑1	❑2	❑3
		by the common use of razor blades or tooth brushes	❑1	❑2	❑3
		by tattooing, piercing	❑1	❑2	❑3
		by sharing blood in brotherhood rituals	❑1	❑2	❑3
		by shaking hands	❑1	❑2	❑3
		by breastfeeding	❑1	❑2	❑3
		from mother to child during pregnancy and childbirth	❑1	❑2	❑3

			Yes	No	Don't know
24	**If you knew someone who is infected with HIV, would you accept**	working with him/her	❑1	❑2	❑3
		eating with him/her	❑1	❑2	❑3
		continuing to meet or associate with him/her	❑1	❑2	❑3
		sharing the cutlery with him/her	❑1	❑2	❑3

25	What is your opinion with the following:	HIV-infected prisoners should be allowed to:	Agree	Disagree
		participate in sports	❑1	❑2
		cook in the prison	❑1	❑2
		work in the prison	❑1	❑2
		It is necessary to put HIV infected prisoners in a separate building	❑1	❑2
		Prisoners living with HIV need support and sympathy	❑1	❑2
		Prison staff should be informed about prisoners' HIV status	❑1	❑2
		An HIV infected prisoner risks infecting the prisoners who share his cell	❑1	❑2
		An HIV infected prisoner risks infecting the prison staff	❑1	❑2
		HIV infected prisoners should be treated the same way as other prisoners	❑1	❑2

26	Do you think that <u>hepatitis B</u> can be transmitted		Yes	No	Don't know
		by vaginal sexual intercourse without condom	❑1	❑2	❑3
		by anal sexual intercourse without condom	❑1	❑2	❑3
		by oral sex	❑1	❑2	❑3
		by contact with the toilet seat	❑1	❑2	❑3
		by drinking from the glass or cup of an HIV infected person	❑1	❑2	❑3
		by kissing	❑1	❑2	❑3
		by a mosquito bite	❑1	❑2	❑3
		by an injection with used needles (medical or injecting drugs use)	❑1	❑2	❑3
		by the common use of razor blades or tooth brushes	❑1	❑2	❑3
		by tattooing, piercing	❑1	❑2	❑3
		by sharing blood in brotherhood rituals	❑1	❑2	❑3
		by shaking hands	❑1	❑2	❑3
		by breastfeeding	❑1	❑2	❑3
		from mother to child during pregnancy and childbirth	❑1	❑2	❑3

27 6	Do you think that hepatitis C can be transmitted		Yes	No	Don't know
		by vaginal sexual intercourse without condom	❑1	❑2	❑3
		by anal sexual intercourse without condom	❑1	❑2	❑3
		by oral sex	❑1	❑2	❑3
		by contact with the toilet seat	❑1	❑2	❑3
		by drinking from the glass or cup of an HIV infected person	❑1	❑2	❑3
		by kissing	❑1	❑2	❑3
		by a mosquito bite	❑1	❑2	❑3
		by an injection with used needles (medical or injecting drugs use)	❑1	❑2	❑3
		by the common use of razor blades or tooth brushes	❑1	❑2	❑3
		by tattooing, piercing	❑1	❑2	❑3
		by sharing blood in brotherhood rituals	❑1	❑2	❑3
		by shaking hands	❑1	❑2	❑3
		by breastfeeding	❑1	❑2	❑3
		from mother to child during pregnancy and childbirth	❑1	❑2	❑3

28	If you knew that someone is hepatitis B or C - infected, would you accept		Yes	No	Don't know
		working with him/her	❑1	❑2	❑3
		eating with him/her	❑1	❑2	❑3
		continuing to meet or associate with him/her	❑1	❑2	❑3
		sharing the cutlery with him/her	❑1	❑2	❑3

29	Do you think that tuberculosis (TB) can be spread from an infected person		Yes	No	Don't know
		By breathing the air around a person who is sick with TB	❑1	❑2	❑3
		By sharing eating/drinking utensils	❑1	❑2	❑3
		Through semen or vaginal secretions shared during sexual intercourse	❑1	❑2	❑3
		From smoking	❑1	❑2	❑3
		From mosquito or other insect bites			

30	Based on your knowledge please indicate for each of the following sentences related to tuberculosis (TB) if is true or false		True	False	Don't know
		The risks for TB transmission are higher in prison than in the community	❑1	❑2	❑3
		A person who is coughing for more than 2-3 weeks should be suspected for tuberculosis	❑1	❑2	❑3
		Tuberculosis can be cured with appropriate medications	❑1	❑2	❑3
		To prevent the spread of tuberculosis in a prison, one should keep doors and windows of the cells closed	❑1	❑2	❑3
		Cloth or paper mask (surgical mask) for contagious TB patients is effective to prevent tuberculosis transmission	❑1	❑2	❑3
		TB patients remain contagious during the entire duration of the treatment	❑1	❑2	❑3

31	According to your knowledge, does a vaccination exist against…?		Yes	No	Don't know
		HIV	❑1	❑2	❑3
		syphilis and other STI's	❑1	❑2	❑3
		tuberculosis	❑1	❑2	❑3
		hepatitis B	❑1	❑2	❑3
		hepatitis C	❑1	❑2	❑3

			Agree	Disagree	Don't know
32	**Do you think that the implementation of the following strategies in your prison would / do prevent the spread of HIV and hepatitis?**	Providing private prolonged visiting rooms for conjugal visits	❑1	❑2	❑3
		Making condoms available in private visiting rooms for conjugal visits	❑1	❑2	❑3
		Making condoms available for prisoners anonymously and free of charge	❑1	❑2	❑3
		Providing sterile syringes and needles for prisoners injecting drugs	❑1	❑2	❑3
		Providing sterile needles for tattooing	❑1	❑2	❑3
		Providing prisoners with information on communicable diseases	❑1	❑2	❑3
		Providing prisoners with information on alcohol & drugs	❑1	❑2	❑3
		Providing prisoners with drug treatment including opioid substitution therapy (methadone or buprenorphine)	❑1	❑2	❑3
		Training prisoners as peer educators on communicable diseases, drugs and alcohol	❑1	❑2	❑3
		Organizing workshops for prisoners conducted by trained health educators on communicable diseases	❑1	❑2	❑3
		Providing access to voluntary HIV counselling and testing to prisoners	❑1	❑2	❑3
		Providing access to voluntary HIV counselling and testing to prison staff	❑1	❑2	❑3
		Systematically testing prisoners for HIV	❑1	❑2	❑3
		Systematically testing staff for HIV	❑1	❑2	❑3
		Systematically testing prisoners for hepatitis B and C	❑1	❑2	❑3
		Systematically testing staff for hepatitis B and C	❑1	❑2	❑3
		Providing prison staff with information on communicable diseases, drugs and alcohol	❑1	❑2	❑3
		Training prisoners as peer educators on alcohol and drugs	❑1	❑2	❑3
		Vaccinating prisoners against hepatitis B	❑1	❑2	❑3

33	In your prison, have you been offered information or training concerning the means of transmission and prevention of infectious diseases?		Yes, within the last 12 months	Yes, more than one year ago	No
		HIV	❑1	❑2	❑3
		syphilis and other STI's	❑1	❑2	❑3
		tuberculosis	❑1	❑2	❑3
		hepatitis B	❑1	❑2	❑3
		hepatitis C	❑1	❑2	❑3

34	As part of your work do you …?		Yes	No	Don't know
		Undergo routine health check-ups	❑1	❑2	❑3
		Get hepatitis B vaccinations	❑1	❑2	❑3
		Have access to post-exposure prophylaxis (PEP)	❑1	❑2	❑3

35	Due to your work in prison have you ever been tested for the following?		Yes, within the last 12 months	Yes, more than one year ago	No
		HIV	❑1	❑2	❑3
		tuberculosis	❑1	❑2	❑3
		hepatitis B	❑1	❑2	❑3
		hepatitis C	❑1	❑2	❑3

36	When did you have your last chest X-ray?	Less than a year	More than a year	Never	Don't know
		❑1	❑2	❑3	❑4

37	If you had a chest X-ray, was it due to your work in prison?	Yes	No
		❑1	❑2

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