

HIV AND TB SERVICES AND SURVEILLANCE IN CORRECTIONAL FACILITIES IN EASTERN AND SOUTHERN AFRICA:

ASSESSMENT OF POLICIES, PRACTICES, AND PERFORMANCE

Consolidated report for Malawi, Lesotho, Namibia, Swaziland, and Zambia

SUMMARY REPORT



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1 EXECUTIVE SUMMARY

Correctional facilities are high-risk settings for the transmission of human immunodeficiency virus (HIV) and tuberculosis (TB). To achieve HIV and TB epidemic control, ambitious international targets calls for countries to scale-up HIV and TB prevention, testing and treatment for vulnerable groups such as detainees. While incarceration necessarily restricts liberty, detainees have a right to a minimum standard of health care at least equivalent to that in the community including effective services along the entire continuum of HIV and TB prevention, treatment and care.

EHPSA commissioned Aurum Research Institute to assess the policies and practices related to HIV and TB data collection and surveillance in correctional facilities of Malawi, Namibia, Lesotho, Swaziland, and Zambia. It aimed to provide a broad review of two topics: HIV and TB prevention, sexual health services and treatment in correctional facilities; and the collection of routine data collection and surveillance in correctional settings in the region.

This critical review employed a combination of literature and policy review, direct system observations, data analyses and key informant interviews. It took place between November 2017 and April 2018.

Key findings included:

- **HIV prevention:** In most countries, measures for HIV prevention were lacking. In all the countries visited, except Lesotho, condom provision to inmates was prohibited, due to the criminalisation of men having sex with men. There were some instances where condoms were being provided at health facilities for use at exit, and not regulated.
- **HIV treatment services:** These were generally good, with particular attention to adherence to antiretroviral therapy (ART) and retention in care, post-release. Provision of same-day ART was evident, particularly in Swaziland and Malawi. Appropriate referral and follow-up of patients, post-release, was particularly good in Namibia and Swaziland. An interesting practice of allowing inmates to continue follow-up at the correctional facility, once released, was identified in Lusaka Central, Zambia.
- **TB services:** Screening services were generally available and well-implemented, while TB infection control measures varied. Facility infrastructure, particularly in patient cells, constituted the greatest challenge to TB infection control.
- **M&E systems:** Many problems were identified in terms of the links between the Ministry of Health and Correctional systems in all the countries. Monitoring and evaluation (M&E) was generally controlled by a department that monitored all correctional activities including transfer of inmates, rehabilitation etc. As the health directorates within Correctional Services did not have specific M&E personnel, the responsibility for health-related M&E systems was unclear. There was duplication of M&E systems between health departments and correctional facilities. In addition, there was a lack of standardised tools for reporting indicators specific to prison populations, very little analysis and trend reporting, and no mechanisms for feedback to facility clinics. On reviewing indicators from all countries, the researchers were able to determine coverage of HIV or TB services at specific time points with no cohort analyses and no systems to avoid duplication of inmates on transfer or release from facilities.

The review concluded that there was a need for some urgent interventions including:

- The introduction of a strong focus on HIV prevention, with specific emphasis on transmission of HIV and high-risk practices such as coercive and forced sex, sharing of needles and razors, tattoos etc. Additionally, a programme to sensitise officials and inmates about sexual violence and encourage reporting of events, as well as provision of condoms and lubricants need to be introduced. This is particularly important in these countries due to the criminalisation of same-sex acts and the cultural challenges that prohibit these activities. Experience and evidence from countries that provide condoms, such as Lesotho and South Africa, would be important to encourage use of condoms in other countries.

- Urgent capacity building on M&E systems for correctional health, along with the introduction of a framework for health M&E in correctional facilities which is aligned to the Ministry of Health tools. This framework needs to take account of indicators and tools already in place and ensure that data specific to correctional facilities is included in the Ministry of Health tools to allow for easier documentation.
- Advocacy for, and improvement of living conditions for inmates, which are currently not conducive to HIV and TB prevention or good health. Reforms of the judicial system to reduce incarceration of juveniles and awaiting trial detainees, will also improve the implementation and outcomes of inmate health programmes throughout the region.

2. INTRODUCTION

2.1 Background

Correctional facilities are high-risk settings for the transmission of HIV and TB. Features of a facility's physical and social environment, often coupled with socio-economic deprivation, can result in conditions that favour the spread of both diseases, especially in low- and middle-income countries. Incarceration and release can interrupt diagnostic and treatment processes and facilitate transmission of infection, a cyclical process among repeat offenders.

The literature estimates HIV and TB prevalence among detainees in the ESA region to be around 15.6% and 5.3% respectively, suggesting a higher prevalence among prison populations than in non-incarcerated populations. It is thus critical for inmates, as well as the external community, that high-quality HIV and TB control programs are established and maintained within the correctional system.

To achieve HIV and TB epidemic control, ambitious international targets for HIV and TB calls for countries to scale-up HIV and TB prevention, testing and treatment for vulnerable groups such as detainees. While incarceration necessarily restricts liberty, detainees have a right to a minimum standard of health care at least equivalent to that in the community, including effective services along the entire continuum of HIV and TB prevention, treatment and care.

A review of the literature on HIV and TB in sub-Saharan African prisons, published between 2011-2015, identified data from fewer than half the countries in the region and found that, where data were available, they were frequently of poor quality and rarely nationally representative. Barriers to prevention, treatment and care services in the literature included severe financial and human resource limitations and fragmented referral systems that prevent continuity of care when detainees cycle into and out of correctional facilities and move between facilities. These challenges are set against the backdrop of weak criminal justice systems, high rates of pre-trial detention and overcrowding.

2.2 About this review

To increase our understanding of these issues, EHPSA commissioned Aurum Research Institute to assess the policies and practices related to HIV and TB services and data collection in the correctional facilities of Malawi, Namibia, Lesotho, Swaziland, and Zambia.

This critical review employed a combination of literature and policy review, direct system observations, data analyses and key informant interviews to address the following questions about TB and HIV services in correctional facilities in the eastern and southern Africa (ESA) region:

- TB and HIV prevention: what services are available, what is the gap between national policies and provision of services and what are the good practice examples of facility-based services?
- Routine HIV and TB data collection and management: what routine data are currently collected, is there a comprehensive data management strategy?

The literature review provided additional evidence on:

- Sexual encounters between male inmates;
- High burden of TB in correctional facilities; and
- Challenges of implementing antiretroviral treatment programmes in these environments.

This summary report is based on the final Aurum Institute report which should be consulted for references and additional detail. It is available at: <http://www.ehpsa.org/critical-reviews/prison-services>.

2.3 Methodology

This study employed a mixed-methods, multi-country case study design and comprised a literature and policy review, direct health system observations and evaluation, key informant interviews, and analysis of HIV and TB data, where such data was available. Terminology differs from country to country and therefore this report uses the following as standard: “correctional services”, “facilities”, “inmates” and “officers”. The term “inmates” represents both people awaiting trial (on-remand detainees) and those who have been sentenced.

Countries were selected for inclusion and invited to participate following introductory meetings with the Correctional Services Ministry (or equivalent body) personnel and other applicable stakeholders in each prospective participant country.

The review took place between November 2017 and April 2018. In total, the researchers visited 24 correctional facilities in the five countries, and conducted 99 interviews, made up of 21 with people in management positions (at site level or headquarters), 33 clinical staff (made up of clinical officers, doctors and nurses), 21 ancillary workers (counsellors, patient attendants or lab technologists) and 25 peer educators. The facilities visited and the HIV and TB profiles of the inmates are summarised in 3.2 below.

Limitations of the study included:

- Selection of facilities was done by the relevant Correctional Services;
- A limited number of sites were accessed and it is not clear that these represented the national picture in each country;
- The brevity of the study visits (three to four days) meant that it was only possible to visit three facilities in close proximity to one another, and the number of interviews at each site was limited; and
- Peer educators were the only inmates interviewed.

The findings, while representing a somewhat superficial assessment of clinical services and M&E systems in a small sample of institutions, do nonetheless offer a glimpse into a subject area that is little known, and is a basis for identifying the main challenges and, issues encountered and determining the needs going forward.

2.4 Correctional service profile in study countries

Of the five study countries, Zambia has the largest inmate population with 18,000 detainees and 87 facilities. In comparison, Namibia, Swaziland and Lesotho have much smaller populations of around 3,000 inmates and 12-13 facilities each. Incarceration rates varied with a relatively low 70 per 100 000 in Malawi to a relatively high 282 per 100,000 in Swaziland, which is similar to that reported for South Africa (293 per 100 000). All of these systems have relatively high numbers of pre-trial detainees, estimated at approximately 20% of all incarcerated persons, except for Namibia (6.6%) and Lesotho where this has been significantly reduced to 1.57% in recent years. Female inmates make up a small proportion of inmates in all countries (range 1% - 3.6%). Juveniles also make up a small proportion, with the highest in Swaziland (6.0%) and Malawi (7.7%). Zambia and Malawi seem to have the highest occupancy, with figures of over 150%, while rates for Lesotho, Namibia and Swaziland are at acceptable levels, compared to reported capacity.

3. FINDINGS

3.1 Literature review

Key findings from the literature review included

- Sexual encounters among male inmates: Research from all countries except Lesotho confirm that homosexual encounters take place in correctional facilities. These may be consensual or coerced and may take place in exchange for food or other items.
- ART implementation: Several studies highlighted the challenges of implementing an antiretroviral therapy programme within correctional facilities. These included a generally unsupportive environment (such as lack of adequate food and punitive staff behaviour), substance abuse, mental health issues and weak health care systems.
- High TB burden: Research from Malawi and Zambia confirmed that prevalence of TB was considerably higher in correctional facilities than the general population. One study in Malawi showed that treatment outcomes were less favourable than the general population due to inmates being transferred out.

3.2 HIV and TB profiles of facilities visited

Table 1: HIV and TB profiles of selected facilities in five study countries

Facility	Total Pop	Total Male	Total Female	# Known HIV+	# Pre-ART	# ART	# TB Treatment	# HIV/TB Co-Infected	# HIV+ on INH*	# HIV+ on CPT**	#HIV+ with Crypto	# STIs Diagnosed
Malawi												
Zomba	2383	2362	21	483	0	483	51	Unknown	Unknown	483	2	Not sure
Chichiri	1834	1790	44	446	0	446	36	-	-	430	9	11
Bvumbwe	300	300			0	18	1	1	-	3	-	-
Maula	2870	2840	30	430	10	420	19	8	Unknown	418	2	Not sure
Byazi	118	118		0	0	0	0	0	0	0	0	0
Dedza	366	350	14 (2 children)	51	4	47	2	2	-	47	2	-
Lesotho												
Maseru Central	791	791	0	211	0	211	10	4	12	29	0	9
Maseru Female	56	0	56	26	0	26	0	0	26	5	0	-
Mohale's Hoek	459			113	2 (refused)	111	1	1	17	39	0	-
Namibia												
Windhoek Central	1266	1200	60	86	32	54	7	1	6	1	-	-
Evaristus Shikongo	390	390	0	58	-	57	1	0	2-3	-	Not in place	-
Swaziland												
Pigg's Peak	348	260	88	66	1	65	0	0	10	64	1	Not known
Matshapha	678	678	0	152	2	150	4	2	19	150	0	Not known
Bhalekane	289	289	0	61	2	59	1	0	11	59	0	Not known
Mawelawela	73	0	73	64	0	64	1	1	Not known (+/- 60%)	64	0	Not known
Zambia												
Lusaka Central												
Mukobeko Max Male												
Mukobeko Medium (includes Mukobeko Female)	900	895 (16 juvenile)	100 (3 juvenile)	188	0	188	4	4	50	2	0	4

*IPT=isoniazid preventive therapy **CPT= cotrimoxazole preventive therapy

3.3 Comprehensive package of care

The study evaluated the package of care available in the study countries. A comprehensive package of care was prescribed by UNODC in 2012 that includes: (1) information, education and communication (IEC), (2) condom programmes, (3) prevention of sexual violence, (4) drug dependence treatment, (5) needle & syringe programmes, (6) prevention of transmission through medical and dental services, (7) prevention of transmission through tattooing, piercing and other forms of skin penetration, (8) post-exposure prophylaxis, (9) HIV counselling and testing (10) HIV treatment, care and support, (11) prevention, diagnosis and treatment of tuberculosis, (12) prevention of mother-to-child transmission (13) prevention and treatment of sexually transmitted infections, (14) vaccination, diagnosis and treatment of viral hepatitis, and (15) protecting staff from occupational hazards.

Highlights of the evaluation, as relevant to the terms of reference of this study, are outlined below.

- **Condom programmes:** Laws prohibiting same-sex intercourse are a barrier to condom programmes in correctional facilities and Lesotho was the only study country with an official condom provision programme. The Lesotho programme is discussed further in 3.5 below. Some correctional services reported that condoms are available in the clinics and are provided to inmates on exit, thereby allowing for some circulation of condoms within facilities.
- **Prevention of sexual violence:** Except for South Africa and Lesotho, the hostile socio-cultural environment, and current laws criminalising same sex relations in most African countries work against any understanding of the possibility and occurrence of sexual and other violence - be this among male inmates or female inmates, or officials and inmates. In this context, violence also covers consensual sexual relations under duress, where one party agrees to sex, out of concern for his/her personal safety or because of dire need (for example: food, soap, bedding etc). None of the facilities visited had any interventions to reduce the likelihood of such sexual relations, for example: protecting juveniles; or separating long-term inmates from short-term and/or remand detainees. A mitigating factor is that there is little privacy in most facilities, which leads to any sexual activity being common knowledge. In Malawi sexual violence is discussed at monthly meetings and inmates are sensitised to the issue.
- **Drug dependence treatment and needle and syringe programmes (NSP):** There was no evidence of usage of hard drugs such as cocaine and heroin in the facilities visited. Cannabis, alcohol and prescription drugs were taken and abused by some inmates in the study country, but drug dependence programmes and NSP were not evident.
- **Prevention of transmission through tattooing etc:** Tattooing and shaving with shared implements were common practice in the facilities visited. However, there was no evidence of relevant HIV prevention activities, regardless of high transmission risk.
- **Post-exposure prophylaxis (PEP):** In all countries, the Ministry of Health provides PEP kits as required. The study found that staff and peer educators fully understood the importance of occupational exposure and potential of exposure to blood during fights. The Lesotho Correctional Services HIV policy requires healthcare workers to ensure that inmates, who have been victims of rape, sexual violence or coercion, have timely access to PEP as well as effective complaint and redress mechanisms and procedures. Other countries only acknowledged PEP usage in the case of physical injuries.
- **HIV Counselling and testing (HCT):** All facilities visited had HCT services and offer HCT on entry and to inmates diagnosed with TB. All sites offer psychosocial support provided by external experts. There were some issues around whether HCT was voluntary or mandatory and a concern that inmates are not encouraged to re-test while in the facility.
- **HIV treatment care and support:** Between 2016 and 2017, universal test and treat (UTT) programmes were successfully initiated and established as routine policy in all study countries, with counselling and ART initiation by a clinical officer, either on-site or at the District Health Office. UTT was found to be fully implemented in Malawi and Swaziland where inmates are started on treatment on the day they are tested, or very soon thereafter. In all the facilities, only those who had refused treatment were not on treatment. In Namibia and Lesotho the researchers found that UTT had just been introduced as policy and was partially implemented by the time of the visits. No nurses have been trained to initiate ART (NIMART). In many facilities, ART initiation was reliant on the Ministry of Health teams and often the ART records were kept at Ministry of Health facilities. In most facilities, where the treatment was initiated outside of Correctional Services, there were larger delays in starting medication and the health workers were less involved and aware of the treatment challenges.

- **IEC:** All countries seemed to lack appropriate educational materials on HIV and TB (news articles, National AIDS Commission magazines, pamphlets, flipcharts, posters, videos etc.). The little that was available was usually provided by NGOs working in the facilities. Despite the lack of materials, there were many activities and education sessions conducted by peer educators and the level of knowledge of inmates was good.

Policies and practices for HIV and TB prevention services in the five countries are summarised in Table 2 below. Key issues to note are the lack of provision of condoms and lubricants for prevention of HIV transmission within facilities in all countries except Lesotho; and the gap between policy and practice as regards regular testing of HIV and provision of PEP.

Table 2: Policies and practices for TB and HIV prevention and treatment services

	Policies					Practice				
	Malawi	Lesotho	Namibia	Swaziland	Zambia	Malawi	Lesotho	Namibia	Swaziland	Zambia
HIV Prevention										
Provision of condoms for prevention of transmission within facilities	N	Y	N	N	N	N	Y	N	N	N
Provision of lubricants for prevention of transmission within facilities	N	Y	N	N	N	N	Partial	N	N	N
HIV testing at regular intervals	N	N	N	Y**	N	Y	Y	Y	Partial	N
HIV testing offered on admission	N	N	N	N	N	Y	Y	Y	Y	Y
Use of rapid diagnostics for HIV testing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Provider Initiated HIV Counselling & Testing (PICT)	Unknown	N	N	Y	Y	N	N	N	Y	N
PEP for HIV	Y	Y	Y	Y	Y	Partial	Partial	Partial	Partial	Partial
Screening for STIs on admission	Y	N	Y	Y	N	Y	N	Y	Y	Y
Treatment of HIV and STIs										
Universal Test and Treat (UTT) for HIV	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Screening for TB										
Screening for TB on admission	Y	Y	Y	Y	N*	Y	Y	Y	Y	Y
TB Screening at regular intervals	Y	Y	Y	Y	N*	Y	Y	Y	Y	Y
Use of rapid diagnostics for TB screening (Xpert MTB/Rif Assay)	Y	N	N	Y	N*	Partial	Y	Partial	Y	Y
Treatment for TB										
Isolation of TB cases	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Referral for DR treatment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Prevention of TB and other diseases										
Cotrimoxazole Preventive Therapy (CPT)	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y
Isoniazid Preventive Therapy (IPT)	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y

*National TB guidelines from 2006 – no guidelines specific to prisons and prisons not included in any of the national guidelines

**Guideline mentions prisoners mentioned as a key population who should be tested regularly

3.4 Monitoring and evaluation systems

In general, all countries were experiencing similar problems with regards to monitoring and evaluation (M&E).

Most correctional services have a dedicated M&E Unit collecting general information on all programmes within the system. While health indicators may be included, the staff in these units are not specialists in health information. In addition to the Correctional Services M&E units, health departments are also interested in health outcomes in the facilities. Often, the Ministry of Health (MOH) requires another set of data, i.e. additional to that required by the M&E Unit. The indicators, definitions and timelines for Correctional Services are not aligned with MOH tools or indicators, with the facilities having to report to 2-3 entities using different reports each time. In Malawi and Swaziland, there was particularly good coordination between the MOH district staff and the correctional facility staff, with facility staff having a good understanding of what was required in terms of MOH documentation.

The study found that there was little utilisation of the information collected, whether for reporting or for programme improvement. In addition, it found that equipment and systems for data reporting were generally paper-based, and transmission of this information relied on physical transportation, for example, Malawian officials may use buses to transport information. In most consultations with the M&E and health department staff, there was an acceptance that the situation was not ideal and they welcomed additional assistance to streamline systems and to utilise data more effectively.

Table 3 below summarises the characteristics of M&E systems in the study countries.

Type of System	Malawi System	Lesotho	Namibia	Swaziland	Zambia
Link with National Health M&E system	No identified link between MOH and MPS systems. Health indicators reported directly to district. Monthly/quarterly report to government after all prisons report into head office.	No identified link between MOH and Prison services. Health indicators reported directly to district. Monthly/quarterly report to government after all prisons report into head office.	No identified link between MOH and Prison services. Health indicators reported directly to district. Monthly/quarterly report to government after all prisons report into head office.	No	No
Dedicated M&E personnel for health	In process: 1 Head Office; 1 per region (4) – November 2016 No health M&E positions; this work by the HIV co-ordinator – December 2017	Yes, M&E officers are in place	None	No	No
Training of personnel on form completion	Approx. 50% trained	Some is done	none	Yes	No
Standardised tools for reporting	Only using tools from the Ministry of Health	Yes, but very poorly developed	Yes, but very poorly developed	Yes	Yes
Standardised indicators with definitions	All indicators originate from strategic plan	No	No	Partial	Yes
Analysis and trend reporting in place	Not identified	No	No	Partial	No
Mechanisms for feedback to prison clinics	None identified	None identified	None identified	Partial	Yes
Electronic data collection/aggregation tools	75% electronic and 25% manual	None	None	No	No

3.5 Best practices

The study identified a number of best practices in the countries visited.

- Test and Treat for HIV:** Universal Test and Treat (UTT) for HIV has been implemented in all the countries that were visited. UTT has been in place since July 2016 in the Malawi Prison Service, where same-day initiation is being implemented. Unlike many other countries, in Malawi there are no delays in adherence counselling or in further laboratory testing. Where there is a clinic on site, TB treatment is initiated immediately for an unwell inmate and ART initiated two weeks later. In Swaziland ART is provided as soon as inmates test positive for HIV, regardless of CD4 count. This is being done consistently and was reported at all facilities, resulting in high numbers of individuals on treatment.
- Condom programme:** Male condoms and lubricants were available to inmates and staff in Lesotho facilities. A more in-depth study done by Lesotho Correctional Services and UNODC found that three quarters of male inmates “had access” to condoms, but just over half said they had access to condoms “every time they were needed”. That study found the majority of inmates (92.8%) understood that condoms protect against HIV but a small percentage held unscientific views on condoms, such as they have worms, cause sterility or carry HIV. Lesotho and South Africa are the only two countries in Southern Africa implementing condom programmes in correctional settings.
- Linkage to care, post-release:** While this is a challenge in all study countries, Lesotho, Malawi and Swaziland pay particular attention to continuity of care for inmates who are released, though this may vary from facility to facility. In Swaziland correctional services have standard operating procedures for linkage to care post-release and a National Referral Tool is filled in for all released offenders. In Malawi, all prisons follow up inmates on chronic treatment post-release, usually by phone.

- **TB infection control:** There is a large emphasis on TB Infection control in Swaziland. This includes attention to infection control in cells by opening windows and allowing inmates access to outdoor spaces during daylight. Personnel are screened for TB and individuals who are exposed to infectious TB patients are provided with respirators and surgical masks. The Matshapha clinic has state-of-the-art facilities with a fully-equipped clinic, TB lab and isolation wards.
- **District health support:** In Malawi, facilities receive strong support from the district health staff who visit the ART clinics and provide good M&E support. Where there is no on-site clinic, patients are taken to the District Health Office (DHO) for treatment initiation. The DHO team also provides support in the form of a clinician/nurse once a week to these facilities, to provide an outpatient clinic, and to examine psychiatric patients, treat skin infections etc. This service is also provided by an NGO once a week. The DHO also provide an ART clinic once a month.
- **Female-centred services:** The Mawelawela facility clinic in Swaziland provides obstetric services, contraception on exit and regular cervical screening for women. This clean and organised facility gives an overall impression of a very high standard of care for female inmates and community members.
- **Engagement of “expert clients”:** Swaziland correctional services engage peer educators to provide health information and adherence support. Other countries do have peer educator programmes but Swaziland seems to place a bigger emphasis on their role and presence and has named them “expert clients”.
- **Staff health:** The Malawian Prison Service provides ART on-site for HIV-positive staff, enabling the facility to maintain staff on duty while they receive treatment. The large numbers of staff reported to be on ART treatment is evidence of the wide-scale implementation of the programme.
- **Electronic Patient System:** Swaziland is phasing in a national electronic patient system. Two facilities are already piloting this system.

4. CHALLENGES AND RECOMMENDATIONS

This section summarises the key challenges identified by the study and proposed solutions.

4.1 HIV prevention

HIV prevention strategies, such as the provision of condoms for inmates currently incarcerated were not implemented due to the criminalisation of same-sex intercourse. The issues of pre-exposure prophylaxis, sexual assault, and post-exposure prophylaxis following sexual exposure were largely ignored in all facilities visited.

Testing for HIV is done on entry in most countries, with very little repeat testing, which may be giving rise to the misconception that HIV transmission is not occurring. More regular HIV testing could be offered. This may provide the evidence needed to understand HIV transmission within facilities. Governments could also consult with other countries, such as Lesotho, where same-sex intercourse is criminalised, but that have provided condoms for the health benefits; and/or consult with countries where these activities have been decriminalized.

Research in Lesotho and South Africa, where condoms are provided in facilities, would provide a greater understanding of the use of condoms in these settings.

Training on Post-Exposure Prophylaxis is required and reporting on sexual assaults needs to be encouraged.

4.2 Screening for TB

There were some deficiencies noted with screening of TB. The use and availability of Xpert TB test needs to be fully implemented and training needs to be improved. Xpert MTB Rif has been shown to be significantly more sensitive than sputum microscopy for TB diagnosis, and should be considered as first line. The use of isoniazid preventive therapy (IPT) was inconsistent. IPT uptake has been a problem worldwide and the introduction of the new once-weekly, three-month regimen for prevention of TB (known as 3HP) may be better accepted.

4.3 Monitoring and Evaluation Systems

As described, M&E systems in the study countries are weak and do not serve to inform management or improve services. In general, there is much data collection done at facility level but reports to the health department and the correctional services are not aligned. Much of the information is neither reviewed nor analysed by correctional services and no trend analyses are being done to identify gaps or guide implementation.

One suggestion is to provide consultancy support to these departments for a short period of time. Such support could include the following strategic steps:

- The initiation of the development of M&E tools which are standardised and aligned with the MOH tools;
- The development of a standard operating procedures, which can be used for training and ensures accuracy and completeness of information, timelines that are harmonised with the MOH timelines for reporting, checking of data and feedback to facilities; and
- Regular monitoring and evaluation visits where the M&E officers support and train the health staff in completion of reports.

4.4 Living Conditions

Poor conditions were prevalent in correctional facilities throughout Malawi and Zambia.

Although not directly part of this study, it is well established that problems such as overcrowding, poor nutrition and inadequate sanitation prejudice the physical and psychological health of inmates. Most participants in this study echoed the well-understood fact that inmates need sufficient food and nutrition, especially those with a chronic disease.

In Malawi, poor and inadequate nutrition and inadequate rations are visible in all correctional facilities and health workers understand the difficulty of achieving good ART adherence when food is inadequate. Apparently, some prisons have been provided with peanut butter. This highly inexpensive and valuable protein could be a good source of nutrition in all facilities

In Zambia, health officials reported that lack of nutrition was particularly difficult in patients on isoniazid and ART. Living conditions were also described as poor with a lack of space to sleep, no bedding and blankets, and this was leading to a large number of skin conditions in patients. Other materials that were not available included tooth brushes, tooth paste and detergents for washing clothes.

In general, an increase in education around good hygiene and the provision of hygiene and sanitation materials would be a quick win. Education should include the dangers of repeated use of unsterile blades and the safe disposal of used blades. It may be worthwhile investigating the cost and security issues of providing clean blades.

The most significant interventions would be for additional resources to be made available, in the form of food and other basic requirement such as soap, buckets, bins and blankets. The cost in terms of treatment for gastro-intestinal infections, rashes and nutritional supplements would be dramatically reduced through the provision of these items.

4.5 Infrastructure for Clinical Services

This is generally inadequate and insufficient in all facilities visited, but was particularly problematic in Lesotho where the study found that clinical services were conducted in a single room with no privacy for patients. The facilities in Namibia and Malawi were old with extremely small clinics – usually a converted cell.

5. REFERENCES

HIV and TB services and Surveillance in Correctional Facilities in Eastern and Southern Africa: Assessment of Policies, Practices, and Performance. Consolidated report for Malawi, Lesotho, Namibia, Swaziland and Zambia. Aurum Institute, July 2018.

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