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HIV prevention, treatment and care in prisons in South-east Asia

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HIV PREVENTION, TREATMENT AND CARE IN PRISONS IN SOUTH-EAST ASIA

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
AusAID	Australian Agency for International Development
DFID	Department for International Development (UK)
DOTS	Directly observed therapy (short-course)
GFATM	Global Fund to Fight AIDS, TB and Malaria
HAART	Highly active antiretroviral therapy
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDUs	Injecting drug users
IEC	Information, education and communication
MMT	Methadone maintenance treatment
MSM	Men who have sex with men
NGO	Non-government organisation
NSP	Needle and syringe program
PLWHA	People living with HIV/AIDS
STI	Sexually transmitted infections
TB	Tuberculosis
TC	Therapeutic community
UNAFEI	United Nations Asia and Far East Institute for the Prevention of Crime and the Treatment of Offenders
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly
UNHCHR	United Nations Office of the High Commissioner for Human Rights
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

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1. INTRODUCTION

1.1 HIV in Asia and in prisons

Around 40 million people worldwide were living with HIV in 2005, with over 8 million of these in Asia. Injecting drug use and unprotected sexual intercourse, including that associated with commercial sex, are driving the epidemic in Asia. Strong progress has been made in the region in implementing and expanding HIV prevention and treatment programs in the community. Harm reduction interventions such as needle and syringe programs have been introduced in India and Indonesia, while Thailand has overseen a 100% condom use program for sex workers. HIV antiretroviral treatment (ART) is becoming available to greater numbers of people living with HIV/AIDS, particularly in resource-poor settings (UNAIDS, 2006a).

Despite these successes, HIV remains a global health threat. One arena in which HIV prevention, treatment and care have been neglected is prison. HIV prevalence in prisons is higher than in the surrounding communities (UNODC/WHO/UNAIDS, 2006). In the United States, HIV prevalence is three times higher among incarcerated populations than in the general population (Maruschak, 2004). In 2002, it was estimated that 8-16% of all prisoners in Indonesia were HIV positive (Ministry of Health Indonesia, 2003), compared to a national prevalence of 0.1-0.2% (UNAIDS, 2006d). This pattern is repeated in prisons around the world. The greater prevalence of HIV in prison is due to the concentration of people from marginalised populations, such as injecting drug users (IDUs) and sex workers, who already have elevated levels of HIV infection. Risk behaviours such as drug injecting and unprotected sex in prison contribute further to the transmission of the virus (see also section 1.3 below).

Prisons do not exist in isolation from the community. The majority of prisoners return to the cities and towns they came from. Resumption of risk behaviours such as unprotected sex (MacGowan et al., 2003) and drug injecting (Dolan, Wodak, Hall, Gaughwin, & Rae, 1996) shortly after release from prison is common. HIV positive prisoners, who may be unaware of their HIV status, risk passing the virus on to their sexual partners and those with whom they share injecting equipment. This was demonstrated in Thailand in the late 1980s. A prison amnesty was closely followed by a sharp increase in HIV prevalence among Bangkok's IDUs – from two per cent in 1987 to 43% in 1988. It is believed that many of the released inmates were HIV positive drug injectors who unwittingly transmitted the virus to their sexual and injecting partners (Wright, Vanichseni, Akarasewi, Wasi, & Choopanya, 1994). This example demonstrates that the failure to implement adequate HIV prevention and treatment programs in prison threatens the success of community-based efforts (UNODC/WHO/UNAIDS, 2006).

1.2 Human rights of prisoners

Although prisoners are necessarily denied some basic rights such as freedom of movement, they retain all other human rights, including the right to health and to be treated with dignity (UNODC/WHO/UNAIDS, 2006). Additionally, HIV prevention, treatment and care programs must have as their basis the promotion of and respect for human rights (UNAIDS, 2005b).

1.2.1 General prison conditions and overcrowding

The Office of the United Nations High Commissioner on Human Rights (UNHCHR) has detailed minimum standards for the treatment of prisoners and the conditions under which they are held. Guidelines for the accommodation of different categories of prisoners; the quantity and quality of food and healthcare; and maintaining institutional discipline are all described. Some of the most important principles, particularly with regard to HIV prevention, treatment and care in prison, are summarised below.

> Men and women shall so far as possible be detained in separate institutions; in an institution which receives both men and women the whole of the premises allocated to women shall be entirely separate. Untried prisoners shall be kept separate from convicted prisoners. Young prisoners shall be kept separate from adults.
>
> All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation.
>
> Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served.
>
> At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry.
>
> Discipline and order shall be maintained with firmness, but with no more restriction than is necessary for safe custody and well-ordered community life…Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences (UNHCHR, 1955).

Adherence to these minimum standards is essential for ensuring the human rights of prisoners are respected and upheld.

UNHCHR notes that the number of prisoners in an institution must not be so large that treatment and rehabilitative efforts are hindered (UNHCHR, 1955). That is, overcrowding of prisons is to be avoided. Overcrowding is of particular relevance to HIV prevention, treatment and care as it increases the likelihood of violence, including sexual violence. Male-to-male sexual assault is a particularly high-risk situation for HIV transmission. Condom use is unlikely and violence increases the likelihood of anal lesions, providing the virus with an entry point into the body. Overcrowding also increases the spread of infectious diseases such as tuberculosis, and increases the likelihood that HIV-infected prisoners will be exposed to and contract infectious diseases.

One of the major factors contributing to prison overcrowding is the incarceration of drug users. In many countries, possession of drugs for personal use is a crime punishable by imprisonment. The incarceration of large numbers of drug users increases the likelihood of drug use in prison, leading to increases in HIV-risk behaviours such as sharing of injecting equipment.

UNODC, WHO and UNAIDS recommend that actions to reduce prison populations and overcrowding be included as part of efforts to prevent HIV transmission in prison.

This may involve legal reforms, for example, the decriminalisation of the possession of drugs for personal use, the introduction of community sentencing practices or diversion programs for drug offenders (UNODC/WHO/UNAIDS, 2006).

1.2.2 Compulsory HIV testing

Compulsory testing of all inmates for HIV was common in prisons during the early stages of the HIV epidemic. While some jurisdictions still enforce compulsory testing, many have abandoned the practice, recognising it as a counter-productive and expensive exercise that contravenes prisoners' rights and produces little or no public health or security benefits (Jurgens, 2001). The *WHO Guidelines on HIV Infection and AIDS in Prisons* strongly argue against compulsory HIV testing of prisoners, stating that compulsory testing is "unethical and ineffective, and should be prohibited" (World Health Organization, 1993). There are more effective, ethical and cost-effective measures to ensure prison health and the safety and security of prisoners and prison staff, including voluntary counselling and testing programs; the use of universal infection control procedures and precautions, in which all body fluid exposures are treated as potentially infectious; and the provision of means to prevent HIV transmission, for example, condoms or sterile needles and syringes.

1.2.3 Segregation of HIV positive prisoners

As with compulsory testing, segregation of HIV positive prisoners cannot be justified on either public health or security grounds. The World Health Organization notes:

> Since segregation, isolation and restrictions on occupational activities, sports and recreation are not considered useful or relevant in the case of HIV-infected people in the community, the same attitude should be adopted towards HIV-infected prisoners. Decisions on isolation for health conditions should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public health standards and regulations. Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds, and as provided for by public health standards and regulations. HIV-infected prisoners should have equal access to workshops and to work in kitchens, farms and other work areas, and to all programs available to the general prison population.

The only exception to the above is in situations where an HIV-infected prisoners' illness poses a realistic threat to the general prison population, or where the health of the infected prisoner is at risk from exposure to the prison population:

> Isolation for limited periods may be required on medical grounds for HIV-infected prisoners suffering from pulmonary tuberculosis in an infectious stage. Protective isolation may also be required for prisoners with immunodepression related to AIDS, but should be carried out only with a prisoner's informed consent. Decisions on the need to isolate or segregate prisoners (including those infected with HIV) should only be taken on medical grounds and only by health personnel, and should not be influenced by the prison administration (World Health Organization, 1993).

1.3 HIV risk behaviours in prison

1.3.1 Injecting drug use

Drug dependence is common among prison populations. Estimates of the prevalence of drug dependence among male prisoners range from 10%-48%; among female prisoners, this rises to 30%-60% (Fazel, Bains, & Doll, 2006). Despite the efforts of prison authorities to prevent drug use, illicit drugs are available in prisons around the world, and many prisoners use drugs while incarcerated (UNAIDS, 1997). Numerous studies have documented injecting drug use in prisons around the world, finding that up to a half of all inmates with a history of injecting drug use continue to inject in prison (see table 1.1). In Scotland, a third of 227 prisoners interviewed had injected drugs; of these, 43% reported injecting in prison (Taylor et al., 1995). A Thai study of 689 prisoners found that half were injecting drug users, and that 49% of the IDUs had injected while incarcerated (Choopanya et al., 2002). Studies from Australia (Butler, Levy, Dolan, & Kaldor, 2003), the United Kingdom (Weild et al., 2000), Brazil (Burattini, Massad, Rozman, Azevedo, & Carvalho, 2000), and Canada (Small et al., 2005), among others, confirm that drug injection in prison is a global phenomenon.

Table 1.1: Percent of IDUs injecting in prison

Region/Country	No. IDUs surveyed	No. (%) injecting in prison
Canada	1,500	405 (27)[1]
New South Wales, Australia	347	177 (51)[2]
Bangkok, Thailand	351	172 (49)[3]
Scotland	76	33 (43)[4]
England & Wales	777	224 (29)[5]

Sources: [1]Small et al., 2005; [2]Butler et al., 2003; [3]Thaisri, 2003; [4]Taylor et al., 1995; [5]Weild et al., 2000

The risks associated with drug injecting are magnified by the prison environment, where those caught with injecting equipment or drugs are usually punished. Because injecting equipment is scarce in prison, needles and syringes are used multiple times, by numerous inmates (Pickering & Stimson, 1993; Small et al., 2005). Under these circumstances, the potential for HIV and other blood borne viral infection transmission is high. Injecting drug use has been identified as mode of HIV transmission in prison in Scotland (Taylor et al., 1995) Australia (Dolan & Wodak, 1999), Lithuania (Caplinskiene, Caplinskas, & Griskevicius, 2003) and Brazil (Burattini, Massad, Rozman, Azevedo, & Carvalho, 2000), while having been incarcerated has been established as a risk factor for HIV infection in Russia (Rhodes et al., 2006), Thailand (Thaisri, 2003) and Iran (Zamani et al., 2006).

1.3.2 Tattooing and body modification

Many prisoners obtain tattoos while in prison. As with needles and syringes used for drug injecting, tattooing equipment in prison tends to be re-used and shared among groups of prisoners (Dolan, Wodak, & Hall, 1999). Receiving a tattoo in prison has been identified as a risk factor for HIV infection in Thailand (Buavirat et al., 2003) and the United States of America (Taussig et al., 2006). It has also frequently been associated with hepatitis C transmission (Hellard, Hocking, & Crofts, 2004).

Other forms of body modification in prison may also place inmates at risk of HIV transmission. Penile modification occurs in prison in parts of South East Asia. A cut is made to the skin of the penis and small beads are inserted. This practice is known as *pasang tasbih* in Indonesia and *fang muk* in Thailand (Beyrer et al., 2003). Further research is required to establish the risk of HIV transmission associated with penile modification.

1.3.3 Unprotected sexual activity

Sexual activity, both consensual and coerced, occurs in prisons. Sex in prison may be heterosexual or homosexual in nature and it may be between prisoners, between prisoners and visitors, or between prisoners and prison guards (WHO/UNAIDS/UNODC, 2007).

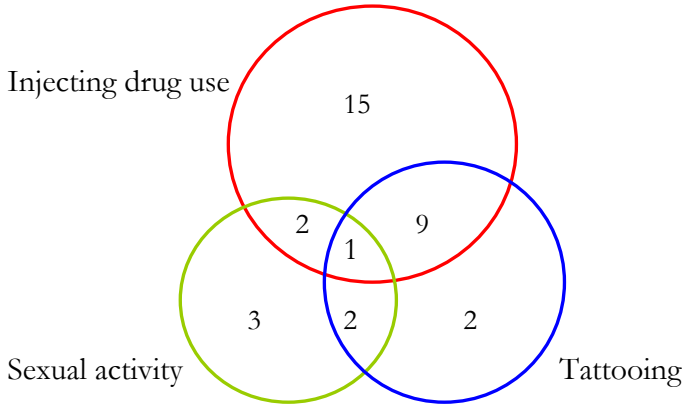
The prevalence of sexual activity in prisons has been assessed in many countries, with widely varying findings. Of 1,009 male prisoners in England and Wales, 2% reported having sex with a man in prison (Green et al., 2003). In Russia, 10-12% of 277 male prisoners had ever had sex in prison (Dolan, Bijl, & White, 2004). In Thailand, a quarter of 689 male prisoners reported ever having sex with men, of whom more than 80% had sex with men in prison (Thaisri, 2003), while in South Africa it is estimated that 65%-80% of male prisoners have consensual sex or are raped in prison (Goyer, 2003). Because of the stigma associated with male-to-male sex, particularly in prisons, these results may underestimate the extent of sexual activity in prison.

Sexual transmission of HIV in prison has been recorded. In Georgia, United States of America, at least 88 male inmates contracted HIV in prison between 1988 and 2005, with male-to-male sex identified as a route of transmission (Taussig et al., 2006).

1.3.4 Multiple risk behaviours

In community settings, individuals involved in one HIV-risk behaviour, for example, injecting drug use, are frequently also involved in other risk behaviours, such as selling or buying sex (MAP, 2004). This fact also holds true in prisons. In a study of the HIV risk behaviours of prisoners in New South Wales, Australia (Dolan, Wodak, & Hall, 1999), just over a quarter reported injecting drugs in prison, 14% had been tattooed in prison and eight percent had been sexually active in prison. Thirteen percent of those surveyed had engaged in two of these risk behaviours and one percent had engaged in all three (see figure 1.1 below).

Figure 1.1: Percent of prisoners engaging in one or more risk behaviours in prison



Source: Dolan et al., 1999

1.4 Prevention programs

1.4.1 HIV information, education and communication

HIV education programs, including peer education programs, are the most widely implemented HIV prevention intervention in prisons (WHO/UNAIDS/UNODC, 2007). HIV education for both prisoners and prison guards is essential for effective HIV prevention in prison. The *WHO Guidelines on HIV Infection and AIDS in Prisons* state the following with regard to HIV information, education and communication (IEC):

> Prisoners and prison staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release. The information should be coordinated and consistent with that disseminated in the general community. Information intended for the general public (through posters, leaflets, and mass media) should also be available to prisoners. All written materials distributed to prisoners should be appropriate for the educational level in the prison population; information should be made available in a language and form that prisoners can understand, and presented in an attractive and clear format.
>
> Prison staff should receive HIV/AIDS prevention information during their initial training and thereafter on a regular basis.
>
> Prisoners should receive HIV/AIDS education on entry, during their prison term, and in pre-release programmes. All prisoners should have an opportunity to discuss the related information with qualified people. Face-to-face communication, both in groups and on an individual basis, is an important element in education and information.
>
> Consultation with, and participation of, inmates and staff in the development of educational materials should be encouraged.
>
> In view of the importance of peer education, both prison staff and prisoners themselves should be involved in disseminating information.
>
> Education on infection control should emphasize the principles of universal precautions and hygiene. The lack of any risk of HIV transmission as a result of normal everyday contact should be emphasized. Excessive and unnecessary

> precautions while handling HIV-infected prisoners should be avoided (World Health Organization, 1993).

While HIV IEC results in increased HIV knowledge among prisoners and prison guards, it is uncertain if knowledge alone leads to decreased HIV risk behaviours and transmission (WHO/UNAIDS/UNODC, 2007). In addition to knowledge, prisoners require the *means* to effect behaviour change, for example, condoms and sterile injecting equipment.

1.4.2 Harm reduction programs

1.4.2.1 Bleach distribution programs

Bleach and other disinfectants can be used to clean needles and syringes used for injecting drugs or tattooing. Bleach distribution is an HIV prevention strategy employed in prisons in Australia, Canada, Indonesia, Iran and many countries in Western Europe and Central Asia (WHO/UNAIDS/UNODC, 2007). The Australian and Canadian programs have been evaluated. Two studies of the bleach distribution program in Australia found that when bleach is available, prisoners who inject drugs will clean needles and syringes between uses (Dolan, Wodak, & Hall, 1998, , 1999). Both the Australian and Canadian studies reported that no serious safety or security concerns arose as a result of the bleach distribution programs (Correctional Service of Canada, 1999; Dolan, Wodak, & Hall, 1998).

There are limitations to the effectiveness of bleach. There are several steps involved in sterilising HIV-contaminated injecting equipment. A typical cleaning protocol is as follows:

> Step 1: Wash the works by filling the syringe barrel to the top with full-strength, undiluted household bleach. Make sure the bleach covers the needle up to the syringe base. Leave the bleach in the syringe for at least thirty seconds. Shake or tap the syringe. Don't squirt the bleach back into the bottle.
>
> Step 2: Rinse the works with water by filling up the syringe barrel to the top. Do this twice to rid the syringe of bleach. Don't squirt the water back into the bottle (Carlson, 1998).

Under laboratory conditions, such protocols adequately disinfect HIV-contaminated equipment. However, drug injection rarely occurs under laboratory conditions. Studies of injecting drug users (IDUs) in the community have found that cleaning times are usually insufficient for disinfecting equipment (Carlson, 1998). This is likely to be even more so for prisoners, who must inject hurriedly in order to avoid detection by guards, and are unlikely to take the time required to adequately clean needles and syringes (Taylor & Goldberg, 1996). Furthermore, needles and syringes in prison are re-used many times, becoming degraded and difficult to clean (Seamark & Gaughwin, 1994). A review of the literature on the effectiveness of bleach in cleaning needles and syringes concluded that under real-world conditions bleach offers little to no protection against HIV infection (World Health Organization, 2004a).

1.4.2.2 Needle and syringe programs

Needle and syringe programs (NSPs) provide sterile drug injecting equipment, primarily needles and syringes, but also tourniquets, alcohol swabs, spoons and cotton wool. The *WHO Guidelines on HIV Infection and AIDS in Prisons* state that "in countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this" (World Health Organization, 1993).

Table 1.2: Countries with, and current status of, prison NSPs

Country	Year NSP began	Status of program
Switzerland	1992	NSP operating in seven prisons
Germany	1996	Despite at least six positive evaluations, several prison NSPs terminated due to political pressure
Spain	1997	Legislation requires all prisons (with the exception of psychiatric institutions and one maximum-security facility) to implement NSP
Moldova	1999	NSP in three prisons
Kyrgyzstan	2002	NSP operating in all prisons
Belarus	2003	NSP operating in three prisons; national government is seeking funding to expand NSP to all prisons
Scotland	2005	NSP in one local jail
Armenia	2006	NSP operating in three prisons
Iran	2006	Two pilot NSP programs operating; expansion to other prisons is planned
Ukraine	Decision has been taken to implement pilot projects and staff training has been conducted.	

Source: Lines et al., 1999, 2006

NSPs have been implemented in prisons in Switzerland, Spain, Germany, Iran and a number of countries in central Europe and central Asia (see table 1.2). A variety of methods of syringe distribution have been employed. The use of free vending machines is common, with the machines modified so that a used syringe must be deposited before a sterile one is provided. New inmates receive a dummy syringe to allow them to access the exchange program. Other programs utilise prison medical staff, peer educators or NGO staff that provide not only sterile needles and syringes, but also sterile water, alcohol swabs, syringe storage containers, condoms and harm reduction education (Lines et al., 2006).

Prison needle and syringe programs have produced a number of positive outcomes in the institutions in which they have been introduced (see table 1.3). Evaluations of Swiss and German prison NSPs found that syringe sharing was drastically reduced. In Switzerland, an evaluation twelve months after the introduction of an NSP into Hindlebank Prison noted that there had been no new cases of HIV, hepatitis B or hepatitis C among the prisoner population. Evaluations in Spain, Germany and Switzerland all found that there was no increase in drug use following the implementation of prison NSP. Indeed, in Germany, the number of prisoners accessing

drug treatment programs increased, suggesting that prison NSPs are an effective outreach and referral tool (Dolan, Rutter, & Wodak, 2003; Lines et al., 2006).

Table 1.3: Sample findings from prison NSP evaluations

Prison, country	HIV/hepatitis C	Needle sharing	Inmate drug use	Drug injecting
Am Hasenberge, Germany	No data	Strongly reduced	No increase	No increase
Basauri, Spain	No new cases	Strongly reduced	No increase	No increase
Hannoversand, Germany	No data	Strongly reduced	No increase	No increase
Hindelbank, Switzerland	No new cases	Strongly reduced	Decrease	No increase
Lehrter Strasse & Lichtenberg, Germany	No HIV, but some hepatitis C	Strongly reduced	No increase	No increase
Lingen 1, Germany	No new cases	Strongly reduced	No increase	No increase
Realta, Switzerland	No new cases	Single cases	Decrease	No increase
Vechta, Germany	No new cases	Strongly reduced	No increase	No increase
Vierlande, Germany	No new cases	Little change	No increase	No increase

Source: Lines R. et al., 2006

A finding common to all evaluations of prison NSPs is that needle and syringe distribution does not affect prison safety and security. There have been no reports of needles and syringes being used as weapons against staff or other prisoners. Indeed, NSPs may improve prison safety. When needles and syringes are prohibited in prison, they are hidden, posing a risk to prison officers conducting searches. When needle and syringe exchange services are in place, this risk is reduced as injecting equipment is regulated and stored in a designated area of the inmate's cell. Should an inmate or staff member be injured, the needle and syringe is less likely to have been used and therefore less likely to contain HIV or hepatitis C-infected blood. Prison NSPs assist in preventing the transmission of HIV and other blood borne viral infections, leading to a healthier and less risky prison environment (Lines et al., 2006; Ministerio del Interior and Ministerio de Sanidad y Consumo, 2002).

1.4.2.3 Condom distribution programs

Condoms are an essential component of HIV prevention programs. When used correctly and consistently, condoms are the most effective tool available to reduce the sexual transmission of HIV and other sexually transmitted infections (UNAIDS/UNFPA/WHO, 2004). UNAIDS recommends that condoms should be

consistently and readily available to all those who need them (UNAIDS, 2005b). Condom distribution in prison is recommended by the World Health Organization:

> Clear information should be available to prisoners on the types of sexual behaviour that can lead to HIV transmission. The role of condoms in preventing HIV transmission should also be explained. Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention. They should also be made available prior to any form of leave or release (World Health Organization, 1993).

Condoms are provided in some or all prisons in Canada, Australia, Brazil, South Africa, Iran, Indonesia, a number of European countries and some states of the United States of America (WHO/UNAIDS/UNODC, 2007). Condoms are typically provided to prisoners through the installation of vending machines in bathrooms and common areas of accommodation wings. Evaluations of condom distribution programs in Australian and the United States of America have found that when available, prisoners will use condoms during sex. Once implemented, both staff and prisoners are generally accepting of condom distribution programs and no jurisdiction that has introduced condom distribution has later reversed this policy. While minor incidents (e.g. using condoms as water balloons) have been recorded, there have been no serious negative consequences associated with distributing condoms in prison (Dolan, Lowe, & Shearer, 2004; May & Williams, 2002; World Health Organization, 1993).

1.4.3 Drug dependency treatment

The goal of drug dependency treatment is to improve physical, psychological and social well-being by reducing or ceasing drug use. Indirectly, drug dependency treatment can also impact on HIV transmission. Effective drug treatment reduces injecting drug use, thus reducing the potential for HIV transmission through the sharing of injecting equipment. Provision of drug dependency treatment also provides opportunities for treatment and care of HIV-infected individuals (World Health Organization, 2005a).

Given the high prevalence of drug dependence among prison populations, drug treatment in prison has the potential to assist in reducing HIV transmission. The *WHO Guidelines on HIV Infection and AIDS in Prisons* note:

> Drug dependent prisoners should be encouraged to enrol in drug treatment programs while in prison, with adequate protection of their confidentiality. Such programs should include information on the treatment of drug dependency, and on the risks associated with different methods of drug use (World Health Organization, 1993).

There are a variety of drug dependency treatment options that can be implemented in prisons, including substitution maintenance treatments (e.g. methadone maintenance treatment) and non-pharmacological treatments (e.g. therapeutic communities).

1.4.3.1 Substitution maintenance treatment

Substitution maintenance treatment involves prescribing a medication with a similar action to the drug of dependence to prevent withdrawal symptoms and drug cravings. At present, substitution treatments are only available for opioid dependence, although

clinical trials of medications suitable for use with psychostimulant (e.g. methamphetamine or cocaine) dependence are underway.

Maintenance treatment is intended to be a long-term treatment for drug dependence. Over many months, or even years, substitution maintenance treatment assists drug dependent individuals to reduce their illicit drug use and associated criminal behaviour, and address health and social problems caused by drug use (World Health Organization, 2005a).

In community settings, substitution maintenance treatment is associated with reduced illicit and injecting drug use and reduced criminal activity. Substitution maintenance treatment is also associated with reductions in HIV seroconversion. In an 18-month follow-up study, Metzger *et al.* found that 22% of 103 IDUs not in treatment contracted HIV, compared to just three and a half per cent of 152 IDUs receiving methadone maintenance treatment (Metzger et al., 1993). The role of substitution maintenance treatment in reducing HIV transmission among IDUs in the community is widely acknowledged. In a joint position paper, WHO, UNODC and UNAIDS state:

> Substitution maintenance therapy is an effective, safe and cost-effective modality for the management of opioid dependence. Repeated rigorous evaluation has demonstrated that such treatment is a valuable and critical component of the effective management of opioid dependence and the prevention of HIV among IDUs.
>
> Provision of substitution maintenance therapy of opioid dependence is an effective HIV/AIDS prevention strategy that should be considered for implementation – as soon as possible – for IDUs with opioid dependence in communities at risk of HIV/AIDS epidemics. Once HIV has been introduced into a local community of IDUs, there is the possibility of extremely rapid spread. Provision of substitution maintenance therapy should be integrated with other HIV preventive interventions and services, as well as with those for treatment and care of people living with HIV/AIDS (WHO/UNODC/UNAIDS, 2004).

The most common substitution treatment for opioid dependence is methadone maintenance treatment (MMT). Methadone is administered orally as a syrup or tablet and prevents drug withdrawal and cravings for 24 hours. MMT is available in prisons in Australia (Black, Dolan, & Wodak, 2004), Canada (Johnson, van de Ven, & Grant, 2001) and many European nations (Kerr & Jurgens, 2004), while pilot MMT programs are underway in prisons in Indonesia (Irawati, Mesquita, Winarso, Hartawan, & Asih, 2006) and Puerto Rico (Heimer et al., 2006). There is strong evidence that MMT in prison reduces injecting drug use and the transmission of blood borne viral infections. In a randomised controlled trial of the prison methadone program in New South Wales, Australia, injecting drug use was significantly lower among treated participants than among control participants. The study was unable to measure the impact of MMT on HIV infection as HIV prevalence was zero in both groups at baseline and follow-up. However, the authors did note a difference in hepatitis C incidence between groups. Incidence was lower among treated participants, although this difference was not statistically significant (Dolan et al., 2003).

In an effort to further study HIV and hepatitis C infection in this cohort, a four-year follow-up study was conducted. Once again, low HIV prevalence and incidence prevented the identification of any impact of MMT on HIV transmission. However,

retention in MMT was associated with reduced risk of hepatitis C infection, with those remaining in MMT for at least five months less likely to contract hepatitis C. In addition to this benefit, MMT had the added effect of reducing re-incarceration. Risk of re-incarceration was reduced by 70% among participants remaining in treatment for eight months or longer (Dolan et al., 2005). Thus, MMT may contribute both directly and indirectly to HIV prevention by reducing injecting drug use among prisoners and reducing the number of IDUs in the high HIV-risk environment of prison. In acknowledgement of the role of the MMT in reducing HIV infection among IDUs in prison, the *WHO Guidelines on HIV Infection and AIDS in Prisons* state that:

> Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons (World Health Organization, 1993).

1.4.3.2 Non-pharmacological treatments

Non-pharmacological treatments for drug dependency include counselling and therapeutic communities. These are interventions that have been widely implemented in prisons. Additionally, some prisons offer "drug-free" units – separate living quarters for prisoners who wish to live in a drug-free environment and sign a contract stating that they will abstain from drug use. These units acknowledge that the general prison environment may not be conducive to abstaining from drug use and that those wishing to abstain may benefit from the support provided by other prisoners who have also made this choice (WHO/UNAIDS/UNODC, 2007).

There has been little research into the effectiveness of non-pharmacological treatments in preventing HIV transmission. However, there is limited evidence to suggest that therapeutic communities, particularly those with an aftercare or post-release component, and drug-free units may reduce HIV risk behaviours such as injecting drug use (WHO/UNAIDS/UNODC, 2007). Thus, non-pharmacological treatments may have a role alongside pharmacotherapy maintenance treatments in HIV prevention for IDUs. Further research into the impact of non-pharmacological treatments on HIV risk behaviours and transmission is required. In particular, specific program elements that contribute to reductions in risk behaviours and transmission need to be identified and operationalised (Larney, Mathers, & Dolan, 2007).

1.5 Treatment and care

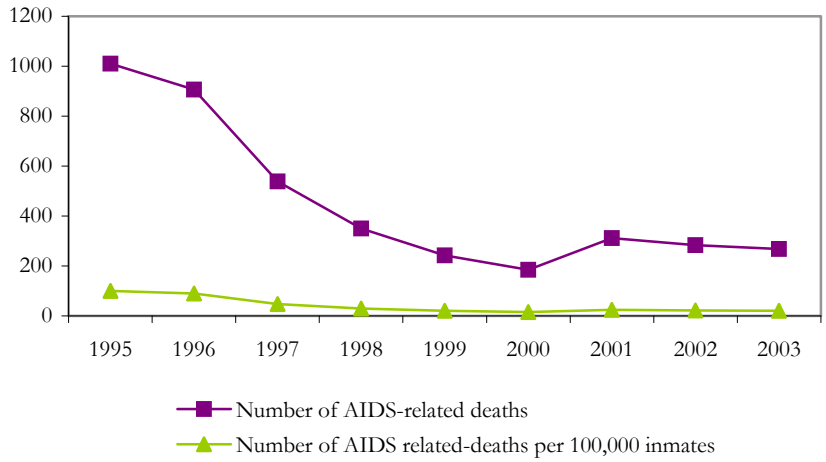
Prison authorities have a duty to provide treatment and care to HIV-infected prisoners to the same standard as that which they would receive in the community (UNODC/WHO/UNAIDS, 2006). This includes antiretroviral treatment (ART), treatment for co-infections such as tuberculosis and psychosocial support.

1.5.1 Antiretroviral treatment

Advances in antiretroviral treatments for HIV, such as highly active antiretroviral therapy (HAART), have significantly improved the long-term health outcomes of people living with HIV. The provision of ART to prisoners can markedly reduce the number of HIV-infected individuals dying of AIDS-related illnesses in custody. In the United States of America, AIDS-related deaths among prisoners decreased by more than 73% between

1995 and 2003, due in large part to improved ART provision (see figure 1.2) (Maruschak, 2004).

Figure 1.2: AIDS-related deaths per year in State prisons, United States of America, 1995-2003



Source: Maruschak, 2004.

ART is readily available in developed countries and increasingly available in developing and transitional nations (WHO/UNAIDS, 2006). Efforts must be made to ensure that prisoners are not denied opportunities to receive ART. The *WHO Guidelines on HIV Infection and AIDS in Prisons* state:

> Treatment for HIV infection, and the prophylaxis and treatment of related illnesses, should be provided by prison medical services, applying the same clinical and accessibility criteria as in the community.
>
> Prisoners should have the same access as people living in the community to clinical trials of treatments for all HIV/AIDS-related diseases. Prisoners should not be placed under pressure to participate in clinical trials, taking into account the principle that individuals deprived of their liberty may not be the subjects of medical research unless they freely consent to it and it is expected to produce a direct and significant benefit to their health.
>
> The decision to hospitalise a prisoner with AIDS or other HIV-related diseases must be made on medical grounds by health personnel. Access to adequately equipped specialist services, on the same level available to the community, must be assured (World Health Organization, 1993).

As access to ART in the community improves, prisons will play a critical role in ensuring continuity of treatment. As great a proportion as one-quarter of HIV-infected individuals are imprisoned at some stage in their lives (WHO/UNAIDS/UNODC, 2007). Increasingly, those prisoners will have been receiving ART prior to imprisonment. Because adherence to ART treatment protocols is crucial to treatment effectiveness, prisons will be required to ensure that new prisoners maintain and adhere to their treatment regimen (Pontali, 2005).

1.5.2 Assessment and treatment of co-infections

The assessment and treatment of co-infections is an important component of treatment for HIV-infected individuals. One of the most common infections seen in HIV-infected prisoners is tuberculosis:

> The prison environment is often conducive to tuberculosis transmission and rates may be higher than in the general population. Furthermore, tuberculosis is increasingly associated with HIV/AIDS, so that the presence of HIV-infected prisoners may increase the risk of tuberculosis transmission. Vigorous efforts are therefore needed to reduce the risks related to the environment (e.g. by improving ventilation, reducing overcrowding and providing adequate nutrition); to detect cases of tuberculosis as early as possible through screening for tuberculosis at entry and at regular intervals during imprisonment, and through contact tracing; and to provide effective treatment (World Health Organization, 1993).

Tuberculosis treatment utilising WHO DOTS protocols has been implemented in prisons in numerous countries, including Russia (Balabanova, 2006) and Thailand (Nateniuyom, 2004).

As with HIV infection, the prevalence of sexually transmitted infections (STI) such as syphilis, gonorrhoea and chlamydia is greater in prisons than in the general community (Niveau, 2006; Zachariah, 2002). This is particularly the case for women prisoners (De Ravello, 2005). Assessment and treatment of STI is important for all prisoners, whether or not they are HIV-positive, as untreated STI increases an individual's vulnerability to HIV infection. Additionally, treating STI among HIV-infected prisoners reduces the risk of HIV transmission to sexual partners and may help in strengthening the immune system (World Health Organization, 2006).

Hepatitis C virus (HCV) is highly prevalent among injecting drug user populations, and commonly co-occurs with HIV infection (Adjei, 2006; Miller, Bi, & Ryan, 2006; Weinbaum, Sabin, & Santibanez, 2005).Where HCV treatment is available to IDUs in the community, assessment and treatment of HCV should also take place in prison.

1.5.3 Other support and care interventions

In addition to medical therapies such as ART, prisoners living with HIV/AIDS should have access to other support and care services such as those provided to people living with HIV/AIDS in the general community. Such services may include psychosocial support; information, education and communication about living with HIV and treatment options; and support groups for HIV-positive prisoners. The *WHO Guidelines on HIV Infection and AIDS in Prisons* pay particular attention to the support and care needs of asymptomatic HIV-infected prisoners, noting that although they may appear healthy, asymptomatic HIV-infected prisoners should have access to medical follow-up and counselling to monitor the progress of their illness and maintain psychological wellbeing (World Health Organization, 1993).

1.5.4 Compassionate release for terminally ill prisoners

While treatment has reduced deaths from AIDS-related illnesses, many HIV-infected prisoners develop debilitating and terminal illness. The early release of prisoners with

terminal illness is practiced in many countries in recognition of the specialised medical, psychological and spiritual needs of individuals confronting their own mortality (Granse, 2003). The *WHO Guidelines on HIV Infection and AIDS in Prisons* note:

> If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom (World Health Organization, 1993).

Compassionate release for terminally ill prisoners is also recommended by the Office of the United Nations High Commissioner for Human Rights (UNHCHR, 1998).

1.6 Summary: HIV prevention, treatment and care in prisons

Prisoners have a right to receive healthcare to the same standard available to the general community, including preventive measures. The information presented above demonstrates that effective and humane HIV prevention, treatment and care efforts in prison are possible, even in resource-poor settings. Furthermore, governments have a responsibility to ensure HIV prevention, treatment and care programs are enacted in prisons, as failure to do so threatens the success of community-based efforts to control the HIV epidemic.

As in the community, prevention must be the mainstay of the response to the HIV epidemic in prisons. Countries as diverse as Australia, Iran, Indonesia and Spain have implemented a range of programs and strategies to prevent HIV infection in prisons, including information, education and communication programs, condom distribution programs, needle and syringe programs and methadone maintenance treatment. Treatment and care interventions for prisoners living with HIV are also vital. Antiretroviral treatment in prison saves lives. As ART becomes more widely available in developing and transitional countries, efforts must be made to ensure prisoners are offered the opportunity to begin treatment. Assessment and treatment of STI and tuberculosis in both HIV-infected and non-infected prisoners should be a priority. Finally, for prisoners with advanced AIDS-related illnesses, compassionate release provides dignity and the opportunity to be with family and friends in a time of great need.

2. AIMS AND METHOD

The aim of the review was to gather information relating to HIV prevention, treatment and care in prisons in the WHO South East Asia region. Countries in this region are Bangladesh; Bhutan; the Democratic People's Republic of Korea; India; Indonesia; Maldives; Myanmar; Nepal; Sri Lanka; Thailand; and Timor-Leste. Countries selected for inclusion in the review were India, Indonesia, Thailand, Nepal and Myanmar. During the data collection phase, Myanmar was excluded due to circumstances beyond the authors' control, leaving four countries for review.

Relevant published and unpublished reports and information from key experts were sought in order to provide a coherent picture of the current situation relating to HIV prevention, treatment and care in prisons in India, Indonesia, Thailand and Nepal.

Information sought for inclusion in the review included:

Community data and information regarding HIV prevention, treatment and care:

- HIV prevalence and distribution in the general community and among high-risk groups such as sex workers, injecting drug users and men who have sex with men.
- HIV prevention strategies available in the community, in particular:
    - Information, education and communication initiatives, including peer-led interventions
    - Harm reduction interventions for injecting drug users:
        - Needle and syringe programs
        - Bleach distribution
    - Condom availability and distribution programs
    - Drug dependency treatment programs:
        - Non-pharmacological or abstinence-based treatment services e.g. therapeutic communities
        - Substitution maintenance treatment
    - Prevention of mother-to-child transmission programs
- The availability and coverage of voluntary counselling and testing services
- The availability and coverage of antiretroviral treatment and other HIV treatment and care interventions

Data and information specific to HIV prevention, treatment and care in prisons:

- Prison management, including:
    - Prison administration
    - Prisoner population statistics
    - General conditions in prisons and other correctional institutions:
        - Quality and quantity of food provided
        - Quality of accommodation
        - Overcrowding
    - Provision of general medical care
- HIV situation in prison:
    - Policies on HIV testing and availability of voluntary counselling and testing in prisons
    - Policies regarding segregation or integration of HIV-positive prisoners
    - HIV prevalence among prisoners
    - HIV risk behaviours in prison:

        - Injecting drug use
        - Unprotected sexual activity
        - Tattooing and other body modification practices
- HIV prevention strategies in prison, including:
    - HIV information, education and communication initiatives, including peer-led interventions
    - Harm reduction programs:
        - Needle and syringe programs
        - Bleach distribution programs
        - Condom distribution programs
    - Drug dependency treatment programs:
        - Non-pharmacological or abstinence-based treatment services
        - Substitution maintenance treatment
- HIV treatment and care in prison:
    - The provision of antiretroviral treatment in prison
    - Assessment and treatment of co-infections
    - Other HIV support and care services
    - Policies regarding compassionate release for terminally ill prisoners

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

A discussion of each country's approach to the issue of HIV in prison is provided at the end of each chapter. A regional summary and recommendations for improved practice conclude the report.

3. INDIA

Table 3.1: HIV/AIDS and imprisonment statistics, India.

Population	1,103,371,000[1]
Number of adults (15+) living with HIV/AIDS (2005)	5.7 million[1]
% of adults (ages 15-49) living with HIV/AIDS (2005)	0.9%[1]
Imprisonment rate (per 100,000) (2004)	31[2]
HIV prevalence among prisoners (nationally; 2000)	1.7[3]

Sources: [1]UNAIDS, 2006c; [2]International Centre for Prison Studies, 2006a; [3]Nagaraj et al., 2000.

3.1 Summary of community situation

3.1.1 HIV prevalence and distribution

With around 5.7 million adults and children living with HIV/AIDS in 2005, India's HIV/AIDS population is second in the world only to South Africa (UNAIDS, 2006c). The UN Population Division projects that India's adult HIV prevalence will peak at 1.9% in 2019. A 2002 report by the Central Intelligence Agency predicted 20 million to 25 million AIDS cases in India by 2010, more than any other country in the world (CIA, 2002). The HIV epidemics in India will have a major impact on the overall spread of HIV in Asia and the Pacific.

Although the number of people with HIV/AIDS in India is very high, current prevalence is low. It estimated that 0.9% of adults were living with HIV/AIDS in 2005 and the male to female ratio was 2.5:1 in the same year (UNAIDS, 2004b).

HIV has spread to all of India's states and territories, with 6 out of 28 states – Manipur, Nagaland in the north east, and Andrha Pradesh, Tamil Nadu, Karnataka and Maharashtra in the south – reporting prevalence levels exceeding 1% in the general population and accounting for nearly 80 percent of all reported AIDS cases in the country (Kaiser Family Foundation, 2005; UNAIDS, 2006f).

Nationally, sexual transmission is driving the AIDS epidemic. This route accounts for approximately 86% of the HIV infections in the country, especially in the wealthier states of the south. Injecting drug use accounts for two percent of transmissions; mother-to-child-transmission, four percent; and blood transfusion, two percent (UNAIDS, 2006a). However, in the north-eastern states and in some metropolitan cities, injecting drug use is the main transmission route (see section 3.1.1.4 below).

Although HIV/AIDS is still largely concentrated in at-risk populations, including sex workers, injecting drug users and men who have sex with men, surveillance data suggest that the epidemic is moving beyond these groups in some regions and into the general population. It is also moving from urban to rural districts (UNAIDS, 2004b).

An estimated 38 percent of new infections in India are occurring in women (UNAIDS, 2004b). Unequal power relations and the low status of women in India, as expressed by limited access to human and economic assets, weakens the ability of women to protect themselves and negotiate safer sex, thereby increasing their vulnerability (World Bank, 2006).

3.1.1.1 Sex workers

Estimates of HIV prevalence in female sex workers vary widely, from 21.6% outside major urban areas (UNAIDS, 2004b) to 70% in Mumbai (Shankaran, 2002) (see table 3.2).

Table 3.2: HIV prevalence among female sex workers in India

Location	Year	Sample size (N)	HIV prevalence (%)
Major urban areas	2001	Data inaccessible	52.3[1]
Outside major urban areas	2004	Data inaccessible	21.6[1]
Urban Southern States	2004	Data inaccessible	50[2]
Tamil Nadu	2004	7,417 members of high-risk groups, 17 focus groups and 160 client observations	9.5[3]
Karnataka, Maharastra, Andhra Pradesh	Data inaccessible	Data inaccessible	4-49[4]
All states	Data inaccessible	Data inaccessible	0-43[4]
Pune (Maharastra)	1993-2002	1359 FSWs attending 3 STI clinics	54[5]
Mumbai	Data inaccessible	Data inaccessible	70[6]

Sources: [1]UNAIDS, 2006c; [2]UNAIDS, 2006e; [3]AIDS Prevention and Control Project/Voluntary Health Services, 2004; [4]Chandrasekaran, et al., 2006; [5]Brahme, et al., 2006; Shankaran, 2002.

The southern states, where the epidemic is mainly spread through heterosexual transmission, generally report the highest prevalence of HIV amongst sex workers. Cities also report high prevalence of HIV among sex workers. In 2002 it was estimated that 70% of Mumbai's 15,000 sex workers were HIV positive (Shankaran, 2002).

In areas where condom use is high, HIV prevalence among female sex workers is relatively low. The comparatively low 9.5% HIV prevalence in population-based samples of female sex workers in Tamil Nadu correlates with high levels (80–90%) of self-reported condom use (AIDS Prevention and Control (APAC) Project/Voluntary Health Services (VHS), 2004).

No information was regarding male or transgender sex workers was identified.

3.1.1.2 Truck Drivers

India has one of the largest road networks in the world and an estimated 2 to 5 million long distance truck drivers and helpers. The extended periods of time that they spend away from their families place them in close proximity to "high-risk" sexual networks, and often results in them having an increased number of sexual contacts (Ekstrand, 2003). A study published in 1999 showed that 87% of 5709 drivers frequently changed their sexual partners, and only 11% used condoms (Kootikuppala, 1999).

3.1.1.3 Men who have sex with men

Homosexuality is illegal in India. However, male to male sexual activity seems common in both urban and rural areas. One population-based study of five rural districts found that ten percent of single men and three percent of married men reported anal sex with a man in the previous year (Chandrasekaran et al., 2006).

UNAIDS reports that 25% of men who have sex with men (MSM) in major urban areas and 5.7% of MSM outside major urban areas are HIV positive (UNAIDS, 2006a). Large proportions of men who have sex with men have regular female sex partners, comprising an important bridge group (i.e. a marginal group who able to transmit HIV to the general community) (Chandrasekaran et al., 2006). A large study of men who have sex with men in Andhra Pradesh found that 51% reported sex with a woman in the past three months; reported condom use was 44% and 16% respectively with last male and female partner (Dandona, 2005).

3.1.1.4 Injecting drug users

There are estimated to be 1.3 million IDUs in India (Aceijas, Stimson, Hickman, & Rhodes, 2004). The most commonly injected drugs are opioids such as heroin and buprenorphine, propoxyphene and pentazocine (UNODC, 2004a). Sharing of needles and other injecting equipment is common. In a National Household Survey of males aged 12-60 conducted in 24 states between March 2000 and November 2001, 97% of IDUs had shared needles. In a rapid assessment survey conducted in fourteen urban sites in the same period, 57.9% of IDUs shared needles (UNODC and Ministry of Social Justice and Empowerment, 2004).

Injecting drug use is a major driver of the epidemic in the northeast states of Nagaland, Manipur and Mizoram, which border Myanmar, an important source of heroin. A recent

study found that 57% of IDUs in Manipur in 2001 were HIV positive (Lisam, 2002). In another study conducted in Manipur in 2000, 75% of IDUs were found to be HIV positive. In the same study, 93% reported having shared injecting equipment and only 42% had accessed a needle and syringe program. In addition, two-thirds were sexually active and yet only three percent reported using condoms (Eicher, 2000).

A further study conducted in Manipur found that the prevalence of HIV infection in female IDUs was 57% compared to 20 percent among female drug users who did not inject. Eighty per cent of the respondents reported having sex with non-regular partners and two-thirds reported sex in exchange for money or drugs (S. Panda, et al., 2001).

Injecting drug users are also found in most of the major cities in India, with HIV prevalence varying widely from city to city (see table 3.3) (National AIDS Control Organisation, 2004).

Table 3.3: HIV prevalence among injecting drug users, India

Location	Year	Sample size (n)	HIV prevalence (%)
National	1998-2003	Data inaccessible	1.3-68.4[1]
New Delhi	1998-2003	Data inaccessible	44.5-45.0[1]
"Other sites" (i.e. outside Delhi)	1998-2003	Data inaccessible	2.0-81.0[1]
Major urban areas	2002	Data inaccessible	4.3 (1.5-7.2) [2]
Outside major urban areas	2003	Data inaccessible	2.8 (2-17.4)[2]
New Delhi	1998-2003	Data inaccessible	14.4[3]
Chennai	1998-2003	Data inaccessible	63.8[3]
Mumbai	1998-2003	Data inaccessible	24.8[3]
Mizoram	1998-2003	Data inaccessible	4.0[3]
Manipur	1998-2003	Data inaccessible	24.4[3]
Manipur City	1997	35	57 (females)[4]
Manipur City	2000	191	75[5]
Manipur City	2001	Data inaccessible	56.7[6]

Sources: [1]Aceijas et al., 2004; [2]UNAIDS, 2006c; [3]NACO, 2004; [4]Panda et al., 2001; [5]Eicher, et al., 2000; [6]Lisam, 2002.

3.1.2 Prevention, treatment and care in the community

The Indian government launched the national AIDS control program (NACP) in 1987 and the National AIDS Control Organization (NACO) in 1992. NACO is a semiautonomous organisation within the Ministry of Health that was set up with financial assistance from the World Bank and technical support from WHO. NACO works closely with NGOs and accepts funding from international donors and private sources (see table 3.4). In 2004, NACO reported that 554 projects had been undertaken by the State AIDS Control Societies through NGOs in different locations in the country, of which over 50 percent were in high-prevalence states (Solomon, 2004). At present there are over 32 bilateral and multilateral donor agencies and foundations working in different states and on different programs to address HIV/AIDS (Morrison, 2006; World Bank, 2006).

Table 3.4: Funding sources for HIV/AIDS programs in India

Donor	Year	$US
PEPFAR (US Global HIV/AIDS Strategy)	2005, 2006	27 million (for 2005) and 29 million (for 2006)[1]
Global Fund	2006	119 million approved (rounds 2 and 4) + 3 million approved for HIV/TB grant (round 3)[2]
World Bank	1991-2006	191 million[3]
Bill and Melinda Gates Foundation	2004-2009	200 million pledged[4]

Sources: [1]US Department of State, 2006; [2]Global Fund, 2006; [3]World Bank, 2006; [4]Morrison & Kates, 2006.

UNAIDS reports $US73 million was spent by the Indian government from domestic sources on HIV/AIDS across all sectors in 2004, up from $US41 million in 2003 (UNAIDS, 2004b). It is also reported that the Indian government will spend $US2.5 billion from 2006 -2011 on HIV/AIDS programs (Sodhi, 2006).

3.1.2.1 Information, education and communication

In 1991 the NACP strategy (NACP1) focused on HIV information, education and communication for the general population. Between 1999 and 2006, the second phase of the NACP (NACP2) continued to expand this program at the state level. Greater emphasis was placed on targeted interventions for high-risk groups, preventive interventions among the general population, and involvement of NGOs and other sectors and line departments, such as education, transport and police.

The third phase of the NACP (NACP3) to be conducted between November 2006- and 2011, aims to provide IEC to high-risk groups such as commercial sex workers, truck drivers, drug users and men who have sex with men. It will also focus efforts on women, adolescents and children.

3.1.2.2 Condom availability

The Department of Family Welfare promotes distribution of condoms through hospitals, clinics, and health centres. The government also provides condoms at greatly subsidised prices. In addition, condoms are widely available at STI clinics and pharmacies, although it is unclear at what cost (Solomon, 2004).

Under the NACP3 11,000 condom vending machines have been installed in colleges, universities and in public toilets at railway stations, gas stations, roadside eateries and hospitals. It plans to have 100,000 vending machines installed by the end of 2007 (Global Health Reporting, 2006).

3.1.2.3 Harm reduction interventions

Manipur was the first state in India to pass government legislation endorsing harm reduction (Solomon, 2004) and needle and syringe programs (NSPs) have been in

operation there since 1994 (M. Sharma et al., 2003). However, a study conducted in 2000 found that less than 37% of the injecting drug using population was being serviced through the NSP and that there was a substantial shortfall of needles and syringes (M. Sharma et al., 2003).

NSPs have also been sanctioned in the southern state of Tamil Nadu (Solomon, 2004). In addition, to 2005, 93 similar interventions were being undertaken in eight states in India by various NGOs. However, because the legal status of harm reduction programs is ambiguous, programs could not be carried out on a large scale. NACO is currently formulating a Bill that will seek to legalise needle and syringe programs (Sinha, 2006).

3.1.2.4 Drug dependency treatment

The approach of the Indian government to illicit drug use is law enforcement led, with limited resources provided for treatment. Buprenorphine maintenance treatment is available in cities including Kolkata, Imphal, Chennai and Mumbai (UNODC, 2004a). There are also 450 centres funded by government grants across the country for "de-addiction" and counselling services. However, because these centres tend to provide services on a fee-paying basis, marginalised street level drug users find services difficult to access (Charles, 2005). A rapid assessment survey conducted by UNODC between 2000 and 2001 found that the treatment capacity in each of the fourteen cities studied was inadequate compared to treatment demand (UNODC, 2004a).

National level drug use monitoring systems have been established in an effort to understand trends in drug use and the implications for the management of drug dependency (Sinha, 2006).

3.1.2.5 Voluntary counselling and testing

According to government sources, over 1,110 voluntary counselling and testing (VCT) centres were operational by the end of 2005. These testing centres served over 970,000 clients in 2005 (NACO, 2005).

NACP3 will include the scaling up of VCT centres, maximizing coverage by promoting demand, capacity building for improving the quality of testing and counseling and strengthening follow-up services (USAID, 2006).

3.1.2.6 Prevention of mother-to-child transmission

UNAIDS reports that 1.6 percent of HIV infected pregnant women were receiving ART to reduce mother to child transmission in 2006 (UNAIDS, 2006a).

3.1.2.7 Antiretroviral treatment

At the end of 2005 there were 52 NACO supported antiretroviral therapy centres providing care to 24,301 AIDS patients. An additional 10,333 patients received treatment through centres supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (NACO, 2006).

At present, antiretroviral treatment coverage is low with only seven percent of 785,000 HIV infected men and women needing treatment receiving ART in 2006 (UNAIDS,

2006a). The government hopes to reach a target of 100,000 people receiving ART by 2007 (Global Health Reporting, 2006).

3.2 Prison situation

3.2.1 Prison management

3.2.1.1 Administration

The governments of states and union territories are responsible for prison administration under the Ministry of Home Affairs (International Centre for Prison Studies, 2006a).

There are 1140 correctional institutions in India (National Crime Records Bureau, 2003). An average of $US257 per inmate was spent by prison authorities during the year 2003-4 (National Crime Records Bureau, 2003), however it is unknown how this was distributed.

Prisons are also used as detoxification centres for drug users (Sarkar, 1995). In prisons in Delhi, drug offenders are housed separately to other inmates (Tihar Prisons, 2006). It is unclear if this is the policy for all prisons in India.

3.2.1.2 Inmates

There were 336,152 prisoners in India in 2004, making for an imprisonment rate of 31 per 100,000 of the national population. Of prisoners, 71% were remandees and four percent were women (International Centre for Prison Studies, 2006a). As so many prisoners are remandees, there is a large inmate turnover; in Tihar Jail (a large prison complex in New Delhi), about 60,000 prisoners are admitted and discharged every year (UNODC and Ministry of Social Justice and Empowerment India, 2002).

In 2003, over half (59%) of prisoners were convicted of murder and 53% of the prison population were serving sentences of life imprisonment(National Crime Records Bureau, 2003). Around eight percent of new admissions to Tihar Jail are drug users (Tihar Prisons, 2006; UNODC, 2004a).

3.2.1.3 Women in prison

In India, social customs make women offenders and ex-offenders vulnerable to suspicion and rejection. Their families often disown them once they enter prison. Low levels of education and poor legal awareness leads to women receiving unduly long sentences (Mangastabam, 2004).

3.2.1.4 Incarceration of drug users

The offence of illicit drug possession or use can result in imprisonment for a period of six-twelve months, or a fine, or both. Possession of as small an amount as one-quarter of a gram of heroin can result in arrest and punishment. The Narcotics Drugs and Psychotropic Substances (NDPS) Act also criminalises traditional forms of drug use. Evidence suggests that, in ignoring the socio-cultural context of traditional drug use, the NDPS Act led to a significant increase in the arrests of low-level drug users. Arrests under the Act in 2001 totalled 16,315, of which 12,400, or 76% were prosecuted and 4,568 convicted (Charles, 2005). Interviews with 1,910 individuals in Tihar Jail, arrested

under the NDPS Act, indicated that 17% were arrested for the possession of small quantities of drugs meant for personal consumption. While the law has provision for these drug users to seek treatment instead of serving a sentence, the provision is rarely utilised (Annuradha, 1999).

Research also shows that many of those arrested on drug charges spend many years in prison before their cases are heard. In some instances those caught with small quantities of drugs are eventually acquitted after spending years behind bars (Charles, 2005).

3.2.1.5 General conditions

Although India has a low imprisonment rate (31 per 100 000 inhabitants), prisons are generally overcapacity (International Centre for Prison Studies, 2006a). The Arthur Road Jail in Mumbai has a capacity of 820 but in 2004 it housed more than 3,400 inmates (Dey, 2004). Tihar Jail has a capacity of 3,637 inmates but housed 11,000 prisoners in 2000 (International Centre for Prison Studies, 2006a).

There is a lack of nutritious food and hygiene and sanitation facilities are severely lacking. Sexual violence is a further concern (Mansuri, 2006). A special commission of inquiry, appointed after the 1995 death of a prominent businessman in India's high-security Tihar Central Jail, reported in 1997 that 10,000 inmates held in that institution endured serious health hazards, including overcrowding, 'appalling' sanitary facilities, and a shortage of medical staff (Human Rights Watch, 2006).

3.2.1.6 General medical care

Tihar Jail in New Delhi employs 78 doctors and 122 paramedical staff for twenty four hour support of dispensaries and hospitals. Every prisoner admitted receives a medical examination. Diagnostic facilities are available and specialists in various disciplines are available for consultation. Dental and eye clinics and leprosy detection and treatment programs have been implemented with the help of NGOs. Hospitals with specialised medical facilities have been identified as referral hospitals for ill prisoners (Tihar Prisons, 2006).

3.2.2 HIV testing of prisoners

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

3.2.3 Segregation of HIV-positive prisoners

There are reports of segregation of HIV-positive prisoners, with approximately 20 HIV-positive inmates in Maharashtra's prisons lodged in separate cells (Mudur, 1995). In Arthur Road Jail, there is an HIV barrack, which houses all HIV-positive prisoners (Mansuri, 2006).

3.2.4 HIV prevalence and risk behaviours in prison

3.2.4.1 HIV prevalence in prison

Only one national study of HIV prevalence in prisons has been conducted, finding that 1.7% of inmates and 9.5% of female inmates were HIV-infected (Nagaraj et al., 2000). There have also been a number of ad hoc studies on HIV prevalence in individual prisons (see table 3.5 below). Mumbai Newsline reported that 18 of 27 inmates who died at Arthur Road Jail, Mumbai, in the previous six months were HIV positive (Dey, 2004).

Table 3.5: HIV prevalence in prison, India

Location	Year	Sample size (N)	HIV prevalence
Nationally	2000	Data inaccessible	1.7% total; 9.5% females[1]
Amritsar Central Jail	2003	500	2.4%[2]
Central Prison, Bangalore, South India	1993	1114	1.8% males[3]
Ghaziahad	1999	249	1.3% inmates aged 15 to 50 years[4]
West Bengal	2000	384	2.3%[5]
Orissa, three prisons	1994-1995	377	6.9%[6]
Madras	1995	Data inaccessible	3.5%[7]
Madurai	1994 -1995	Data inaccessible	4.3% total; 2% male; 14.2% female[7]
Thirunelveli	1995	Data inaccessible	0.5%[7]

Sources: [1]Nagaraj, et al., 2000; [2]Aggarwal, et al., 2005; [3]Sundar, et al., 1995; [4]Singh, et al., 1999; [5]Nag, et al., 2006; [6]Pal, et al., 1999; [7]Palaniappan, 1995.

3.2.4.2 Injecting drug use in prison

No prevalence data regarding drug use in prison were identified. However, among injecting drug users, incarceration is a risk for HIV infection, indicating injecting drug use in prisons. A study conducted in Chennai in 2005 found that HIV prevalence was 37% among 48 IDUs who were 'ever in jail', compared to 21% among 20 IDUs who had never been incarcerated. The authors found that 16% of HIV risk among IDUs in Chennai could be attributed to having been imprisoned (S. Panda et al., 2005).

Many prisoners incarcerated for drug use are discharged and readmitted frequently as remandees (UNODC and Ministry of Social Justice and Empowerment India, 2002). This large turnover in prison population facilitates the transmission of HIV in the general community.

3.2.4.3 Men who have sex with men

Sex between men is reported to be common in prisons in India (Donde, 2006; Lahiri, 2006; Palve, 2006). In a study conducted in Arthur Road Jail, 71.6% of 75 employees and

677 inmates said that they thought sex between men was common in prisons. Eleven percent of inmates and staff engaged in homosexual activity in prison. A study in a district jail near Delhi found that 28.8% of 184 male inmates had a history of sex with men (S. Singh, Prasad, & A, 1999).

3.2.4.4 Tattooing and body modification

No evidence could be found on the prevalence of tattooing and other body modification within prisons in India. However, there were reports of interpersonal violence (involving lacerations, bites and bleeding in two or more participants), which could present risks of transmission (Donde, 2006).

3.2.5 Prevention interventions

3.2.5.1 Information, education and communication

There have been several interventions conducted in prisons in India. The Government of Andhra Pradesh started a sexual health programme titled Partnership for Sexual Health (PSH Prison Project) in January 2000. The project was managed by Andhra Pradesh AIDS Control Society and operated in eleven jails in Andhra Pradesh. Three trained staff members provided HIV education. The program also included counselling, referral and medical treatment (Mohammed, 2002).

In Mumbai, the Mumbai District AIDS Control Society and the International Labour Organisation are conducting a workplace intervention program at the Arthur Road Jail but it is unclear what the intervention involves (Palve, 2006).

In West Bengal, Vivekananda International Health Centre has been delivering an AIDS intervention program in 20 prisons. The program, reaching 50,000 prisoners and staff, includes education about STI and HIV (Nag, 2006).

In Gujarat, an information and education program conducted by NGOs aims to change prisoner attitudes and HIV risk behaviours (Pachpinde, 2002).

3.2.5.2 Drug dependency treatment

Treatment and rehabilitation of drug users is not a priority in the overall functioning of prisons. Prison staff are yet to be sensitised to the issue of drug use and the needs of drug users. Furthermore, as many of the prisoners who are placed in treatment programs are on remand, they are frequently released before completing treatment (UNODC and Ministry of Social Justice and Empowerment India, 2002).

Drug offenders received at Tihar Jail are admitted to a "de-addiction" centre for detoxification and treatment of withdrawal symptoms. Treatment components are unclear, but a psychiatrist works with the prisoner for approximately one week (Tihar Prisons, 2006). In 2005, there were three detoxification centres with 72 detoxification beds: 60 for adult males and 12 for adolescents. The prison has no centre that caters exclusively to female users.

After detoxification, drug offenders are segregated from the other prisoners and placed in therapeutic communities run by NGOs including the Association for Scientific

Research on Addictions (AASRA) and the AIDS Awareness Group. As many as 800 prisoners live within the therapeutic communities (Tihar Prisons, 2006; UNODC and Ministry of Social Justice and Empowerment India, 2002).

In the therapeutic communities in Tihar Jail, senior prisoners serve as team leaders and supervisors. Staff members from AASRA, including psychiatrists, psychologists, sociologists and social workers, serve as trainers, facilitators and counsellors. Inmates engage in a range of activities including counselling, education, meditation, family therapy, anger and grief workshops as well as recreational activities. The ideal ratio of staff to inmates is 1:20, however, in practice inmates greatly outnumber staff (Tihar Prisons, 2006; UNODC and Ministry of Social Justice and Empowerment India, 2002).

No other drug treatment programs in prison were identified. UNODC has recommended that the Government of India initiate a process of inquiry in major prisons in India, and where necessary, set up the required facilities for the treatment of drug users (UNODC and Ministry of Social Justice and Empowerment India, 2002).

3.2.5.3 Harm reduction programs

The distribution of condoms is against prison policy as male-to-male sex is regarded as a crime in India (Donde, 2006; Pachpinde, 2002). However, a government run prison intervention in Andhra Pradesh includes condom distribution (Lingamallu, 2002). There are no prison needle and syringe programs in India (Mansuri, 2006; Mudur, 1995). No information regarding bleach distribution was identified.

3.2.6 HIV treatment and care

3.2.6.1 Antiretroviral treatment provision

The total number of HIV-infected prisoners in need of and with access to ART in prison is not clear. A program to offer legal aid to prisoners has assisted some HIV-infected inmates to continue ART while in prison (Mansuri, 2006). The Government of Andhra Pradesh has started a sexual health program that provides treatment for HIV, although it is unclear what sort of treatment is provided(Mohammed, 2002).

3.2.6.2 Assessment and treatment of co-infections

Treatment for STI is provided in 42 prisons in Andhra Pradesh by Hindustan Latex Limited under an agreement with the Andhra Pradesh State AIDS Control Society (Lingamallu, 2002). Partnership for Sexual Health and other NGOs provide STI treatment in prison in Surat, Gujarat (Pachpinde, 2002).

3.2.6.3 Other support and care services

STI education and counselling services are provided in 42 prisons in Andhra Pradesh by Hindustan Latex Limited under an agreement with the Andhra Pradesh State AIDS Control Society (Lingamallu, 2002). Partnership for Sexual Health provide STI education, counselling and referral services in Surat, Gujarat (Pachpinde, 2002).

3.2.6.4 Compassionate release for terminally ill prisoners

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

3.3 Discussion

HIV prevalence in prisons in India is at least twice that of the general community (1.7%-6.9%, compared to 0.9%). Among women prisoners, prevalence levels of 9.5%-14.2% have been reported.

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

Limited HIV prevention programs are available in Indian prisons. HIV information, education and communication programs such as those in prisons in Mumbai, Andhra Pradesh and others should be expanded to all prisons across the country. Improving access to drug dependency treatment, including substitution maintenance treatment, would be another positive step. Harm reduction strategies, including condom distribution programs and needle and syringe programs, will further assist in reducing the risk of HIV transmission in prison.

Treatment of HIV and STI is also important in stemming HIV in prisons. Voluntary counselling and testing should be promoted and access to HIV and STI treatment improved.

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

Large numbers of unsentenced prisoners pass through India's prisons each year. Legal reforms to increase non-custodial options for monitoring offenders who have been charged but not yet tried are recommended.

4. INDONESIA

Table 4.1: HIV/AIDS and imprisonment statistics, Indonesia

Population:	222 781 000[1]
No. of adults (15+) living with HIV/AIDS (2005)	170,000[1]
% of adults (ages 15-49) living with HIV/AIDS (2005)	0.1[1]
Imprisonment rate (per 100,000) (2005)	45[2]
HIV prevalence among prisoners (2002)	8.6-15.4%[3]

Sources: [1]UNAIDS, 2006a; [2]International Centre for Prison Studies, 2006b; [3]Ministry of Health, Indonesia, 2003.

4.1 Summary of community situation

4.1.1 HIV prevalence and distribution

In 1987, Indonesia confirmed its first case of AIDS, in a foreigner living in Bali. The first AIDS death in an Indonesian, also in Bali, was in June 1988. In 1992-1993, 2 in every 100,000 blood donors tested HIV positive; by 1994-1995, this had risen to 3 in every 100,000. From 1995 on, prevalence increased sharply. Between 1990 and 2000, there was an eight-fold increase in HIV infections in blood donors (National AIDS Commission, 2003).

Presently, national HIV prevalence is low, at 0.1%-0.2%. There were an estimated 170,000 people aged over 15 living with HIV/AIDS in 2005. The majority of infections are in men, with a male-to-female ratio of 4.7:1 (UNAIDS, 2006a). At present, HIV infection is concentrated in high-risk groups such as injecting drug users and sex workers. However, the state of the HIV epidemic in the province of Papua provides a warning as to the potential for a nationwide, generalised epidemic. Among female sex workers in Merauke, Papua in 2000, HIV prevalence of 26.5% was recorded. This concentrated epidemic in sex workers and their clients has moved into the general

population, with adult prevalence at 1% in five villages – ten times the national prevalence level (MAP, 2004; UNAIDS, 2006a).

4.1.1.1 Sex workers

There are an estimated 190,000-270,000 female sex workers in Indonesia (Riono & Jazant, 2004). Nationally, HIV prevalence among female sex workers ranges from two percent to five percent (Ministry of Health Indonesia, 2003). However, in some areas much higher prevalence is seen. As noted above, in Merauke, Papua in 2000, prevalence was 26.5%. In 2002 in Sorong, Papua, 18.7% of female sex workers were HIV-infected, while in Riau, just over 8% are infected (Riono & Jazant, 2004). There are also regions where prevalence among sex workers is still relatively low. In Java, only one of a sample of 200 female sex workers was HIV-infected (Sugihantono, 2003). In Jakarta, estimates range from a low of 0.5% to a high of five percent (Ministry of Health Indonesia, 2003).

Few female sex workers consistently use condoms with clients. A 2002 study asked 204 sex workers in Jakarta, Bandung and Surabaya to keep a "condom diary", recording client condom use. Of 5,603 sexual contacts recorded (including a small percentage with non-commercial partners such as boyfriends), almost half did not involve condoms. Only 12 sex workers (5.9%) used condoms in all their sexual contacts over a two-week period, and only three (1.5%) used condoms in all their sexual contacts over a four-week period (Basuki, 2002). Of 2,026 clients of sex workers interviewed in Bali, only one third had used a condom the last time they had sex with a sex worker (Ford, Wirawan, & Muliawan, 2002).

There are an estimated 2,100-2,900 male sex workers throughout Indonesia. HIV prevalence data for male sex workers is limited. A survey of 250 male sex workers in Jakarta in 2002 found HIV prevalence to be 3.6% (Pisani et al., 2004). This data was used to estimate a national HIV prevalence among male sex workers of 2.7%-5.3% (Ministry of Health Indonesia, 2003). There are early indications that HIV prevalence in male sex workers may be increasing. In 2002, 2.7% of those surveyed at sentinel sites in Jakarta were HIV-infected; in 2004, this had increased to 3.8% (National AIDS Commission Indonesia, 2006).

In addition to male-identified sex workers, some *waria*, or transgender males, engage in sex work. HIV prevalence in *waria* sex workers has risen dramatically, from six percent in 1997 to 23% in 2002 (Riono & Jazant, 2004). In 2004, over one quarter of *waria* sex workers were HIV-infected, placing them second only to injecting drug users in terms of HIV prevalence (MAP, 2004; National AIDS Commission Indonesia, 2006).

A survey of Jakarta-based male and *waria* sex workers found that anal sex without a condom is common. Just over half (56.5%) of male sex workers used a condom with their most recent client, compared to less than half (42.6%) of *waria* sex workers surveyed (Pisani et al., 2004). Furthermore, there are indications that HIV-infected male and *waria* sex workers are more likely than non-infected sex workers to engage in unprotected anal sex (see Figure 4.1).

Figure 4.1: Percent of male and *waria* sex workers reporting unprotected anal sex in the previous month, by HIV status

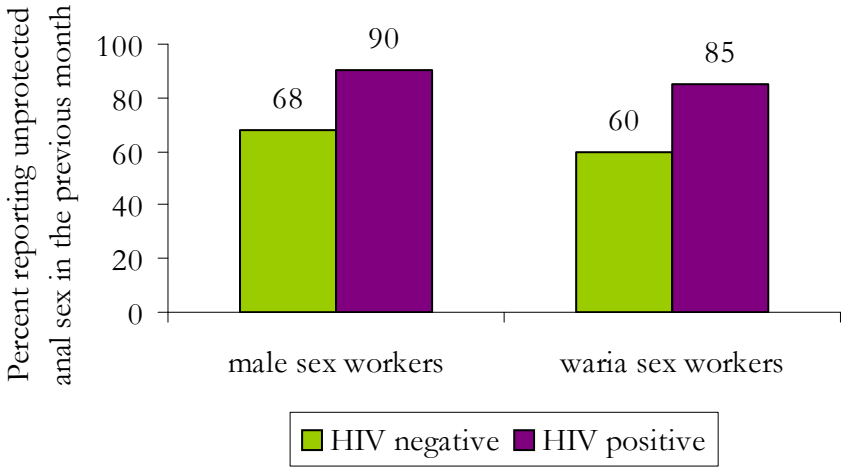


Figure adapted from *AIDS In Asia: Face the Facts – a Comprehensive Analysis of the AIDS Epidemics in Asia.* Washington D.C., Monitoring the AIDS Pandemic Network, 2004.

4.1.1.2 Injecting drug users

There are widely differing estimates of the extent of injecting drug use in Indonesia. Government estimates suggest there are 40,000 IDUs (Directorate General Correction, 2005), while others estimate that there may be as many as one million (Aceijas, Stimson, Hickman, & Rhodes, 2004). Another recent estimate placed the number of injectors in the range of 148,000-167,000 (Pisani, 2006).

The most commonly injected drugs in Indonesia are heroin and crystal methamphetamine (UNODC Regional Centre for East Asia and the Pacific, 2006). While some regulations exist around the sale of needles and syringes, in practice they are readily available from pharmacies and other retailers. However, the cost can be prohibitive for IDUs (Reid & Costigan, 2002). Syringe sharing remains commonplace and in 2004-2005, IDUs accounted for an estimated 80% of new HIV infections (Open Society Institute, 2006). Nationally, HIV prevalence among IDUs was estimated at 19.8%-33.5% in 2002 (Ministry of Health Indonesia, 2003). In Jakarta in 2002, prevalence was 48% among IDUs seeking treatment (Riono & Jazant, 2004), while in West Java in 2003, 43% of IDUs tested for a sentinel surveillance survey were HIV-infected (National AIDS Commission Indonesia, 2006).

4.1.1.3 Men who have sex with men

HIV prevalence among men who have sex with men (MSM) is estimated at 0.4%-1.3%. Among *waria*, prevalence is 9.3%-14.3% (Ministry of Health Indonesia, 2003). In 2004, 43% of MSM correctly identified ways of preventing sexual transmission and rejected major misconceptions about HIV transmission. In the same year, over half of MSM reported using a condom the last time they had anal sex. These figures are in spite of poor coverage of HIV prevention services for MSM; in 2005, less than two percent of MSM were reached by HIV prevention programs (National AIDS Commission Indonesia, 2006).

As in many Asian countries, MSM in Indonesia may not necessarily identify as homosexual. Many MSM also have sex with women, and sex with *waria* is widely considered to be more akin to sex with a woman than with a man (Pisani et al., 2004). Of MSM who also have sex with women, much male-to-female sexual activity is in the context of long-term relationships in which condoms are rarely used, placing the female partner at risk of contracting infections acquired through the male's MSM activity (MAP, 2004). The fluidity of sexual identities and practices creates difficulties for HIV prevention programming. Estimating the size of the MSM population is complex, leading to difficulties in assessing need for and coverage of prevention interventions, and prevention interventions must address men who have sex exclusively with men; men who have sex with men and women; and men who have sex with *waria*.

4.1.2 Prevention, treatment and care in the community

HIV prevention, treatment and care efforts in the community are co-ordinated at the national level by the National AIDS Commission (NAC). The NAC determines Indonesia's National HIV/AIDS Strategy and collaborates with UN and donor agencies to develop prevention and treatment programs (National AIDS Commission, 2003).

In 2005, total funding committed to HIV/AIDS related activities was almost US$65 million. The national government provided US$13 million of this, with the remainder provided by international donors including DFID, USAID, AusAID and the Global Fund to Fight AIDS, TB and Malaria. Of the US$65 million, US$8.7 million was distributed to government ministries and agencies, including the Ministry of Health, the National Narcotics Board and the National Family Planning Board. Of this funding, 42% was expended on HIV prevention programs and 12.5% on treatment and care. The largest proportion, 44.5% was expended on program development and co-ordination. The remaining one percent went towards human resources and vulnerability reduction for women (National AIDS Commission Indonesia, 2006).

4.1.2.1 Information, education and communication

Information, education and communication (IEC) programs are central to the National AIDS Commission's approach to HIV prevention. The *National HIV/AIDS Strategy* recommends that IEC focusing on HIV transmission and prevention be integrated into the curriculum of formal and informal educational institutions, such as schools and workplace training centres. IEC through religious channels is also encouraged (National AIDS Commission, 2003).

4.1.2.2 Condom availability

Condoms are legal and widely available via retail outlets. A survey conducted in 2000 found that condoms were available in over 90% of pharmacies and supermarkets (DKT International, 2000). The *National HIV/AIDS Strategy* aims to promote condom use "at every risky sexual encounter" (National AIDS Commission, 2003).

DKT Indonesia, an NGO, has been contracted by the Indonesian government to conduct social marketing activities to promote condom use as HIV and STI prevention as well as contraception. Funding for these projects is provided by the Indonesian and German national governments, DKT International and the Bill and Melinda Gates Foundation. DKT Indonesia also sells low-cost condoms and actively seeks to distribute

condoms in areas where they have previously been unavailable. In 2005, DKT Indonesia sold 57.7 million condoms. The organisation also provides safe sex packages including condoms and education materials to truck drivers and education for sex workers on negotiating condom use with clients (DKT International, 2006).

4.1.2.3 Harm reduction interventions

The *National HIV/AIDS Strategy* notes that the implementation of harm reduction interventions should involve partnerships between the National AIDS Commission, the National Narcotics Board, the police and government ministries. However, it does not go so far as to describe what harm reduction interventions may be implemented.

There are at least 20 needle and syringe programs (NSPs) throughout Indonesia. The legal status of these programs is ambiguous. In Bali, for example, local authorities are supportive of harm reduction efforts for drug users and various NGOs are permitted to offer sterile injecting equipment to IDUs. Elsewhere, needle and syringe distribution must be conducted discreetly as a component of other outreach efforts (Open Society Institute, 2006). Coverage of harm reduction services for IDUs is poor, with less than six percent of Indonesia's IDUs in contact with an HIV prevention program in 2005 (National AIDS Commission Indonesia, 2006).

4.1.2.4 Drug dependency treatment

Drug dependency treatment and services available in Indonesia include detoxification, counselling, residential rehabilitation and in some areas, methadone maintenance treatment (Passa, 2005; UNODC Regional Centre for East Asia and the Pacific, 2005). The Drug Dependency Hospital (RSKO) is the largest drug treatment centre in Jakarta, in the main providing short-term detoxification services. The hospital also runs a pilot methadone maintenance treatment program. In addition to providing MMT, Sanglah Hospital, Denpasar offers HIV education and cognitive behaviour group therapy sessions (Passa, 2005). Other locations in which MMT is available include Fatmawati Hospital, Jakarta and Dr. Soetomo Hospital, Surabaya (Centre for Harm Reduction, 2005). These programs are generally small-scale and often dependent on donor funding. Preliminary findings from small MMT programs in Jakarta and Denpasar show that after six months in treatment, IDUs reduce their drug use, criminal behaviours and HIV risk behaviours (World Health Organization, 2005c). Private drug treatment and rehabilitation centres also exist in addition to numerous NGO-operated treatment and rehabilitation programs (AIDS Project Management Group, 2005).

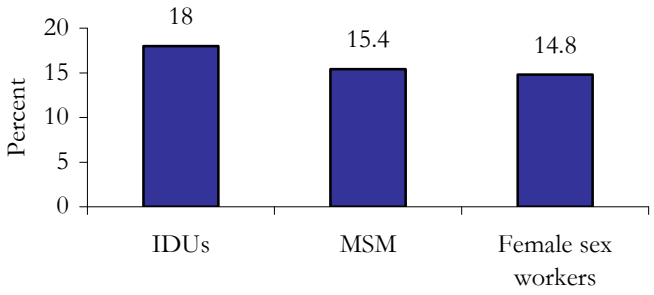
4.1.2.5 Voluntary counselling and testing

The Ministry of Health has published and distributed guidelines for voluntary conselling and testing (VCT) that are informed by WHO policy and recommendations. In 2005, there were 71 VCT sites around Indonesia (World Health Organization, 2005b). Some VCT sites are co-located with methadone maintenance treatment programs (Passa, 2005).

Presently, access to VCT is poor. As shown below in figure 4.2, less than one in five injecting drug users, female sex workers and MSM report having received an HIV test in the previous 12 months (National AIDS Commission Indonesia, 2006). A study of injecting drug users in Bali noted that barriers to accessing VCT included fear of an HIV-positive result, fear of reactions from friends and family, stigmatisation against people

living with HIV and the misconception that there is no treatment for HIV (Ford, Wirawan, Sumantera, Sawitri, & Stahre, 2004).

Figure 4.2: Percent of IDUs, MSM and female sex workers who received an HIV test in the previous twelve months and know the result



Source: Country Report on the Follow-up to the Declaration of Commitment to HIV/AIDS (UNGASS Indicators Country Report, 2004-2005). Jakarta, National AIDS Commission, 2006.

4.1.2.6 Antiretroviral therapy

Antiretroviral therapy (ART) is provided at over 60 sites around Indonesia. In 2005, an estimated 12,000 Indonesians were in need of ART. WHO/UNAIDS reports that 3,301 people living with HIV/AIDS were receiving ART by September 2005, falling short of the Ministry of Health's 2005 target of 10,000 ART patients (World Health Organization, 2005b).

4.2 Prison situation

Indonesia is the only country in the world to have produced a National Strategy specifically to guide HIV prevention, treatment and care efforts in prison: the *National Strategy: Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention, 2005-2009*. The Strategy provides a comprehensive framework for HIV prevention, treatment and care, with a particular focus on reducing injecting drug use-related HIV transmission (Directorate General Correction, 2005). Additionally, Prison Working Committees on HIV Prevention are being established to co-ordinate prevention, treatment and care activities at the provincial level (Juniartha, 2004).

4.2.1 Prison management

4.2.1.1 Administration

Indonesia's 402 correctional institutions are operated by the Directorate General of Corrections under the Ministry of Law and Human Rights. Thirteen institutions are "narcotic prisons" – prisons specifically for drug offenders.

4.2.1.2 Inmates

The number of prisoners has increased markedly in recent years. According to official figures, between 2000-2004, the prison population increased by 64%, from 54,314 to 88,887 (see table 4.2) (Directorate General Correction, 2005). In 2005, the prison population was 99,946, of whom 42% were awaiting trial (International Centre for Prison

Studies, 2006b). Approximately 20% of the population are incarcerated for drug offences, but research suggests around half of prisoners are drug users (Directorate General Correction, 2005; UNODC Regional Centre for East Asia and the Pacific, 2005).

A sentence of death can be applied in cases of murder, terrorism or drug trafficking. Currently, there are at least 90 prisoners sentenced to death (Amnesty International, 2006), including a number of foreigners.

Table 4.2: Prison population, institutional capacity and percent of prisoners incarcerated for drug offences

	Year					
	2000	**2001**	**2002**	**2003**	**2004**	**2005**
Total no. prisoners	54,314	59,448	67,960	71,587	88,887	99,946
Institutional capacity	64,619	64,619	64,345	66,891	68,141	68,141
Occupancy rate (%)	84	91.9	105.6	107.0	130.4	146.7
No. (% of total) prisoners incarcerated for drug offences	No data available	No data available	7,211 (10.6)	11,973 (16.7)	17,060 (19.2)	No data available

Sources: 2000-2004 data: Directorate General Corrections, 2005; 2005 data: International Centre for Prison Studies, 2006b.

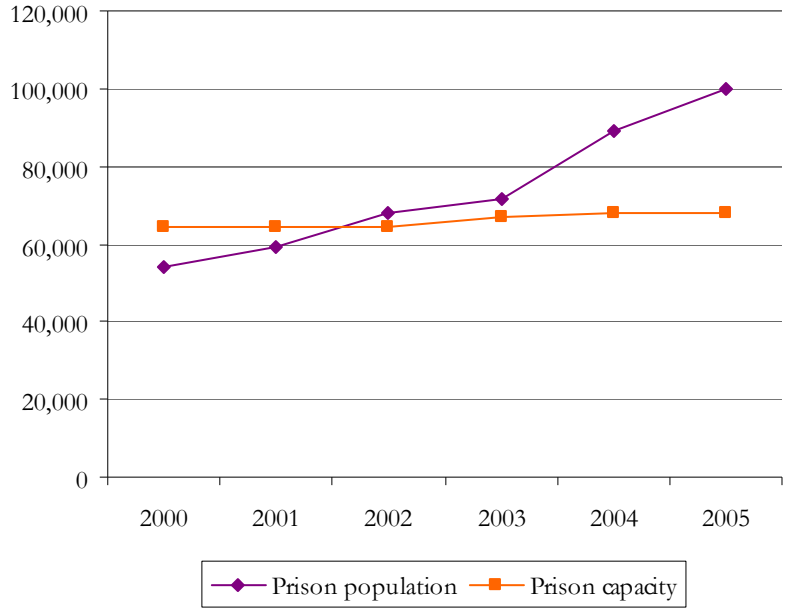
4.2.1.3 General conditions

In line with the increase in the prison population, overcrowding has become a concern. Figure 4.3 shows that increases to the capacity of the prison system have not kept pace with the increase in the prison population. In 2002, prisons were at 105% of their capacity. By 2004, this had increased to 130%. In 2005, with a population of 99,946 and an official capacity of 68,141, occupancy was 147% (see also table 4.2) (International Centre for Prison Studies, 2006b). The increase in overcrowding coincided with an increase in the proportion of prisoners incarcerated for drug offences. In 2002, 10% of prisoners were drug offenders; by 2004, this proportion had almost doubled (see table 4.2) (Directorate General Correction, 2005).

4.2.1.4 General medical care

The Directorate General of Corrections is responsible for the provision of medical care to prisoners. Ill prisoners are also sometimes referred to hospitals in the community. In a rapid assessment conducted in 2005, prison health staff reported that healthcare facilities were limited and few medicines were available to treat sick prisoners (Dolan, 2005a). The Directorate General of Corrections acknowledges the lack of equipment and medication and the impact this has on the medical care of inmates (Directorate General Correction, 2005).

Figure 4.3: National prison population and capacity, 2000-2005



Source: 2000-2004 data: Directorate General Correction, 2005; 2005 data: International Centre for Prison Studies, 2006b.

4.2.2 HIV testing of prisoners

Voluntary counselling and testing (VCT) is available to prisoners, however the Directorate General of Corrections notes that access to VCT is "not optimal" (Directorate General Correction, 2005). Prisoners in some provinces are included as a sentinel population for surveillance purposes. A sample of prisoners is selected at random and tested anonymously (MAP, 2004).

4.2.3 Segregation of HIV positive prisoners

It is the policy of the Directorate General of Corrections that HIV-infected prisoners have the right to confidentiality regarding HIV status and the right to access treatment and support without discrimination. To this end, prisoners living with HIV/AIDS are accommodated with the general prison population (Directorate General Correction, 2005).

4.2.4 HIV prevalence and risk behaviours in prison

National HIV prevalence among prisoners was estimated at 12 % (range 8.6%-15.4%) in 2002 (Ministry of Health Indonesia, 2003). The Directorate General Correction also collects HIV prevalence data by province (see table 4.3). These data show that wide variations exist between provinces, from a high level of 21% in Banten and West Java to a low of less than one percent in East Kalimantan.

HIV infection in prison is concentrated in injecting drug users. A study in Kerobokan prison, Bali, found that 56% of inmates with a history of injecting drug use were HIV-infected (Dolan, Kite, Black, Aceijas, & Stimson, 2007).

Table 4.3: HIV prevalence in prison populations, by province, 1999-2003

Province	HIV prevalence (%)				
	1999	2000	2001	2002	2003
DKI Jakarta	1.69	17.53	22	7.55	17.65
West Java	0.9	7.0	20.6	5.0	21.1
East Java	-	-	0.68	-	4.23
Bali	18.7	-	9.6	10.2	10.7
Lampung	-	-	2.5	2.3	2.8
Babel	1.0	-	-	-	-
DYI Yogyakarta	-	2.8	-	-	-
Banten	-	-	-	10.8	21.3
East Kalimantan	-	-	-	-	0.36

Source: Directorate General Correction, 2005.

4.2.4.1 Injecting drug use

Although quantitative data are limited, injecting drug use appears to be the most common HIV risk behaviour in prison. A rapid assessment of HIV and drug use in Indonesian prisons found that a range of drugs was available and used, and that heroin and methamphetamine were injected. Prisoners, guards and prison health staff all concurred that drug injection occurred in prison, with health staff noting that they sometimes observed injection marks on inmates' arms (Dolan, 2005a). A study of IDUs in Surabaya found that 21% had been in prison in the previous year; of these, 31% injected while in prison. Similarly, 17% of IDUs surveyed in Bandung had been imprisoned in the previous year, of whom 18% injected in prison (Devaney, Reid, & Baldwin, 2006).

4.2.4.2 Sexual activity

Sexual activity between inmates is reported to be "common". A study in two prisons in West Timor reported that 56% of prisoners had sex with men in prison, although it is unclear if this figure referred to the entire sample or just the proportion of the sample that reported having sex in prison (Sadipun, 2002). Most prisoners, guards and prison health staff interviewed for a rapid assessment in prisons in Jakarta agreed that sex between inmates occurred. There have been reports of prisoners exchanging sex for food, money and protection, and of prisoners paying guards for private rooms for having sex (Dolan, 2005a).

4.2.4.3 Tattooing and other body modification

The proportion of prisoners receiving tattoos in prison is unknown, but as with other HIV risk behaviours, tattooing is known to occur. Ink can be purchased from prison shops and inmates with expertise in tattooing can charge other inmates for their services. Tattoo needles are used on multiple inmates with little to no cleaning between inmates (Dolan, 2005a).

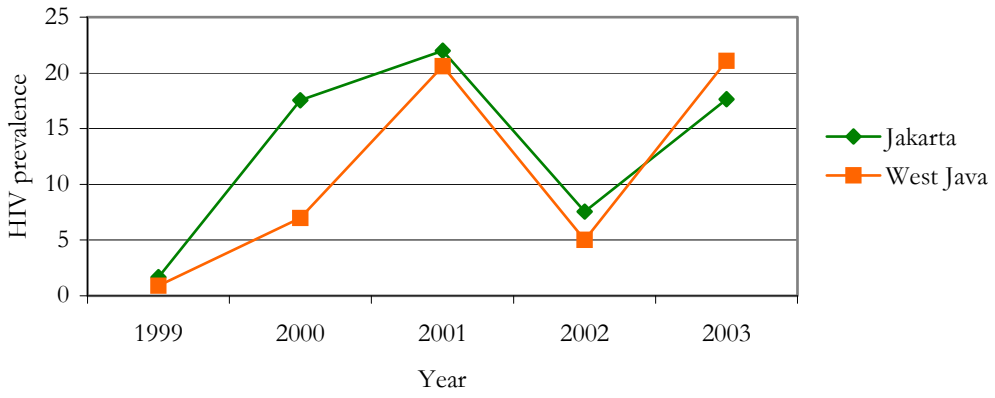
Penile modification appears to be common among prisoners. The insertion of beads into the head of the penis, known as *pasang tasbih*, has been reported in prisons in Jakarta (Dolan, 2005a) and West Timor (Sadipun, 2002). The West Timor study also found that

45% of prisoners surveyed had practiced "self-circumcision" during their imprisonment (Sadipun, 2002).

4.2.4.4 Evidence suggestive of HIV transmission in prison

Reports of widespread HIV risk behaviours in prison are supported by the data shown in figure 4.4. These data show HIV prevalence in prison in Jakarta and West Java, 1999-2003, as determined by anonymous surveillance surveys (taken from table 4.3, above). Recorded prevalence increases between 1999-2001, before a sharp decrease in 2002. This does not represent a real drop in prevalence in the prisons, but reflects a change in data collection methods. In 2002, only newly-received inmates were included in the surveillance sample. In 2003, the sampling strategy again included all inmates, and prevalence returned to the levels seen in 2001. These data show that only 5%-10% of inmates are HIV-positive on entry to these prisons, but that approximately 20% of the total population are infected. While not conclusive, this suggests that HIV is being transmitted in prison, through unsafe drug injecting, unprotected sexual activity and other risk behaviours (MAP, 2004).

Figure 4.4: HIV prevalence in prisons in DKI Jakarta and West Java, 1999-2003



Source: Directorate General Correction, 2005.

4.2.5 Prevention interventions

The *National Strategy* on HIV in prison has a strong focus on prevention through information, education and communication; drug dependency treatment; and harm reduction for prisoners engaging in HIV risk behaviours (Directorate General Correction, 2005).

4.2.5.1 Information, education and communication

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

families and other prisoners and relations between HIV negative and HIV positive prisoners had improved (Angela, Booker, & Morgan, 2005).

4.2.5.2 Drug dependency treatment

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

In addition to non-pharmacological treatment options, Kerobokan prison runs a methadone maintenance treatment (MMT) program. As at July 2006, the program had 31 patients. There are plans to expand MMT both within Kerobokan and to other Indonesian prisons (Irawati, Mesquita, Winarso, Hartawan, & Asih, 2006).

4.2.5.3 Harm reduction programs

Pilot bleach and condom distribution programs have begun in a small number of prisons in Indonesia. However, anecdotal reports suggest inconsistent availability of these supplies. There is high-level support for the expansion of condom distribution programs, with "provision of access and method of having safe sexual intercourse" listed as an activity to be implemented under the relevant National Strategy (Directorate General Correction, 2005).

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

4.2.6 Treatment and care

4.2.6.1 Antiretroviral treatment provision

Antiretroviral treatment (ART) is not widely available in prisons. The Directorate General of Corrections has committed to improving prisoner access to ART (Directorate General Correction, 2005).

4.2.6.2 Assessment and treatment of co-infections

Access to general medical care is poor. The Directorate General of Corrections has identified improving access to treatment for STI and tuberculosis as a priority (Directorate General Correction, 2005).

4.2.6.3 Other support and care services

Kerobokan Prison offers a support group for prisoners living with HIV/AIDS, known as "Positive Chat" (I. Winarso, personal communication, October 2006). It is not known if other prisons offer similar support groups. Planned activities to improve support and care services in prison include education and training for those involved in the care and treatment of HIV-infected prisoners; increasing the number of counsellors available to prisoners; and establishing a peer network for prisoners living with HIV/AIDS (Directorate General Correction, 2005).

4.2.6.4 Compassionate release for terminally ill prisoners

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

4.3 Discussion

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

Several of the activities described in the *National Strategy*, including bleach and condom distribution programs and methadone maintenance treatment (MMT), have been implemented on a pilot basis. These programs should be expanded to other prisons urgently. Narcotic prisons, with their concentration of injecting drug users, should be prioritised for the implementation of harm reduction and drug dependency treatment programs.

Lack of funding is a major impediment to the expansion of HIV prevention, treatment and care in prisons. Indonesia has been successful in attracting funding to support prevention and care efforts in the community and there is no reason why this success should not be replicated in prisons. In addition to supporting the expansion of harm reduction and other prevention projects currently in the pilot stage, funds should be sought to improve voluntary counselling and testing services; to increase the number of

prisoners receiving antiretroviral therapy; and to improve services for the assessment and treatment of co-infections such as tuberculosis, STI and hepatitis C.

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

5. THAILAND

Table 5.1: HIV/AIDS and imprisonment statistics, Thailand.

Population	65,444,371[1]
No. of adults (15+) living with HIV/AIDS (2005)	580,000[1]
% of adults (ages 15-49) living with HIV/AIDS (2005)	1.4%[1]
Imprisonment rate (per 100,000) (2005)	265.8[2]
HIV prevalence among prisoners	1.9-25%[3]

Sources: [1] UNAIDS, 2006b; [2]International Centre for Prison Studies, 2006d; [3]Various; see below under section 5.2.4.1.

5.1 Summary of community situation

5.1.1 HIV prevalence and distribution

In 2004, an estimated 580,000 people were living with HIV/AIDS in Thailand and 21,000 people died of AIDS that same year. The overall prevalence for adults is 1.4 percent. An estimated 220,000 people living with HIV were women 15 years and older and the male to female ratio of reported HIV cases is 1.6:1 (UNAIDS, 2006b).

Thailand has achieved substantial success in HIV control with the annual number of new HIV infections decreasing from 142,819 in 1991 to 21,260 in 2003. National HIV prevalence was 1.4% in 2004, down from 1.8% in 2003 and more than two percent a decade earlier (UNAIDS, 2006b; UNDP, 2004). However, the AIDS epidemic is far from over and infection levels in the most at-risk populations are much higher than in the general population (see below). Furthermore, over 90 percent of AIDS deaths in Thailand are occurring in the most productive sector of the workforce, those aged between 20 and 49 years. Indeed, AIDS has become one of the leading causes of death in Thailand (UNDP, 2004). A study conducted in five provinces in 2000 found AIDS was

the third leading cause of death, accounting for more than 11% of all deaths (Chuprapawan, 2003).

Almost one third of adults living with HIV/AIDS in Thailand are women, and as many as half of new adult infections are now among women, most of whom are infected by their husbands or partners. Violence puts women at greater risk of HIV infection. A study in 2000 found that more than 40% of Thai women surveyed had been physically and/or sexually abused by a partner. Condom use is almost non-existent in such incidents and the threat of violence often prevents women from negotiating safe sex. Furthermore, once infected, women can encounter severe stigma and discrimination (UNDP, 2004).

Of the AIDS cases reported to date with a known route of transmission, heterosexual transmission accounts for the highest proportion of cases (88%), followed by injecting drug use (six percent) and perinatal transmission (five percent) (UNAIDS, 2004a). The routes of HIV transmission have recently been changing. During the 1990s most HIV transmission occurred through commercial sex. More recently, male clients of sex workers and male injecting drug users are infecting their wives and girlfriends, with the result that as many as half of new HIV infections each year occur within marriage or long-term heterosexual relationships where condom use tends to be very low (UNAIDS, 2005a; World Health Organization, 2004b).

5.1.1.1 Sex workers

Officially prostitution is illegal in Thailand, but it is widely tolerated (US Department of State, 2003). Estimates indicate there are at least 100,000 and possibly more than 200,000 sex workers in the country. There is evidence that the number may be increasing. A survey over the period 1998-2003 recorded a 50% increase in the total number of sex service establishments. This increase was due to growth in the number of indirect sex service establishments, where sex workers are employed in settings such as massage parlours, clubs, bars, restaurants and hotels (UNDP, 2004).

Table 5.2: HIV prevalence among sex workers, Thailand

Location	Year	Sample size (N)	HIV prevalence (%)
Nationally	2001	Data inaccessible	16.6 among female direct sex workers, 9.6 among male sex workers, 5.1 among female indirect sex workers[1]
Bangkok and outside Bangkok	2004	Data inaccessible	4.3 among female sex workers (FSW) in Bangkok 5.7 (0-30.8) among FSW outside Bangkok[2]
Bangkok	2004-2005	148 venue- based FSW; 67 street-based FSW;	4.7 among venue-based FSW, 43.3 among street-based FSW[3]

Sources: [1]Country Coordinated Mechanism Committee, Thailand, 2002; [2]UNAIDS, 2006b; Nhurod, et al., 2006.

HIV prevalence among sex workers peaked in the mid-nineties, declining since then largely as a result of a government-supported 100% condom use campaign. However,

prevalence in this group is still higher than in the general population. Prevalence varies greatly between Bangkok (4.3%) and rural settings (0-30.8%), between direct (16.6%) and indirect sex workers (5.1%) and between venue-based (4.7%) and street-based (43.3%) sex workers. HIV prevalence in male sex workers is also high, at 9.6% (see table 5.2).

In recent years, condom use among brothel-based sex workers has decreased from 96% in the mid-1990s to as low as 50% in some locations (UNDP, 2004).

5.1.1.2 Men who have sex with men

There is a large community of men who have sex with men (MSM) in Bangkok. Low range estimates place it between 300,000 and 500,000 (Girault, 2005). HIV prevalence among MSM in Thailand is much higher than in the general population and rising. In Bangkok in 2005, 28 percent of MSM were HIV positive, up from 17 percent in 2003 (Van Griensven, 2006).

Almost one quarter of MSM surveyed in 2003 had had sex with women in the previous six months, creating a bridge for HIV transmission between the MSM and heterosexual populations (UNDP, 2004).

5.1.1.3 Injecting Drug Users

There are estimated to be 50,000 – 100,000 injecting drug users (IDUs) in Thailand (Devaney, Reid, & Baldwin, 2006). This group account for an estimated five percent of all HIV infections (UNODC, 2004b) and about 25% of new infections, which could rise to 40% in the next few years (Inkochasan, 2006).

Although there have been decreases in HIV infection among sex workers and pregnant women, HIV prevalence among IDUs has changed little since the 1980s. In 1997-1998 HIV prevalence among IDUs rose dramatically, from two percent to 43%, with as many as five percent becoming infected per month. One of the greatest increases was in Chiang Mai where infection rates rose from one percent in 1998 to 61% a year later (UNODC Regional Centre for East Asia and the Pacific, 2004). Studies report current prevalence among IDUs to be between 20-56% nationally and up to 91% in rural areas (see table 5.3).

Table 5.3: HIV prevalence among IDUs

Location	Year	Sample size (N)	HIV prevalence (%)
Nationally	2006	339	54[1]
Bangkok	2004	Data inaccessible	38[2]
Outside Bangkok	2004	Data inaccessible	42.2 (0-75) [2]
Nationally	1998-2003	Data inaccessible	20-56[3]
Bangkok	1998-2003	Data inaccessible	34[3]
Outside Bangkok	1998-2003	Data inaccessible	0-91[3]

Sources: [1]Inkochasan, et al., 2006; [2]UNAIDS, 2006b; [3]Aceijas, et al., 2004.

HIV in drug users spreads non-injecting sex partners and children. In Thailand, approximately three percent of the estimated 29,000 new HIV infections in 2000 occurred among women with partners who injected drugs and shared injecting equipment (Human Rights Watch, 2004).

5.1.2 Prevention, treatment and care in the community

Approximately $US92.8 million was spent by the Thai government from domestic sources on AIDS across all sectors in 2004 (UNAIDS, 2006a). Prevention programs account for eight percent of the national AIDS program budget, at five US cents per capita (World Bank, 2000).

Thailand has been praised for its rigorous and comprehensive HIV prevention programs. In 1991, HIV/AIDS prevention and control became a national priority at the highest level. Various preventive programs were implemented on a national scale: continuous, large-scale IEC campaigns on prevention; intensive health education; and promotion of 100% condom use in sex establishments. Other preventive measures that have been carried out include blood screening, counselling services at reproductive health clinics, anonymous clinics and comprehensive care services for people living with HIV/AIDS. These measures proved to be highly effective in HIV/AIDS prevention and control in Thailand and served as examples for many other countries to replicate and implement (UNESCAP, 2006).

In recent years, preventive programs are having less effect. Officially, the 100% condom use program remains in place, though it is promoted with less vigour than a decade ago. Substantial budget cuts to national HIV/AIDS programs as a result of a financial crisis in 1997 are a major factor contributing to the lack of vigour in prevention programs. This crisis came just as a new National AIDS Plan was being rolled out. As the currency was devalued and inflation increased, prices of imported condoms rose, as did those of HIV testing kits and many of the drugs used to treat opportunistic infections (UNDP, 2004).

From 2003, the national budget for AIDS received a welcome boost from the Global Fund to fight AIDS, Tuberculosis and Malaria. The Global Fund approved $US140 million to the Thai Ministry of Public Health and local NGO Raks Thai Foundation for strengthening national prevention and care of HIV/AIDS; enhancing HIV-related care and treatment for HIV-infected mothers and children; HIV prevention among migrant workers; and increasing care and support for IDUs (Country Coordinated Mechanism Committee Thailand, 2003). Funds are also provided by bilateral donors and NGOs including Australia, the United States of America, Canada, Japan, the United Kingdom, the Netherlands, Family Health International, Population Services International and John Hopkins University.

5.1.2.1 Harm reduction interventions

In February 2004, UNODC estimated that barely one percent of IDUs in Thailand were receiving harm reduction services (Human Rights Watch, 2004). Government support for harm reduction is limited (Raks Thai Foundation, 2006), and government policy regarding needle and syringe programs in Thailand is ambiguous. While there are no government-supported NSPs (UNDP, 2004), neither is there any clear legislation prohibiting the operation of NSPs, and while the possession of needles and syringes

frequently leads to arrest, injecting equipment can be purchased from pharmacies throughout the country (Gray, 1998).

NGOs have taken the lead in providing harm reduction services in Thailand. In 2003, the Global Fund awarded the Raks Thai Foundation, a coalition of former and current drug users, $US900,000 for peer based HIV prevention, care and support for IDUs. Activities include the creation of four Harm Reduction Centres (office spaces where education and outreach activities can be coordinated); the provision of HIV and safer injecting education by peer leaders and NGOs to health care providers, police, prison staff, and policy makers; and the provision of peer-based outreach, education, counselling and referral in four communities (Human Rights Watch, 2004; Raks Thai Foundation, 2006).

Other current harm reduction services in Thailand include NGO-managed NSPs, HIV education programs, drop-in centres and peer outreach services. In 1989, at drug treatment centres in Bangkok and Thanyarak Hospital, free bleach was provided along with instructions on needle disinfection. Such services are still confined mainly to the capital, the main constraints against expansion into provincial regions being the lack of resources and the shortage of outreach programs (Devaney, Reid, & Baldwin, 2006; UNDP, 2004).

There are some harm reduction services in provincial areas. A pilot NSP was started in the 1990s among the Akha people in the north of Thailand. Other examples are the HIV/AIDS Prevention and Care for Hill Tribes of Northern Thailand and the Mae Chan Harm Reduction projects. The latter provides NSP services to nine hill tribe villages in Chiang Rai province. The Asian Harm Reduction network also continues to produce Thai language advocacy materials on HIV and drug use. Generally, the government has not been supportive of such projects (Devaney, Reid, & Baldwin, 2006; UNDP, 2004).

5.1.2.2 Drug dependency treatment

In 2002, there were 7,065 drug dependency treatment facilities in Thailand. In addition to dedicated drug treatment centres, community health centres and hospitals offered treatment to drug users. In late 2002, a law requiring the treatment and rehabilitation of drug users was enacted, and the Thai government declared a "war on drugs". All drug users were required to seek treatment. In the three months from February 2003, drug users seeking treatment were placed in an existing facility or one of thousands of newly established rehabilitation centres or military-style "boot camps". The aim of these centres and camps was to provide skills to assist users to live drug-free (Vongchak, 2005).

From April 21, 2003, drug users who had not sought treatment were detained for compulsory treatment (to be discussed further in section 5.2.1.3). Drug users were asked to enter treatment or face arrest. Community leaders were pressured to turn known drug users over to local police, creating an environment in which drug users were feared and discriminated against. Fear of arrest reduced the willingness of injecting drug users to obtain sterile injecting equipment, leading to increases in needle and syringe sharing (Human Rights Watch, 2004). In excess of 2,000 people were killed in the first year of the war on drugs; many of the deaths were of drug users at the hands of police (Human Rights Watch, 2004). While there is some evidence that drug injection decreased during this period, methamphetamine and opium smoking and consumption of alcohol and prescription sedatives increased (Vongchak, 2005). Methamphetamine and alcohol use

are associated with HIV risk-taking behaviours such as unsafe sex and multiple sex partners (Bryant, 2006; Vongsheree, 2001). Rather than reducing demand for drugs, the war on drugs simply shifted demand from some substances to others.

Access to voluntary drug treatment, particularly substitution maintenance treatment, remains limited. Methadone treatment is restricted to periods of 90 days (World Health Organization, 2005c). The World Health Organization recently conducted a trial of MMT in Bangkok, utilising serial 90-day treatment periods. Of 118 participants, 96 (81%) were retained in treatment for three months and 80 (68%) were retained for six months. Significant reductions were seen in participant drug use, criminal involvement and HIV risk behaviours (World Health Organization, 2005c).

5.1.2.3 Voluntary counselling and testing

Voluntary counselling and testing (VCT) has been a major component of HIV prevention in Thailand for over a decade and has been available in all government hospitals since 1992. HIV testing levels among the population are high, at 52.1% (Visrutaratna, 2006), however coverage is uneven (UNDP, 2004). According to a survey conducted for UNAIDS in late 2003, people in Bangkok can easily access free or affordable VCT but less than 50% of those in rural areas enjoy similar access (UNDP, 2004).

NGOs also provide VCT services. The Thai Red Cross Society (TRCS) has provided VCT services to over 8,000 people annually at its Anonymous Clinic in Bangkok since 1991 (Vannakit, 2006).

Concerns have been raised about VCT services in the country. A review by the World Bank in 2000 concluded that VCT were underutilised and raised questions about the overall quality of counselling services. While some hospitals can and do provide systematic and appropriate services (including pre- and post- test counselling), other sites are struggling to do so. Excessive workloads, burnout of staff and inadequate counselling skills are all factors. Of particular concern is the reported lack of privacy and confidentiality for patients (UNDP, 2004).

5.1.2.4 Prevention of mother-to-child transmission

In 2000 the government confirmed a policy of universal access to services for preventing mother-to-child HIV transmission and integrated the intervention into the new universal health coverage scheme, the 30 Baht Treat All scheme (UNDP, 2004). However this has not guaranteed access to all HIV positive pregnant women.

Estimates on the number of HIV infected women receiving ART vary widely. UNGASS reports that 83.4% of HIV infected women were receiving ART in 2004. In contrast, a WHO/UNAIDS/POLICY coverage survey reported that 30.6% of pregnant women were receiving ART in 2005 (absolute numbers are not reported) (UNAIDS, 2006a).

In 2003, the Global Fund provided funding to the Thai Ministry of Health to scale up HIV care and treatment for HIV positive mothers, their partners and infected babies to cover all 76 provinces in Thailand. It includes funding for antiretroviral treatment for 19,920 people (Country Coordinated Mechanism Committee Thailand, 2003).

5.1.2.5 Antiretroviral treatment

As of 2003, the Ministry of Public Health has been officially committed to ensuring equal access and proper treatment for all people living with HIV/AIDS, including antiretroviral therapy (ART) for those who seek it. Through the National Access to Anti-retroviral Program, the government has been subsidising ART for an increasing number of people living with HIV/AIDS (UNDP, 2004). There are currently over 800 sites in Thailand providing ART (UNAIDS, 2006b).

Table 5.4: Number/percentage of people receiving ART

Source	Year	No./% of people on ART
WHO '3 by 5' Initiative	2005	60% of people needing treatment were receiving ART[1]
Ministry of Public Health, Thailand	2005	71,291 people with HIV were receiving ART[2]
UNAIDS	2005	59% (81,000) of people needing treatment were receiving ART[3]
UNGASS	2004	39.2% of people with advanced HIV infection were receiving ART[4]

Sources: [1]WHO/UNAIDS, 2006; [2]Jirawattanapisal & Chasombat, 2006; [3]UNAIDS, 2006b; [4]UNAIDS, 2006a.

WHO/UNAIDS estimate that 100,000 adults were in need of ART in 2005 (UNAIDS, 2006b). Approximately 60% of those in need are receiving treatment (see table 5.4). Although there is a government commitment to providing ART, many eligible persons living with HIV/AIDS are not yet receiving these medications. Cost and lack of awareness remain significant barriers to ART access in Thailand. In a study of 423 symptomatic HIV positive people who had never received ART, 43% (n=181) cited high cost as the reason for not starting treatment, a quarter (n=105) did not know about ART and 22% (n=95) thought they were not candidates for treatment (Lertpiriyasuwat, 2004).

5.2 Prison situation

5.2.1 Prison management

5.2.1.1 Administration

Prisons are administered by the Department of Corrections under the Ministry of Justice. In 2005 there were 55 provincial prisons, 24 district prisons, 26 central prisons, 4 remand prisons, 25 correctional institutions, 2 Detention Houses and 1 'House of Relegation' (International Centre for Prison Studies, 2006d).

Healthcare is administered by the Medical Services Division of the Department of Corrections (UNAFEI, 2002).

5.2.1.2 Inmates

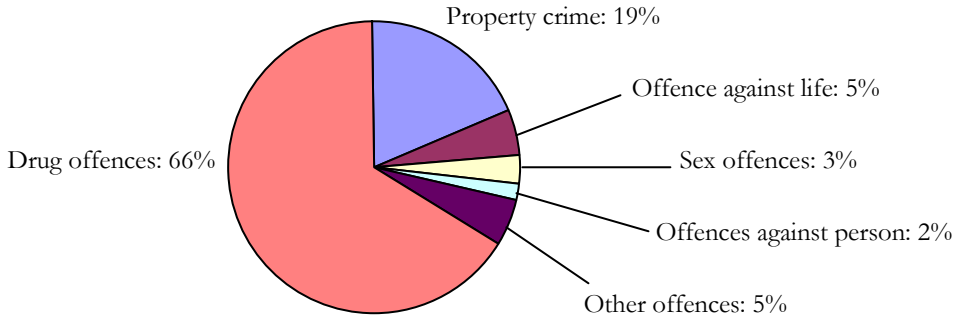
According to government sources, there were 164,975 prisoners in Thailand in 2005, making for an imprisonment rate of 265.8 per 100,000 people. Of these 17.2% were women and one quarter were pre-trial detainees (APCCA, 2005). Officially, pre-trial detainees are to be housed separately from the sentenced population; however, lack of

facilities often results in the two groups being housed together. Nationally, the staff/inmate ratio was 1:23 in 2002 (Department of Corrections Thailand, 2002). Also in 2002, 47% of prisoners received a sentence of one to five years, and 71% of prisoners were aged between 20 and 40 years (Department of Corrections Thailand, 2002).

5.2.1.3 Incarceration of drug offenders

Drug offences are the most commonly prosecuted crimes in Thailand. In 2005, almost two-thirds (64%) of prisoners in Thailand were drug offenders (Ringrowd, 2005). In 2002, the proportion of inmates prosecuted for drug offences was more than three times as great as the proportion prosecuted for the second most common offence, property crime (see figure 5.1).

Figure 5.1: Imprisonment by offence type



Source: Department of Corrections, Thailand, 2002.

Severe penalties for drug offences contributed to a rapid increase in the imprisonment rate, from 270 per 100,000 in 1998 to a peak of 402.6 per 100,000 in 2002 (APCCA, 2004; UNAFEI, 2005). As noted above, the imprisonment rate has recently returned to levels similar to those seen in the late 1990s.

The war on drugs required that all drug users who did not seek voluntary treatment be detained for compulsory treatment. Depending on the amount of drugs used by an individual, and the amount found in their possession on arrest, drug users detained for compulsory treatment are assigned to one of four treatment options: military boot camp for four months; an in-patient drug treatment facility; supervision in their local community; and regular reporting to probation authorities (Vongchak, 2005).

5.2.1.4 Incarceration of women

Although there was a dramatic increase in the general prison population in 2002 and 2003, there was a greater increase in the number of female prisoners. In 1991, seven percent of prisoners were women. By 2002, 20% were women (UNAFEI, 2003). In the same year, 87% of female prisoners were drug offenders, an increase from 39% in 1990 (Department of Corrections Thailand, 2002).

5.2.1.5 General conditions

Overcrowding is a concern. Nationally, prison occupancy is 151% (International Centre for Prison Studies, 2006d) and space per inmate is 2.25 square meters (UNAFEI, 2002).

The budget that the Department of Corrections receives for food for each prisoner per day is US$0.73. The Department concedes that the quality and quantity of the food is insufficient and has thus allowed the establishment of a store in front of the prison to cook and sell food to relatives. Poor sanitation and hygiene are also of concern (UNAFEI, 2002).

5.2.1.6 General medical care

In each prison there is a nursing home that provides basic medical services for sick prisoners. Prisoners in need of long-term treatment are transferred to the Central Correctional Hospital in Bangkok, the only hospital of the Corrections Department. The hospital has a capacity of 300 beds (UNAFEI, 2002). The hospital receives $US5.32 per patient per year (Amnesty International, 2002).

For a total prison population of over 100,000, the Corrections Department employs 14 doctors and 5 dentists (US Department of State, 2003). The majority of prisons in Bangkok have physicians, registered nurses, laboratory capacity and an ambulatory unit. Provincial prisons have no physicians or laboratory facilities, and only one to two licensed practical nurses with two years of education in nursing college (Nateniuyom, 2004).

There is a high incidence of deaths in custody from AIDS related illnesses and such as tuberculosis in prisons in Thailand. Lack of appropriate treatment contributes to this outcome (Amnesty International, 2002).

5.2.2 HIV testing of prisoners

Compulsory HIV testing for prisoners was cancelled in 2000 (UNDP, 2004). No further information regarding access to VCT was identified.

5.2.3 Segregation of HIV positive prisoners

In 1994 it was reported that 200 HIV-positive inmates had volunteered to isolate themselves in a specialised unit equipped with facilities to sterilize laundry and utensils. This unit could house as many as 500 people (Reuters, 1994). No recent reports of segregation of prisoners were identified.

5.2.4 HIV prevalence and risk behaviours in prison

There have been no national-level studies of HIV in prison in Thailand. However, there have been a number of ad hoc studies conducted on the general prison population and among risk groups. Prevalence levels vary from less than two percent to 25% (see table 5.5). Of all male AIDS cases in Thailand, two percent have been diagnosed in prison (Ministry of Public Health Thailand, 2000).

Table 5.5: HIV prevalence in prison

Location	Sample size	Year	HIV prevalence
Klong Prem Prison (Bangkok)[1]	689	2001-02	25.4% (but unclear if sample selected according to previous risk factors).
Klong Prem Prison (Bangkok) [2]	5000	1994	6% (300 cases)
Klong Prem Prison Hospital (Bangkok) [3]	350	1995	20-30%
Prisons of ten provinces[4]	Data inaccessible	1991	12% among men newly admitted; 19% among men about to be discharged
Bitichitawej Hospital for mentally ill offenders[5]		325	1.9%

Sources: [1]Thaisri, et al., 2003; [2]Reuters, 1994; [3]Hunt, 1995; [4]Weniger, et al., 1991; [5]Desananjali, 1994.

Having been incarcerated is an independent risk factor for HIV infection among Thai men, especially IDUs and MSM (Beyrer et al., 2003; Choopanya et al., 2002). Despite high levels of HIV-related knowledge among prisoners, high levels of drug use, sexual activity, and tattooing within correctional facilities have been reported (Buavirat, Sacks, & Chiamwongpaet, 2002).

5.2.4.1 Injecting drug use

There are several studies that indicate that injecting drug use and the sharing of needles is common in prisons and holding cells (see table 5.6). In a study of male IDUs in a treatment centre in northern Thailand, 15.8% who had ever been jailed had injected in prison (Beyrer et al., 2003). In a prospective cohort of 705 drug injectors in Klong Prem Prison, 38% had injected while in prison and 97% of those who had injected had shared injecting equipment while in prison (Thaisri, 2003). A case-control study of former prisoners found that 51% of 175 HIV-infected cases had injected heroin while in holding cells, compared to 36% of 172 non-infected controls. Half of the cases had shared needles in holding cells, compared to 31% of controls (Buavirat et al., 2003).

Incarceration has been known to be a risk factor for HIV infection among IDUs in Thailand for over ten years (Beyrer et al., 2003; Choopanya, 1991; Choopanya et al., 2002). A risk assessment among a large cohort of Bangkok IDUs found only two risk factors to be independently associated with HIV infection: having shared needles in the previous six months and having been in prison. Bangkok IDUs with a history of imprisonment were about twice as likely to be HIV infected as those who had never been in prison and in terms of absolute risk, 80 percent of all IDUs with HIV infection had ever been imprisoned (Choopanya, 1991).

A prospective cohort of 689 male inmates in Bangkok Central Prison found that HIV incidence was 4.18 per 100 person years, which is comparable to that of Bangkok IDUs. All inmates who seroconverted during the study were injecting drug users (Thaisri, 2003).

Among a cohort of IDUs in Bangkok between 1995-1998, inmates who injected while incarcerated had a higher incidence of HIV infection (35.3 per 100 person years of observation) than those had been incarcerated but had not injected (11.3 per 100) and those who had not been incarcerated (4.9 per 100). The authors of this study concluded that 'it is likely that a large proportion of this risk results from the sharing of drug injection equipment in settings where access to clean syringes and needles is severely limited' (Vanichseni et al., 2001).

Table 5.6: Prevalence of injecting drug use and needle sharing in prison

Location	Sample Size	Year	Results
Treatment centre cohort in northern Thailand[1]	272	1992-2000	15.8% of male IDU who had ever been jailed, had injected in prison
Klong Prem Central Prison (Bangkok)[2]	689 male inmates	2001-2002	38% (n= 268) had injected while in prison, 97% (n=259) of those who injected while in prison shared injecting equipment while in prison
17 methadone clinics of the Bangkok Metropolitan Administration[3]	347 IDUs (175 HIV positive cases and 172 HIV negative controls)	2000-2001	31% of HIV cases and 22% of controls reported injecting heroin during a median incarceration time of 52 weeks in prison; 51% of cases and 36% controls reported injecting during approximately one week in a holding cell; 50% of cases and 31% controls reported sharing needles in the holding cell.

Sources: [1]Beyrer, et al., 2003; [2]Thaisri, et al., 2003; [3]Buavirat, et al., 2003.

Thailand's HIV epidemic provides an example of the impact on the community if HIV is uncontrolled in prisons. A prison amnesty in 1997 saw the release of hundreds of prisoners, including many who were IDUs. Shortly thereafter, HIV prevalence among IDUs presenting for drug treatment in Bangkok rose dramatically from two percent to 43%. It is believed that a number of IDUs became infected with HIV in prison and on their release, unwittingly transmitted the virus to their injecting and sexual partners (Wright, Vanichseni, Akarasewi, Wasi, & Choopanya, 1994).

5.2.4.2 Sexual activity

More than one quarter of 689 male inmates surveyed in Bangkok reported ever having sex with men; of them, more than 80 percent reported sex with men during incarceration (Thaisri, 2003). Sexual risks involving male inmates and staff, or between female inmates and male staff may be primary HIV risks for prisoners who do not inject (Beyrer et al., 2003).

5.2.4.3 Tattooing and other body modification

Tattooing in prison occurs in unhygienic conditions and is a possible risk factor for the transmission of HIV. Tattooing and sharing razor blades are common in prisons in Thailand (Beyrer et al., 2003; Thaisri, 2003). A case-control study found that a

significantly greater proportion of HIV-infected IDUs (59%) than non-infected controls (42%) had received a tattoo during incarceration (Buavirat et al., 2003).

The insertion of penile implants (*fang muk* in Thai) is common among Thai male prison populations and may increase HIV transmission risk (Beyrer et al., 2003).

5.2.4.4 Evidence suggestive of HIV transmission in prison

A study conducted in 1991 in prisons in ten provinces found that HIV prevalence was 12% among newly admitted men, but 19% among men about to be discharged. This suggests the transmission of HIV in prison (Weniger, 1991).

5.2.5 Prevention interventions

To date, the response to HIV in prison has been uncoordinated and access to prevention programs has been poor. The Ministry of Justice recognises this and has welcomed collaboration with external United Nations entities to consider new methods to assess the HIV/AIDS situation in prisons (UNDP, 2004).

5.2.5.1 Information, education and communication

Prisoners are presented with HIV/AIDS related information when they start their sentence and again just before they are released. It is unclear how widespread or consistent this practice is. There are reports that some medical staff serving in prison facilities, of their own accord, try to provide HIV/AIDS education and counselling. Medical staff also provide some HIV/AIDS training for prison guards (UNDP, 2004).

The Population and Community Development Association has delivered HIV education programs in Klong-Prem prison. Guards and selected inmates were trained to be peer educators. Staff from the Ministry of Public Health have provided instruction on pre and post-test counselling (Payapvipapong, 2000).

In addition, the Global Fund has recently provided funding to Raks Thai Foundation to deliver educational workshops to increase the capacity of prison staff to provide HIV prevention to IDUs in prison (Raks Thai Foundation, 2006).

5.2.5.2 Drug dependency treatment

Substitution maintenance treatment is not provided in prisons in Thailand.

Therapeutic communities (TCs) have operated in Thai prisons since 1994. TCs are co-ordinated by the Orthopaedic Nurses Certification Board, Thanyarak Institute on Drug Abuse and private sector organisations. The aim of the TC programs is abstinence, achieved with the support of the peer group and families. There are three categories of TC operating in prison:

1. *Eighteen-month program*: A long-term program with orientation, rehabilitation, re-entry, and follow-up phases. Prisons that operate this program need to provide a specific area for TC residents to live separately from other prisoners;

2. *Four-month intensive program:* A program short-term or pre-release prisoners. Apart from TC principles and practices, short-term vocational training programs are provided to assist prisoners find jobs after release;
3. *Combination program:* This program is arranged for prisoners who do not qualify for the above programs and where a specific area for TC cannot be provided. Only some TC principles are practiced (Ringrowd, 2005).

All drug users are required to participate in activities such as group counselling, social support group activities and educational and vocational training. Inmates who do not satisfy the requirements of the drug treatment program are referred back to the judicial system for further sentencing or treatment (Sungkawan, 2004).

In 2005, the Department of Corrections implemented a project entitled 'Vivat Polamaung Rachatan' in five correctional institutions across Thailand. The four-month program consists of military disciplinary practice, TC programs and vocational training. Inmates who complete this program receive consideration for special parole. In 2005, 1600 prisoners were enrolled in this program (Ringrowd, 2005).

5.2.5.3 Harm reduction programs

There are no needle and syringe or bleach distribution programs in Thai prisons (Beyrer et al., 2003).

100,000 condoms were distributed to prisons nationwide during the 15th International AIDS Conference in Bangkok in 2004 (Asian Economic News, 2004). Since that time, condom availability has been limited (World Bank, 2000). It is reported that medical staff serving in prisons sometimes distribute condoms (UNDP, 2004).

5.2.6 HIV treatment and care

The Global Fund has provided Raks Thai Foundation with funds for the training of prison staff in the HIV treatment, care and support of inmates who are IDUs. However, the funding proposal submitted does not include a budget for the provision of ART or care and support of inmates who are HIV positive. It is hoped that once the success of the project is demonstrated, opportunities for more sustained funding from national and international sources will arise (Raks Thai Foundation, 2006).

5.2.6.1 Anti-retroviral treatment

No information on anti-retroviral treatment in prison was identified.

5.2.6.2 Assessment and treatment of co-infections

The TB-DOTS strategy has been implemented in eleven prisons in Bangkok and nearby provinces since 1998 through the collaboration of the National Tuberculosis Program (NTP), the Ministry of Public Health and the Department of Corrections. Some prisons have reached the national target to cure 85 percent of new TB cases. However, provincial prisons are less able to achieve this target because of a lack of health service capacity (Nateniuyom, 2004). No information on the treatment of other co-infections was found.

5.2.6.3 Other support and care services

A local community group for people with HIV/AIDS, the Wednesday Friends Group, has assisted inmates in setting up a peer support group in Klong Prem Prison (Payapvipapong, 2000).

5.2.6.4 Compassionate release for terminally ill prisoners

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

5.3 Discussion

The lack of HIV prevention interventions in prisons was a likely contributor to the first HIV epidemic in Thailand in the 1980s (Wright, Vanichseni, Akarasewi, Wasi, & Choopanya, 1994). The country has achieved substantial success in curbing the HIV epidemic in the country since then, however, AIDS is still one of the leading causes of death in Thailand (UNDP, 2004). Prevalence in high risk populations, particularly injecting drug users but also men who have sex with men and sex workers, is several times that of the general population. Prevalence among IDUs remains extremely high, at 20-56 percent and possibly higher in some rural areas.

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

There have been some HIV prevention efforts within prisons, such as HIV education provided by NGOs. However, there is an urgent need for harm reduction programs, including condom distribution and needle and syringe programs. Prevention interventions must be expanded to include all detention facilities, including holding cells.

There is an absence of HIV treatment and care interventions in prisons. The National Access to Anti-retroviral Treatment (ART) program, which provides subsidised ART throughout Thailand, should be expanded to include free ART for prisoners. The same clinical criteria for determining treatment eligibility in the community should be applied to prisoners.

The punitive approach to drug dependence has reduced the willingness of drug users to seek treatment or harm reduction services. High numbers of injecting drug users have been imprisoned and many continue to inject in prison, contributing to the spread of HIV. The imprisonment of drug users has also contributed to high levels of overcrowding in prison. A less punitive approach to drug dependence that focuses on the provision of effective treatment in the community is recommended. This will encourage drug users to access treatment and help reduce the number of injecting drug users in prison.

6. NEPAL

Table 6.1: HIV/AIDS and imprisonment statistics, Nepal.

Population	27,132,000[1]
Number of adults (15+) living with HIV/AIDS (2005)	74,000[1]
% of adults (15-49) living with HIV/AIDS (2005)	0.5[1]
Imprisonment rate (per 100,000) (2005)	26[2]
% of prisoners living with HIV/AIDS	unknown

Sources: [1]UNAIDS, 2006e; [2]International Centre for Prison Studies, 2006c.

6.1 Summary of community situation

6.1.1 HIV prevalence and distribution

AIDS was first reported in Nepal in 1988. Currently, HIV prevalence in the adult population (ages 15-49) is estimated at 0.5% (range 0.3-1.3%). Approximately 70% of infections are in men (UNAIDS, 2006e).

Despite low general prevalence of HIV, concentrated epidemics are underway among high-risk populations such as sex workers, migrant and transport workers, men who have sex with men (MSM) and injecting drug users (IDUs). The potential for HIV to pass from these risk groups to the wider population, resulting in a generalised epidemic, is high.

6.1.1.1 Sex workers

In Kathmandu, 17% of sex workers are HIV positive (UNAIDS, 2006e). Prevalence in rural areas is lower but still higher among the general population. For example, in the Terai region four percent of tested sex workers are HIV positive (FHI, 2000). Condom use among sex workers' clients is inconsistent. Clients may bargain for sex without a condom, or the workers may perceive a client as being healthy or attractive and therefore HIV negative (L. Shrestha, Tamang, Acharya, Pelto, & Shrestha, 2004).

Many sex workers travel to India. Some go by choice, but as many as 12,000 women are trafficked across the border annually for the purposes of sexual exploitation (UNODC, 2005). Involvement in sex work in India is a risk factor for HIV infection; of the women surveyed in the Terai, HIV prevalence was 17% among those who had worked in India, compared to one percent among those who had not (FHI, 2000).

Very little is known about male sex workers in Nepal. Most male sex workers are street based, but some also work from parlours popular with foreign tourists. Condom use is reported to be low (FHI, 2001).

6.1.1.2 Mobile populations

Economic migration, from rural to urban areas and to India, is common in Nepal (Puri & Cleland, 2006). Migrant workers commonly have multiple sexual partners and visit sex workers, yet condom use is low and infrequent (Poudel, Jimba, Okumura, Joshi, & Wakai, 2004; Puri & Cleland, 2006). A study in one Nepalese community found HIV prevalence to be 10% among returned migrants (Poudel et al., 2003).

Transport workers (e.g. truck drivers) are also at risk of HIV infection. As with migrant workers, multiple sexual partners and contact with sex workers is common and condom use is irregular (Khadka, 2004). Among truck drivers engaging the services of sex workers in the Terai, prevalence was 1.5% in 2000 (FHI, 2000).

6.1.1.3 Men who have sex with men

A rapid assessment of MSM in 2001 found that HIV knowledge was poor, condom use was infrequent and there were no support services catering for MSM in Nepal. Many MSM also had female sexual partners. Limited data suggest HIV prevalence among MSM in Kathmandu to be four percent (FHI, 2001).

6.1.1.4 Injecting drug users

Estimates of the number of IDUs in Nepal range from 24,000-58,000 (Aceijas, Stimson, Hickman, & Rhodes, 2004). The drugs most commonly injected include buprenorphine (known by the brand name Tidigesic) and heroin (Reid & Costigan, 2002). HIV prevalence among IDUs across Nepal is estimated at 40%; in Kathmandu, this rises to 70% (Aceijas, Stimson, Hickman, & Rhodes, 2004; S. Panda & Sharma, 2006).

6.1.2 Prevention, treatment and care in the community

Nepal's National HIV/AIDS Strategy guides HIV prevention, treatment and care efforts. The Strategy has been translated into an Action Plan to be financed under a public-private partnership framework. The plan for 2005-206 was been costed at US$23.6 million of which just over US$14.5 million had been contributed by funding partners. Major funding partners include DFID, USAID and GFATM (NCASC, 2005a).

The role of the current violent conflict between Maoist rebels and government forces in impeding HIV prevention and treatment efforts has yet to be fully examined. The conflict has led to increased rural-to-urban and international migration and subsequent population mixing, while one-fifth of sex workers surveyed stated that they had entered

the sex trade as a direct result of conflict. The conflict has also created difficulties in the implementation of HIV prevention activities and created barriers to accessing HIV prevention services (S. Singh, Mills, Honeyman, Suvedi, & Pant, 2005).

6.1.2.1 Information, education and communication

Peer education is an important prevention intervention in Nepal. Peer educators have been utilised to improve HIV knowledge among sex workers (Thapa, 2004) and to build linkages between sex workers and sexual health clinics (Huzdar, 2004). The drug user organisation Recovering Nepal has advocated with policymakers for improved drug treatment services and services for people living with HIV/AIDS (PLWHA) and has co-operated with media outlets to raise awareness of stigma and discrimination against IDUs and PLWHA (Lawson et al., 2004; POLICY Project, 2005).

6.1.2.2 Condom availability

Condoms are legal throughout Nepal and available from pharmacies and other retailers. Population Services International (PSI) began a national condom promotion program in 2002, involving a media campaign promoting condom use, widespread distribution of condoms to retailers and targeted condom promotion to high-risk groups including sex workers. Between 2002 and 2004, the number of condoms sold in Nepal increased from 12 million to 23 million (Honeyman, 2005).

Condoms are also promoted via the annual "Condom Day", an initiative of the Nepal Red Cross Society. Activities include distribution of free condoms, street theatre and songs promoting condom use, awareness-raising rallies and formal presentations of scientific papers by NGOs and government authorities (Nepal Red Cross Society, 2004).

6.1.2.3 Harm reduction interventions

Needles and syringes for drug injection can be purchased at pharmacies. However, they can be relatively expensive and pharmacists may be unwilling to sell them to people they suspect of using drugs (FHI, 1999). Syringe sharing is common and cleaning methods, if employed, are usually inadequate (Burrows, Panda, & Crofts, 2001; Reid & Costigan, 2002). Needle and syringe programs (NSPs) operate in Kathmandu and Pokhara. The Lifegiving and Lifesaving Society (LALS), a Nepalese NGO, provides NSP and outreach services in Kathmandu Valley. LALS distributes sterile needles and syringes, condoms, vials of bleach, alcohol swabs and collects used injecting equipment at over 60 sites around Kathmandu. In addition to these services, LALS operates a drop-in centre, develops and distributes training manuals on outreach and HIV prevention and care, conducts advocacy with pharmacists to increase their willingness to sell syringes to IDUs and conducts peer education training (Burrows, Panda, & Crofts, 2001; Dixon, 1999; M. Singh, 1998).

6.1.2.4 Drug dependency treatment

There are conflicting reports as to whether the Nepalese Government provides drug treatment facilities or funding to treatment agencies. A rapid assessment carried out in Kathmandu Valley 2000 reported that there is a government-run detoxification service and a government-run rehabilitation centre (Burrows, Panda, & Crofts, 2001); however, a

more recent report states that there are no government treatment services (POLICY Project, 2005).

There are more than 30 voluntary drug treatment centres run by community-based organisations or NGOs. These centres typically utilise the therapeutic community treatment model. At least one treatment centre is run by the police. It is uncertain whether this is a compulsory treatment centre (Burrows, Panda, & Crofts, 2001; FHI, 1999).

A small methadone maintenance treatment (MMT) program operated from 1994 to 2002 from a psychiatric hospital in Lalitpur. An evaluation of this program was conducted in 1998. At that time, there were 204 patients registered with the program. Almost half of the patients (44%) had been using heroin and/or illicit buprenorphine for more than seven years. Almost all patients (96%) had been injecting drug users, and 40% reported sharing injecting equipment. Involvement with the criminal justice system was common, with 38% reporting having been in police custody for offences such as theft; drug possession and distribution; and violence. The number of times in police custody ranged from one to six and duration in custody ranged from a few days to 'a couple' of years. Voluntary counselling and testing (VCT) was available to patients; of the 111 who underwent testing, 46 (42%) were HIV positive (D. M. Shrestha, 2002).

Patients on the program experienced a number of benefits. Only 3% of patients were taken into police custody while in treatment. Patients' families were interviewed for their opinions of the treatment; 86% reported that there had been a significant improvement in the health of the patient; 81% reported that the patient was taking on greater responsibilities (e.g. finding employment, providing financial support); and 88% reported that the patient was not using any other drugs, including alcohol. Finally, of 50 patients who were HIV negative on commencement of methadone treatment, only two had seroconverted after twelve months in treatment (D. M. Shrestha, 2002). Despite these findings demonstrating the effectiveness of MMT in Nepal, the program was suspended in 2002. At present, there are no services providing any form of substitution maintenance treatment (personal communication, D.M. Shrestha, September 2006).

There are some major concerns in the provision of drug dependency treatment. It is reported that some treatment centres practice mandatory HIV and hepatitis testing of clients. No pre-test counselling is provided and some institutions refuse to admit clients who are infected with HIV or hepatitis. Access to drug treatment is also a concern. It has been estimated that as few as 8-13% of drug users in Kathmandu Valley are being reached by treatment services. Furthermore, the costs associated with drug treatment are prohibitive for the majority of users. This is particularly the case for women users, who typically have less access to money and less family support than male users (Burrows, Panda, & Crofts, 2001; FHI, 1999; POLICY Project, 2005).

6.1.2.5 Voluntary counselling and testing

The National HIV/AIDS Strategy has as an objective the establishment of an accessible and confidential VCT system. As part of this effort, The National Centre for AIDS and STD Control recently released comprehensive guidelines for VCT (NCASC, 2003a). These guidelines emphasise the importance of voluntary and informed consent and pre- and post-test counselling.

VCT services in Nepal have had mixed success. The Association of Medical Doctors of Asia - Nepal (AMDA Nepal) instituted a VCT program in 2003 in which the overwhelming majority of those tested returned for their results and received post-test counselling. Over two years, 1,513 clients received pre-test counselling, of whom 1458 (96%) underwent serological testing and 1,433 (94% of the total, or 98% of those tested) received post-test counselling (Pokharel, Bhagat, & Dhakal, 2005). However, a program targeting injecting drug users in Kathmandu Valley was less successful, with only 7% of 303 males and 11% of 57 females tested returning for their results and counselling (Dhungel, 2004).

6.1.2.6 Prevention of mother-to-child transmission

As prevalence of HIV increases, programs for the prevention of mother-to-child transmission (PMTCT) become increasingly important. The National Centre for AIDS and STD Control recently initiated a program for PMTCT in three sites, with plans to expand to six sites (NCASC, 2005b). Components of the program include VCT, antiretroviral prophylaxis, infant feeding counselling and support, guidelines for safe obstetric care and referral for care of HIV infected mothers and infants (L. Shrestha, 2005).

6.1.2.7 Antiretroviral treatment

Antiretroviral treatment (ART) for HIV was first provided in Nepal in 2003. In 2005, there were 160 people receiving ART (NCASC, 2005b). With funding from the National Government, GFATM and others, a target of 1,000 patients receiving ART has been set for 2006 (NCASC, 2003b, , 2005b). Estimates of ART coverage range from 1-11% (UNAIDS, 2006a).

A recent study at a major tertiary care hospital raised concerns about the quality of treatment and care provided to HIV patients. It reported that 13 patients were discharged without further care as soon as a diagnosis of HIV had been made; that four patients were prescribed ART, but all received inappropriate dosages or combinations; and that six of seven patients with opportunistic infections were prescribed incorrect dosages of medication (N. K. Shrestha, Bhatta, & Bhatta, 2006).

6.2 Prison situation

Prisoners are identified in the National HIV/AIDS Strategy as a 'vulnerable group' requiring targeted intervention. The Strategy acknowledges that once HIV is introduced into prisons, it can spread rapidly through sex and injecting drug use (NCASC, 2002). The objectives of the Strategy in relation to prisons are twofold: "to increase awareness and understanding among decision makers as regards HIV/AIDS/STI in prison" and "to ensure that every prisoner is aware of the risks of HIV/AIDS/STI and has the power and means to act on that knowledge" (NCASC, 2005a). The draft National HIV/AIDS Programme budgets approximately US$400,000 for prison-based HIV prevention, treatment and care activities (Steinberg, Gilligan, Rijal, & Pokharel, 2003).

6.2.1 Prison management

6.2.1.1 Administration

Nepal has 73 prisons with an official capacity of 5000 (International Centre for Prison Studies, 2006c). These institutions are administered by the Department of Prison Management within the Home Ministry of the national government. The prisons employ approximately 2,000 security staff (Steinberg, Gilligan, Rijal, & Pokharel, 2003).

A four-year, DFID-funded project to improve and reform prison management began in 2004; however, funding support was suspended in March 2005 as a result of concerns raised by the King's dismissal of the national government (DFID, 2005).

6.2.1.2 Inmates

In 2005, the prison population was estimated to have been 7,135, with women comprising eight percent of prisoners (International Centre for Prison Studies, 2006c). Over half of all inmates are unconvicted and awaiting trial. The structure of Nepal's penal system is such that the only options for sentencing convicted offenders are fines (for minor offences) or imprisonment. Many offenders cannot afford to pay their fines and are also imprisoned (Ministry of Home Affairs Department of Prison Management, 2003). The death penalty was abolished in 1997 (Amnesty International, no date).

Male and female prisoners are housed separately. There is no segregation of inmates by offence status or age. Mentally ill offenders and juveniles are housed with the general adult population (Ministry of Home Affairs Department of Prison Management, 2003).

6.2.1.3 Women in prison

Prior to 2002, abortion under any circumstances was characterised as infanticide and punishable by 20 years in prison. A significant proportion of women in prison were incarcerated for procuring an abortion. Often, women who miscarried pregnancies were also suspected of having abortions and imprisoned. In 2002, abortion was decriminalised; however, women remain imprisoned for abortion-related crimes (Centre for Reproductive Law and Policy/Forum for Women Law and Development, 2002).

6.2.1.4 General conditions

Overcrowding is a major concern, with the prison population at 140% of official capacity. The problem has been exacerbated by the Maoist conflict, with five prisons destroyed by rebels in 2001/2002 (Ministry of Home Affairs Department of Prison Management, 2003). In some prisons, overcrowding is so severe that toilet facilities are shared by men and women (Centre for Reproductive Law and Policy/Forum for Women Law and Development, 2002).

Accommodation, recreational and educational facilities in prisons are reported to be inadequate. Food is of poor quality and is insufficient to sustain good health (Ministry of Home Affairs Department of Prison Management, 2003). In a survey of 57 women prisoners, 72% reported that the food provided in prison was insufficient for their needs (Centre for Reproductive Law and Policy/Forum for Women Law and Development, 2002).

6.2.1.5 General medical care

The Department of Prison Management is responsible for providing medical care to inmates. General medical care as provided by the Department is limited (CVICT, 2001), and access is impeded by the requirement in many cases that prisoners fund their own treatment (Centre for Reproductive Law and Policy/Forum for Women Law and Development, 2002). A survey of 57 women prisoners found that only one third felt that medical care was "always available". Just over half felt that medical care was "usually available", while just over 10% said medical care was rarely or never available. It should be noted that although significant proportions of women felt that medical care was adequate, this must be seen in context. The women interviewed for this survey generally gave low priority to their health needs, evidenced by the finding that although three-quarters of the women surveyed said they were ill, one third of them had not requested medical attention (Centre for Reproductive Law and Policy/Forum for Women Law and Development, 2002).

Medical services provided by the Department of Prison Management are supplemented by those provided by NGOs who enter prisons to provide basic healthcare and mental health support. The Centre for Victims of Torture (CVICT) operates Mobile Health Clinics that travel to all prisons in Nepal, providing basic medical services, psychiatric care to mentally ill inmates and documenting the treatment of inmates and physical conditions of the prisons (CVICT, no date). In the course of their prison visits, CVICT have identified a number of severely mentally ill prisoners. These inmates are transferred to Dulikhel prison and are seen monthly by a psychiatrist who provides and monitors medication (B. Sharma & van Ommeren, 1998).

6.2.2 HIV testing of prisoners

The National Centre for AIDS and STD Control guidelines for VCT state that mandatory HIV testing is not permitted in Nepal (NCASC, 2003a). The only reference to HIV testing of prisoners located stated that prisoners are not routinely tested for HIV. Prisoners are not included as a 'priority group' for the provision of VCT services in the National HIV/AIDS Strategy (NCASC, 2002).

6.2.3 Segregation of HIV-positive prisoners

Limited information suggests that HIV positive prisoners are not segregated from the general prison population (Family Planning Association of Nepal, 2002).

6.2.4 HIV prevalence and risk behaviours in prison

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

As recently as 1999, the Ministry of Home Affairs denied that sex occurs in prisons, because 'men are separated from women in prisons' (FHI, 1999). However, more recent policy documents including the National HIV/AIDS Strategy and the National HIV/AIDS Action Plan and Budget acknowledge that prisoners engage in sexual activity and discuss the need for condom distribution in prisons (NCASC, 2002). The extent of sexual activity in prisons is unknown, however, one key expert has claimed that male-to-

male sex in prison is 'very common' (FHI, 1999). There has been a report of a female prisoner becoming pregnant and bearing a child after a sexual relationship with a male prisoner, suggesting that heterosexual activity is also occurring(Centre for Reproductive Law and Policy/Forum for Women Law and Development, 2002).

The Ministry accepts that drug use occurs in prison. A study of five prisons in Eastern Nepal carried out in-depth interviews with 95 inmates, of whom 27 (28%) were drug users. It is unclear if they had access to and were using drugs in prison. Of the drug users, 75% 'always' shared needles when injecting. Again, it is uncertain if this referred to behaviour in prison or in the community (Paul, Gupta, Sharma, & Deb, 2002). Prisoners caught using drugs are subjected to 'increased punishment', although it is unclear what form this may take (FHI, 1999).

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

Policy documents acknowledge the lack of awareness of HIV risk behaviours in prison. The National HIV/AIDS Action Plan for 2005-2006 lists "behavioural studies of prisoners" as an activity to be undertaken to remedy this situation (NCASC, 2005a).

6.2.5 Prevention interventions

As noted above, prisoners have been identified in the National HIV/AIDS strategy as a vulnerable population requiring targeted HIV prevention activities. Planned prevention activities include sensitisation workshops for both prison officers and prisoners and condom distribution to enable prisoners to reduce the risk of sexually-transmitted HIV (NCASC, 2005a). There are no NGO-initiated HIV prevention activities in prison (personal communicaton, P. Adhiakri, September 2006).

6.2.5.1 Information, education and communication

The National HIV/AIDS Strategy and National HIV/AIDS Action Plan both emphasise the role of information, education and communication (IEC) strategies in HIV prevention in prison. These documents state that staff are to receive training on HIV and STI, while peer educators are to be trained to provide information and education to inmates (NCASC, 2002, , 2005a). IEC materials on HIV and STI, hepatitis and condom use are to be developed and provided to inmates (Steinberg, Gilligan, Rijal, & Pokharel, 2003).

HIV education for both prison staff and inmates has been commenced on an ad-hoc basis. The UNODC Regional Office for South Asia recently conducted training in HIV prevention among incarcerated drug users with prison staff. The training aimed to sensitise prison officials to the issues of drugs and HIV in prisons settings (UNODC Regional Office for South Asia, 2006).

An education project carried out in one women's and two men's prisons in Kathmandu trained peer educators in HIV prevention and counselling. The peer educators helped to design and implement HIV education strategies suitable for prisons and distributed educational materials to other inmates (Upadhyay, 1998).

6.2.5.2 Drug dependency treatment

UNODC Regional Office for South Asia has reported that no drug dependency treatments are provided in prison (UNODC Regional Office for South Asia, 2005). No reports of treatment programs, be they therapeutic communities, psychosocial interventions or substitution maintenance treatment, were located to contradict this.

6.2.5.3 Harm reduction programs

There are no needle and syringe programs in Nepal's prisons. The Draft National HIV/AIDS Programme for Nepal makes reference to the distribution of bleach to prisoners (Steinberg, Gilligan, Rijal, & Pokharel, 2003); however, bleach distribution is not discussed in finalised policy documents such as the National HIV/AIDS Action Plan and Budget. No reports were located to confirm the commencement of bleach distribution in prisons.

Conflicting information regarding condom availability was identified. According to a 1998 report, condoms were made available in two male prisons in Kathmandu (Upadhyay, 1998). However, more recent policy documents state that there are no condom distribution mechanisms in prison (NCASC, 2002). Both the National HIV/AIDS Strategy and the National HIV/AIDS Action Plan include condom distribution as a program to be implemented (NCASC, 2002, , 2005a).

6.2.6 HIV treatment and care

6.2.6.1 Anti-retroviral treatment provision

No prisoners are on ART (personal communicaton, P. Adhiakri, September 2006). No policy documents specify the provision of ART to prisoners as an activity for implementation.

6.2.6.2 Assessment and treatment of co-infections

No information could be located on the assessment and treatment of co-infections. However, access to general healthcare is limited, reducing the likelihood that co-infections are identified and treated (Ministry of Home Affairs Department of Prison Management, 2003).

6.2.6.3 Other support and care services

No information was located on other support and care services available to HIV positive prisoners. No NGOs are involved in HIV treatment and care services for prisoners (personal communicaton, P. Adhiakri, September 2006).

6.2.6.4 Compassionate release for terminally ill prisoners

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

6.3 Discussion

There is recognition in government policy documents that prisons and prisoners require greater attention if Nepal is to effectively stem the HIV epidemic. However, the information reviewed reveals that action is lacking. Nepal is not unique in this regard; prisons are often neglected in HIV prevention efforts (UNODC/WHO/UNAIDS, 2006). This neglect threatens the success of community-wide HIV prevention efforts.

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

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

The current National HIV/AIDS Strategy is due for review in 2007. In addition to reiterating support for and scale-up of the activities outlined in the current Strategy, the revised Strategy could incorporate a wider range of prevention interventions, such as bleach distribution, sterile needle and syringe exchange and drug dependency treatment.

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

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

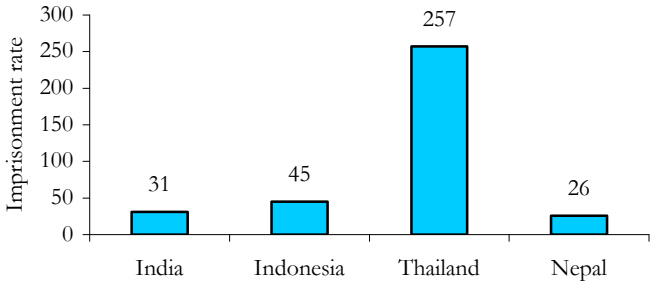
Finally, interventions and legal reforms aimed at reducing the size of the prison population should be encouraged. The provision of substitution maintenance treatment to prisoners reduces re-incarceration, leading to reductions in prisoner numbers (Dolan et al., 2005). The introduction of methadone maintenance treatment in prison, in conjunction with a linked community-based methadone treatment program, is warranted. In terms of law reform, the abandoned Department of Prison Management Project had begun to explore options for non-custodial sentences, such as community service orders, for minor offenders (Ministry of Home Affairs Department of Prison Management, 2003). Resumption of activities to encourage this and other reforms that encourage reductions in the prison population and alternatives to incarceration are strongly recommended.

7. REGIONAL SUMMARY

7.1 Rates of imprisonment and prison conditions

Imprisonment rates were generally low (less than 50 per 100,000), with the exception of Thailand (see table 7.1 and appendix 1).

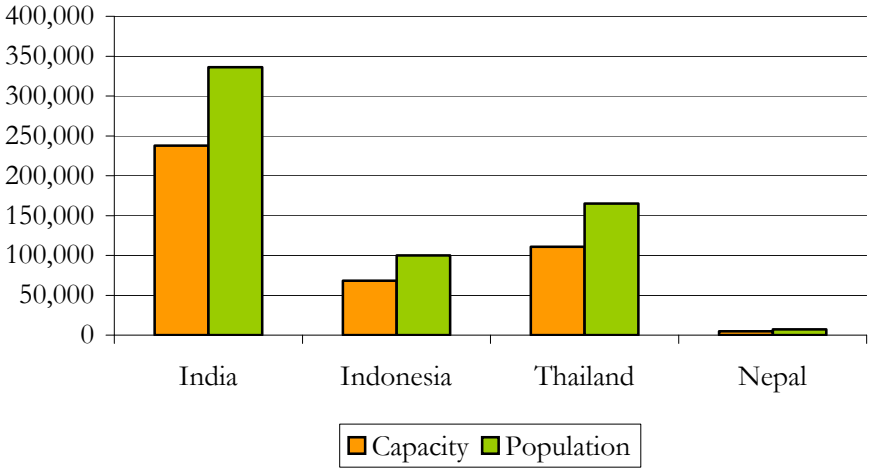
Table 7.1: Imprisonment rate per 100,000 of national population, by country



Source: International Centre for Prison Studies 2006a, 2006b, 2006c, 2006d.

Overcrowding was common to all countries surveyed, with occupancy levels of between 140%-150% reported (see table 7.2 and appendix 1). In Indonesia and Thailand, the prison population has increased rapidly in recent years as a result of increases in the incarceration of drug users.

Table 7.2: Overcrowding, by country



Source: International Centre for Prison Studies, 2006a, 2006b, 2006c, 2006d.

7.2 HIV testing of prisoners

No reports of current, compulsory HIV testing of prisoners in the countries surveyed were identified. In all countries surveyed, the availability of voluntary counselling and testing (VCT) in prison appears to be limited (see appendix 2). For example, the Indonesian government acknowledges that VCT services in prison are "not optimal" (Directorate General Correction, 2005).

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

7.3 Segregation of HIV-positive prisoners

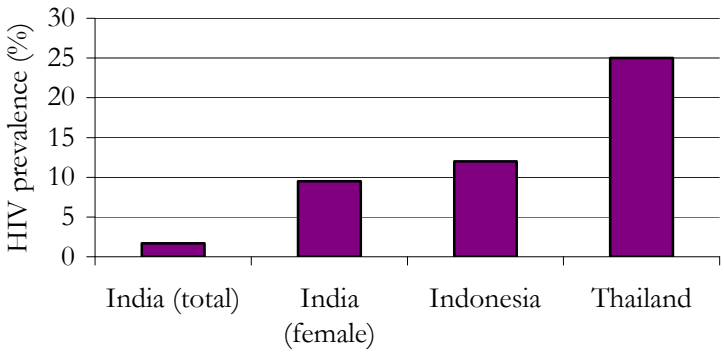
No country surveyed routinely practices segregation of HIV-positive prisoners. However, reports from India (Mansuri, 2006; Mudur, 1995) and Thailand (Reuters, 1994) suggest individual prisons may practice segregation (see appendix 2).

7.4 HIV prevalence and risk behaviours in prison

7.4.1 HIV prevalence

Data regarding HIV prevalence in prison were available for India, Indonesia and Thailand, but not Nepal (see appendix 3). Indian data from 2000 show national prevalence to be 1.7%; among women, this rises to 9.5% (Nagaraj et al., 2000). In Indonesia, national prevalence was estimated in 2002 to be 12% (range 8.6%-15.4%) (Ministry of Health Indonesia, 2003). Surveillance data shows wide variation between provinces, with prevalence levels in 2003 ranging from 0.36% in East Kalimantan to over 21% in Banten and West Java (Directorate General Correction, 2005). No national data exist for Thailand, but in 2003 a quarter of 689 inmates surveyed in Klong Prem Prison, Bangkok, were HIV-infected (see table 7.3) (Thaisri, 2003).

Table 7.3: HIV prevalence in prison



Data suggestive of HIV transmission in prison were identified for Thailand (Weniger, 1991) and Indonesia (Directorate General Correction, 2005).

7.4.2 Injecting drug use

Drug use occurs in prisons in all four countries surveyed, although no prevalence data is available for Nepal (see appendix 4). More than a third of Thai prisoners with a history of injecting drug use inject in prison, while half of IDUs in holding cells inject (Buavirat et al., 2003; Thaisri, 2003). A study in India found that 0.8% of prisoners injected drugs in prison (UNODC and Ministry of Social Justice and Empowerment India, 2002). In Indonesia, up to a third of IDUs who have been in prison injected during incarceration (Devaney, Reid, & Baldwin, 2006). Studies in Thailand (Choopanya, 1991), India (S. Panda et al., 2005) and Nepal (FHI, 1999) suggest that being incarcerated is a risk for HIV infection for IDUs in the general community.

7.4.3 Unprotected sexual activity

Male-to-male sexual activity occurs in prisons in all countries surveyed, but only Thailand has prevalence data. Of prisoners with a history of male-to-male sexual activity, 80% had sex with a man in prison (Thaisri, 2003).

7.4.4 Tattooing and other body modification practices

Reports of prisoners being tattooed in prison were identified in India, Indonesia and Thailand. A Thai study found that HIV-infected IDUs were significantly more likely to have been tattooed during incarceration than non-infected IDUs (Buavirat et al., 2003).

Other body modification practices identified in prisons include self-circumcision in Indonesia (Sadipun, 2002) and penile modification (inserting beads into the head of the penis) in Indonesia (Dolan, 2005b) and Thailand (Beyrer et al., 2003). The HIV risks associated with these practices are unknown.

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

7.5 Prevention interventions

7.5.1 HIV information, education and communication

HIV information, education and communication (IEC) programs were the most commonly implemented HIV prevention measure in prisons in all of the countries surveyed. Indonesia (Directorate General Correction, 2005) and Thailand (UNDP, 2004) provide comprehensive IEC to prisoners. In India (Mohammed, 2002) and Nepal (Upadhyay, 1998), there have been some ad hoc interventions in individual prisons.

The focus of IEC programs is generally HIV transmission and prevention. IEC in Indonesia also includes harm reduction information (Directorate General Correction, 2005).

7.5.2 Drug dependency treatment

Of all countries surveyed, Indonesia provides the most comprehensive drug dependency treatment interventions. Non-pharmacological treatment options provided include one-on-one counselling, group therapy and therapeutic communities. Methadone maintenance treatment (MMT) is available in Kerobokan prison in Bali. The Directorate General Correction plans to implement MMT in other prisons throughout Indonesia (Irawati, Mesquita, Winarso, Hartawan, & Asih, 2006).

None of the other countries surveyed provide any form of substitution maintenance therapy in prison. Both India (UNODC and Ministry of Social Justice and Empowerment India, 2002) and Thailand (Ringrowd, 2005) operate therapeutic community programs. Nepal does not offer any drug dependency treatment in prison.

7.5.3 Harm reduction programs

7.5.3.1 Bleach distribution

Bleach distribution programs exist in Kerobokan prison in Indonesia and there are plans to extend these programs to other prisons (Directorate General Correction, 2005). Prisons in India, Nepal and Thailand do not provide bleach.

7.5.3.2 Needle and syringe programs

No prisons in India, Indonesia, Thailand or Nepal provide needle and syringe programs.

7.5.3.3 Condom distribution programs

There is a condom distribution program in Kerobokan prison in Indonesia with plans to extend this to other prisons in the country (Directorate General Correction, 2005). In Thailand it is reported that medical staff distribute condoms (UNDP, 2004). Condoms have been distributed through ad hoc programs in prisons in India (Lingamallu, 2002) and Nepal, however, ongoing distribution is uncertain.

7.6 HIV treatment and care

7.6.1 Antiretroviral treatment provision

Some prisoners are receiving ART in prisons in India but exact numbers are uncertain (Mansuri, 2006). In Indonesia ART is not widely available but the government is committed to improving access to this medication (Directorate General Correction, 2005). ART is not provided in prisons in Thailand or Nepal.

7.6.2 Assessment and treatment of co-infections

In all countries surveyed, access to general medical care in prisons is poor. Treatment for STI is provided in some prisons in India (UNDP, 2004). In Thailand the TB DOTS strategy has been implemented in prisons in Bangkok and surrounding provinces (Nateniuyom, 2004). No information on the assessment and treatment of co-infections was found for prisons in Nepal or Indonesia, however the Indonesian government has identified improving access to treatment for STI and TB as a priority (Directorate General Correction, 2005).

7.6.3 Other support and care services

Ad hoc support and care services are available in prisons in India, Thailand and Indonesia. In India, counselling is provided in some prisons for inmates with STI (UNDP, 2004). A local community group for people with HIV/AIDS has assisted inmates in setting up a peer support group in Klong Prem Prison in Bangkok, Thailand (Payapvipapong, 2000). In Indonesia support groups are offered in some prisons and there are plans to improve support and care services (I. Winarso, personal communication, June 2006). No HIV support and care services were identified in Nepal.

7.4.4 Compassionate release for terminally ill prisoners

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

8. RECOMMENDATIONS

This report reviewed HIV prevention, treatment and care in prisons in India, Indonesia, Thailand and Nepal. The review revealed that few HIV prevention, treatment and care interventions have been implemented in prisons in these countries. However, it has also highlighted some innovative programs that can serve as models for the region. Indonesia in particular has made excellent progress in improving the provision of HIV prevention, treatment and care in prison.

The following recommendations may assist in providing guidance to prison authorities aiming to improve their HIV prevention, treatment and care services. These recommendations apply to all prisons, not just those in the correctional systems discussed in this report.

8.1 Seek donor funding specifically for prison-based programs

Improving HIV prevention, treatment and care in prison may require significant financial resources. In resource-poor settings, prison authorities should seek funding from international donors specifically for prison-based programs. Prison authorities may wish to identify partners such as local or international NGOs that can assist in project implementation and evaluation.

8.2 Create an enabling environment

8.2.1 Working within the "Three Ones" principles, develop specialised responses to HIV in prison

UNAIDS promotes the "Three Ones" principles to ensure the effective and efficient use of resources. The "Three Ones" are:

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One National AIDS Co-ordinating Authority, with a broad-based multisectoral mandate.
- One agreed country-level Monitoring and Evaluation System.

Most countries have used these principles to develop their response to HIV/AIDS. However, prisons have often been neglected in this response. Prison authorities must ensure that specialised responses to HIV in prison are included in existing "Three Ones" frameworks.

8.2.2 Develop national strategies for prison healthcare

Attention can be drawn to the needs of prisons by developing national strategies for prison health and/or HIV prevention, treatment and care. The strategy should be consistent with and refer to the national HIV/AIDS action framework. The *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention*, produced by the Indonesian Direction General of Corrections, is an excellent example of a national prison HIV strategy (Directorate General Correction, 2005).

8.2.3 Form prison working groups

Focused working groups that report to the national HIV/AIDS co-ordinating authority can help to guide the implementation of activities outlined in national strategies. Working groups should comprise representatives from prisons, healthcare and NGOs. In Indonesia, Prison Working Groups have been established at the national and provincial levels. This has improved co-ordination of HIV prevention activities between prisons (Prabawanti & Puteranto, 2005).

8.2.4 Conduct HIV sensitisation workshops with key stakeholders

Understanding of HIV is imperative for creating an environment supportive of HIV prevention, treatment and care in prison. Key stakeholders, including prison security and health staff, government officials and policy-makers, must be informed about the issues of HIV prevention, treatment and care in prison. HIV education and training workshops, such as those conducted in Nepal by UNODC Regional Office for South Asia, should be conducted with all key stakeholders (UNODC Regional Office for South Asia, 2006).

8.3 Introduce routine data collection processes

This report and others (Dolan, Kite, Black, Aceijas, & Stimson, 2007) have identified the lack of data on HIV in prisons as a concern, particularly in Asia and the Pacific (Warren et al., 2006). In order to better understand HIV in prison, authorities should collect data regarding HIV and STI prevalence among prisoners. Data collection should be carried out in both metropolitan and rural areas and should be conducted annually. This can be achieved by testing a random sample of inmates for HIV and common STI. In doing so, certain ethical principles must be observed. Prisoners must give voluntary and informed consent prior to the collection of their blood sample and they must be given the option of declining to participate.

The replication of this review on a regular basis is also recommended as a cost-effective strategy for producing a regional overview of the current situation of HIV prevention, treatment and care in prison. The four countries included herein should also be included in future reviews and the addition of other countries in the South-East Asia region should be considered.

8.4 Improve general prison conditions

Prison conditions should be improved to meet the standards of the *Minimum Standard Rules for the Treatment of Prisoners* (UNHCHR, 1955). This may mean improving the quality or quantity of food and water provided; improving the standard of accommodation or providing increased access to general medical care.

8.5 Introduce prevention strategies

As in the community, prevention should be the mainstay of the response to the HIV epidemic. A variety of programs that have been successful in community-based prevention strategies can also be implemented in prisons. Prevention programs introduced in prisons should also be implemented in holding cells and other short-term detention facilities, as research from Thailand suggests these are high-risk environments for HIV transmission (Buavirat et al., 2003).

8.5.4 Condom distribution programs

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

8.5.5 Needle and syringe programs

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

8.5.6 Methadone maintenance treatment

Methadone maintenance treatment (MMT) is the only drug dependency treatment that has been shown to reduce HIV transmission among injecting drug users (Metzger et al., 1993). In countries where MMT is available in the community, it should also be made available in prisons. Pilot programs underway in Indonesia are an excellent example of MMT in prison (Irawati, Mesquita, Winarso, Hartawan, & Asih, 2006).

8.5.5 Voluntary counselling and testing

Voluntary counselling and testing (VCT) for HIV should be available to prisoners. VCT may be provided by prison medical services or NGOs. In all cases, voluntary and informed consent must be obtained to conduct an HIV test, and prisoner confidentiality must be maintained.

8.5.6 Treatment of co-infections and STI

Untreated STI increase vulnerability to HIV infection. All inmates should be offered treatment for STI. Screening and treatment for tuberculosis, using WHO DOTS protocols, should also be provided in prisons.

8.5.7 Interventions for vulnerable populations

Women in prison have special needs in relation to HIV prevention, treatment and care. Female prison populations often have high levels of STI, increasing vulnerability to HIV infection. STI screening and treatment should be made available. Women prisoners are vulnerable to sexual assault by male guards, or in mixed sex institutions, male prisoners. Wherever possible, female guards should be employed to work in women's prisons. In mixed-sex institutions, men and women should be segregated. Finally, HIV-infected prisoners who are pregnant should be offered ART and other assistance to prevent mother-to-child HIV transmission.

Juveniles are another prison population requiring specialised HIV prevention, treatment and care services. Juvenile prisoners should be segregated from adult prison populations

to reduce the risk of sexual assault, and age-appropriate HIV information, education and communication should be provided.

8.6 Provide antiretroviral treatment

8.6.1 Increase capacity of prison medical staff to provide antiretroviral treatment

Antiretroviral treatment (ART) regimes can be complex. Prison doctors and nurses should receive training in determining patient eligibility for treatment and ART prescribing.

8.6.2 Ensure continuity of antiretroviral treatment

Adherence to antiretroviral treatment protocols is crucial for effective HIV suppression. Treatment adherence is also important in preventing the emergence of drug-resistant strains of HIV. As access to treatment in the community improves, increasing numbers of individuals receiving ART will enter prison. Prison healthcare services should ensure treatment continuity (Pontali, 2005).

8.6.3 Increase access to antiretroviral treatment

In addition to ensuring continuity of treatment, prison healthcare services should expand access to ART so that prisoners can commence treatment. Eligibility for ART in prison should be determined using the same clinical criteria applied in the community (Pontali, 2005).

8.7 Transfer responsibility for prison health to public health authorities

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

A more appropriate way to provide healthcare to prisoners is through public health authorities such as the local Ministry or Department of Health. Several countries, including Norway, France, Italy and some jurisdictions in Australia, have recognised this and have transferred responsibility for prison healthcare to health ministries. That is, prison health is the responsibility of those whose expertise lies in healthcare rather than security. This ensures a consistent approach to healthcare for all citizens, including those in prison, and often leads to improvements in the quality of care available to prisoners (UNAIDS, 1997).

8.8 Introduce programs to reduce prison populations

Overcrowding of prisons leads to difficulties in prison management and increases the transmission of infectious diseases such as TB and HIV. Reducing prison populations removes people from a high-HIV risk environment and contributes to healthier, safer prisons.

8.8.1 Methadone maintenance treatment in the community

In addition to reducing HIV transmission among injecting drug users, methadone maintenance treatment (MMT) reduces criminal activity among heroin users (Lind, Chen, Weatherburn, & Mattick, 2005). Providing MMT in the community is a crime-control measure that can lead to reductions in the prison population.

8.8.2 Alternatives to imprisonment

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

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

- *Warnings*: Police issue an official warning or admonition to the offender
- *Supervision and support*: The offender can maintain their daily routine, but must report to a nominated authority such as police or a probation officer
- *Restrictions of liberty in the community*: For example, house arrest or electronic monitoring
- *Community integration*: The offender is required to perform community service work
- *Treatment orders*: The offender is required to attend treatment, for example, drug dependency treatment
- *Mediation*: The offender is required to meet with the victim of their crime and complete formal mediation proceedings (Lappi-Seppala, 2003)

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

Many prison systems house large numbers of individuals who have been charged with an offence but are not yet convicted. For example, in India almost three-quarters of the prison population are pre-trial detainees (International Centre for Prison Studies, 2006a). Reducing the number of pre-trial detainees imprisoned would have a significant impact on prison overcrowding. Alternatives to imprisonment for this group, such as community supervision, are recommended.

8.9 Disseminate best practices

Much of the scientific evidence for HIV prevention, treatment and care programs in prison has been generated in countries outside the Asian region. Countries that implement HIV programs in prison should disseminate the results of their work through conference presentations and journal articles, in order to build an evidence base for HIV prevention, treatment and care in prisons in Asia.

8.10 Conclusion

Asia is second only to Africa in terms of absolute numbers of HIV infections. Asia has also been home to some stunning successes in HIV prevention in the developing world. However, the role of prisons in the HIV epidemic has largely been ignored. Prisoners are often seen as less deserving of healthcare or other assistance, particularly when resources are scarce. Yet it must be remembered that prisoners are only temporarily removed from the general community. At some stage, most prisoners will be released and resume living among the general population. When prisoners are released, so too are their illnesses. The HIV epidemic in Thailand in the late 1980s and 1990s is thought to have begun with the mass release of a number of HIV-infected prisoners. The released prisoners, who were likely unaware of their HIV status, returned to their communities, transmitting HIV to their sexual and drug injecting partners. Each time an HIV-infected prisoner leaves prison and resumes their life, a small-scale version of this scenario is played out. HIV prevention, treatment and care in prison are crucial if countries are to effectively control the HIV epidemic.

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APPENDIX 1: IMPRISONMENT RATES AND PRISON OCCUPANCY LEVELS

	Prison population	Imprisonment rate per 100,000 of population	Capacity of prison system	Occupancy level (%)
India	336,152	31	237,617	141
Indonesia	99,946	45	68,141	147
Thailand	164,975	257	110,900	149
Nepal	7,135	26	5,000	143

APPENDIX 2: COMPULSORY TESTING OF PRISONERS AND SEGREGATION OF HIV POSITIVE PRISONERS, BY COUNTRY

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

APPENDIX 3: HIV PREVALENCE IN PRISON, BY COUNTRY

	City/region/prison	Year	Sample size	HIV prevalence
India	Nationally	2000	Data inaccessible	1.7% of inmates; 9.5% of female inmates
	West Bengal	2006	384	2.3%
	Amritsar Central Jail	2005	500	2.4%
	Ghaziahad	1999	249	1.3% of inmates aged 15 to 50 years
	Orissa, three prisons	1999	377	6.9%
	Madurai	1996	Data inaccessible	4.3%; 2% of male inmates; 14.2% of female inmates
	Central Prison, Bangalore	1995	1114	1.8% of male inmates
	Madras	1995	Data inaccessible	3.5%
	Thirunelveli	1995	Data inaccessible	0.5%
Indonesia	Nationally	2002	Population estimate	12% (range 8.6%-15.4%)
	DKI Jakarta	2003	Data inaccessible	17.65%
	West Java	2003	Data inaccessible	21.1%
	East Java	2003	Data inaccessible	4.23%
	Bali	2003	Data inaccessible	10.7%
	Lampung	2003	Data inaccessible	2.8%
	Banten	2003	Data inaccessible	21.3%
	East Kalimantan	2003	Data inaccessible	0.36%
Thailand	Klong Prem Prison (Bangkok)	2003	689	25.4% (but unclear if sample selected according to previous risk factors).
	Klong Prem Prison Hospital	1995	350	20-30% of patients in the hospital
	Klong Prem Prison	1994	5000	6% (300 cases)
	Bitichitawej Hospital for mentally ill offenders	1994	325	1.9%
	Prisons of ten provinces	1991	Data inaccessible	12% among men newly admitted; 19% among men about to be discharged
Nepal	No data available; a rapid assessment in 1999 reported that drug injectors with a history of imprisonment were 4.6 times more likely to be HIV positive injectors who had never been imprisoned			

APPENDIX 4: PREVALENCE OF HIV RISK BEHAVIOURS IN PRISON, BY COUNTRY

	India	Indonesia	Thailand	Nepal
Drug use, including injecting drug use	There is evidence of drug use in prison; no prevalence data available	Government acknowledgement of drug use in prison. Rapid assessment found evidence of drug use and injecting. 31% of IDUs in Surabaya with a history of imprisonment had injected in prison. 18% of IDUs in Bandung with a history of imprisonment had injected in prison.	15.8% to 38% of IDUs inject in prison; 44% of IDUs inject in holding cells	Government acknowledgement of drug use in prison; no prevalence data available
Sexual activity	There is evidence of sexual activity in prison; no prevalence data available	Government acknowledgement of sex in prison; limited prevalence data suggest sex is common.	Of 689 male inmates one quarter reported ever having sex with men; of them, more than 80% reported sex with men during incarceration.	Government acknowledgement of sex in prison; no prevalence data available
Tattooing	No data available	Tattooing reportedly common. No prevalence data available.	Tattooing and sharing razor blades reportedly common. No prevalence data available.	No data available
Other body modification	No data available	45% of prisoners surveyed in West Timor had practiced "self-circumcision" in prison. Penile modification is reportedly common; no prevalence data are available.	Penile modification is reportedly common; no prevalence data are available	No data available

APPENDIX 5: HIV PREVENTION IN PRISON, BY COUNTRY

	India	Indonesia	Thailand	Nepal
HIV information, education and communication programs	Ad hoc IEC programs for prisoners.	IEC common. Professional and peer educators. Group and one-on-one programs available	IEC materials provided on admission and prior to release. Medical staff offer HIV education for prison guards. NGOs (e.g. Raks Thai Foundation) involved in training prison guards and inmates to be peer educators.	Ad hoc IEC programs for staff and prisoners
Drug dependency treatment	Therapeutic community program in Tihar prisons. No substitution maintenance treatment	Therapeutic community programs, counselling, self-help groups. Methadone maintenance treatment in Kerobokan prison; plans to extend MMT to other prisons.	Therapeutic community programs. No substitution maintenance treatment	No drug dependency treatment in prison
Bleach distribution programs	No data available.	Bleach distribution program in Kerobokan prison; plans to extend to other prisons	No bleach distribution programs in prison	Situation uncertain; bleach distribution is discussed in policy documents
Needle and syringe programs	No needle and syringe programs in prison.	No needle and syringe programs in prison	No needle and syringe programs in prison	No needle and syringe programs in prison
Condom distribution programs	No ongoing condom distribution programs. Condoms have been distributed in at least one prison in Andhra Pradesh.	Condom distribution program in Kerobokan prison; plans to extend to other prisons	Reports that medical staff distribute condoms. 100,000 condoms distributed in prisons in 2004	Situation uncertain; condoms have previously been made available through ad hoc programs. Condom distribution is discussed in policy documents

APPENDIX 6: HIV TREATMENT AND CARE IN PRISON, BY COUNTRY

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

APPENDIX 7: ORGANISATIONS/PROJECTS PROVIDING HIV PREVENTION, TREATMENT AND CARE IN PRISONS

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

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

APPENDIX 8: KEY DOCUMENTS

8.1 Policy documents

Standard Minimum Rules for the Treatment of Prisoners. Office of the United Nations High Commissioner for Human Rights. Available from http://www.unhchr.ch/html/menu3/b/h_comp34.htm

WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva, World Health Organization, 1993. Available from http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf.

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8.2 Evidence for HIV prevention, treatment and care programs in prison

8.2.1 Overview

Effectiveness of Interventions to Manage HIV/AIDS in Prison Settings (Evidence for Action Technical Papers). Geneva, World Health Organization, in press.

8.2.2 Condom distribution programs

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8.2.3 Needle and syringe programs

Lines R., *et al. Prison Needle Exchange: Lessons From a Comprehensive Review of International Evidence and Experience (2nd Edition)*. Montreal, Canadian HIV/AIDS Legal Network, 2006.

8.2.4 Methadone maintenance treatment

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

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

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8.2.5 Antiretroviral treatment

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