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United Nations Office on Drugs and Crime

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN PRISONS

TECHNICAL GUIDE





UNITED NATIONS OFFICE ON DRUGS AND CRIME
Vienna

**Prevention of
Mother-to-Child Transmission
of HIV in Prisons:
A Technical Guide**



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Abbreviations and acronyms

| | |
|--------|--|
| AIDS | Acquired immunodeficiency syndrome |
| HBV | Hepatitis B virus |
| HCV | Hepatitis C virus |
| HPV | Human papilloma virus |
| HIV | Human immunodeficiency virus |
| ILO | International Labour Organization |
| PEP | Post-exposure prophylaxis |
| PMTCT | Prevention of mother-to-child transmission |
| PrEP | Pre-exposure prophylaxis |
| TB | Tuberculosis |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNODC | United Nations Office on Drugs and Crime |
| WHO | World Health Organization |

In this technical guide, the term “prisons” refers to all places of detention within a country, and the term “people in prison” refers to all people detained in those places, adults and juveniles, during the investigation of a crime, awaiting trial, after conviction, and before and after sentencing

INTRODUCTION

Approximately 7 per cent of the world's prison population are women. While they are a minority among the prison population, more than 714,000 women and girls are held in prisons and other closed settings, either sentenced or in pretrial detention. This number has increased by about 53 per cent since the year 2000 compared with 20 per cent for the male population, and is rising on all continents. [1] High turnover of incarcerated women is observed due to short sentences and a high number of women held in pretrial detention.

Acquired immunodeficiency syndrome (AIDS) and tuberculosis (TB) are among the main causes of death in prisons, with people in prison five times more likely to be living with HIV than adults in the general population. [2] It is estimated that 3.8 per cent of the global prison population are living with HIV and 2.8 per cent have active TB. [3]

Women in prison are at higher risk of acquiring HIV, TB and other infections than men. In prison, they have a higher prevalence of HIV than men, and an even higher prevalence than women living in the community. [3,4] This may result in a higher proportion of children born in prison being at risk of HIV infection than children born in the community. In West and Central Africa, HIV prevalence among women in prison is almost double that of men (13.1 per cent vs 7.1 per cent); in Eastern Europe and Central Asia, it is almost three times higher (22.1 per cent vs 8.5 per cent). [3]

The same challenges that lead to women becoming incarcerated are often those that lead to their increased HIV infection risk, and include punitive laws such as those which criminalize sex work and drug use, prolonged detention and high rates of pretrial detention. Their situation is exacerbated by stigma, gender-based violence and inequality, discrimination and HIV risk behaviours. [5,6]

People in prison are entitled to enjoy the highest attainable standard of health and humane treatment. International decrees mandate equivalence of care and access to equitable health services for people in prison free of charge, as stated in the United Nations Standard Minimum Rules for the Treatment of Prisoners. [7] However, more and more women who are vulnerable to HIV infection, both before entering prison and during imprisonment, are finding themselves in periods of detention in locations which do not provide adequate HIV/AIDS-related services.

Not only is HIV prevention, diagnosis, treatment and care often poor in prisons, [8] but women's specific health-care needs, including access to sexual and reproductive health, treatment of infectious diseases including sexually transmitted infections, as well as nutrition and hygiene

requirements, are neglected. [9,10,11,12] The limited access for women (and their children) to antenatal and postnatal care, labour and delivery services and antiretroviral therapy poses a serious challenge to the prevention of mother-to-child transmission of HIV. [9] This leads to infants born in prisons being at high risk of contracting HIV during pregnancy, delivery or breastfeeding.

The rise in the global female prison population, women's unique vulnerabilities to HIV infection and insufficient provision and inequitable access to HIV services places the prevention of mother-to-child transmission (PMTCT) in prisons high on the agenda of HIV prevention among key populations.

In May 2017, the twenty-sixth session of the Commission on Crime Prevention and Criminal Justice held in Vienna adopted resolution 26/2 "Ensuring access to measures for the prevention of mother-to-child transmission of HIV in prisons". [13] This technical guide has been developed in response to the Commission's resolution 26/2, and is based on international guidelines, in particular World Health Organization (WHO) guidelines relevant to PMTCT.

This technical guide is intended to support countries in their efforts to increase their capacity to eliminate mother-to-child transmission of HIV in prison, and achieve the ultimate goal of ending AIDS as a public health threat by 2030, "leaving no one behind".

Purpose, scope and intended audience

Purpose

The purpose of this technical guide is to support countries in providing high-quality HIV and sexual and reproductive health services to women in prison to ensure the elimination of new HIV, TB, hepatitis B and C virus (HBV, HCV) and syphilis infections among women and their children in prisons.

Scope

The technical guide provides a framework of standard operational procedures to ensure implementation of prevention of mother-to-child transmission (PMTCT) of HIV services for women and their children in prisons. It consists of three key areas, namely:

- Prerequisites to ensure access to PMTCT services for women in prison
- Technical guidance for the implementation and application of PMTCT services in prisons
- Key stages for the development and implementation of PMTCT services in prisons

The technical guide focuses on overcoming the specific challenges in providing PMTCT services in prisons by providing recommendations from a public health perspective that prison services in all countries should strive to achieve, particularly those with a high burden of co-infection with TB, HBV and HCV, syphilis and other sexually transmitted infections. [14]

Intended audience

The intended audience for the technical guide is policymakers, stakeholders in relevant ministries, including health, justice and interior, development partners, prison commissioners, senior prison management and staff, health-care providers, practitioners, civil society organizations, peer workers, communities and women in prison.



Implementation of PMTCT services in prison requires a robust prison health system and effective linkages to community health-care services, in accordance with international standards on women's health in prison settings.



1.

PREREQUISITES TO ENSURE ACCESS TO PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES FOR WOMEN IN PRISON

To ensure that women and their children in prisons have access to PMTCT services, the following elements are required, which can be adapted according to the country context and current protocols and legislation.

KEY ELEMENTS TO ENSURE ACCESS TO PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES IN PRISONS

- Robust monitoring of HIV and related risk behaviours, TB, HBV, HCV, syphilis and other sexually transmitted infections, cervical cancer, and pregnancy and birth rates in prisons to inform country-specific PMTCT policies and strategies.
- Advocacy, communication and sensitization of policymakers, prison managers and staff, and health-care professionals working in prisons on the public health importance of integrating HIV services with sexual and reproductive health programming for women in prison.
- Supportive and enabling laws, policies and practices in place and revised where required, including supportive and enabling laws for populations at risk of HIV, such as those relating to sex work and same-sex relations and alternatives to punishment or conviction for drug use. These laws and policies should also strengthen links and coordination between the health, justice and social service sectors, and communities, civil society organizations and other relevant partners.
- Consideration and use of alternatives to imprisonment and pretrial detention for women, pregnant women and women who have committed minor and non-violent offences, based on the Bangkok Rules.^a

- Implementation of prison health reform initiatives that respond to the health needs of incarcerated women in a gender-responsive and equitable manner.
- Capacity-building and empowerment of women in prison, prison staff and prison health-care staff.
- Provision and scaling up of quality accessible and evidence-based health service delivery for women and children in prisons based on comprehensive sexual and reproductive health and maternal and child health care. This includes HBV and human papilloma virus (HPV) vaccination; screening, treatment and follow-up for cervical cancer, syphilis, HBV, HCV and other sexually transmitted infections and co-infections; condoms and lubricants; birth control and pregnancy tests; antenatal and postnatal care; and prevention, diagnosis and treatment of co-morbidities.
- Establishing effective linkages to ensure continuity of care within prison systems, across prison facilities, and connecting facility-based health services, infectious disease prevention and treatment networks, and community health-care and social services.
- Promoting regional sharing of experience and facilitating dialogue and collaboration between governments and civil society organizations at the country level and between countries.

^aGeneral Assembly resolution 70/175. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). New York: United Nations; 2015.

Quality PMTCT of HIV services requires prison-based health services to adhere to the following minimum standards in order to improve women's health and well-being while incarcerated:

- Suitable non-custodial measures should be made available for women as appropriate.
- All medical screening or examinations should be undertaken on a voluntary basis in a manner that safeguards privacy, dignity and full confidentiality.
- Health screening on admission should be comprehensive, covering general health, mental health, TB, reproductive health including pregnancy and sexually transmitted infections (HIV, HBV, HPV, syphilis), sexual abuse and other forms of violence experienced prior to admission, drug dependence and other related health issues.
- Treatment should be immediately offered to everyone who tests positive for HIV in prison, and must always be accessible and available.
- Gender-responsive health-care services, comprehensive mental health-care and rehabilitation programmes should be at least equivalent to those available in the community.
- Children accompanying their mothers in prison should also undergo health screening and receive health care at least equivalent to that in the community.
- Programmes to prevent HIV infection and treat AIDS-related conditions including comprehensive PMTCT services should be responsive to the specific needs of all women.
- Women in prison should receive information and education about all preventive measures and treatment related to HIV and other sexually transmitted infections.



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Effective PMTCT in prison requires human rights-based, evidence-based and gender-responsive interventions which use a public health approach and are tailored to the prison context.



2.

TECHNICAL GUIDANCE FOR THE IMPLEMENTATION AND APPLICATION OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES IN PRISONS

Prevention of mother-to-child transmission of HIV is a highly effective intervention with great potential to improve maternal and child health. In 2016, the World Health Assembly endorsed three new WHO global health strategies on HIV, sexually transmitted infections and HBV. These strategies mandate Member States to collaborate towards the goals of zero new HIV infections in infants by 2020, elimination of congenital syphilis as a public health threat by 2030, and the achievement of less than 0.1 per cent prevalence of the HBV surface antigen among children by 2030. Global commitments have now extended from “dual” elimination of mother-to-child transmission of HIV and syphilis as a public health priority, [15] and are working towards “triple” elimination by incorporating the elimination of mother-to-child transmission of HBV into mother and child health programmes.

Addressing global gaps in the coverage of key HIV services centres on the scale-up and programming of services for PMTCT and the “not leaving behind” of key populations such as people in prison. [16,17,18] WHO has underscored the importance of addressing key populations in national responses to HIV and the critical role of different service delivery approaches in addressing their needs for health and other services. [16,19] Hence, this technical guide focuses on how to address and implement the four components of comprehensive PMTCT [20,21] within the prison context.

THE FOUR COMPONENTS FOR PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

- Preventing new HIV infections among girls and women of childbearing age; pre- and post-exposure prophylaxis (PrEP, PEP) and combination prevention
- Preventing unintended pregnancies among women living with HIV through access to sexual and reproductive health services with integration of family planning
- Preventing HIV transmission from women living with HIV to their babies
- Using antiretroviral drugs to treat HIV infection in women living with HIV, their children and families, with the provision of appropriate and comprehensive treatment, care and support

Multiple interventions contribute to PMTCT, including primary prevention of HIV, prevention of unintended pregnancies among women living with HIV, integration of HIV and sexual and reproductive health services, effective access to HIV testing and counselling throughout the life course, initiation of lifelong antiretroviral therapy with support for adherence, retention and viral suppression for mothers living with HIV, safe delivery practices, optimal infant feeding practices and access to postnatal antiretroviral prophylaxis for infants.

Effective PMTCT programmes require women and their infants to have access to and to take up specific interventions including antenatal care, HIV testing services and HIV treatment and care during pregnancy, use of antiretroviral therapy by pregnant women living with HIV, safe childbirth practices and appropriate infant feeding, uptake of infant prophylaxis and other postnatal care services. [22] In 2016, the WHO consolidated guidelines on the use of antiretroviral drugs for preventing and treating HIV infection recommended lifelong antiretroviral therapy for all people living with HIV from the time when any adult (including pregnant and breastfeeding women) or child is first diagnosed with HIV infection. [17] This expanded the “Option B+” approach that had been recommended for pregnant and breastfeeding women by WHO in 2012 [23] to a “Treat All” approach. For people living with HIV who receive opioid substitution therapy, antiretroviral therapy should be initiated and maintained in settings in which opioid substitution therapy is provided. [24,25]

The following sections contain recommendations for strengthening four key areas in the prison context which will have a significant impact on the provision of high-quality PMTCT of HIV services for women and children in prisons:

1. Political commitment and enabling environments for the elimination of mother-to-child transmission in prisons
2. PMTCT service provision for women in prison and their children
3. Quality assurance and quality improvement of PMTCT in prisons
4. Monitoring and evaluation of prison PMTCT services

2.1 Political commitment and enabling environments for the elimination of mother-to-child transmission in prisons

The development of global and national HIV and PMTCT programmes has been a key feature in progress towards combating the HIV/AIDS epidemic over the last two decades. Stronger political leadership in fostering collaboration is required between prison health authorities and Ministries of Health, Justice, and others, for quality delivery of HIV and health care services in prisons. This will ensure that connection is made between policies and service delivery options that tie national efforts to specific prison-focused work.

Key recommendations to support and ensure political commitment and enabling environments for PMTCT of HIV in prisons include:

- Developing and maintaining equivalence of care policies and practices for PMTCT services for all women and their children in prisons, including adolescents, indigenous and ethnic minorities, and migrants/refugees/displaced persons.
- Strengthening collaboration between Ministries of Health and Justice, national health and prison authorities, prison administrations and community services, including civil society organizations (e.g., organizations that represent the rights of people in prison, people living with HIV and key populations at risk of acquiring HIV).
- Promoting a joint strategic approach to place prison health on a par with prison security, while maintaining prison health as an independent state responsibility.
- Investing in and scaling up comprehensive sexual and reproductive health programming for women in prison through effective linkages with community-based and led services and civil society organizations. This includes maternal, neonatal, child and adolescent health and nutrition.
- Sharing and communicating success stories, lessons learned and good practices.
- Establishing a multisectoral working group forum consisting of Justice and Health Ministries, other government departments and other institutions.
- Addressing gender disparities that put women and children at increased risk of HIV infection and that hinder their access to care.
- Promoting continuity of HIV services on admission to prison, during interfacility transfer and upon release from prison.

Key actions to strengthen commitment and leadership for achieving full coverage of integrated HIV prevention, treatment and care programming in prisons within programmes focusing on maternal, newborn, child and adolescent health and on sexual and reproductive health include:

- Strengthening management and use of strategic information with regard to HIV risk behaviours, epidemiological data and prevalence.

- Reviewing and revising laws, policies and practices from human rights and public health perspectives, emphasizing the State's responsibility to protect, promote and improve people's health including within prisons.
- Considering and using alternatives to imprisonment for minor non-violent offences, such as home detention or community service. Reducing imprisonment and pretrial detention of women in line with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules).
- Prioritizing the needs of women in prison and their children in the prison environment when planning national HIV/AIDS programmes and distribution of resources.
- Strengthening cross-sectoral partnerships for providing HIV and maternal, newborn, child and adolescent health services to women, infants and young children in prisons, and advocating for increased resources at country and regional levels.
- Scaling up HIV and PMTCT programming in prisons through a joint health and justice partnership approach, joint funding, joint prison staff and prison health staff capacity-building and integrated data collection tools covering prison health and public health.
- Linking prison health with community health/primary health-care services to ensure seamless health care and continuity of services between prisons and in the community.
- Involving people in prison and prison staff in the development and application of prevention measures, in the dissemination of information and in the combating of stigma and discrimination.
- Providing for basic needs (water, food, sanitation, feminine hygiene products, fresh air, adequate living conditions, unrestricted access to basic medical care and respect for human rights) via a joint interest of authorities responsible for health in prisons.

2.2 Prevention of mother-to-child transmission provision for women and their children in prisons

This section is intended to support prison staff in providing quality PMTCT services for women in prison.

Staffing and resources

Recommendations for sufficient and effective resources to deliver gender-responsive, human rights-based services include the following:

- HIV and PMTCT services for women in prison should be designed taking into consideration national policy and guidelines and developed by a prison project team that includes a senior prison manager, the head of health care, health-care providers and community and civil society representatives.

- Addressing the acute need for more skilled and qualified health-care professionals in prisons. Efforts should counter the perceived low status and poor working conditions of prison health staff, and include training staff members in HIV, sexual and reproductive health and PMTCT services.
- The training of prison staff and prison health-care providers should include strengthening capacity in human rights, medical ethics and gender equality approaches which will support the delivery of high-quality comprehensive health care for women in prison.
- The training of health-care staff working in prisons should include the detection and reporting of signs of sexual violence.
- Health-care services should act with full clinical independence and should only be geared towards protecting the health of people in prison and the prevention and treatment of disease. “Dual loyalty” to health and security interests must be avoided.
- Sexual and reproductive health and PMTCT programming should consider the health needs of people in prison (and their children) and prison staff, particularly the resulting traumatic physical, psychological and social demands of prison life. These include overcrowding, threats of violence, conflicts, language barriers, distance from families, drug use, unfavourable environments, increased exposure to infectious diseases such as TB, HIV and other sexually transmitted infections, experience of stigma, substandard accommodation, prolonged pretrial detention, and transfers between prisons.
- Addressing and managing prison-specific barriers, e.g., stockouts of medication, poor access to health services outside prison due to human resources or security control issues, lack of counselling services for women, perceived and real threats to confidentiality, issues related to stigma, violence and discrimination, high staff turnover and staff shortages, and gaps in training.

Awareness and empowerment

Recommendations for developing and supporting advocacy, sensitization and empowerment of women in prisons, along with support from peer mentors, civil society organizations and the charity sector include:

- Ensuring that each member of the prison staff shares responsibility for sexual and reproductive health and PMTCT programming.
- Ensuring that health-care workers, prison officers and people in prison are aware of the effects of stigma and discrimination upon every aspect of pregnancy and childbirth, including the delivery of babies born to mothers living with HIV.
- Providing all women in prison and prison staff with information, education and communication materials on HIV and other infections that are tailored to the prison setting. This awareness-raising should be developed in conjunction with civil society organizations and the prison community, and include peer-based education. It is crucial that pregnant women are educated on the benefits to them and their babies of knowing their HIV status, and, if living with HIV, their HIV viral load.

- Women should be allowed to request to be examined or treated by a female physician or nurse to the extent possible (Bangkok Rule 10.2). [10,11]
- Involving women in prison in the planning and delivery of sexual and reproductive health and HIV interventions and programmes.
- Contracting civil society organizations that can provide community-led services in prisons and post release.

Prevention of harm

The following interventions are recommendations to countries to prevent the transmission of HIV and other blood-borne viruses (e.g., HBV, HCV and sexually transmitted infections such as syphilis), and can be implemented in accordance with national or international guidelines:

- Condom and lubricant programmes
- Prevention of sexual violence and reporting signs of possible sexual violence to competent authorities including by health-care and prison staff
- Needle and syringe programmes and naloxone for drug overdose management
- Opioid substitution therapy and other evidence-based drug dependence treatment
- Post-exposure prophylaxis
- Pre-exposure prophylaxis (according to national and international guidelines for the community)
- HIV testing services
- Antiretroviral therapy
- Targeted information, education and communication for people who inject drugs and their sexual partners
- Prevention, vaccination, diagnosis and treatment for TB and HBV
- Protection of staff from occupational hazards
- Prevention of transmission through medical or dental services
- Prevention of transmission through tattooing, piercing and other forms of skin penetration

Sexual and reproductive health programming in prisons

Sexual and reproductive health programming in prisons should include a “life-course” approach to health with sexual and reproductive health education starting with prevention of unintended pregnancies and HIV transmission in women and girls of childbearing potential and moving through antenatal and postnatal care.

Effective sexual and reproductive health services for all women and girls in prison need to be gender-responsive, human rights-based and comprehensive. Services should include full access to

(emergency) contraception; pregnancy testing; HIV testing; PMTCT; PEP; PrEP; prevention and treatment of HBV, HCV, sexually transmitted infections, HPV and cervical cancer; sexual and reproductive health education; and appropriate diet and nutritional supplements for women and children. Service models can be situated within prisons, ensuring referral between prison facilities and with linkages to community health services.

Recommendations for optimal sexual and reproductive health interventions in prisons include:

- Informing, educating and empowering all women in prison, also regarding health promotion and confidentiality, on admission and regularly during incarceration in an easily understandable manner (pamphlets, awareness sessions, peer-support).
- All women in prisons, including those living with HIV, should be permitted intimate partner visits, as applicable.

Medical screening

With women's consent:

- Screening for HIV, TB, HBV, HCV, syphilis and other sexually transmitted infections, and for cervical and breast cancer on admission to prison and at appropriate intervals throughout incarceration.
- Screening all women of childbearing potential for pregnancy on admission into prison to exclude any undiagnosed pregnancies.

Prevention

- Informing and educating all people in prison on measures to prevent pregnancy and infection, and providing easy and discreet access to condoms and other prevention interventions.

Treatment and care

- Preparing individualized treatment and care plans, involving the various health-care providers and the women themselves.
- Providing access to specialized health care where needed, covering mental health, chronic health conditions, HIV (including counselling and support), TB, HBV, HCV, syphilis and other infectious diseases, drug and alcohol dependence, learning disabilities, and sexual and reproductive health.
- Providing free and voluntary (emergency) contraception, post-pregnancy termination care, (rapid) HIV testing (where possible partner testing) and counselling, antiretroviral therapy and HIV viral load testing, at a standard equivalent to services in the community.
- Ensuring clinical independence and that women in prison feel comfortable with and are accepted by their service providers.

Antenatal care

- Screening pregnant women in prisons to identify nutritional deficiencies and anaemia; monitoring monthly weight gain, foetal well-being and fundal height; to cover detailed sexual and reproductive health and obstetric history, potential risks of HIV and sexually transmitted infections; and to identify effective remedial actions.
- Management of care should be individually tailored, including treatment and care of maternal medical conditions and infectious diseases. If a current or potential labour complication is identified (e.g., breech delivery), referral must be made to specialized care in the community.
- Discussing feeding options (baby dietary scale, breastfeeding) and birth plans early in pregnancy.
- Informing pregnant women of the benefits of knowing their HIV status and, if living with HIV, their CD4 count and HIV viral load, for their health and the health of their children. During antenatal care, voluntary HIV testing should be recommended and, if declined, repeated at every antenatal care visit or during any other medical consultation or patient contact with prison or community health services.
- Providing antiretroviral therapy for women in prison already or newly diagnosed as living with HIV, especially ensuring antiretroviral therapy for pregnant women living with HIV.
- Providing information on drug use and pregnancy, including the offer of opioid substitution therapy for opioid dependent women.
- Involving male partners in antenatal care and the birth itself as a support measure subject to prison security measures and required consent.

Labour and delivery

- Admitting pregnant women in prison nearing delivery to hospitals.
- With the onset of labour, transferring women with a detailed transfer note encompassing all relevant obstetric history, medication, potential risks or anticipated complications to the nearest maternity unit outside the prison, unless the prison has a labour ward. If there is no option to transfer out of the prison, and if advanced labour commences, prison protocol written by prison medical staff and community obstetric services must be in place to provide instructions to prepare the women for delivery, and inform relevant family members.
- Ensuring safe childbirth practices.
- If the women in labour are living with HIV, avoid artificial rupture of membranes, prolonged labour, unnecessary vaginal examinations, routine episiotomy or tearing. Antiretroviral therapy should be administered according to WHO and country-specific guidelines in cases of late HIV diagnosis and precipitated labour.
- If delivery and neonatal care occurs outside prison, prison health-care providers should communicate with the hospital to ensure that the discharge summary, transfer notes and any medication required for immediate care (1-2 weeks) accompany the mother on her return to prison.
- Instruments of restraint should never be used on women during labour, during birth or immediately after birth.

Postnatal care

- Providing information on appropriate breastfeeding in the context of ongoing antiretroviral therapy as per WHO and country-specific guidelines, retesting during breastfeeding if there is an ongoing risk of HIV infection.
- If new mothers choose breastfeeding, put their babies to the breast within an hour of birth. The importance of no mixed feeding in the first six months should be emphasized.
- Ensuring nutritional needs are met by providing adequate mother and child nutrition and access to safe drinking water and sanitation in prison.
- Providing a quiet, undisturbed location for breastfeeding mothers to feed their infant.
- Ensuring adequate paediatric medical care (early diagnosis and provision/adherence to antiretroviral therapy, whereby every infant born to a mother living with HIV should receive a course of medication linked to high transmission risk and the infant's feeding method).
- Health-care providers in prisons should educate women on neonatal care, early infant diagnosis of HIV, HBV, HCV and syphilis, how to prevent unwanted future pregnancies and planning for future pregnancies once released. They should immunize the infant as per country protocols, give information on medical circumcision for male infants (according to national guidelines), provide necessary infant vaccinations and vitamin K as per routine schedules, and record all interventions in the logbooks provided.
- Providing comprehensive care for HIV-exposed infants, including antiretroviral prophylaxis, general health services (including immunizations), and early infant diagnosis through linkage of both mother and child to appropriate care and treatment.
- Postnatal care should include the promotion of mother and baby bonding (“kangaroo care”) [27] for those who require it, visits to prison-based health-care services, and monitoring of mother and baby care as per country-specific guidelines.
- Pre-release preparations should be adequately planned and provided to ensure continuity of care and access to community services after release.
- Where available, providing linkage to programmes and projects that aim to end violence against women, and linkage to services and responses to gender-based and sexual violence.
- PMTCT programmes should provide support to women for HIV prevention, treatment and care in prisons before, during and after pregnancy. This is particularly important in terms of dealing with HIV-related stigma and potential negative reactions in the event of partners testing positive.

HIV prevention, testing, treatment and care in prisons

Optimal HIV programming for women in prison is crucial due to the unique vulnerabilities of contracting HIV, and risk behaviours often engaged in by women in prison (unsafe sexual practices, injecting drug use, tattooing and piercing).[28] The comprehensive package of 15 key interventions [29] for effective HIV prevention and treatment in prisons is best delivered as a whole for maximum impact.

Implementation of HIV testing services must adhere to the WHO 5 Cs of HIV testing: consent, confidentiality, counselling, correct results and connection (linkages).[30]

Recommendations for implementing quality HIV testing, treatment and care services in prison include:

- All women in prison should be offered HIV testing services on admission to prison.
- All women in prison receiving HIV testing services must give informed consent, and should be informed of the process.
- All prison counselling work related to HIV should be undertaken within a code of ethics that governs the conduct of counsellors and prison staff.
- Confidentiality of HIV testing services must be respected and ensured.
- Women in prison should have easy access to voluntary HIV testing services at any time during their imprisonment.
- HIV testing services in prisons should be accompanied by high-quality pre-test information, testing services and quality assurance mechanisms to ensure correct test results, and post-test counselling.
- Women in prison who inject drugs should have access to needle and syringe programmes.
- Women in prison who use opioids should have access to opioid substitution therapy (in particular when pregnant), and naloxone should also be available for them as well as for the first responders of overdose incidents.
- Addressing HIV transmission via tattooing, piercing and other risk behaviours that involve the sharing of sharp instruments.
- If pregnant and living with HIV, the risk of HIV transmission to the infant and the benefit of PMTCT interventions should be discussed. Practitioners should be impartial and avoid using imperatives (“you must”, “do not”), and consultations should end with the patient being calm and stable.
- All pregnant women living with HIV in prison should receive antiretroviral therapy with appropriate counselling regardless of gestational age. Ensure that women understand what HIV drugs are, why they are needed and what they can and cannot do (treatment literacy). Counselling should address women’s concerns surrounding antiretroviral therapy (e.g., toxicity, side effects) and support adherence to therapy.
- Inclusion of specific protocols for antenatal care, labour and postnatal care including immediate neonatal diagnosis and care.
- Where required, engage cultural mediators to support access to and care of ethnic and indigenous minorities or migrant/refugee/displaced women.

Prevention and management of co-infections and co-morbidities

Prevention, screening, assessment and management of co-infections with TB, HBV, HCV and syphilis and other sexually transmitted infections should be included in HIV and PMTCT-related services. The elimination of mother-to-child transmission of HIV should be an integral part of the triple elimination approach including HBV and syphilis. [31]

Women in prison have a higher prevalence of mental health disorders such as self-harm, depression, substance dependence, and post-traumatic and psychosocial stress than the general population. [32] These rates are usually higher among people in prison living with HIV.

To optimize health outcomes and improve adherence to antiretroviral therapy for women living with HIV, routine screening and management of these co-morbidities should be provided in prison and should include:

- Using a trauma-informed approach that adheres to the following principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical and gender issues.
- Ensuring access to comprehensive mental health care and rehabilitation programmes for women in prison.
- Providing strategies and support to prevent suicide and self-harm among women in prison.

Continuity of care within and outside the prison

Continuity of care is particularly important for women, who are often on short sentences but need long-term physical and mental health care. [33] Thus, a clear referral and linkage strategy addressing transfer between prisons and upon release is vital. [34]

Key elements for optimal sexual and reproductive health and PMTCT service delivery are based on linkage to care between prisons and community settings, on admission, stay and upon release, and include:

- On admission to prison, retrieval of any medical records or prescriptions from clinical care women have been receiving prior to detention (e.g., PrEP, antiretroviral therapy) to ensure the same care regimen.
- A collaborative care pathway using a primary care model with support from clinical and psychological specialists, health-care providers, cultural mediators and nurses coming into the prison.
- Linkage to care within the prison environment, ensuring health referrals during internal transfers within the correctional system.
- Effective referral mechanisms for all health interventions that are not available in prison, including transfer to outside services and access of outside physicians to the prison,

whenever necessary and in a timely manner. Security protocols are required to be in place on a 24-hour basis to ensure emergency medical assistance to women in prison as required.

- Clear referral pathway charts visible to all staff to ensure emergency medical assistance and continuity of prevention, treatment and care for HIV/sexually transmitted infections and TB.
- Every prison with women should establish and sustain close cooperative relationships with maternity units and other relevant health care following delivery for mothers and their babies, and links to HIV treatment and care services or specialized services in the community.
- Support of linkage by “through the gate” work [35] with health services, civil society organizations and community leaders, which should be provided regardless of nationality or country of origin.
- Continuity of antiretroviral therapy for women living with HIV in prisons to reduce their risk of developing resistance to treatment. Connections to HIV services should include effective referral to appropriate follow-up services, including long-term prevention and treatment support. “Mobile health passports” and detailed discharge records and plans are required.
- On transferral, all women and their children must be given a supply of antiretroviral therapy to last until linkage can be made to the new prison location and, if they are being released, to community-based HIV care. If there is an inter-prison transfer prior to the baby’s first birthday, or if the baby is released to an outside facility, transfer notes (and a “Road to Health” chart [36] if applicable) are necessary to facilitate continuity of treatment and care.
- Supporting models that address the multiple stigma of living with HIV and being released from prison, which can include social workers, peer programmes, formerly incarcerated people as mentors, mobile outreach (e.g., to the homeless, sex workers and women who inject drugs) and village health workers.
- Linking prisons with sustainability to counter the wider determinants of health relating to poverty, social isolation, lack of social support for women rejected by their families, absent partners, homelessness and difficulties in gaining employment, training or life skills.
- Developing strategies to provide social support for people upon release from prison.

2.3 Quality assurance of prevention of mother-to-child transmission services in prisons

Quality assurance and quality improvement systems are essential for a coherent and functioning PMTCT service delivery system at all levels. They help ensure that the needs and expectations of women in prison are met. These are ongoing processes that provide permanent feedback on how well PMTCT programmes have been established and how well they are functioning.

Recommendations for implementing effective quality assurance of PMTCT services in prison include:

- Strategic planning to ensure the sustainability of PMTCT services in prisons, including financial, material and human resources; training, organizational development, service availability, coverage and accountability; and community ownership.
- Understanding and responding to local, regional and national conditions and context.
- All service providers should comply with set national standard operating procedures and specific neonatal, PMTCT, HIV testing and antiretroviral therapy strategies based on national guidelines and in line with international standards.
- All persons providing PMTCT services should undertake required gender norms/equality/human rights/medical ethics training and skills development, and receive supervision and support to improve their practice. Refresher training to keep abreast of new guidelines should occur regularly as part of the cascade of training and capacity-building, and be authorized by the national health authority or professional regulatory body.
- Training model for all staff involved in the provision of PMTCT services, and also one designed for senior management and prison officers. This model can be supported by online learning to avoid disruption to prison schedules, and by peer-to-peer training using master trainers to cascade and counter high staff turnover.
- Supporting governance through prison quality improvement plans, and internal and external inspection mechanisms based on ethical standards, key performance indicators and regular clinical audits. Protocols must be in place to sanction those breaching patient confidentiality, not adhering to PMTCT guidelines, or the overruling of clinical decisions by prison staff.
- Developing mechanisms to support HIV treatment adherence by addressing HIV stigma and discrimination among people in prison and among staff, ensuring the confidentiality of the HIV status of people in prison, and allowing women in prison access to care and treatment without discrimination by prison officials.
- Implementing effective procurement and supply mechanisms to provide a consistent supply of reproductive health commodities and other combination prevention strategies, such as antiretroviral therapy, treatment for TB and viral hepatitis, opioid substitution therapy, contraception, etc. and to prevent stockouts, with sufficient test kits and other laboratory and diagnostic services and commodities.

2.4 Monitoring and evaluation of prevention of mother-to-child transmission services in prisons

To adequately address the needs of women living with HIV in prisons, and in particular those who are pregnant, understanding the data elements of this population is crucial. The monitoring and evaluation of prison-based PMTCT programming should generate reliable data that are widely shared among stakeholders and translated into improved policy and timely and effective solutions to challenges related to PMTCT service delivery.

Recommendations for implementing effective monitoring and evaluation of PMTCT services in prisons include:

- Integrating prisons into ongoing national surveillance, monitoring and evaluation systems of HIV programmes and PMTCT services.
- Developing a monitoring and evaluation plan to oversee PMTCT service delivery in prisons, such as the number of women and children in prison receiving PMTCT services and the impact at the individual and community levels.
- Determining disease burden among women in prison, and monitoring the following disaggregated epidemiological data: prevalence of HIV, TB, HBV, HCV, syphilis and other sexually transmitted infections among the female prison population (and their children); specific risk factors for transmission, levels of knowledge and attitudes on these diseases; national and prison targets; availability and quality of prison-based health services; prison conditions and required infrastructure; and optimal standards for PMTCT provision.
- Linking core indicators (common identifiers) to existing monitoring and evaluation systems for HIV/AIDS, TB, HBV, HCV and other sexually transmitted infections.
- Ensuring confidentiality of patient records.
- Conducting regular situation and needs assessments of prison health systems, legal and policy environments, human resources and financial issues, staff, and challenges in the provision of HIV and PMTCT services to people in prison and other closed settings.
- Increasing coordination and collaboration with key stakeholders to avoid duplication of data collection and gaps in surveillance.
- Assessing the roll-out of PMTCT services in prison by comparing outcomes over time to goals and objectives. Use a logic framework model based on input (efforts), outputs (efficiency), outcomes (effectiveness, change), availability and quality of services in the prison, and monitoring of progress towards PMTCT goals.

Key efficacy, consistency and quality indicators for PMTCT services in prisons include:

- Size of female population in each prison/number of women in prison
- Age of women in prison
- Number of pregnant women in prison
- HIV prevalence rate of women in prison
- Number of women living with HIV in prison who know their HIV status
- Number of women who inject drugs in prison
- Number and percentage of pregnant women tested for HIV (target 100 per cent)
- Number and percentage of pregnant women tested for syphilis (target 100 per cent)
- Number and percentage of pregnant women tested for HBV (target 100 per cent)

- Number and percentage of women living with HIV who are pregnant (at admission, while in prison and upon release)
- Number and percentage of pregnant women retested for HIV after a further 12 weeks (or as per country-specific guidelines)
- Number and percentage of pregnant women retested and found to be HIV positive
- Number and percentage of pregnant women living with HIV in prison enrolled for PMTCT
- Number and percentage of pregnant women living with HIV in prison starting or retained on antiretroviral therapy
- Number and percentage of pregnant women living with HIV in prison retained on antiretroviral therapy after 12 months
- Number and percentage of pregnant women tested positive and treated for syphilis (target 100 per cent)
- Number of infants born in prison
- Number and percentage of HIV-exposed infants tested for HIV according to country-specific guidelines
- Number and percentage of infants tested positive for HIV
- Number and percentage of exposed infants that received antiretrovirals at birth for prophylaxis according to national guidelines
- Number and percentage of infants tested positive for HIV and started on antiretroviral therapy (target 100 per cent)
- Number and percentage of HIV-exposed infants that receive cotrimoxazole at six weeks

Research on HIV and women in prison should be encouraged to fill the evidence gap, and should be conducted according to ethical principles for conducting research with persons in closed settings. Research findings should complement data from surveillance, population surveys, periodic evaluation and cohort observations for women living with HIV.



Ensuring access to PMTCT services in prison is key to giving women in prison a better chance of staying healthy and giving birth to healthy babies, and ultimately contributes to healthier communities.



3.

KEY STAGES FOR THE DEVELOPMENT AND IMPLEMENTATION OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION PROGRAMMES IN PRISONS

The key stages for the development and implementation of quality PMTCT programming in prisons are:

- Sensitization and collaborative work
- Situation and needs assessment
- Planning and preparation
- Implementing
- Monitoring and evaluating

Stage 1. Sensitization and collaborative work

Establish a national/provincial steering committee and/or site level technical working groups with service providers to raise national support for ensuring that PMTCT services for women and children are promoted within prison settings.

Potential members can include representatives of:

- Ministries of justice, interior and health
- Mental health secretariat
- Prison authorities including prison management and prison health service
- National AIDS, HIV and TB control programmes

- National sexual and reproductive health/maternal, child, newborn and adolescent health programmes
- National drug control authorities
- National central statistics office
- Relevant civil society and community-based organizations working with women, people released from prisons, sex workers, people who inject drugs, homeless people, women living with HIV
- Relevant international organizations, for example, United Nations bodies
- Human rights organizations
- Relevant faith-based organizations
- Staff associations/unions
- Technical assistance partners
- People in prison and people released from prisons including women living with HIV

Recommendations for sensitization and collaborative work with relevant stakeholders include:

- Developing a shared common vision, with identification of key partners including community-based and civil society organizations, an agreed work plan relevant to the country with realistic and shared priorities, co-action and collaboration, and communication of early success and engagement at national, regional and local levels.
- Reviewing legal frameworks and prison/health policy frameworks.
- Raising national awareness of HIV, PMTCT and prison issues among health and justice decision makers, politicians and in the community.
- Identifying and sensitizing key national and regional stakeholders within a partnership approach.
- Engaging civil society partners within a comprehensive approach to stakeholder identification and engagement.
- Identifying key normative guidance for adaptation and inclusion with prison guidance.
- Identifying sustainable funding streams.

Stage 2. Situation and needs assessment

Conduct a situation and needs assessment per country (where possible using available information and rapid situation assessment methods) to identify the epidemiological situation and gaps in service provision, and health-care linkage between the prison and the community.

Recommendations for conducting robust situation and needs assessments include:

- Assessing regional and countrywide data on rates and trends in HIV and sexually transmitted infections in the community and in prisons using desk reviews, assessment reports, epidemiological studies, prison records including health and HIV services, national documents and empirical publications.
- Conducting mapping of available prison health services.
- Developing data collection tools. Data on service uptake should be collected on a regular basis, and integrated into the national health information system.
- Assessing staff (numbers, knowledge and skills) and people in prison (knowledge, attitude, behaviours, practices and stigma).
- Identifying collaborative networks at national, regional and local levels.

Stage 3. Planning and preparation

Whenever possible, national guidance documents, standard operating procedures for training and information, education and communication materials on PMTCT should be used and adapted for the prison context. This will save resources and time and also ensure stronger alignment with national messages.

Recommendations for strategic planning and preparation for PMTCT programming in prisons include:

- Developing nationally adapted PMTCT technical guides, tools and protocols according to WHO guidelines and UNODC technical briefs.
- Adhering to relevant country-specific consent protocols and treatment guidelines to conform with national standards that apply in the community.
- Developing standard operating procedures for service provision, staff training and connecting prison-based PMTCT services with community health-care services.
- Ensuring adequate and sustainable resources, including domestic funding, to implement PMTCT services in prison.
- Designing information, education and communication materials to complement counselling and support services, based on whether or not the services described are provided within or outside prison. For example, an easy-to-read leaflet with “infographic” methods suitable for poor literacy levels and language issues can be distributed to all individuals entering prison, and at regular intervals during their stay, to draw their attention to available HIV testing and other HIV prevention, treatment and care services.
- Identifying staff issues, logistical problems relating to physical space, equipment and medical supplies, budgets, programme management plans, setting of goals and objectives, programme timelines and sites where applicable.

- Ensuring that all testing and infection control logistics and sexual and reproductive health commodities are available, complete, up-to-date and in good order (e.g., within expiry dates, in sterile packs, etc.).
- Ensuring that medication (such as antiretroviral therapy and medication for TB and other opportunistic infections, HCV, sexually transmitted infections, opioid substitution therapy as well as contraception) is readily available and dispensed in accordance with national pharmaceutical standards (e.g., in secure packaging, within expiry dates, stored in refrigerators, alternative power supply, etc.). Ensure that a supply chain is in place, monitored and adhered to.
- Developing training manuals, and initiating capacity-building activities and a cascade of training for prison staff and prison health staff.
- Developing release and referral forms to help facilitate successful referral within prisons and out of prison into the community. These forms need to be country or region specific, taking into account the range of available services.

Stage 4. Implementing

The institutional framework for implementation focuses on different actors or stakeholders with clear responsibilities. A sound institutional framework for ensuring access to measures for PMTCT in prisons at the local level requires the following organizations and actors to be in place:

- Service providers ranging from government departments and municipalities, to health-care providers and professionals for the implementation of PMTCT programmes in prisons.
- Correctional institutions and jurisdictions should establish and ensure supportive policies and environments for the implementation of PMTCT programmes in prisons.
- Local health authorities should oversee the quality assurance of PMTCT programmes in prisons.
- All stakeholders including civil society and community-based organizations should develop and communicate relevant policies, advocate on behalf of incarcerated women and their children, develop and test tools for providing PMTCT services for women in prison, increase awareness of the need for these programmes and mobilize local communities to get involved.

The organizations and actors in this institutional framework need to be cooperative, and have clearly defined roles and responsibilities. Thus, they need to work transparently and in dialogue with each other. It is helpful to build partnerships on the basis of policies accepted by all parties.

The composition of institutions in any given country will depend on the nation's institutional structures, experience and needs.

The implementation of PMTCT services in prisons is supported by the:

- Provision of services by practitioners trained and qualified to deliver antenatal care, labour, delivery and postnatal care, and neonatal support and interventions, such as nurses, midwives, prison medical officers, social workers, general practitioners and peer educators trained in PMTCT.
- Generation of a comprehensive listing of key responsible staff and roles for PMTCT in prisons.
- Generation of optimal standards for ensuring the quality of health-care records, whether paper-based or computerized, and their integration into wider health systems.
- Development of an implementation route designed to place pregnant women nearing delivery in maternity waiting homes or admit them to hospitals for delivery.
- Development of an integrated sexual and reproductive health/PMTCT service model with linkage components between prison facilities and external facilities/service providers. The aim is to set up, monitor and continuously improve linkage to support the continuity of care bridging prison and community care systems.
- Linkage to services for women living with HIV facing or who have faced gender-based violence, in order to fully support their adherence to antiretroviral therapy and support/care services.

Stage 5. Monitoring and evaluation

Although personal information on people in prison should be protected as a key element of human rights, more transparency and robust monitoring of health services are needed to measure and improve HIV and sexual and reproductive health services for women living with HIV in prison. Monitoring and evaluation systems can help prison and national officials identify gaps in service accessibility and quality, and make it straightforward for prison systems to improve patient care and ensure confidentiality.

Recommendations for the monitoring and evaluation of PMTCT services in prisons include:

- Designing and implementing a framework for PMTCT monitoring and evaluation and data management plans (developed by steering committees), in line with national level monitoring and evaluation frameworks.
- Defining the overall goals, indicators and targets, setting baselines and regularly updating selected indicators.
- Focusing on taking stock of the responsibilities assigned to different stakeholders.
- Conducting quarterly data collection, analysis and dissemination of results on predetermined health indicators and linking them with public health data. Where necessary, PMTCT services should be revised and updated to better meet indicator targets as needed.
- Implementing regular monitoring and evaluation training for key staff.
- Assessing the roll-out of new or innovative programmes on PMTCT in selected sites.
- Promoting prison system sustainability, scale-up, prison and community service linkage and capacity-building, internal inspection and audit.



ADDITIONAL RESOURCES

Selected websites and key publications

UNODC/ WHO/The Joint UNAIDS Programme on HIV/AIDS (2006). HIV/AIDS prevention, care, treatment and support in prison settings: A framework for an effective national response. Available at www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf

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Canadian HIV/AIDS Legal Network. Available at <http://www.aidslaw.ca/site/our-work/prisons/?lang=en>

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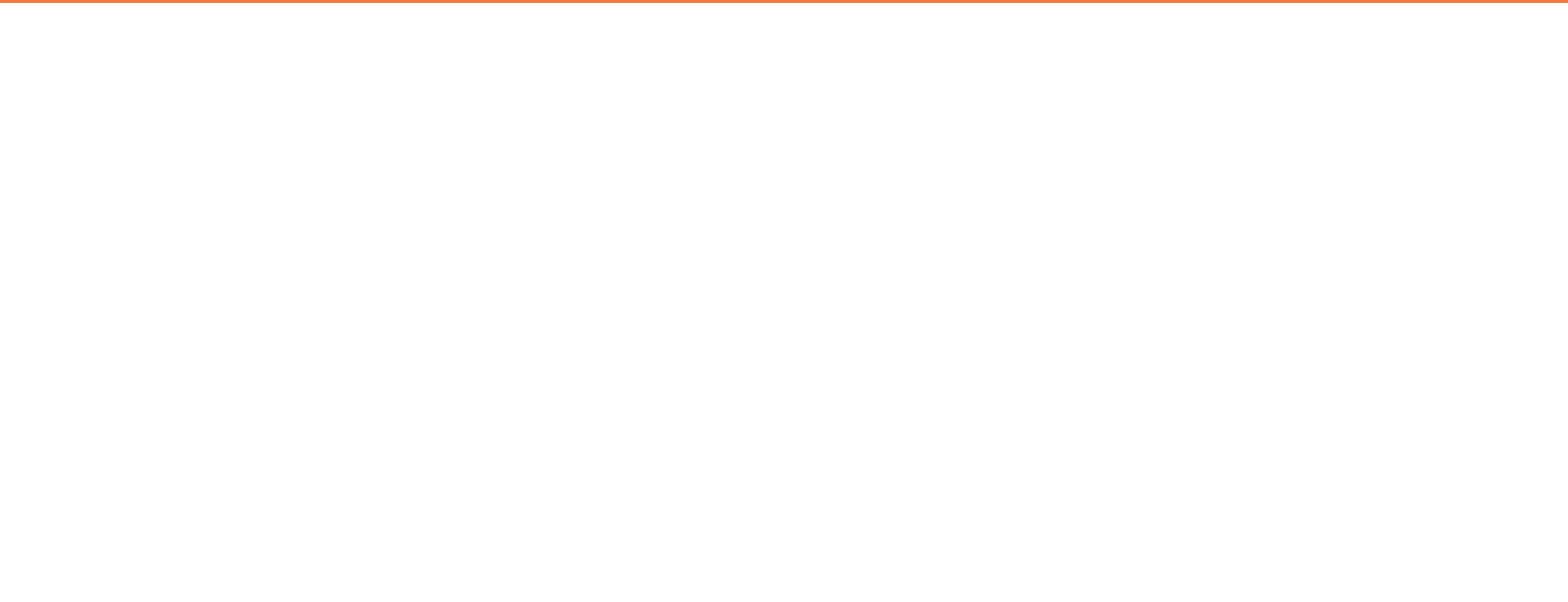
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