Agenda item 6

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UPDATE ON HIV IN PRISONS AND OTHER CLOSED SETTINGS

12-14 December 2017 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
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Additional documents for this item: none

Action required at this meeting – the Programme Coordinating Board is invited to:

See decision points in paragraphs below:

The Programme Coordination Board is invited to:

123. *Take* note of the report.

124. *Request* the Joint Programme to support Member States, civil society organizations, communities and other relevant stakeholders to enhance coordinated rights-based and people-centered national responses to improve the availability, accessibility, acceptability and quality of comprehensive HIV prevention, treatment and care services, for people in prisons and other closed settings, including people living with HIV and other key populations, and the continuity of HIV services on admission to and release from prisons and other closed settings.

125. *Request* the Joint Programme to report on progress and concrete actions taken at a meeting of the PCB in 2020.

Cost implications for decisions: *none*

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CDC	(US) Centers for Disease Control and Prevention
EU	European Union
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HBV	hepatitis B virus
HCV	hepatitis C virus
ILO	International Labour Organization
OST	opioid substitution therapy
PCB	Programme Coordinating Board
SDG	Sustainable Development Goals
TB	tuberculosis
UBRAF	Unified Budget Results and Accountability Framework
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
WHO	World Health Organization

I. INTRODUCTION

1. Globally, there are more than 10.35 million people held in prisons on any given day.[1] The total annual global prison population is significantly greater due to high turnover in the incarcerated population. One third of the imprisoned people are in pretrial detention centres. The global incarceration rate has risen by 6% over the past 15 years and now stands at 144 per 100 000. Health in prisons is complicated by the elevated risk for the transmission of infectious diseases, including HIV, and by limited access to health services.[1]

2. The prison population is unevenly distributed across countries. The United States of America (USA) has the largest incarceration rate and the greatest number of incarcerated persons in the world, comprising approximately 20% of the global total.

3. HIV exists in prison settings in all regions of the world, although HIV prevalence within prison populations differs from region to region. HIV prevalence is especially high in sub-Saharan Africa (reflecting the high prevalence of HIV in the general population) and in eastern Europe and Asia (reflecting the large proportion of people who inject drugs who are incarcerated). A systematic review published in 2016,[2] estimated that 389 000 (3.8%) people in prisons were living with HIV, 1.55 million were living with HCV (15.1%), 492 500 with chronic HBV infection (4.8%), and 286 000 with active tuberculosis (2.8%).

4. Since 2000, the total female prison population has increased by 50% compared to 18% among the male prison population. Women in prison represent 5–10% of the global prison population. However, HIV prevalence among women in prisons is typically higher than among men in prisons.[3]

5. These data show that preventing and treating HIV infection in prisons is a worldwide challenge. Places of incarceration are among the many settings where HIV infections can be prevented, and where people living with HIV can obtain a test to discover their HIV status and be provided with treatment and care. Like everyone else in society, the people held in these facilities have the right to health. The facilities have both a public health and human rights obligation to provide them with the necessary services and to help manage the HIV epidemic.[4] People in incarceration therefore should be offered health services, as well as linkage to health services upon release and access to prevention services both inside and outside the facilities. Previous reports have shown that the health outcomes of prisoners and detainees, including key populations who are incarcerated, can improve significantly when treatment and comprehensive prevention programmes are available.[5]

6. In October 2015, the 37th meeting of the Programme Coordinating Board (PCB) of UNAIDS discussed the issue of HIV in prisons and other closed settings.[6,7]

7. The PCB discussion occurred shortly after the United Nations (UN) General Assembly had adopted the resolution “Transforming our world: the 2030 Agenda for Sustainable Development”,[8] which envisages a world of universal respect for human rights and human dignity, the rule of law, justice, equality and non-discrimination. With the adoption of this resolution, all countries and all stakeholders pledged that no one will be left behind: “recognizing that the dignity of the human person is fundamental, we wish to see the goals and targets met for all nations and peoples and for all segments of society. And we will endeavour to reach the furthest behind.”[9]

8. To achieve Agenda 2030 and the Sustainable Development Goals (SDG) and targets, it is essential that human rights-based, gender- and age-sensitive, public health-oriented and evidence-informed measures for comprehensive HIV prevention, treatment and care should be made accessible to all people in prisons and other closed settings.

9. The 37th session of the PCB adopted the *UNAIDS Strategy 2016–2021: on the Fast-Track to end AIDS*, making UNAIDS the first UN body to have translated the SDGs into its organizational strategy. The focus was particularly on SDG 3 (good health and wellbeing, including achieving Universal Health Coverage, and ending the AIDS and tuberculosis epidemics), SDG 5 (gender equality and women's empowerment), SDG 10 (reduced inequalities), SDG 16 (peace, justice and strong institutions) and SDG 17 (partnerships for the goals).[10]

10. The UNAIDS Strategy argues that the HIV response has shown that addressing the entire spectrum of human rights—civil, cultural, economic, political, social, sexual and reproductive—is a prerequisite for ending the AIDS epidemic and delivering dignity, equity and sustainable development. A people-centered approach is needed to realize the rights of *all* people.[11]

11. One way to reduce the HIV burden in prison populations would be to decriminalize personal drug use, same-sex sexual relations and sex work. Punitive laws, policies and practices violate human rights in every region of the world and lead to the incarceration of key populations who are at high risk of HIV infection. In addition, as the UNAIDS Strategy notes, "criminalization of sexual and gender minorities, sex work and drug use contribute to stigma, discrimination and violence against key populations, including by state actors, and is a key barrier to an evidence-informed, rights-based AIDS response." The UNAIDS Strategy goes on to note that prisons and other closed settings "often lack adequate health services, while mandatory HIV testing, often conducted without confidentiality or privacy, is common".[12]

12. Criminal law disproportionally affects certain population groups such as racial and ethnic minorities, migrants, and impoverished communities. The UN Special Rapporteur on Extreme Poverty and Human Rights reported in 2011 that "disproportionately high numbers of the poorest and most excluded are arrested, detained and imprisoned."[13] Although the majority of people who are incarcerated are men, gendered discrepancies in criminal law affect women and should also be acknowledged.[14]

13. While important, the elimination or absence of laws and policies of discriminatory laws against people living with HIV and people at risk of HIV infection is not enough to ensure effective protection of human rights and guarantee access to health services. Actively protecting the rights of marginalized populations is essential for mitigating social stigma and discrimination, including within criminal justice and prison contexts, and it must be given priority.[15]

14. UNAIDS is committed to promote and support an effective response to HIV in prisons and other closed settings that is integrated into the core functions of the UN Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the UNAIDS Secretariat, including by supporting country partners, communities, civil society organizations and other stakeholders.

15. This report is an update of the 2015 report on HIV in prisons and other closed settings.[16] It provides an update on HIV in prisons and other closed settings around the world, describes key changes that have occurred, and outlines the main elements of a successful HIV response in those settings, in line with decisions taken at the 37th PCB. Those decisions:

- "Request[ed] the Joint Programme to support Member States and civil society in accelerating efforts to increase access to HIV prevention, treatment and care services for people in prisons and other closed settings, including people living with HIV and other key populations, in line with the UNAIDS strategy 2016–2021: On the Fast-Track to end AIDS, and report on concrete actions taken at a future meeting of the Programme Coordinating Board;

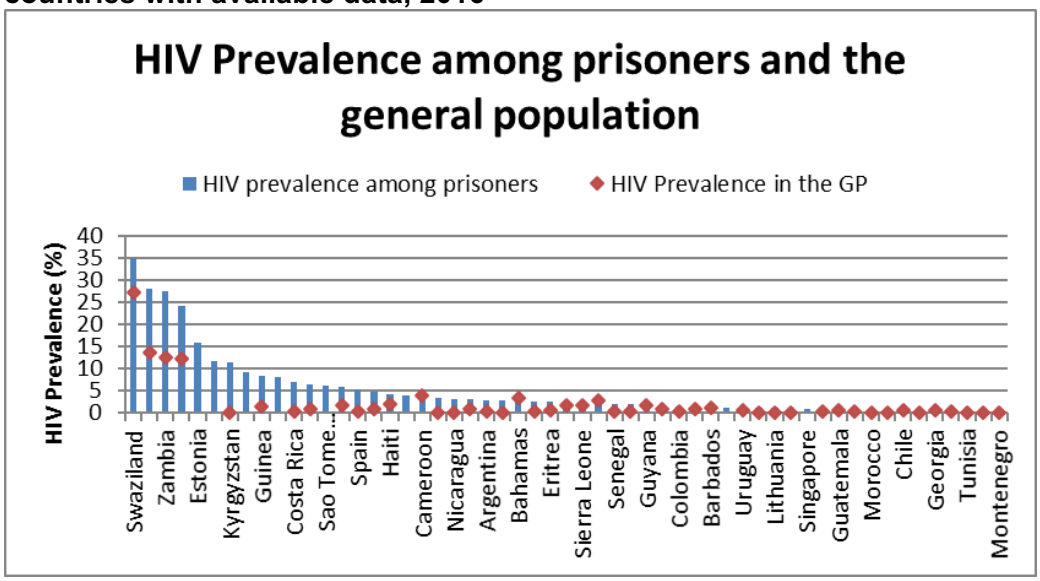
- "Encourage[d] the Joint Programme and relevant partners to address issues related to HIV and health in prisons and other closed settings by building upon the momentum and fully engaging in the 2016 Special Session of the United Nations General Assembly on the World Drug Problem and in the 2016 High-Level Meeting on HIV".[17]

16. This report also presents the most recent data on the epidemiological situation in prisons and other closed settings in relation to HIV, viral hepatitis B and C (HCV), and tuberculosis (TB) infections, as well as describing the HIV response in those settings. It highlights the potential to expand and improve HIV programmes in prison systems, and it provides examples of actions taken to introduce a rights-based and public health approach in prisons. Finally, the report identifies key recommendations for action at country and global levels.

II. THE CURRENT HIV SITUATION IN PRISONS AND OTHER CLOSED SETTINGS

17. Globally, the prevalence of HIV among people in prison is much higher than in the general population,[18] with incarcerated persons on average five times more likely to be living with HIV compared with adults outside prisons.[19] Yet the response to this state of affairs has been poor.

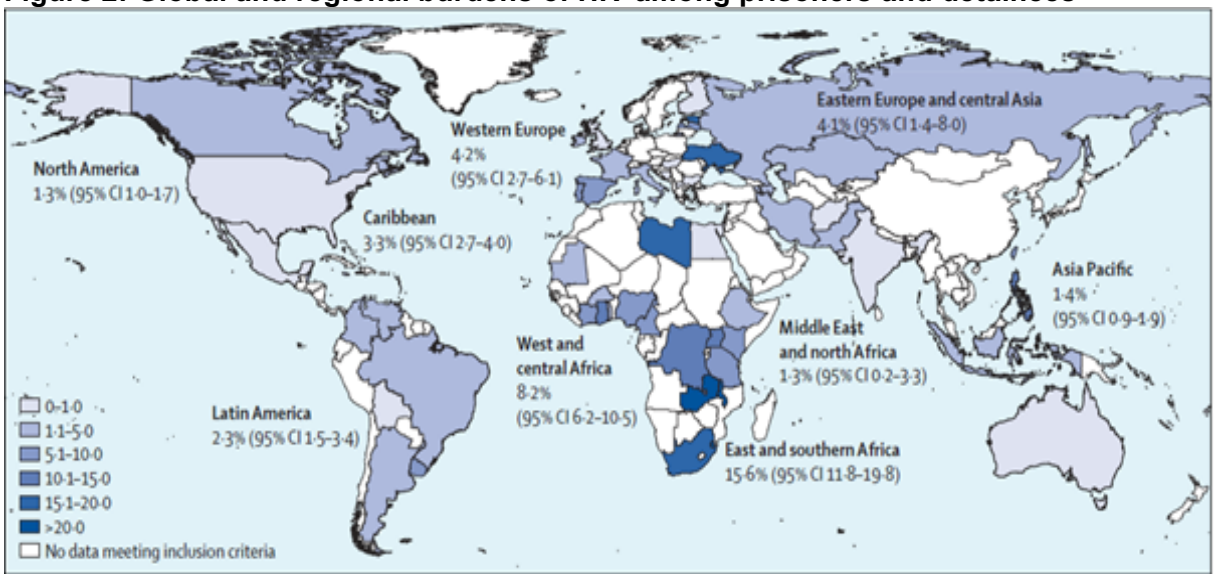
Figure 1: HIV prevalence among people in prisons and in the general population in countries with available data, 2016



Source: Global AIDS Monitoring 2017

18. Risk behaviours such as sharing of used needles and syringes, unprotected sex and sexual violence put people in prisons at heightened risk for HIV and viral hepatitis infection, while overcrowded and poorly ventilated living conditions heighten the risk of TB transmission. In addition, key populations (such as people who inject drugs, sex workers and, in some countries, transgender persons and gay and other men who have sex men) tend to be overrepresented among incarcerated populations. In many countries, the criminalization of drug use and certain sexual behaviours leads to the high representation of key populations, such as people who inject drugs, in prisons.[20] The lack of HIV testing and prevention services as well as treatment services in prisons can further contribute to the increased risk and prevalence of HIV among incarcerated persons.

Figure 2: Global and regional burdens of HIV among prisoners and detainees



Source: Dolan K, Wirtz AL, Moazen B, Ndeffo-Mbah M, Galvani A, Kinner SA et al. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. Lancet. 2016;388(10049):1089–1102. (Data are for 2005–2015)

19. Prisons offer ideal opportunities to provide treatment and care, with minimal loss to follow-up during the period of incarceration. HIV prevention programmes also provide opportunities to address risk behaviours and conditions for a range of other communicable diseases that are prevalent in prisons and closed settings.

High representation of key populations in prisons

20. Punitive laws, policies and practices lead to the incarceration of people who are most affected by HIV, such as people who inject drugs and sex workers, who are disproportionately represented in prisons worldwide as a result. More than 100 countries criminalize sex work or aspects of sex work,[21] while 72 countries[22] criminalize same-sex sexual relations. Such application of the criminal law increases the risk of incarceration for sex workers, transgender persons, and gay and other men who have sex with men. Further, incarcerated lesbian, gay, bisexual or transgender persons face major risks of sexual and other violence and abuse in prisons.[23] In addition to the risk of HIV transmission in prisons, members of key populations who are detained or imprisoned may also have been at high risk of HIV prior to incarceration.[24] The availability of HIV prevention and harm reduction services, as well as screening and testing for HIV and associated comorbidities, such as viral hepatitis C and TB are important for securing incarcerated persons' basic right to health.

21. Many countries have adopted HIV-specific laws or invoked general criminal law provisions to prosecute people living with HIV who allegedly do not disclose their HIV status prior to sexual relations (HIV non-disclosure), expose others to HIV (HIV exposure) and/or transmit HIV (HIV transmission). In 2016, 72 countries had HIV-specific legislation, and many countries also allow HIV criminalization under general law. Prosecutions of people living with HIV under these laws have been reported in 61 countries.[25]. These laws and their application lead to further incarceration of people living with HIV, including members of key populations and vulnerable groups who are reported to be particularly targeted with HIV criminalization in some countries.

22. As of October 2017, more than 30 countries retained the death penalty for drug offences[26] and a significant percentage of the prison population comprises individuals convicted of offences related to their drug use, who are drug dependent or who live with mental health problems. It has been estimated that 56–90% of people who inject drugs, depending on the country, will be incarcerated at some stage in their lives. In some countries, people who inject drugs comprise up to 50% of the population held in closed settings. Yet, opioid substitution therapy (OST) and other drug dependence treatment, needle and syringe programmes and provision of naloxone to manage opioid overdose events in prisons are exceedingly rare and often completely lacking.[27]

23. Many of the challenges associated with HIV infection, drug use and mental health issues in closed settings can be reduced if non-custodial alternatives to imprisonment are implemented for the consumption or possession for personal use of drugs and for petty crime are relevant in 2017. The reform of drug laws to reduce incarceration for drug use, as seen in Portugal, and provision of evidence-based services, including drug and mental health treatment, in communities can also ease those challenges.[28 29 30 31] High numbers of imprisoned people who inject drugs are associated with a heightened risk of HIV transmission. In addition, many prisoners begin injecting drugs for the first time in prison.[32]

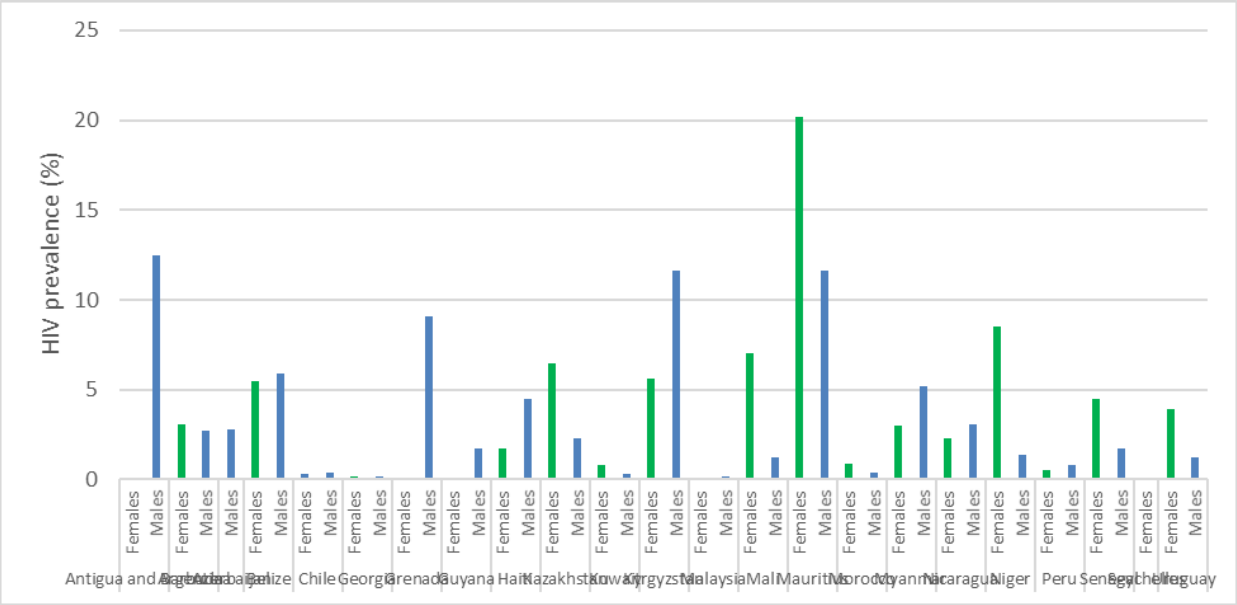
24. Criminal justice systems that involve long delays before charges are brought to court, and where detention facilities can be overcrowded, facilitate the risk of transmission of HIV and other communicable infections during detention. Even though human rights standards set out specific, limited grounds for imposing pre-trial detention, the arbitrary and excessive use of pre-trial detention is a global human rights problem.[33] Pre-trial detainees represent, on average, 30% of people held in closed settings. Yet access to health care in pre-trial detention is even poorer than in prisons.[34]

25. Transgender persons are also at high risk of abuse in prisons and other closed settings,[35] and their experiences while incarcerated have been shown to have very damaging effects on their wellbeing and health.[36] A report from 2016 showed high percentages of transgender women experience sexual victimization from other prisoners or from prison staff.[37]

Women

26. Women represent a minority of the prison population (5–10%)[38] with an estimated 700 000 women and girls held in penal institutions around the world. Women in prison tend to be from socially marginalized groups and they are more likely to have engaged in sex work and/or drug use, compared with women in the rest of the population.[39] These factors contribute to women's increased likelihood to be living with HIV infection in prisons. Other factors also increase women's risk of contracting TB, including coinfection with HIV, overcrowding and a lack of access to health services.[40] Women in prison are especially vulnerable to sexual assault, including rape, by other prisoners and prison staff. They are also at risk of sexual exploitation and may engage in sex for the exchange of goods.[41]

Figure 3: HIV Prevalence among men and women in prisons and other closed settings



Source: Global AIDS Monitoring 2017

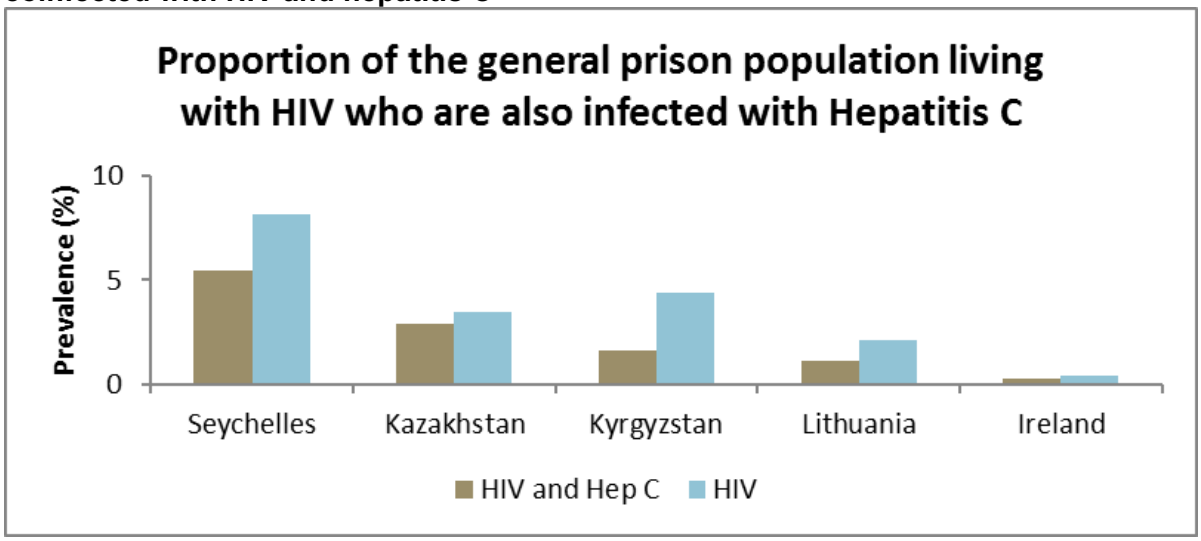
Structural barriers and overcrowding

27. Prison overcrowding is a global problem. Crowded conditions can make it difficult to prevent and manage infectious diseases and other health threats. In 2017, according to the International Center for Prison Studies, 115 countries had a prison occupancy higher than 100%, including 22 with occupancy above 200%, and four countries with an occupancy rate of over 300%.[42]

28. Overcrowding, unsanitary conditions and poor ventilation puts the health of people in prison at great risk, by increasing their exposure to infectious diseases, such as TB and viral hepatitis; facilitating violence, bullying and sexual assault; limiting access to exercise and open-air environments; and comprising nutrition, diets and basic hygiene.[43] People living with HIV are especially susceptible to tuberculosis.

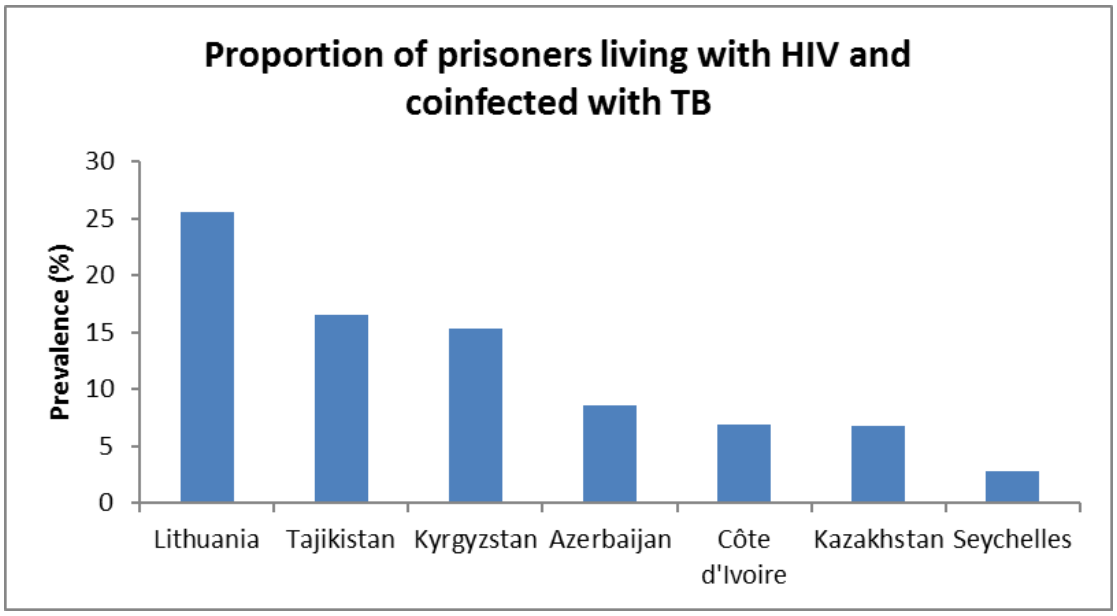
29. The absence of needle and syringe programmes and other harm reduction services in prisons increases the infection risks associated with injecting drug use. The use of contaminated injecting equipment when using drugs is one of the primary routes of HIV transmission in prisons.[44]

Figure 4: Proportion of people in prisons and other closed settings who are coinfected with HIV and hepatitis C



Source: Global AIDS Monitoring 2017

Figure 5: Proportion of people in prisons and other closed settings who are coinfected with HIV and TB



Source: Global AIDS Monitoring 2017

A need for stronger political awareness and engagement, and increased funding

30. Medical services in prisons are often underfunded, and staff members tasked with providing health services are not necessarily trained to perform those roles. As a result, health facilities and medical or dental equipment may not be sanitary and health staff may lack the training to practice universal precautions. This increases the risk of transmission of HIV, viral hepatitis and other communicable diseases.

31. Health officers should have the skills and autonomy to determine the prevention, treatment or other health needs of their patients, including possible transfers to public health services. Addressing detainees' health needs may contribute to rehabilitation and successful reintegration into the wider community. Transferring control over health services in closed settings to public health authorities will have a positive impact on the

provision of a comprehensive package of HIV interventions in closed settings in prison and would benefit public health in general.[45]

32. Funding of health care budgets for prisons should reflect the special health care needs of the prison population, and should be treated as an integral to the public health sector.[46]

Lack of services within prisons

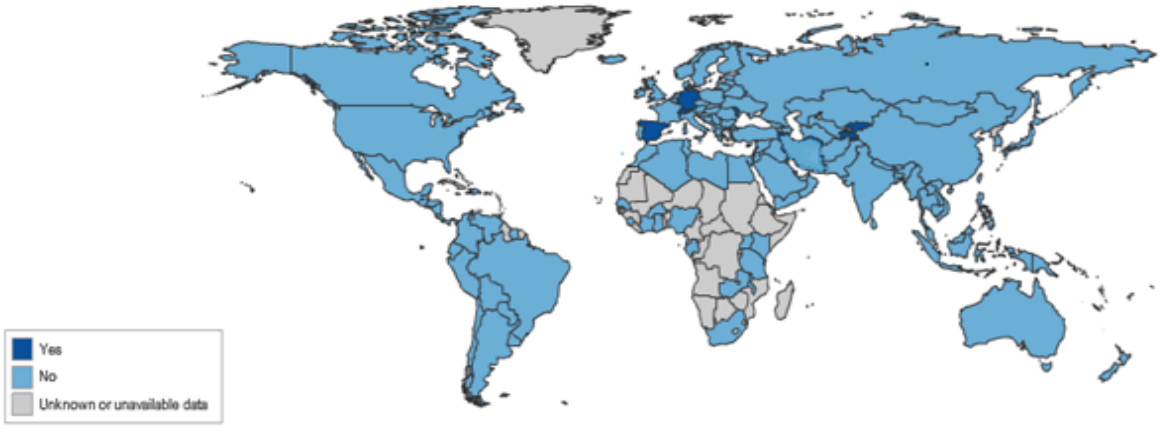
33. The lack of political will and, consequently, resources are the main reasons for the failure to implement comprehensive programmes that can reduce the risk of HIV transmission in prisons and the failure to protect the health of incarcerated people living with HIV. Security concerns from corrections officers are often cited as a reason, due to the mistaken belief that such programmes would encourage injecting drug use and unsafe sexual behaviour among prisoners and detainees.

34. Various laws, policies and practices hinder the distribution of condoms to people in prisons and other closed settings in most countries. In 2017, only about 40 countries reported that condoms and lubricants were available to people in prisons as an HIV prevention service, and only 23 countries reported the number of condoms that were distributed. Almost 70 countries confirmed that condoms were not available in places of incarceration.[47 48]

35. In countries where condoms are provided in prisons, they are often not easily accessible (with distribution limited to a small number of prisons) and lubricants are seldom provided. Access to female condoms is even scarcer. In many countries, access to condoms in prisons is limited to conjugal visiting rooms and not for use between incarcerated persons. Access to these prevention tools should be expanded: unsafe sex facilitates the transmission of HIV and other sexually transmitted infections in prisons.[49 50]

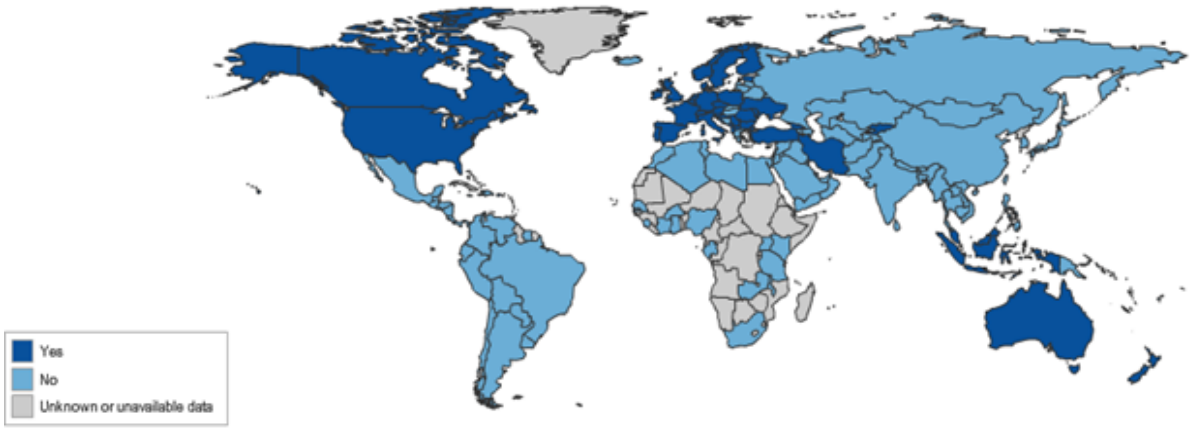
36. Availability and accessibility of confidential and voluntary HIV testing and treatment are an important component of the HIV services that should be available in prisons. In 2017, 68 countries reported having laws and policies in place to provide confidential, free and accessible HIV testing services to all incarcerated persons at any time, and to conduct testing with the informed consent of individuals who are then linked to confidential and post-testing counselling services.[51]

Figure 6: Countries that have at least one needle and syringe programme in prisons



Source: Global state of harm reduction 2016. London: Harm Reduction International; 2016.

Figure 7: Countries with opioid substitution therapy sites in prisons.



Source: Global state of harm reduction 2016. London: Harm Reduction International; 2016.

37. Harm reduction is another important component of HIV prevention among people who are incarcerated. It includes making sterile needles and syringes and OST available to incarcerated persons who inject drugs. Currently, only 8 countries run at least one needle and syringe programme in prisons and 52 countries operate at least one OST site in prisons (a 21% increase since 2014).[52] Data on the number of needles and syringes distributed in prisons and the number or proportion of incarcerated persons receiving OST are scarce. Greater efforts are needed to improve monitoring and evaluation of these services in order to ensure that harm reduction and HIV prevention services are accessible to the people who require them.

38. In 2017, 104 countries reported having policies to make ART available to all incarcerated persons living with HIV.[53] Data from 2016 indicated that 27 out of 30 countries reported that they were providing ART to at least 50% of incarcerated persons *diagnosed with HIV*.[54] Note that this does not mean 50% of incarcerated persons living with HIV were receiving ART. Nevertheless, it does underscore the potential to reach and treat this key population of people living with HIV.

39. Table 1 below indicates fairly high uptake of beneficial policies. However, the extent to which these policies are implemented is not known. For example, data regarding HIV testing and treatment services in prisons and other closed settings are limited. Improved monitoring and evaluation of existing HIV services can help reduce HIV transmission and HIV-related illness and mortality in prisons, as well as inform necessary improvements.

Figure 8: ART coverage among incarcerated persons diagnosed with HIV infection

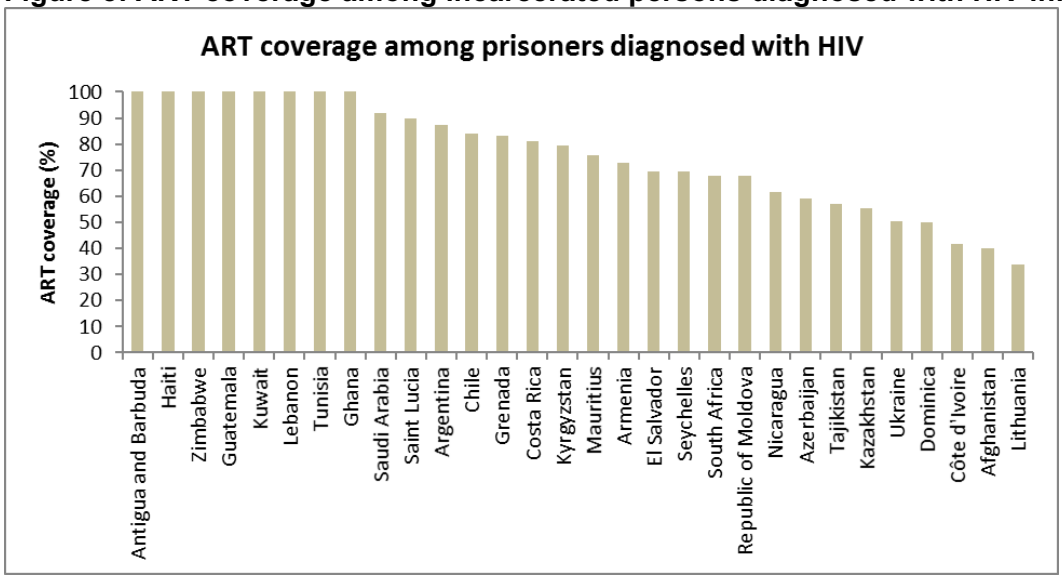


Table 1: Policies as reported by governments and civil society, 2016

Reported Policy	Reported by government			Reported by civil society		
	#Countries reporting	#Reporting policy	%Reporting Policy	#Countries reporting	#Reporting Policy	%Reporting Policy
Needle and syringe distribution	129	8	6%	122	9	7%
Opioid substitution therapy offered	126	24	19%	121	21	17%
Condoms and lube distributed	127	50	39%	123	42	34%
HIV testing: Informed Consent	128	113	88%	118	108	92%
HIV testing: Free	128	126	98%	120	116	97%
HIV testing: Confidential	124	118	95%	118	106	90%
HIV testing: Available any time	122	101	83%	117	86	74%
HIV Testing: Relevant IEC distributed	122	114	93%	115	97	84%
HIV testing: Pre- &Post-test confidential counselling	124	117	94%	118	102	86%
HIV testing: Equal access to test	125	114	91%	118	101	86%
ART available to all prisoners in country	125	119	95%	121	99	82%
Participate in national response planning	127	34	27%	118	29	25%
Condoms for prisoner in national condom strategy	109	52	48%	N/A	N/A	N/A

Source: 2017 National Commitments and Policy Instrument.

Stigma and discrimination

40. HIV stigma and discrimination in prisons has dramatic consequences for the physical and psychological health of people in prisons, and can hamper effective HIV prevention, treatment and care measures. It can deter people who are at risk of HIV infection from taking precautionary steps or accessing HIV testing and treatment services.[55]

41. UNODC, WHO and UNAIDS have stressed that mandatory HIV testing for incarcerated persons is both unethical and ineffective,[56] and should be prohibited. The enforced segregation or isolation of people living with HIV in prisons and closed settings has detrimental effects on the physical and mental health of people living with HIV in prisons, and violates their rights.[57] Yet, mandatory testing and the segregation of people living with HIV in prisons still occur in some countries.[58]

42. These practices should cease. Discriminatory policies toward people living with HIV should be neither promulgated nor practiced.[59] All HIV testing programmes in closed settings should be linked to HIV care and treatment programmes.

Barriers to healthcare and HIV services in prisons

43. Lack of access to HIV prevention services puts people in prisons at increased risk of HIV infection. It also places people living with HIV in prisons at increased risk of declining health, coinfection with TB and viral hepatitis, and possibly death.

44. There is often a lack of integration between health care provision and social support systems between prisons and the community. Community health care and social welfare services seldom include prisons in their planning and service designs, partly because the responsibility for health services in prisons typically rests with the Ministry of Interior or the Ministry of Justice, rather than with the Ministry of Health. The necessary coordination is complicated further by the fact that prisons and other closed settings in many countries are operated by private companies (even though human rights standards still apply to those arrangements).[60]

45. Effective coordination between health services and the criminal justice system, especially concerning police and pre-trial detention centres, is essential for meeting the health needs of people passing through those facilities. Police cells and pre-trial detention centres are often unprepared to continue the provision of essential treatment (e.g. OST, antiretroviral therapy or treatment for TB), because of a lack of resources, an absence of clear policy directives, and poor coordination between health services in custodial centres and those in the wider community.

46. Continuity of care on admission to, and after release from prison is also challenging, again due to a lack of coordination between different government departments. This contributes to the neglect of incarcerated persons' health.

Lack of continuity of care

47. Health in prisons has rarely been addressed as a general public health issue, partly due to the closed nature of prisons and places of detention.[61] Yet for the vast majority of people in these facilities, detention or imprisonment is temporary, after which people re-enter their communities; people in prisons and other closed settings are part of the wider community. UNAIDS made this clear in 1996, when it stated: "Prisoners are the community. They come from the community, they return to it. Protection of prisoners is the protection of our communities."[62]

48. Incarcerated persons require adjustment periods that include a continuation of services both when they enter into detention and when they return to the community after release. After-care programmes are important so that, upon their release, persons can receive the support they need to continue with their treatments. Interrupted antiretroviral therapy (ART) can undo the benefits of treatment and, as viral loads rebound, lead to further transmission of HIV. Discontinuation of treatment can also lead to drug resistance and treatment failure in the future. Linkage to care in the community is therefore vital, both for the individuals and the receiving communities. It ensures that the benefits of providing HIV services (similarly, treatment for TB and other diseases, and OST) in prisons are not lost when people regain their liberty.[63] Therefore, HIV prevention programmes in prisons must also ensure linkage of continued services outside the prison upon release.[64]

49. ART, harm reduction services, such as OST and needle and syringe programmes, and HIV testing, counselling and care should also be available to people leaving prisons and re-entering the larger community.

III. CATALYZING POLITICAL COMMITMENTS TO STRENGTHEN A HUMAN RIGHTS AND PUBLIC HEALTH APPROACH TO HEALTH IN PRISONS

50. This section reviews the actions taken to strengthen a human rights and public health approach to issues related to HIV and health in prisons and other closed settings. After outlining key political commitments and engagements at the global level since 2015, it describes the technical guidance and tools that have been introduced as well as actions undertaken by the Joint Programme and other stakeholders since 2015. The final section describes examples of actions taken at regional and country level, highlights the example of Viet Nam.

Global political commitments since 2015

51. *2030 Agenda for Sustainable Development (September 2015)*.[65] The 2030 Agenda for Sustainable Development envisages a world of universal respect for human rights and human dignity, the rule of law, justice, equality and non-discrimination. By adopting this resolution, all countries and all stakeholders pledged that no one will be left behind: “recognizing that the dignity of the human person is fundamental, we wish to see the goals and targets met for all nations and peoples and for all segments of society. And we will endeavour to reach the furthest behind”.[66]

52. UNAIDS 2016–2021 Strategy on the Fast-Track to end AIDS[67] *(August 2015)*. In order to reduce inequality in access to services and commodities, the result area 4 aims at ensuring tailored HIV combination prevention services are accessible to key populations, including prisoners, and calls for availability of effective and appropriate HIV and health services and commodities in an enabling social, legal and policy environment, as well as the meaningful engagement of these groups in the response.

53. *UN General Assembly—UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) (December 2015)*.[68] The “Nelson Mandela Rules”, as agreed to at the UN in 2015, state that the provision of health care for people in incarceration is a government responsibility and should be provided free of charge and without discrimination based on legal status.[69] Rules 24 to 35 emphasize the provision of health care services in prisons, with Rule 24 stating that:

- The provision of health care for incarcerated persons is a State responsibility. They should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status;
- Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, TB and other infectious diseases, as well as for drug dependence.

54. United Nations General Assembly Special Session on Drugs[70] *(April 2016)*. In preparation for the UN General Assembly Special Session on the World Drug Problem, UNODC organized seven regional dialogues on drug policy and HIV, addressing, among other issues, stigma and discrimination as major barriers for the HIV response. In April 2016, Member States adopted an Outcome Document, which promotes access for people in prisons to a broad range of interventions, including psychosocial, behavioural and medication-assisted treatment. It also emphasizes the importance of rehabilitation, social reintegration and recovery-support programmes in prisons and after release, and paid special attention to the specific needs of women, children and youth.

55. The Outcome Document supports non-discriminatory access to health, care and social services in prevention, primary care and treatment programmes, including those offered to persons in prison or pretrial detention, which are to be on a level equal to those available in the community. It also called for actions to ensure that women, including detained women, have access to adequate health services and counselling, including those needed during pregnancy.

56. 2016 Political Declaration on ending AIDS[71] *(June 2016)*. The Political Declaration on Ending AIDS reaffirms the commitment to end the AIDS epidemic by 2030 and to reach the goals and targets set by Agenda 2030. It explicitly emphasizes the importance of promoting, protecting and fulfilling all human rights and the dignity of people living with, at risk of, and affected by HIV as an objective and means to ending the AIDS epidemic.[72] The Political Declaration notes that many national HIV prevention, testing and treatment programmes provide insufficient access to services for key populations, including people in incarceration.[73]

57. The Political Declaration also notes a lack of progress made in reducing the transmission of HIV among people who inject drugs, and calls for ensuring access to HIV-related services, including treatment and outreach services, in prisons and other custodial settings.[74]

58. In July 2016, the African Commission on Human and Peoples' Rights issued *Guidelines on the conditions of arrest, police custody and pre-trial detention in Africa*. The guidelines note that pre-trial detention disproportionately affects vulnerable and marginalized populations who are unlikely to have the means to afford legal representation and assistance. The guidelines call on African States to take the necessary, legal, policy and other measures to end arrests, detentions and pre-trial detentions that violate human rights.[75]

59. Commission on Narcotic Drugs[76] *(March 2017)*. The Commission on Narcotic Drugs passed Resolution 60/8, which calls for measures to prevent HIV and other blood-borne diseases associated with the use of drugs. It also urges Member States and other donors to continue to provide bilateral funding for the global AIDS response, and to strive to ensure that such funding contributes to addressing the growing HIV epidemic among people who inject drugs, and HIV in prison settings.

60. *Commission on Crime Prevention and Criminal Justice*[77] *(May 2017)*. A resolution passed by the Commission on Crime Prevention and Criminal Justice calls on Member States to include prisons in their efforts to eliminate mother-to-child transmission of HIV. It specifically requests UNODC, in collaboration with relevant Cosponsors, to develop technical guidance on measures for preventing mother-to-child transmission of HIV in prisons, based on international guidelines, and to support Member States in increasing their capacity to implement those guidelines in prisons.

IV. TECHNICAL GUIDANCE, TOOLS AND ACTIONS FROM THE JOINT PROGRAMME AND OTHER STAKE HOLDERS SINCE 2015

61. *Technical guide on the continuity of HIV services in prisons (forthcoming)*. UNODC is developing a technical guide to ensure continuity of HIV services for people on admission to, transfer between and release from prisons. It will include guidance to address the high rate of overdose deaths among recently released prisoners among the challenges to be overcome. The guide is expected to be launched at the International AIDS Conference in Amsterdam in 2018.

62. *HIV and AIDS in places of detention toolkit (2008)*.[78] This toolkit is being updated in 2017 for policymakers, programme managers, prison officers and health care providers in prison settings. It provides information and guidance to individuals and entities that manage prisons and work with incarcerated persons. The updated toolkit will emphasize a comprehensive package of HIV services in prisons and include a module to address the specific health needs of women in prisons, in-line with international standards.

63. *PMTCT technical guide*.[79] In response to the resolution of the 26th session of the Commission on Crime Prevention, UNODC and partners are developing in 2017 a technical guide on the prevention of mother-to-child transmission of HIV in prisons. The guide will support countries to provide essential HIV and other health services to women in prisons to support the uninterrupted provision of those services throughout pregnancy. It is expected to be finalized in 2018.

64. *Tool for monitoring harm reduction in prisons.* In 2016, Harm Reduction International developed a tool for better informed, more consistent and sustained monitoring of HIV, HCV, TB and harm reduction in prisons by national, regional and international human rights-based prison monitoring mechanisms.[80]

65. *Assessing compliance with the "Nelson Mandela Rules"*: *A checklist for internal inspection mechanisms (August 2017)*.[81] The UN Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules") constitute the universally acknowledged minimum standards for the management of prison facilities and treatment of prisoners. They have been of tremendous value and influence in the development of prison laws, policies and practices around the world. UNODC designed a checklist to assist Member States in conducting internal or administrative inspections to assess compliance of their national prison systems with the Rules, thereby supporting their implementation at national level.

66. *WHO consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016*.[82] These guidelines outline a comprehensive package of evidence-based HIV-related recommendations for key populations, including people in prisons. They are intended to increase awareness about the needs and priorities of key populations, and improve access, coverage and uptake of effective and acceptable services. They also provide a knowledge base for mobilizing stronger commitment to adequately fund and implement services.

67. *Agenda for zero discrimination in health-care settings*. The UNAIDS Secretariat and WHO's Global Health Workforce Alliance jointly launched the Agenda in March 2016 to guide collective advocacy, leadership, accountability and implementation of evidence-informed interventions. The aim is to eliminate discrimination from health services everywhere, including in prisons.[83]

68. UNODC regional programmes are supporting countries in mounting effective national responses to HIV in prisons. For example, the *Regional Programme for the Arab States, 2016–2021,*[84] includes a sub-programme on health in prisons and requests national authorities to improve access to health services in those settings. As part of the programme, UNODC advocates with Member States and civil society organizations to increase incarcerated persons' access of health services. The programme emphasizes the need to prioritize implementation of the comprehensive package of HIV prevention, treatment and care services in prisons as outlined in the UNODC/ILO/UNDP/WHO and UNAIDS policy brief. [85]

69. On Nelson Mandela Day in 2016, the African Correctional Services Association and the African HIV in Prisons Partnership Network issued an urgent call for action on HIV and health in prison settings in Africa**.** The call emerged from a pan-African consultation on HIV and health in prison settings, held in Durban, South Africa during the 2016 International AIDS Conference. The call recognizes progress made in improving access equity to health and HIV services in prisons since the first *Southern and Eastern African Declaration of Commitment for HIV and AIDS Prevention, Care, Treatment and Support in Prisons*, which was adopted in 2009. However, it also highlights the persistently high disease burden in prisons, as well as the several challenges, barriers and gaps that remain.

70. *The EMCDDA European questionnaire on drug use among people in incarceration and methodological guidelines (April 2017).*[86] This tool is designed for collecting information that can be used to improve health and social services and facilities for people in incarceration, and to improve their physical, psychological and social conditions.

71. UNDP's *Legal environment assessments for tuberculosis: An operational guide*,[87] published in July 2017, aims to help build national capacity for an inclusive process to develop a human rights framework for TB and to bring national laws and policies in line with the framework. The rights of people in incarceration are included as a focus.

72. *Using complaints to address healthcare violations: A guide for healthcare users and community-based organisations*,*[88]* published in August 2016 by the Southern Africa Litigation Centre, includes examples of health-care violations that prisoners may experience.

73. The updated *UNDP Global Fund capacity development toolkit*, launched in 2017, includes a section on critical enablers.[89] It offers practical guidance on how to promote and protect human rights and gender equality, and develop enabling legal and policy environments for everyone, including incarcerated persons and other key populations, in national HIV, TB and malaria strategies and programmes.

74. An informal working group was established in 2017 to coordinate efforts to increase awareness of health-related issues for people in prisons and other closed settings. It includes representatives from the WHO departments of HIV and TB, UNODC, UNAIDS, the US Centers for Disease Control and Prevention (CDC), the International Committee of the Red Cross, Harm Reduction International and Stop TB.

75. WHO is considering the development of a technical update on prisons and HIV, TB, viral hepatitis and drug use or dependence. The update would consolidate relevant recommendations and guidelines with regard to prevention, testing and treatment services, including the 2007 WHO/UNODC/UNAIDS “evidence for action” papers.

76. The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) is developing its first information note on prisons, with support from the UNAIDS Secretariat, as well as the CDC, the International Committee of the Red Cross, Harm Reduction International and other key stakeholders.

77. The UNAIDS Secretariat and UNODC will participate in an international meeting on health in prisons in Lisbon on 10–12 December 2017, which is cosponsored by WHO Europe, the European Monitoring Centre on Drugs and Drug Addiction and Public Health England.

78. The UNAIDS Secretariat added an indicator set to the Global AIDS Monitoring system in 2017. As part of their commitment to the 2016 Political Declaration on ending AIDS, countries are now asked to report also on their policies and HIV response in prisons and other closed settings.[90]

V. COUNTRY AND REGIONAL ACTIONS SINCE 2015

79. UNDP has supported countries in the sub-Saharan Africa, Latin America and the Asia-Pacific regions to organize national dialogues on HIV, human rights and the law and conduct legal environment assessments of policies, laws and practices. The latter include ensuring access to acceptable, affordable and good-quality HIV services, including harm reduction services, and to law reform to protect the rights of people who use drugs in prison. The initiative has informed, for example, the 2016 *Seychelles HIV & AIDS national action plan to remove legal barriers*; the 2016 *Report on assessment of the legal environment for HIV and AIDS in Lesotho*, and the 2015 *Legal environment assessment for the HIV/AIDS response in Nigeria*.

80. The UNDP/Global Fund partnership, which supports TB programmes in 11 countries, has begun implementing new TB grants in Belize, Djibouti, Kyrgyzstan, Panama and Turkmenistan. The grants focus on populations that are especially vulnerable to TB, including incarcerated persons. Working closely with national governments and civil society organisations, this initiative has resulted in 820 000 people receiving treatment for TB, including almost 18 000 people who received treatment for multidrug-resistant TB.

Sub-Saharan Africa

81. UNODC initiated a new programme on HIV prevention, treatment and care in prisons in sub-Saharan Africa for 2017–2020, which builds on the experiences and achievements of other UNODC programmes in southern Africa. The programme is intended to take the HIV response further and move towards a service delivery-level approach to HIV and sexual and reproductive health rights in prisons in countries that currently receive UNODC technical assistance. Those countries are: Angola, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Republic of Tanzania, Zambia and Zimbabwe. In addressing country needs and gaps in a tailored manner, UNODC is supporting national responses that are gender-appropriate, human rights-oriented and evidence-based.

82. UNODC continued implementation of a HIV prevention, treatment, care and support in prison settings in sub-Saharan Africa project in 10 countries: Angola, Ethiopia, Lesotho,

Malawi, Mozambique, Namibia, Swaziland, Republic of Tanzania, Zambia and Zimbabwe. The project developed the first HIV service delivery toolkit for HIV in prisons in sub-Saharan Africa, which comprises guidelines, standard operating procedures and training manuals covering seven thematic areas. The materials were presented at the International AIDS Conference in Durban in July 2016.

83. UNDP continued implementation of the Global Fund Africa regional HIV grant for removing legal barriers to access, forming a partnership with the AIDS and Rights Alliance of Southern Africa, Enda Santé, the Kenya Legal and Ethical Issues Network on HIV and AIDS, and the Southern Africa Litigation Centre. The grant is aimed at strengthening the legal and policy environment to reduce the impact of HIV and TB on key populations in 10 countries in sub-Saharan Africa: Botswana, Côte D'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Republic of Tanzania, Uganda and Zambia. Lawyers who have participated in the trainings have successfully represented clients in criminal cases.

84. The Africa Regional Judges Forum on HIV, Human Rights and the Law, established in 2014, deliberates on HIV and TB-related jurisprudence as part of a UNDP initiative to sensitize senior judges and uphold the rights of people living with or vulnerable to HIV. Discussions on HIV and TB in prisons from health and criminal law perspectives were a key focus of the 2017 annual meeting. Judges who have participated in the meetings have been party to important rulings related to HIV in prisons.

85. In Zimbabwe, UNODC finalized an assessment of TB prevalence and factors associated with TB transmission in prisons in 2016.[91] It also conducted a review of selected health services in prisons, documented good practices, and carried out a legal review of rules, legislation, and policies affecting HIV in prisons.

86. The first Namibia Correctional Services health policy and strategic plan was developed in 2015 with technical support from UNODC, which also refurbished two ambulances for the Namibia Correctional Services to support the provision of health services at remote detention facilities.

87. In Kenya, capacity building activities to address the health needs of women in prisons were implemented, and continued access to OST was assured for persons who were hospitalized or incarcerated in 2017. UNODC provided technical support to the Federal Prison Administration on HIV interventions in prison settings, including the development and implementation of a cascade strategy and standard operating procedure for peer education. UNODC supported translation into Amharic of the HIV training manual, *An integrated approach to HIV and AIDS in prison*.

88. In Zambia, UNODC and UNDP supported prison reforms, prison health promotion and HIV prevention aligned with the "Nelson Mandela Rules". UNODC, in collaboration with the Centre for Infectious Disease Control of Zambia and the In-But-Free NGO, supported the revision of prison staff training curricula in line with the Rules in 2017. In partnership with the CDC, the Ministry of Health and the Zambia Correctional service, UNODC conducted a rapid assessment of modes of transmission of HIV and other communicable diseases in prison settings.

89. Also in Zambia, UNODC in 2015 supported the operationalization of the Zambia Correctional Services 2015–2020 Health Strategic Plan, and facilitated the establishment of a Model Prison Health Care Centre (Kabwe Medium Prison Clinic) for provision of primary health care and integrated sexual and reproductive health and HIV services. It procured medical equipment and furniture to improve clinic services.

90. In the Republic of Tanzania, UNODC supported the national prison service in refurbishing a model health clinic that provides services to both prisoners and prison staff. UNODC provided technical assistance, supported the relevant Ministries in developing training materials, standard operating procedures and guidelines on HIV interventions in prisons in 2016.

Middle East and North Africa

91. UNODC advocated for the alignment of prison health sector plans with the recommended comprehensive package of HIV prevention, treatment and care services for prison settings. It implemented capacity building activities for senior officials of different line ministries and directorates in Egypt, Morocco and Tunisia on harm reduction and HIV, viral hepatitis, sexually transmitted infections and TB prevention, treatment and care among male and female prisoners, in line with international standards in 2017. In addition, in collaboration with the International Committee of the Red Cross, it conducted two regional workshops on health in detention for prison senior managers and medical doctors, in 2016 and 2017.

92. UNODC conducted a regional advocacy and capacity building workshop on HIV prevention, treatment and care in prison settings in August 2016 in Tehran for senior prison officials, national HIV programme managers and health professionals working on HIV in prisons from Afghanistan, Iran (Islamic Republic of), Kazakhstan, Kyrgyzstan, Pakistan, Tajikistan and Uzbekistan. The recommendations underlined, among other issues, the need to extend evidence-informed, rights-based, age- and gender-responsive HIV and other health services to all people in prisons, improve quality and optimize coverage of effective HIV services in prisons, and improve strategic information to guide policies and actions and ensure accountability.

93. In Afghanistan, UNODC provided technical assistance to the Ministry of Public Health for developing a national strategic framework for 2016–2020 for prevention and control of HIV, advocated for the removal of legal barriers to improve access to harm reduction services, including needle and syringe, OST and condom programmes in seven prisons (Badakhshan, Balkh, Ghazni, Herat, Kandahar, Kunduz and Nangrahar). UNODC also contributed to the development of a comprehensive proposal to the Global Fund.

94. UNDP continued to implement Global Fund grants on HIV, TB, malaria and health system strengthening in Afghanistan, where injecting drug use is the main driver of the HIV epidemic. The HIV grant is enabling essential prevention services for key populations, particularly people who inject drugs and prison populations.

95. In Morocco, UNODC conducted a prison HIV and drug use assessment in five prisons and provided capacity building to address the health needs of women in prisons in 2016.[92] In Egypt, it supported the establishment of three HIV testing and counselling centres in three regions and provided training for prison authorities to address the health needs of women in prisons. In Libya, UNODC organized a training session and a study tour to Beirut, Lebanon, for 14 professionals from the Libyan National Centre for Disease Control and civil society organizations working on HIV prevention, treatment and care, including in prisons.

Eastern Europe and Central Asia

96. In Ukraine, UNODC and partners successfully advocated for introducing OST in prison settings, a move the Government approved in 2016. UNODC provided inputs to the strategy and to an action plan on sustainable responses to TB and HIV epidemics. Technical support was provided to prison health authorities to develop standard operating procedures on ART and HIV testing and counseling, along with training on HIV/TB case management and HIV testing and counselling in prison settings.

97. UNODC supported five prison staff training facilities in Ukraine to develop a training manual for on-the-job training on HIV for prison staff and to conduct a training of trainers workshop in 2016. UNODC's efforts helped ensure that prison staff are regularly trained on HIV, human rights, stigma and discrimination issues as part of existing staff training and development schemes.

98. In cooperation with the National Police of Ukraine and the National Academy of Internal Affairs, in 2015–2016, UNODC produced video learning materials on HIV, occupational safety, policing of key populations and the role of police in HIV responses, which reached almost 14 000 police officers.

99. In Moldova, UNODC built the capacity of civil society and community-based organizations and helped improve the availability of HIV and other health services in prison settings by supporting implementation of needle and syringe, OST and other harm reduction activities in prisons. Since 2015, advocacy events with civil society and community-based organizations, law enforcement and prison authorities, UN agencies and other partners were implemented. UNODC contributed to the development of a manual for prison staff on comprehensive HIV prevention in prisons in 2016. An assessment of the accessibility, coverage and quality of the comprehensive package of services in prisons was conducted to guide the development of an action plan and adjustment of relevant policies and practices in line with the "Nelson Mandela Rules".

100. In Kazakhstan, an assessment study on alternatives to incarceration for drug-using offenders who had committed non-violent crimes was finalized in 2016. In Kyrgyzstan and Tajikistan, UNODC assessed existing methods and established partnerships for monitoring and evaluating HIV services in prisons. It also identified areas for their improvement and for provision of targeted technical assistance and capacity building. Ongoing activities focus on supporting harmonized data collection, analysis and reporting in prisons and pre-trial centres in coordination with national and international partners.

101. In Kyrgyzstan, since 2015, UNODC led a national discussion and facilitated collaboration between civil society partners, the Ministry of Health and other Government bodies for the development of a road map on transitioning to domestic funding for harm reduction. The draft road map was presented to the Health Insurance Fund and Ministry of Finance. The advocacy efforts contributed to the allocation of domestic funding for procurement of needles and syringes for HIV harm reduction services in prisons. As part of its partnership with the Global Fund, UNDP, in coordination with the Kyrgyz Government, provides prison hospitals with medicines and laboratory supplies, including methadone and medicines for treating HIV and TB.

102. As part of UNODC's regional activities, an assessment study on alternatives to incarceration for drug using offenders who committed non-violent crimes was finalized and a regional assessment report covering Afghanistan, Iran, Kazakhstan, Kyrgyzstan, Pakistan, Tajikistan and Uzbekistan was launched in June 2016.

Asia and the Pacific

103. UNDP, the UNAIDS secretariat and the Economic and Social Commission for Asia and the Pacific released *Review of country progress in addressing legal and policy barriers to universal access to HIV services in Asia and the Pacific* in 2016. The report highlights progress, challenges and future priorities in addressing legal and policy barriers to achieving universal access to HIV services in the region, including in prisons and other closed settings.

104. In Nepal, UNODC developed the capacities of health-care providers in prisons and relevant NGOs on the prevention of mother-to-child transmission of HIV in prison in 2017. It provided training for senior Government policy-makers, senior law enforcement officials, armed police force and prison authorities to sensitize them about drug use, drug conventions and the “Nelson Mandela Rules”.

105. In Pakistan, UNODC strengthened the capacities of health-care providers in prisons and of members of relevant NGOs for preventing mother-to-child transmission of HIV in prisons in two provinces in 2017. It also supported the establishment of HIV services in two female prisons (in Karachi and Hyderabad) for women who use drugs. Awareness-raising activities were implemented on safe sex, safe injecting practices, condom use, health education, hygiene (for both prisoners and prison staff), voluntary counselling and testing, primary health care and sexually transmitted infection treatment.

106. In Indonesia, since 2015, UNODC has advocated for evidence-based approaches to improve the quality of HIV testing and counselling services in prisons, and has helped improve the awareness among government officials and NGOs of the need to protect women’s health in prisons.

107. In Myanmar, since 2016, UNODC jointly with WHO and UNAIDS supported the development of the standard operating procedures for health-care services in prisons with the inclusion of the 15 key interventions of the comprehensive package.

Latin America and the Caribbean

108. In January 2017, UNDP and the Global Fund announced a new grant agreement for TB programmes in Bolivia, focusing on TB/HIV co-infections, drug-resistant TB and TB in prison populations.

109. In Panama, a national dialogue resulted in a Government pledge to strengthen HIV prevention and care in prisons, and to develop a new national HIV law. The new Bill has been drafted and awaits enactment.

COUNTRY CASE EXAMPLE: VIET NAM

In Viet Nam, UNODC and partners successfully supported the Government to expand the first OST site in prisons (opened in 2015). UNODC provided training on HIV prevention and care for staff members and peer educators in prisons, including provision of OST services. More than 80 male peer educators from Phu Son Prison (Thai Nguyen) received training for trainers on HIV prevention and drug dependence treatment, which could benefit as many as 1,200 prisoners in their respective prisons. Information and education materials on HIV prevention and the benefits of methadone were also produced and distributed.

UNODC and the Ministry of Public Security reviewed the pilot phase of the delivery of OST in prisons, in liaison with the respective national health and AIDS, security and prison authorities, representatives of the national drug control authorities, and communities of

people who use drugs. In addition, UNODC and partners held advocacy meetings with 180 senior prison officials from 57 national prisons to take stock of the lessons learnt from the pilot phase. Based on the pilot phase it was recommended to further expand OST services to other prisons. Among the lessons was the importance of prison leadership and of close collaboration with community-based OST service units for scaling up the interventions. A plan to scale up the OST services in prisons was agreed and UNODC was asked to support the Government to help ensure successful implementation.

In 2017, UNODC provided technical support to 60 prisons and trained Vietnamese prison health-care workers to improve access to quality HIV counselling and testing services and to enhance continuity of HIV care and treatment for people in prisons in line with international standards. UNODC also assessed the current situation and identified needs for targeted technical assistance and capacity building for monitoring and evaluating HIV services in prisons. It then supported the development and launch of an electronic tool for monitoring the HIV epidemic and services in prisons, including hands-on training for prison health staff.

UNODC facilitated a study visit for the Bangladesh Ministries of Home Affairs and of Health and Family Welfare, and the International Centre for Diarrhoeal Disease Research to Viet Nam to share the lessons learnt in Viet Nam and to promote the expansion of OST programmes in communities and in prison settings.

VI. CONCLUSIONS AND RECOMMENDATIONS

110. HIV in prisons and other closed settings is both a public health and a human rights issue, and should be addressed urgently. Stakeholders should take intensified actions to ensure that the AIDS epidemic is ended as a public health threat by 2030, leaving no one behind, as presented in the UNAIDS Strategy 2016–2021 and in line with the 2030 Agenda for Sustainable Development and the Political Declaration on Ending AIDS. To achieve these objectives, it is essential that measures for comprehensive HIV prevention, treatment and care are human rights-based, gender- and age-sensitive, public health-oriented and evidence-informed, and are accessible to all people in prisons and other closed settings.

111. The burden of HIV, TB and viral hepatitis in places of incarceration can be reduced with legal, policy and criminal justice reforms that prevent unjust incarceration and avoid extended pretrial detention. These steps can be combined with increased resources and strengthened political commitments to ensure adequate conditions of confinement and availability of comprehensive HIV prevention interventions and medical care in prisons. Strong and effective linkages to care upon release are also urgently needed.

112. A public health approach to illness and prevention in prisons should be adopted, and prevention (including harm reduction) and treatment services should be offered.

113. Linkage programmes should be created and promoted to help released prisoners re-integrate into the community, with assurances of access to ART and other health services.

114. Protective laws, policies and programmes should be put in place and should be adequately resourced, monitored and enforced.

115. Country reporting to UNAIDS on their HIV response in prisons and other closed settings began in 2017. The ability of the Secretariat to observe progress in this area will improve over time and will be reflected in future reporting.

To these ends, countries are recommended to:

116. End punitive laws, policies and practices, especially against key populations, that lead to overcrowding of prisons and other closed settings and that hinder access to rights-based and evidence-informed HIV prevention, treatment and care services.

117. Integrate care for HIV, mental health challenges and addiction for people living in closed settings;[93]

118. Improve the generation and dissemination of strategic information on the epidemiological situation and responses to HIV and other infectious diseases in prisons and other closed settings in order to better inform policy and/or programme implementation decisions;

119. Scale up high-quality, comprehensive health, including HIV, services in prisons and other closed settings to reach all people in those facilities, with a particular focus on key affected populations;

120. Enhance coordinated actions by governments, communities and civil society, international funders, UNAIDS and other relevant partners in and across countries, to improve the availability, accessibility, acceptability and quality of HIV prevention, treatment and care services;

121. Develop and implement prison reform initiatives that address the underlying living and working conditions, and implement a comprehensive package of HIV prevention, treatment and care services in prisons;

122. Ensure that comprehensive services include linkages to prevention, care and treatment services in the community upon release.[94]

VII. DECISION POINTS

The PCB is invited to:

123. Take note of the report.

124. Request the Joint Programme to support Member States, civil society organizations, communities and other relevant stakeholders to enhance coordinated rights-based and people-centered national responses to improve the availability, accessibility, acceptability and quality of comprehensive HIV prevention, treatment and care services for people in prisons and other closed settings, including people living with HIV and other key populations, and the continuity of HIV services on admission to and release from prisons and other closed settings.

125. Request the Joint Programme to report on progress and concrete actions taken at a meeting of the PCB in 2020.

[End of document]

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