



# **Technical Brief**

## Prisons and Other Closed Settings: Priorities for Investment and Increased Impact

**Allocation Period 2023-2025**

Date published: 30 November 2022



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<b>Introduction</b>	<b>3</b>
<b>Executive Summary</b>	<b>6</b>
<b>1. Priorities for Investment</b>	<b>11</b>
1.1 Prevention	11
1.2 Table: Priority programming versus approaches not supported by the Global Fund	20
1.3 Screening and testing	20
1.4 Treatment and retention	22
1.5 Removing gender- and human rights-related barriers to services	23

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<b>2. Investment Approach</b>	<b>28</b>
2.1 Understand: Continue to know your epidemic and its updated resource needs.	28
2.2 Design: Develop a mix of interventions that maximizes impact	29
2.3 Deliver: Ensure high-quality and efficient service delivery for optimal scale-up	30
2.4 Sustain: Strengthen the sustainability of health systems.	31

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<b>3. Good Practice Example</b>	<b>33</b>
3.1 Peer-based needle and syringe program in Moldovan prisons	33

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<b>4. List of Abbreviations</b>	<b>34</b>
<b>5. Resources</b>	<b>35</b>

# Introduction

People in prison and other closed settings<sup>1</sup> are a “key population” disproportionately impacted by HIV and TB. **This technical brief is meant to support applicants to the Global Fund to plan for effective HIV and HIV/TB services in prisons and other closed settings.**

Drawing on lessons from past programming and guidance from UN partners, this document highlights key approaches to increase prevention, diagnosis and treatment in prisons and other closed settings. For details on the full range of interventions that the Global Fund supports in the HIV and TB response, applicants should consult the Global Fund Information Notes on [HIV](#) and [TB](#), and the [Modular Framework Handbook](#). For programming on malaria prevention and treatment in prisons and other closed settings, please see the brief on [Equity, Human Rights, Gender Equality and Malaria Technical Brief](#).

The Global Fund’s [2023-2028 strategy](#) includes a focus on closing the HIV prevention gap and increasing availability of HIV and TB testing and treatment for key populations in a range of settings, including closed settings. Reducing human rights-related barriers to services and strengthening people-centered care and community-led responses in the HIV and TB response are also priorities in this strategy.

All Global Fund applicants are asked to prioritize evidence-based and rights-based, high impact interventions. Upper middle-income countries are only eligible for Global Fund support to maintain or scale up services for key populations, including people in prisons and other closed settings. Evidence shows that HIV and TB interventions can be high impact in all different types of prisons and other closed settings, and in countries of all income levels.

Some prison systems do not provide HIV prevention services, believing that acknowledging sex and drug use will encourage undesirable behavior.<sup>2</sup> Others offer TB or HIV services but not both, or offer services to men but not to women.<sup>3</sup> Sex and drug use are common inside all closed settings, so measures to help people protect themselves from HIV, sexually transmitted infections (STIs) and viral hepatitis should also be common.

Rates of TB in prisons and other closed settings are sharply higher than in the general population<sup>4</sup> making TB prevention and treatment essential. Since people are transferred between facilities and move between closed settings and the community, it is important to create services inside closed settings equivalent to those outside, and linkages to ensure continuity of services for those released.

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<sup>1</sup> There are many different terms for places that hold people who are awaiting trial, those who have been convicted. Different terms are also used for those who are detained while awaiting entry into a country, or for security reasons. The term “prisons and other closed settings” in this document refers to all places of detention associated with criminal justice, and the terms “people in prison” or “detainees” refer to all those detained in criminal justice and prison facilities, including adult and juveniles during the investigation of a crime, while awaiting trial, after conviction, before sentencing and after sentencing. The Global Fund joins UN agencies in calling for closure of compulsory drug detention or rehabilitation centers, and does not support work inside these facilities.

<sup>2</sup> UNODC (2008). [HIV and AIDS in places of detention: A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings](#).

<sup>3</sup> APMG Health (2019). [Global Summary of Findings of an Assessment of HIV Services Packages for Key Populations in Six Regions. Stop TB Partnership \(Year TBD\). Key Populations Brief: Prisoners](#).

<sup>4</sup> UNODC (2022). [Prison Reform and Alternatives to Imprisonment](#).

People in prison are adolescents and adults, male and female, drug-using and non, trans and gender diverse. Programming should be available to and reflect the needs of these different groups.

Risk to people in prison comes not just from lack of adequate TB or HIV services, but also from policies that increase detention or prevent coordination of treatment between prison and community health facilities. Long waits in pretrial detention, overcrowding, lack of adequate ventilation, sanitation or nutrition in closed settings all increase the risk of transmission of HIV and TB and worsen the health of people living with these infections. Key populations affected disproportionately by HIV in communities, such as men who have sex with men, sex workers, trans and gender-diverse people and people who inject drugs, are criminalized in many countries, making arrest and imprisonment major barriers to access prevention, diagnosis and treatment services. These same populations often face higher levels of stigma or violence inside prisons and other closed settings, both from other detainees and staff.

**The Global Fund’s technical review panel evaluates proposals for plans to deliver comprehensive HIV and TB prevention, testing and treatment in prisons and other closed settings, and for how countries plan to remove human rights- and gender-related barriers to services for those imprisoned.** Integrating these approaches is essential for impact.

The Global AIDS Strategy calls on countries to sharply scale up HIV programming to ensure that 90% of key populations, including people in prison and other closed settings, have access to HIV prevention services. The Global Plan to End TB similarly seeks to reach 90% of key populations at greatest risk, including people in prisons (see Box 1).<sup>5</sup>

**Box 1: [Global AIDS Strategy](#) and [Global Plan to End TB](#): Key targets**

- 90% of people in prisons and other closed settings have access to comprehensive HIV prevention: sexual/reproductive health and harm reduction services integrated with or linked to mental health services.
- 90% of people in prisons and other closed settings have access to voluntary HIV testing and treatment.
- 90% of people in prisons and other closed settings have access to TB testing, preventive therapy and treatment
- Less than 10% of people in prisons and other closed settings experience stigma or discrimination; less than 10% of women experience gender inequality/violence; and less than 10% of countries have punitive legal or policy environments that lead to denial or limitation of services.

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<sup>5</sup> Stop TB Partnership (2022). [The Global Plan to End TB: 2023-2030](#).

Reducing unnecessary imprisonment and providing alternatives to incarceration are also critical to containing HIV and TB. The Global AIDS Strategy, the Global Fund Strategy, and political declarations on HIV and TB by the UN General Assembly emphasize the importance of changing punitive laws that impede the HIV and TB response.<sup>6</sup>

This technical brief is intended to support countries applying to funding from the Global Fund – the largest donor to HIV and TB services in prisons and other closed settings – to move towards that goal.

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<sup>6</sup> UNAIDS (2021). [Global AIDS Strategy 2021-2026](#). The Global Fund (2022). [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \(2023-2028\)](#). UN General Assembly (2021). [Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030](#).

# Executive Summary

Programming such as distribution of condoms and sterile injecting equipment and use of pre-exposure prophylaxis are high impact interventions for HIV and viral hepatitis prevention in prisons and other closed settings. By contrast, the creation of “drug-free units” in prisons, or interventions that demand people in closed settings to stop having consensual sex or using drugs, have not been successful in reducing HIV or viral hepatitis epidemics.<sup>7</sup>

Studies of closed settings have found TB levels to be as much as 1000 times higher than in the community.<sup>8</sup> TB Infection rates among people incarcerated in low and middle income countries range between 12 to 26 times higher than in general population.<sup>9</sup> With people moving frequently between closed settings and outside, TB screening, provision of tuberculosis preventive therapy (TPT) and treatment in prisons are key for containing infection both in closed settings and in the wider community. Structural changes in prisons and other closed settings, such as reducing the number of detainees, prevention of overcrowding and provision of adequate ventilation, sanitation and nutritional support, are also critical. To be effective, TB responses in prisons require support and training for patients and health care workers, collaboration between prison and public health services, and engagement of communities, including organizations and networks led by those formerly incarcerated.

**The Global Fund defines certain interventions as “program essentials”:** elements critical to a country’s HIV and TB response, whether in closed settings or in the community. In their funding requests, all applicants are requested to provide an update on their country’s status towards achieving these program essentials. Applicants from High Impact and Core portfolios as defined by the Global Fund, should describe in their funding narrative how they plan to introduce or scale up any of the program essentials that are not yet fully implemented.

**HIV prevention program essentials** in prisons and other closed settings include:

- **Condoms and lubricants** provided free of charge and made available at a variety of locations and times, without detainees having to request them and without being seen by others.
- **Harm reduction for people who inject drugs.** The Global Fund supports [the comprehensive harm reduction package recommended by WHO](#) to reduce transmission of HIV, hepatitis B and C in prisons and other closed settings. Three interventions: provision of needle and syringe programming (NSP), opioid substitution therapy (OST) and the opioid overdose antidote naloxone are particular priorities.

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<sup>7</sup> WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#). See also, WHO, UNODC, UNAIDS et al (2007). [Evidence for Action Technical Papers: Effectiveness of Interventions to Address HIV in Prisons](#)

<sup>8</sup> Stop TB Partnership (2018). [Stop TB Field guide 2: Strategies for Effective TB Case Finding in Prisons and Closed Settings](#).

<sup>9</sup>Cords, O., Martinez, L., Warren, J. L., O'Marr, J. M., Walter, K. S., Cohen, T., ... & Andrews, J. R. (2021). Incidence and prevalence of tuberculosis in incarcerated populations: a systematic review and meta-analysis. *The Lancet Public Health*, 6(5), e300-e308.



- **Pre-exposure prophylaxis for HIV** where available, provided voluntarily and not as a substitute for other HIV prevention measures.

**Violence prevention and response services including both violence prevention and support for victims**, are important for people in prisons and other closed settings. For rape victims, this should include post exposure prophylaxis for sexually transmitted infections (STIs) and HIV, emergency contraception where required, mental health support, and voluntary access to forensic medical examination, legal support and safe and effective complaint mechanisms.

The Global Fund supports **additional HIV prevention interventions in prisons and other closed settings** including testing and treatment for hepatitis B and C; STI testing/treatment; support for health information and demand creation activities; and for women, reproductive and sexual health services including contraception/family planning services, perinatal care and prevention of mother-to-child transmission of HIV, syphilis and hepatitis B and C.

### **Human Rights Program Essentials**

Removing human rights- and gender-related barriers to services for people in prisons and other closed settings is essential to both the HIV and TB response. Programs should address the structural barriers faced by people in prison, including groups with specific needs, such as women, trans- and gender diverse people, minors in detention and people who use drugs.

All applicants are requested to provide an update on their country's status towards achieving four human rights program essentials. Applicants from High Impact and Core portfolios should describe how they plan to introduce or scale up any that are not yet fully implemented. To highlight the importance of this work in prisons and other closed settings, the Global Fund has included interventions to reduce human rights-related barriers specific to prisons and other closed settings in its [Modular Framework Handbook](#) for both HIV and for TB programming.

The four human rights program essentials:

- (1) **Integration of measures to reduce gender and human rights barriers into HIV and TB programming**, including commitment to give those in closed settings access to the full range of HIV and TB programming available in the community, to advocate for and offer services tailored to the needs of women, trans and gender diverse individuals and young people, and to create reporting and redress mechanisms for those targeted by staff or other prisoners on the basis of gender, sexual orientation or age.
- (2) **Reduction of stigma and discrimination** in prison health services (and elsewhere), including staff training on duty to care, and an end to involuntary HIV testing, confidentiality violations, and screening of medical requests or denial of treatment by non-health staff.
- (3) **Activities to increase legal literacy and access to justice**, including “know your rights” trainings for detainees and access to legal support and due process.

- (4) **Analysis and reform, including by organizations and networks led by those in prison or formerly imprisoned, and by criminalized groups at highest risk for HIV** for decriminalization of same sex behaviour, sex work, gender expression or drug use/possession for personal use, as well as for reform of policies such as solitary confinement of TB patients and detention of minors with adults.

In addition to these, the Global Fund supports a wider range of approaches recommended by UNDP, UNODC, UNAIDS and WHO as effective in removing human-rights and gender-related barriers to services. Work supported includes reduction of stigma and discrimination in family, community and workplace settings (important for those released from prison), in **education settings** (important for training of prison staff), in **emergency and humanitarian settings** (to ensure service continuation in closed settings during conflict or natural disaster) and in the justice system (important to increase rights respecting law enforcement and prevent arbitrary, discriminatory or unnecessary incarceration that violates international human rights norms).

The Global Fund also supports empowerment of people in prison and those recently released to monitor health provision, organize peer support, and advocate for program or policy change. People in prisons or those released are the “key population” least likely to be included in planning and development of HIV programming, with only 22 of 195 countries reporting to UNAIDS that former or current prisoners participated in formation of policies, guidelines or strategy development.<sup>10</sup>

**Testing and treatment for HIV and TB are program essentials** to protect those in prisons and other closed settings, and the health of the public. Testing that does not link people to care, or that informs prison staff but not those tested of their status, is harmful and not supported by the Global Fund.

- **HIV testing must only take place with the voluntary, informed consent of the person tested.** Testing should be confidential, with link to support and immediate antiretroviral treatment (ART) for those testing HIV positive.
- **TB screening should be conducted at entry and periodically afterward, followed by treatment and separate accommodation** for those with active TB. TB preventive therapy should be offered to those with latent infection and to all those with HIV and without symptoms of active infection.
- **Diagnosis and treatment for those with active TB infection** including for multidrug resistant TB involves training and support for both prison staff and patients. Support from prison leadership – and treatment in a separate area (prison hospital ward, TB wing or cellblock, but not in solitary confinement and with length of isolation decided only by medical staff) – are critical, as is coordination with health authorities for those requiring treatment and follow-up upon release.

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<sup>10</sup> UNAIDS (2021). [National Commitment and Policy Instrument](#).



- As in community settings, treatment should be **confidential, voluntary, easy to start and continue, and accessible** to all people in prisons and other closed settings without delay or interruption.
- Programmes should also engage in **pre-release planning** and link individuals to care upon exit or transfer.

Effective programming focuses both on the **what** of HIV and TB services – which commodities to provide – as well as on **how** they will be delivered.<sup>11</sup> In evaluating plans for programming in prisons and other closed settings, the Global Fund supports funding requests that:

- **Assess needs and priorities for HIV and TB services.** Assessment should **meaningfully engage people in prison and community organizations led by key populations disproportionately affected by HIV and imprisonment**, such as those formerly incarcerated, sex workers or people who inject drugs – in determining approaches to service delivery and needed policy change. When conducting assessments in closed settings, it is critical to obtain advance agreement with prison staff to protect anonymity and data security, and clear communication about this to those surveyed.<sup>12</sup> Disaggregating data (e.g., by facility, services for women, men, adolescents) is important when designing services and to monitor impact.
- **Design a mix of interventions that strengthen each other.** HIV is the most important risk factor for the development of TB, and TB is the main cause of death for people living with HIV. Offering HIV and TB prevention and treatment in prisons and other closed settings, where risk for both is elevated, is therefore critical. Provision of needle and syringe programming (NSP) and opioid substitution therapy (OST) to people who inject drugs reduces HIV risk, but also helps prevent HCV reinfection of those treated. Antiretroviral medication used for oral PrEP for HIV can also be used to treat chronic hepatitis B. **Integration of sexual and reproductive health services, mental health services and HIV and TB services** can reduce infections and improve treatment adherence.
- **Deliver effective and efficient services, as gauged by people in prison and those recently released, civil society organizations working with those in prison, as well as by prison health staff. Continuity of services for those moving between community and closed settings**, or between closed facilities, is critical to avoid treatment disruption. Peer support and meaningful involvement by people in prison and those formerly incarcerated can strengthen delivery of prevention, diagnosis and treatment, and play a critical role in strengthening linkages to community care and social reintegration. Even if starting services in only one or two facilities, country applicants should **plan for scale-up** with concrete targets and timelines for service expansion. Evaluation should include real-time tracking of service delivery and regular HIV prevention performance review, and ongoing assessment of service gaps, accountability processes, and changes to policies and

<sup>11</sup> Global HIV Prevention Coalition (2017). Discussion Paper 3: [Systematic and Efficient Service Delivery at Scale](#).

<sup>12</sup> Global Fund (2022). [Community Systems Strengthening Technical Brief](#).

environmental factors shaping risk (e.g., new laws sparking arrests, prison overcrowding, COVID-19 or TB outbreaks).

- **Sustain services by creating mechanisms for service funding and continuation.** Health services in prisons are best overseen by, budgeted for and delivered by the same authorities that oversee public health in the community. If this is not yet viable, countries should **include prison authorities in all stages of national planning and in all funding requests for HIV and TB services** and strengthen links between prison and community HIV and TB services. **“Social contracting” with nongovernmental organizations, particularly community-led organizations** (e.g., those led by former prisoners and/or by other key populations overrepresented in prison settings such as LGBT people, people who use drugs, etc.), can increase uptake and sustainability of services both in prisons and for those recently released.



### Key resources for planning and programming in prisons

Additional resources are included in sections of this technical brief (see Section 5 for a summary list). In addition to the Global Fund Information Notes on [HIV](#) and [TB](#) and the [Modular Framework Handbook](#), some resources are particularly recommended:

#### For guidance on evidence-based programming:

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#) and

UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions](#)

WHO (2020): [Consolidated guidelines on tuberculosis: Modules 1, 2, 3 and 4](#)

#### For practical examples and support on programming and community engagement:

Stop TB Partnership (2020). [Engage & Empower: Supporting access to TB Health Services for Prisoners and other persons deprived of liberty](#)

Stop TB Partnership (2018). [Stop TB Field guide 2: Strategies for Effective TB Case Finding in Prisons and Closed Settings](#)

UNODC, INPUD, et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)

#### Additional Global Fund technical briefs to complement the information here:

- [Harm Reduction for People Who Use Drugs: Priorities for Investment and Impact in HIV Programming](#)
- [Removing Human Rights-related Barriers to HIV services](#)
- [Removing Human Rights-related Barriers to TB services](#)
- [Key Populations](#)
- [Community System Strengthening](#)
- [Gender Equality](#).

# 1. Priorities for Investment

## 1.1 Prevention

Approaches such as distribution of condoms and sterile injecting equipment are effective in reducing HIV, viral hepatitis and sexually transmitted infections (STIs) transmission in prisons and other closed settings. Preexposure prophylaxis for HIV (see PrEP/PEP, below) has also been effective in prisons and other closed settings. By contrast, creation of “drug free” units or interventions to stop people from having consensual sex or using drugs have not been shown to reduce epidemics of HIV, hepatitis or STIs.<sup>13</sup>

The Global Fund supports the range of prevention approaches identified by the UN Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the United Nations Joint Programme on AIDS (UNAIDS) as essential for impact. When combined with testing and treatment and approaches to remove human rights-related barriers to services, these measures have successfully reduced HIV, viral hepatitis and TB for people in prison and other closed settings.<sup>14</sup> People in prison and those recently released play a critical role in program design, delivery and evaluation. Global Fund staff and technical reviewers consider the level and extent of key population involvement, including attention to gender responsiveness, when evaluating proposed programming and the work of Country Coordinating Mechanisms (CCM).

### A. Priority HIV Prevention Programming

#### a) Condoms and lubricants

The Global Fund supports provision of male and female condoms and compatible lubricants to all those in prisons and other closed settings, as well as training for staff and people in prison on use and effectiveness. No prison system allowing condoms has documented any increase in consensual or forced sex as a result, and none has reported security problems or any other major negative consequences.<sup>15</sup>

- Detainees should have free access to condoms and lubricants at all hours, without having to ask, and out of view of prison staff/or other people in prison and without punishment for use.
- Condoms and lubricants should be provided free for conjugal/intimate visits, and to people upon release.

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<sup>13</sup> WHO (2022) [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations.](#)

<sup>14</sup> UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions:](#)

<sup>15</sup> UNAIDS (2016). Do No Harm: Health, Human Rights and People who Use Drugs. <https://www.unaids.org/en/resources/documents/2016/do-no-harm>

## b. Harm reduction for people who inject drugs, including those in prison

Harm reduction is an HIV program essential for the Global Fund, which supports [the comprehensive package recommended by WHO](#) to reduce transmission of HIV, hepatitis B and C and overdose. Three approaches are highest priority: needle and syringe programming (NSP), opioid substitution therapy (OST), and overdose prevention with naloxone, though the entire comprehensive package of harm reduction services, as outlined by WHO and UNODC, should be provided.

- **Needle and syringe programming (NSP)**

NSPs have been successfully implemented in men's and women's prisons, in civilian and military systems, in facilities using individual cells or barracks-style housing, and in countries of different resource levels.<sup>16</sup> Despite fears, evaluation of prison NSPs have found no use of needles as weapons against staff or other prisoners, and no increase in drug consumption. Instead, they have experienced increased referral to drug dependence treatment.<sup>17</sup>

- Programs should provide **a full range of injection equipment** such as waters, filters, spoons, cookers, tourniquets to reduce risk of HIV, hepatitis C and other kinds of infections.
- WHO recommends **use of low dead space syringes**. If acceptable to people who use drugs, use them. Single-use or autodestruct syringes are not suitable for NSP, and not recommended. Provision of bleach for disinfection without also providing sufficient needles and syringes to avoid sharing or repeat use is not recommended.
- Needle and syringe programs can be operated through prison health services, NGOs working with prison staff, or by peers. As in communities, **peer-led programs can help to increase reach and accessibility in prisons** (see Section 3, Best Practices).
- **Training and education for prison staff and detainees** about NSP and harm reduction can help increase uptake and acceptance.
- Offering only a small number of needles will not impact HIV transmission – **aim for the recommended level of ~200 needles and syringes per person per year** for HIV prevention.<sup>18</sup>

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<sup>16</sup> UNODC (2015). [Handbook for Starting and managing needle and syringe programmes in prisons and other closed settings](#).

<sup>17</sup> WHO Euro (2014). Prisons and Health. Chapter 8: [TB prevention and control care in prisons](#).

<sup>18</sup> UNAIDS (2019). [Needles and syringes distributed per person who injects drugs](#).



## Resources on NSP in prisons and other closed settings

For more information, see:

The Global Fund (2022). [Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming](#)

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)

UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions](#)

UNODC (2015). [Handbook for Starting and managing needle and syringe programmes in prisons and other closed settings](#)

UNODC, INPUD et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)

UNODC (2008). [HIV and AIDS in places of detention: A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings](#)

WHO, UNAIDS and UNODC (2007). [Guide to Starting and Managing Needle and Syringe Programmes](#)

- **Opioid Substitution Therapy (OST)<sup>19</sup>**

The medicines methadone or buprenorphine help people dependent on opioids reduce injection, and risk of HIV, HCV or overdose both in prison and upon release.

- When creating national guidelines, **set rules for staffing, storage and service delivery that include prisons and other closed settings**. Aim to reach 50% of people in prison dependent on opioids.
- **OST can be delivered in pre-trial detention and detention settings** and should be available without delay, including to those continuing or beginning treatment. Facilities can either provide OST or permission for outside health services/ NGOs to deliver medicine. UN human rights experts have found denial of OST to those undergoing painful withdrawal symptoms be cruel and degrading, and even to rise to the level of torture in some circumstances.<sup>20</sup>
- **Offer OST at a dosage that the patient indicates is effective**. WHO recommends treatment of 60-120 milligrams daily of methadone, and 8-24 mg of daily buprenorphine.<sup>21</sup> Urine testing after initiation of OST is not required, and should not be used to punish patients or exclude them from treatment.

<sup>19</sup> This brief uses the term “OST”, opioid substitution therapy. This is also known as opioid substitution treatment, opioid agonist maintenance treatment (OAMT), opioid agonist treatment (OAT), or medication-assisted treatment (MAT). Methadone maintenance therapy is also known as MMT.

<sup>20</sup> UNAIDS (2016). [Do No Harm: Health, Human Rights and People who use Drugs](#)

<sup>21</sup> WHO (2009). [Guidelines for the psychosocially-assisted pharmacological treatment of opioid dependence](#) (2009).

- **Patients receiving rifampin for TB often require higher doses of methadone**, since that medicine sharply reduces the amount of methadone available in the body. Interaction between OST and certain HIV antiretrovirals may also require OST dosage adjustment.
- **OST should be available both to those on treatment before incarceration and to those wishing to start in prison or other closed settings**, including pregnant women.
- **As with NSP, education both of prison staff and people in prison and other closed settings** can reduce misconceptions and increase treatment uptake.
- **Ensure linkage to community OST upon release**, including provision of needed ID documents, medical records, adequate dosage for day of release/travel from facility and arrangement for immediate access to OST in the community. Peer navigators can offer important support in treatment access and social reintegration.



### Resources on opioid substitution therapy (OST)

For more information, see:

The Global Fund (2022). [Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming](#)

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)

UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions](#)

UNODC, INPUD et al, (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)

WHO (2009). [Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings](#)

WHO (2007). [Interventions to Address HIV in Prisons: Drug Dependence Treatments](#)

WHO (2009). [Guidelines for the psychosocially-assisted pharmacological treatment of opioid dependence](#).



## Box 2: Imprisonment in a Pandemic: Lessons learned from COVID-19

COVID-19 brought service disruption and heightened risk for people in prisons and closed settings across the world. Some changes, however, improved conditions in prisons and other closed settings, even temporarily. These offer lessons important for future HIV and TB programming.

- Decreased police harassment or detention of people who use drugs in police lockup (Mexico, Russia).
- Release on bail and suspended sentences for people awaiting trial or convicted of minor offenses to reduce overcrowding (Ethiopia, Kenya, Indonesia, India, Iran and others).
- Creation of “e-justice” rooms in prisons to allow for online court hearings and consultation with lawyers and relatives, increasing speed of procedures and decreasing time spent in pretrial detention (Moldova).
- Initiation of methadone treatment in prison for those who could no longer travel to outside facilities for OST (Kenya).
- Compassionate release for the elderly, those with HIV or other serious/ life-threatening medical conditions (Afghanistan, Argentina, Belarus and others).

### • Naloxone for overdose prevention

Overdose is a leading cause of death for people who inject drugs. Those recently released from prison are at particularly higher risk.

Naloxone, the medicine to reverse opioid overdoses, is safe, easy to administer, non-abusable and lifesaving. WHO recommends that the medicine should be made available to all those most likely to witness an overdose.

Programming should prioritize:

- Provision of naloxone (and if using intramuscular form, equipment to administer it) to people in prisons and other closed settings, and to be taken away upon release.
- Basic training and communications to raise awareness and enhance use of naloxone by people who inject drugs in prisons and other closed settings, and as part of pre-release plan.
- Changes in regulation or practice to ensure that people face no penalties for naloxone use/possession in closed settings or upon return to the community.



### Resources on naloxone for overdose prevention

For more information, see:

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)

UNODC, INPUD, et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)

WHO (2014). [Guidelines on Community Management of Opioid Overdose](#)

WHO (2014). [Preventing Overdose Deaths in the Criminal Justice System](#)

### c) PrEP and PEP

Medication taken before HIV exposure and continued during periods of HIV risk (Pre-exposure prophylaxis, or PrEP) or immediately after exposure (post-exposure prophylaxis, or PEP) can greatly reduce risk of getting HIV.

The Global Fund supports offering PrEP or PEP to people in prisons or other closed settings. This should be **in addition to**, not as a substitute for, NSP and OST for people who inject drugs.

Whether used in closed or community settings, both PrEP and PEP should be **voluntary and delivered with full, informed consent**.

- **PrEP:** WHO recommends PrEP via **daily oral medication** (tenofovir disoproxil fumarate, via a dapivirine vaginal ring, or through long-acting injectable cabotegravir).
  - **Regular HIV testing is needed for PrEP** (see Testing, Section 1.2, below).
  - **PrEP can be safely integrated with OST, NSP or treatment of hepatitis B and C.**
  - People in prisons and other closed settings have sharply higher rates of HBV and HCV infection. Since data is limited on the effects of long-acting injectable cabotegravir on those with impaired liver function, **consider alternate forms of PrEP or other HIV prevention approaches for those with acute hepatitis or advanced liver disease.**<sup>22</sup>
- **PEP** involves starting oral antiretroviral treatment within 72 hours of exposure to HIV and continuing for 28 days.
  - PEP is useful for people in prison or closed settings and for prison staff exposed to needle stick injuries, instances of sexual intercourse unprotected by PrEP or condoms, or for other isolated instances of exposure (such as a single injection with nonsterile equipment).
  - While PEP should be offered to victims of rape, additional support is also needed (see violence prevention and response, below).

Clear guidelines for PrEP and PEP should be developed and communicated to people in prisons and other closed settings, as well as to all staff working in these settings.

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<sup>22</sup> WHO (2022). [Differentiated and simplified pre-exposure prophylaxis for HIV prevention.](#)



For more information on PrEP and PEP, including dosing regimens, contraindications and testing requirements, see:

WHO (2022). [Differentiated and simplified pre-exposure prophylaxis for HIV prevention](#)

WHO (2022). [Guidelines on long-acting injectable cabotegravir for HIV prevention](#)

WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#)

## B. Additional prevention interventions

### a) Violence prevention and response

People in prisons and other closed settings report high levels of violence, including sexual violence.

To reduce risk, women should be held separately from men, and juveniles separate from adults. Trans and gender diverse individuals should be housed according to their preference, and if separated for safety, not held in isolation.

- Services supported by the Global Fund include violence prevention programs, as well as services for victims/survivors such as post-violence counseling, referral and linkages to care including mental health support, medical care and management.
- Violence victims should have a safe and confidential method to report incidents.
- In addition, rape victims should be offered post-exposure prophylaxis for HIV and other sexually transmitted infections, full SRH services, hepatitis B vaccination and forensic examination and legal services offered on a voluntary basis.

**b) Hepatitis B and C prevention, testing and treatment** are supported by the Global Fund for people in prison and other closed settings, regardless of their HIV status, when offered as part of comprehensive HIV programming. Treating hepatitis C in prisons and other closed settings, for example, will be undermined if it is not accompanied by provision of sterile injecting equipment to reduce infection/reinfection.

- Applicants seeking funding for hepatitis B or C treatment should make a strong investment case, noting service gaps, financing, known prevalence, and/or risk and rates of infection.
- Staff providing medical, dental or gynecological care should be equipped for and trained on blood safety precautions and offered hepatitis B vaccination and training on how to offer non-stigmatizing treatment to people with hepatitis.
- People in prisons and other closed settings should be offered hepatitis B vaccination and materials to reduce risk of hepatitis B or C transmission through tattooing or piercing.

- WHO recommends rapid hepatitis B vaccination (3 doses in three weeks) for people who inject drugs without chronic HBV infection, and notes that this may also be appropriate for others in prisons and other closed settings.
- Babies born in closed settings should receive their first HBV vaccine within 24 hours after birth and complete their course of vaccination.
- The Global Fund can support treatment of chronic hepatitis B for people in prison and other closed settings, as well as provision of tenofovir to prevent vertical transmission during pregnancy, in line with [WHO guidelines and eligibility criteria](#).
- The Global Fund can also support HCV treatment of people in prisons and other closed settings. WHO recommends treatment for all those with active HCV infection except pregnant women, with no need to wait for possible viral clearance or to require that people stop injecting drug use before treatment.<sup>23</sup> Treatment can be effectively provided by non-specialists at prison health clinics.<sup>24</sup>
- Though costs for diagnostics vary, decreases in price of HCV medications have made diagnosis and treatment more accessible (<US\$100) even in resource- limited settings.



### Resources on hepatitis diagnosis and treatment

For more information, see:

The Global Fund (2022). [Prioritization Framework for Supporting Health and Longevity among People Living with HIV](#)

WHO (2022). [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#)

WHO (2022). [Simplified service delivery and diagnostics for hepatitis C infection](#)

WHO (2018). [Guidelines for the care and treatment of persons diagnosed with chronic hepatitis C virus infection](#)

### c) Sexual and reproductive health (SRH) services

In addition to condoms and lubricant, people in closed settings are entitled to the same package of sexual and reproductive health services available in the broader community. These include, but are not limited to, voluntary STI check-ups and treatment, screening for HPV, breast, cervical and anal cancer, and other reproductive and sexual health services.

- To reduce barriers to treatment, syndromic STI treatment and case management (not waiting for lab results when people show common signs and symptoms) is prioritized.
- SRH services should include screening for anal and cervical cancer, and a full range of reproductive health services including contraception, abortion, post-abortion care,

<sup>23</sup> WHO (2022) [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#)

<sup>24</sup> WHO (2022). [Simplified service delivery and diagnostics for hepatitis C infection](#).

and for those who are pregnant, perinatal care and medicine to prevent vertical transmission of HIV, syphilis, hepatitis B and C or HIV.

- Trans and gender diverse people receiving hormone therapy should continue to receive this and other gender affirming care while in detention.



## Resources on gender and sexual and reproductive health

For more information, see:

UNODC (2022). [Technical brief: transgender people and HIV in prisons and other closed settings](#)

UNODC (2022). [Prevention of mother-to-child transmission of HIV, hepatitis B and C and syphilis](#)

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)

UNODC (2016). [Addressing the specific needs of women who inject drugs. Practical guide for service providers on gender-responsive HIV services](#)

### d) Health communication and demand creation

With many prison systems adopting a “zero tolerance” stance on sex, drug use, or gender diversity, prison staff and detainees both lack accurate information on HIV prevention.

The Global Fund supports efforts to inform staff and people held in closed settings about HIV and TB prevention, diagnosis and treatment in a manner that is inclusive, non-stigmatizing, rights- and evidence-based. Work supported includes:

- Individual or group interventions to educate about and build demand for programming on safer injection, safer sex, PrEP, overdose prevention, and hepatitis B and C prevention, testing and treatment.
- Individual and group interventions to increase awareness of and demand for TB prevention, testing and treatment.
- Education on and demand creation for HIV and TB services tailored to subgroups of people in prison, including women, trans and gender diverse individuals, people about to be released, and those with latent TB infection.

To help people in closed settings protect themselves, their sexual and injecting partners and their social networks, health communication is most effective when paired with programming, such as provision of condoms, PrEP, sterile injecting equipment, OST and TPT.

## 1.2 Table: Priority programming versus approaches not supported by the Global Fund

Priority for HIV/TB programming in prisons and other closed settings	Harmful/not Supported by Global Fund
Key harm reduction interventions for people who use drugs: needle and syringe programming, opioid substitution therapy, and naloxone for overdose reversal (including upon release).	Creation of drug free units, distribution of bleach for needle/syringe disinfection without provision of sterile injecting equipment.
Condoms and lubricants, available to all without staff permission/knowledge.	Abstinence campaigns, isolation or punishment for consensual sexual activity.
Voluntary HIV, hepatitis B and C testing with fully informed consent and confidentiality of test results and other health information.	Forced HIV/hepatitis or drug testing, or testing that informs prison staff but not those tested of the result
PrEP for those without HIV but with ongoing HIV risk, offered voluntarily and with informed consent.	PreP imposed involuntarily.
TB screening, TB preventive therapy for those with latent infection and those with HIV, and treatment for those with symptoms/active infection.	Solitary confinement of those with active TB infection.
Immediate ART for those testing HIV positive.	Denial or screening of requests for HIV treatment or other medical services by non-health staff.
Reduction of rights-related barriers to health (and other) services, including through staff training, creation of abuse reporting/redress mechanisms, and access to legal aid.	Denial of treatment/degrading or cruel treatment or discrimination based on gender, sexual orientation, history of sex work or illegal drug use.
Advocacy, including by organizations and networks led by former prisoners, for decriminalization of key populations and reform of harmful policies and regulations (compulsory treatment, solitary confinement, shackling of those in labor, etc.).	Compulsory drug treatment centers as an “alternative to incarceration.” Compulsory drug treatment contravenes the Global Fund’s minimum human rights standards. The Global Fund has joined UNAIDS, UNODC, WHO and nine other UN agencies to call for the closure of compulsory detention/drug rehabilitation facilities.

## 1.3 Screening and testing

Testing is a gateway to treatment for HIV, hepatitis B and C, and for TB treatment when combined with other diagnostic tools. Testing alone, however, is not sufficient. **The Global Fund supports testing for HIV, hepatitis B and C, and screening and testing for TB, that link people in prisons and other closed settings to accessible, affordable and available, quality prevention and treatment** (see sections 1.1 and 1.3).



Priorities include:

- Voluntary testing for HIV, STIs and hepatitis B and C, offered with full and informed consent and with confidentiality protection for results. Test results and medical records – whether for HIV, STIs, or viral hepatitis – should not be shared with non-health staff. Testing that informs any prison staff of results without also notifying the people tested is harmful and not supported.
- TB screening at entry, at regular intervals, and prior to release/transfer, using a combination of methods (clinical questionnaires, chest x-rays, LAM urine testing, periodic mass screening, self-referral, contact investigation, etc.). Portable X-ray equipment and computer-aided detection software, can increase accessibility and reliability of chest X-rays to detect TB when access to medical facilities or trained radiologists is limited.
- Voluntary tuberculosis preventive therapy (TPT) should be offered for those with latent infection and for those with HIV and without symptoms of active infection (cough, weight loss, fever).
- Testing for multidrug/extensively drug-resistant TB is recommended for those with active TB and HIV infection.
- Rapid, point-of-care diagnostics including rapid HIV tests, LAM urine testing for TB and molecular tests for drug/multidrug resistant TB, are particularly useful in pre-trial, prisons and other closed settings where length of stay is uncertain or where laboratory support is limited, and where those tested may have advanced HIV disease.
- Voluntary notification and testing of injection or sexual partners of those with HIV, or of those in close contact with people with active TB (“index testing/contact investigation”) should be conducted with attention to confidentiality and approaches that do not increase risk of violence or stigma.



### Resources on HIV and TB testing and screening

For more information, see:

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)

Global Fund (2021). [Chest Radiography and Computer-aided Detection \(CAD\) Solutions for Tuberculosis Programs](#)

WHO (2021). Consolidated guidelines on tuberculosis. [Module 2: Systematic screening for tuberculosis disease](#)

WHO (2021). Consolidated guidelines on tuberculosis. [Module 3: Diagnosis: Rapid diagnostics for tuberculosis detection](#)

WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#)

Stop TB Partnership (2018). [Stop TB Field guide 2: Strategies for Effective TB Case Finding in Prisons and Closed Settings](#)

WHO Euro (2014). [Prisons and Health. Chapter 8: TB prevention and control care in prisons](#)

## 1.4 Treatment and retention

People in prison and other closed settings can and should be effectively treated for HIV, TB, hepatitis and sexually transmitted infections. A key is offering **quality treatment that is easy to start, and to continue even as patients move between facilities, or between detention and the community.**

The Global Fund supports proposals for programming that:

- **Offer immediate ART** to all people with HIV in prisons and other closed settings, in line with WHO guidelines and recommendations.
- **Support treatment of those with active TB infection** in a separate prison hospital ward or cellblock (but not in solitary confinement) until they are no longer infectious. Length of time in isolation should be decided only by medical staff. Use of shorter TB treatment regimens [in line with WHO guidelines and eligibility criteria](#) is recommended.
- Control of airborne infection, and adequate sanitation and nutritional support, are also critical for TB patients and will require support from prison leadership.
- **Bring HIV, hepatitis B and C and TB treatment to detainees as much as possible**, minimizing the need for transfer to or coordination with external facilities and associated delays.
- **Use peer navigators to help people start treatment** and to remain in care.
- **Make sure health data is not shared with non-health staff** and that confidentiality is protected.
- **Train and support health workers, other prison staff and detainees** to increase uptake and retention and reduce stigma (see section 1.4).
- **Integrate OST, HIV, hepatitis and TB services, ideally with other SRH services**, to increase efficiency and reduce patient burden (see section 2.3). Where appropriate for patients, use of all oral, shorter treatment regimens for multidrug resistant TB is recommended.
- **Include pre-release planning and linkage to services for those leaving** prisons or other closed settings. Collaboration between prison and public health providers, linkages to treatment, peer accompaniment and support are particularly important for those with active TB infection, where treatment interruption may result in the emergence of drug resistance and further spread.



For more information, see:

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)

UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions](#)

WHO (2022). Consolidated guidelines on tuberculosis: [Module 4: treatment: drug-resistant tuberculosis treatment](#)

### 1.5 Removing gender- and human rights-related barriers to services

People in prisons and other closed settings retain their human rights to health, due process and protection from violence, cruel, inhuman or degrading treatment. Importantly, this means States are obligated to provide those in close settings access to the same quality health services, including SRH, HIV and TB services available to those outside. Women, trans and gender diverse people in prison and other closed settings should have access to the same services as men, and to services tailored to their needs. Adolescents in prisons and other closed settings should also have access to information and programming to prevent HIV and hepatitis B and C, and to treatment where needed.

Applicants seeking HIV funding for key and vulnerable populations, including people in prisons and other closed settings, should describe existing human rights barriers to HIV and TB services and plans to address them. Ending gender inequality and discrimination is a strategic priority for the Global Fund, and applicants should attach to their funding request assessments of human rights-related barriers and gender assessments (including in prisons and other closed settings). Countries that are part of the Global Fund's [Breaking Down Barriers initiative](#) have completed comprehensive human rights assessments and are expected to base their funding requests on the results of the most recent assessment.<sup>25</sup> Countries without such assessments are encouraged to use the Global Fund's new rapid assessment tool as part of the process of developing the funding request.<sup>26</sup>

UNAIDS, WHO, UNDP and the Global Fund have recommended several program areas as effective, evidence-based approaches to removing human rights-related barriers to HIV services (see Box 4). All of these are relevant for people in prisons and other closed settings and should be included in funding requests. All are enhanced through meaningful engagement of communities directly affected, including people in prison or those formerly incarcerated, and by key populations disproportionately affected by HIV and criminalization outside of closed settings. **At a minimum, the Global Fund expects countries to address**

<sup>25</sup> The 20 countries involved in the Breaking Down Barriers initiative are Benin, Botswana, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Honduras, Indonesia, Jamaica, Kenya, Kyrgyzstan, Mozambique, Nepal, the Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine.

<sup>26</sup> [Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools](#)

**four human rights “program essentials”** and asks all applicants to provide an update on their country’s status toward achieving these. Funding requests from Core and High Impact countries should describe how they plan to introduce or scale up any program essential that is not yet fully implemented.

**Box 3: Key program areas to reduce human rights-related barriers to services for people in prisons and other closed settings**

- Eliminate stigma and discrimination in all settings.
- Improve legal literacy (“know your rights”).
- Ensure non-discriminatory provision of health care.
- Increase access to justice.
- Ensure rights-based law enforcement practices.
- Improve laws, regulations and policies relating to HIV and HIV/TB.
- Reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity.

Community mobilization and advocacy for human rights are key to all of these.

**Program Essential: Integration of measures to reduce human rights- and gender-related barriers to services in HIV and TB programming.**

Women in prisons and other closed settings often have higher rates of HIV and STIs, and are more likely to have used drugs than men. Yet, many prisons systems do not offer them equal HIV or TB programming and fail to provide screening or services specific to their needs.<sup>27</sup> Adolescents in detention are often provided no HIV prevention information despite ongoing sexual activity and drug use.

These service failures are compounded by practices and policies that shame and stigmatize people in prisons and other closed settings for their vulnerability. Prison staff may sexually harass or rape women detainees or shackle those giving birth during their labour. Trans and gender diverse people also experience violence and harassment, are denied requests to be housed based on their gender identification or may be deprived of access to hormone therapy or other gender-affirming services.

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<sup>27</sup> UNODC (2014). [Handbook on women and imprisonment: 2<sup>nd</sup> Edition](#)... APMG Health (2019). [Global Summary of Findings of an Assessment of HIV Services Packages for Key Populations in Six Regions](#).

Examples of work to reduce human rights- and gender-related barriers to services include:

- **Advocacy to ensure that people in prisons and other closed settings have access to HIV and TB services available outside**, including access to harm reduction, HIV, STI and TB testing and treatment, sexual and reproductive health services and legal support.
- Advocacy to remove barriers to services for minors, including revision of age restrictions and increased physician discretion in provision of HIV prevention services to young people in detention who use drugs or engage in sexual activity.
- **Analysis and programming to identify and address gender-based barriers** in provision of HIV/TB services to women in all their diversity, including stigmatization and shackling of pregnant women, and solitary confinement and denial of hormone therapy to trans and gender diverse individuals.
- **Creation of reporting and redress mechanisms for those experiencing abuses or being targeted by staff or other prisoners** based on gender, sexual orientation, history of drug use or sex work or age.

**Program Essential: Integration of measures to reduce human rights- and gender-related barriers to services in HIV and TB programming.**

Some prison health services stigmatize detainees with HIV or STIs or bar some (e.g., those actively using drugs, LGBT people, sex workers) from treatment. Health staff may reveal the HIV status of patients to other staff or detainees, forcibly test people for drugs and impose penalties for positive result or deny health care as a form of punishment.

The Global Fund supports activities to reduce stigma and discrimination in health provision in prisons and other closed settings, including:

- **Changes in policy and practice to remove treatment restrictions** based on drug use, sexual preference or gender diversity, and to end forced testing for HIV or other health conditions, denial of OST or other medical treatment as punishment or screening of health requests by non-health staff.
- **Training (ongoing, rather than one-off) for health care and other prison staff** and for people in prison and other closed settings, on duty to treat, confidentiality protection, and person-centred and destigmatizing care.

The Global Fund also supports work to reduce stigma and discrimination in other settings, including in families, communities, the workplace and the educational system (all important for those released from prison and for training of medical and other prison staff), in emergency/humanitarian settings (important for continuation of HIV/TB services in closed settings during conflict or natural disaster) and in the justice system (important to preventing unnecessary detention (see next item and Box 4).

## **Program Essential: Legal literacy (know-your-rights) programming and increased access to justice.**

Imprisonment is a major barrier in the HIV and TB treatment “cascade,” placing people in contexts where risk continues but where means of prevention or treatment are often unavailable. For many detained without cause, held for months while awaiting trial, or sentenced severely for minor offenses, work to increase access to justice is essential to the success of HIV and TB programming. In addition to work to increase rights-respecting law enforcement (see Box 4) and to decriminalize (see next Program Essential), the Global Fund supports activities to increase legal literacy and access to justice for those in prisons and other closed settings, including:

- **“Legal literacy” and “know your rights” trainings** and materials for people in prisons and other closed settings, and for prison health providers and other prison staff.
- **Training and salary support for organizations, attorneys and paralegals offering legal support** inside prisons and other closed settings.
- **Creation of confidential hotlines, medical-legal partnerships and crisis response mechanisms** to address sexual violence, denial of treatment, discrimination and compassionate release requests.
- **Strategic litigation** to reform harmful practices or compel rights-respecting HIV, hepatitis or TB services.

## **Program Essential: Support for efforts, including community-led efforts, to analyze and reform harmful laws and policies.**

The Global Fund, aligned with the Global AIDS Strategy and UN common positions on [incarceration](#) and [drug policy](#), supports work to advance alternatives to incarceration, reform laws and policies that harm the HIV response. Prioritized programming includes:

- **Analysis and advocacy, including by those directly affected, to decriminalize** same sex behaviour, sex work, gender expression or possession of harm reduction equipment or drugs for personal use.
- **Reform of harmful policies inside prisons and other closed settings** including forced testing and treatment for HIV, solitary confinement or forced treatment of those with TB infection, detention of minors with adults, shackling of those in labour or detention of gender diverse persons according to gender assigned at birth rather than their stated preference.
- **Activities to sensitize parliamentarians, relevant ministries, judges, prosecutors and religious and traditional leaders** to the negative health and social impacts of criminalization and incarceration for non-violent offenses.



- **Advocacy for other legal and policy reform**, including an end to compulsory treatment for drug dependence, sex work, same-sex behaviour or gender variance, and removal of prohibitions on distribution of HIV prevention materials for key populations.

The Global Fund supports other mobilization and empowerment activities for people in prisons and other closed settings and those formerly incarcerated, including community-led monitoring of service delivery and peer-led support for prevention and treatment. The Global Fund also supports funding and capacity building for organizations or networks led by those formerly incarcerated, and for key population groups disproportionately affected by HIV and imprisonment, to enable their participation in national, provincial and local decision-making on HIV and TB.

#### **Box 4: Rights respecting law enforcement**

For many in prison, the government “service” with which they had most contact prior to incarceration was law enforcement. Key populations at highest risk for HIV are often subjected to arrest and/or police extortion or harassment. In some countries, possession of relatively small amounts of drugs leads to more severe penalties than those for murder, rape, kidnapping or bank robbery.<sup>1</sup>

The Global Fund supports development of trainings and incentive programs to increase sensitization of police and judges, to decrease arrest /incarceration in line with international human rights requirements and to increase referral to services. This can include:

- Community-led monitoring of law enforcement abuses, sentencing patterns, arrest quotas and punitive detention practices.
- Curriculum creation and training at police academies and for officers already in service, with participation by representative of key populations where they are safe and supported.
- Programs incentivizing referral to HIV services as an alternative to arrest/incarceration and ending police use of condoms or injecting equipment as evidence of wrongdoing.
- Sensitization of judges and prosecutors on the benefits of decriminalization and alternatives to incarceration, and the risks/rights violations of disproportionate sentencing and compulsory treatment.

<sup>1</sup> [UNAIDS \(2016\). Do No Harm: Health, human rights and people who use drugs](#)



## Resources on removing human rights-related barriers to services

For more information on planning, costing and acting to remove human rights- and gender-related barriers to services for people in prisons and other closed settings, please see:

The Global Fund (2022). [Removing Human Rights-related Barriers to HIV Services](#)

The Global Fund (2022). [Removing Human Rights-related Barriers to TB Services](#)

The Global Fund (2022). [Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools](#)

UNODC (2022). [Technical Brief: Transgender People and HIV in Prison and other Closed Settings](#)

UNODC (2022). [Prisons and HIV](#), including information on responding to the specific needs of women and people who inject drugs in prison, and promoting prison and criminal justice reform

Stop TB Partnership (2020). [Engage & Empower: Supporting access to TB Health Services for Prisoners and other persons deprived of liberty](#)

UNODC, INPUD, et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)

UNODC (2014). [Training manual for law enforcement officials on HIV service provision for people who inject drugs](#)

UNODC (2007). [Handbook of Basic Principles and Promising Practices on Alternatives to Imprisonment. Criminal Justice Handbook Series](#)

## 2. Investment Approach

### 2.1 Understand: Continue to know your epidemic and its updated resource needs.

Data on risk for and prevalence of HIV, HCV, STIs and TB in closed settings, including assessment of sexual and injecting practices, are essential for programming. Information about policies/practices that affect access to prevention, diagnosis or treatment in closed settings, and about interaction between prison and broader public health system, is also critical.

- Prisoners and prisoner-led organizations or networks remain a critically important source of information on how programs need to evolve/improve, and should be meaningfully engaged in assessment, design and implementation. This includes women, young people and people who use drugs.

- Assessment of HIV and TB risk including integrated biobehavioural surveillance (IBBS) should include people in prisons and other closed settings. In addition to questions about drug use and HIV risk, these assessments should include questions about experiences of stigma, discrimination, cruel and degrading treatment and other human rights violations.
- Protection of participants is crucial in assessing needs in prisons and other closed settings. Prior to any assessment, agree on anonymity and data protection with prison administration and communicate this to other prison and staff and all participants.
- Data from prisons and other closed settings should be disaggregated – that is, collected and analysed based on gender, geographic location, and type of facility (men's or women's facility, pre-trial or prison, barracks style or individual cell, etc).
- Include assessment of conditions of detention, practices of prison staff r infrastructure that affect rates of incarceration and that help or hinder delivery of services (see section 1.5).
- Even if starting small, set targets and timelines for program expansion to additional facilities, types of closed settings, etc.



## Resources on needs assessment

For more information, see:

WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)

Global HIV Prevention Coalition (2020). [HIV Prevention Self-Assessment Tool for Prisoners](#)

UNAIDS (2019). [The Privacy, Confidentiality and Security Assessment Tool: Protecting personal health information](#)

Harm Reduction International [formerly IHRA] (2016). [Monitoring HIV, HCV, TB and Harm Reduction in Prisons: A Human Rights-Based Tool to Prevent Ill Treatment](#)

Global HIV Strategic Information Working Group (2017). [Biobehavioral Survey Guidelines](#)

UNODC (2010). [HIV in prisons: Situation and needs assessment toolkit](#)

## 2.2 Design: Develop a mix of interventions that maximizes impact

Many countries do not identify people in prison as a key population, or offer services only in a few prisons or to male prisoners but not to women.<sup>28</sup> People in prison and other closed settings have higher prevalence of HIV, TB, hepatitis B and C, and overdose more often than those outside. A mix of interventions is needed. TB is the main cause of death of people with HIV, and HIV increases risk of TB infection, making services to prevent and treat both

<sup>28</sup> APMG Health (2019). [Global Summary of Findings of an Assessment of HIV Services Packages for Key Populations in Six Regions](#).

particularly critical. Women in closed settings are more likely to have a history of substance use than male detainees.

The Global Fund supports funding requests that:

- **Follow needs assessment with service creation.** Assessment makes little sense if not followed up with service provision.
- **Provide services that reinforce each other.** Condom provision reduces STIs, and STI treatment reduces risk of HIV transmission. Providing a full range of sterile injecting equipment along with the rest of the comprehensive harm reduction package reduces HIV risk and helps prevent reinfection of those treated for HCV.
- **Integrate services to reduce burden on patients and staff.** Integration of TB testing and tuberculosis preventive therapy (TPT) with provision of OST, for example, can increase TPT uptake and retention. Ideally integrate all SRH services. HIV testing for those on PreP and HCV testing are both recommended every three months for those in prison, and can be offered together.
- **Tailor and offer services to all those in need, including women in all their diversity and minors.** Those in prison and other closed settings include adolescents and adults, drug-using and non-, men, women and trans or gender diverse people.



### Resources on comprehensive and integrated services

For more information, see:

The Global Fund (2022). [Removing Human Rights-related Barriers to TB services](#)

UNODC, INPUD et al, 2017. [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)

WHO (2016). [Integrating Collaborative TB and HIV Services within a Comprehensive Package of Care for People Who Inject Drugs](#)

Stop TB Partnership (2015). [Key populations brief: prisoners](#)

UNODC (2016). [Addressing the Specific Needs of Women Who Inject Drugs: Practical Guide for Service Providers on Gender-responsive HIV Services](#)

## **2.3 Deliver: Ensure high-quality and efficient service delivery for optimal scale-up**

People in prison and other closed settings often move between closed settings and from closed settings to the community. Making quality prevention, diagnosis and treatment easy to access and continue is critical to HIV and TB programming. Service efficiency should be evaluated by people in prison or those recently released, not just by the prison system and staff. Important lessons from past Global Fund programming include:

- **Protect anonymity/confidentiality.** This includes not only confidentiality of HIV or hepatitis services, but offering access to HIV prevention services without collecting names or revealing use to other people. Where names and medical data are needed, as with OST or HIV treatment, confidentiality of data must be protected.
- **Avoid mandatory drug testing and other expensive, ineffective control measures.** Urine testing for drugs increases tensions and violence and shows limited evidence in reducing drug use.<sup>29</sup> Supply control measures are also often expensive, without evidence to confirm effectiveness in reducing drug use or HIV risk.
- **Use peer support to increase reach and retention.** Peer volunteers, prisoner-led organizations and networks have helped deliver HIV and overdose prevention, education on TB treatment and control, assistance with HIV treatment and other services (see section 3).
- **Strengthen communication mechanisms and multisectoral collaboration.** Since health staff, prison administration, outside providers and NGOs can all be involved in delivering HIV and TB services, mechanisms to facilitate communication and agreement between prison staff and other HIV and TB service providers can be critical for continuity of care, problem solving and reducing delay. Collaboration between prison and health authorities, and use of peer accompaniment and support for social reintegration, is particularly critical for TB treatment, where treatment interruption may result in drug resistance and community spread.
- **Offer legal support.** Lack of documents, outstanding fines, and arrest are major factors in delaying release from prison or interrupting continuity of treatment. Integrating legal and health services for people in closed settings and for those recently released, can help.
- **Facilitate entry to community health services.** People released from closed settings should be provided with a copy of their medical records, medicine for ongoing treatment (and for people who inject drugs) naloxone for overdose and links to health services in the community.
- **Evaluation.** Applicants should plan for evaluation of impact, including real-time tracking of service delivery, regular HIV prevention performance review and accountability process (including service users), ongoing assessment of service gaps, changes to policies and environmental factors (e.g., new arrest patterns, prison overcrowding, COVID-19 outbreaks, new drugs in the marketplace) shaping risk in prisons and other closed settings.

## 2.4 Sustain: Strengthen the sustainability of health systems.

Global Fund grants are for a three-year period, making it important to plan for longer-term sustainability from the start. The best way to ensure coordination and continuity of service, as well as cost-effective procurement, is for the same system responsible for public health

<sup>29</sup> WHO, UNODC et al (2007) Evidence for Action: Drug Dependence Treatment in Prisons and Other Closed Settings.

on the outside to deliver those services in closed settings. If this is not yet possible, countries should prioritize:

- Inclusion of prison authorities in all committees and working groups responsible for planning and funding the response to HIV and TB, including in the CCM
- Facilitation of information sharing and medical record transfer between prison and public health systems and engagement of prison health staff with community-based and community-led care.
- Explicit plans and targets for funding and delivery of prison HIV and TB services and technical advisory group including prison authorities, health providers, prisoners, prisoner-led organizations and other key stakeholders.
- Clarity on what will be funded from health and from the prison administration, and mechanisms if needed to pool resources (e.g., creation of an interagency mechanism to transfer funds or commodities).
- “Social contracting” to fund prisoner-led networks and NGOs able to help deliver training and services in prisons and other closed settings, to support those released, and to strengthen monitoring of and advocacy for HIV and TB services in prisons and other closed settings.



### Resources on budgeting for and sustaining HIV and TB services

For more information, please see:

The Global Fund (2022). [Resilient and Sustainable Systems for Health \(RSSH\) Information Note](#)

The Global Fund (2020). [Sustainability, Transition and Co-financing Guidance Note](#)

UNDP (2019). [Guidance note for the analysis of NGO social contracting mechanisms](#): the experience of Europe and Central Asia

WHO, UNODC et al (2013). [Good governance for prison health in the 21<sup>st</sup> century](#)

## **3. Good Practice Example**

### **3.1 Peer-based needle and syringe program in Moldovan prisons**

NSPs have been operating in prisons in Moldova since 1999, when an anonymous survey of prison conditions by an NGO first documented widespread needle sharing and high HIV risk. Concerned by the results, authorities changed regulations to allow needles and syringes into prisons as part of the national HIV program and agreed to work with the NGO to pilot peer-based NSP. Today, NSPs are run in all adult detention facilities in Moldova by inmate volunteers working in collaboration with medical staff and with ongoing support and training from NGOs.

The NSPs also serve as sites for condom distribution, health information, peer support and overdose management. All volunteers have been trained in providing first aid, and naloxone is available at every NSP site. The director and medical director of the Department of Penitentiary Institutions – both strong supporters of harm reduction efforts – further expanded the range of prevention services in 2005, introducing OST with methadone.

The program has brought positive attention from other prison authorities around the world. There has been no use of needles as weapons against staff or fellow prisoners, and even prison staff who were initially opposed to the approach now support it. The Department of Penitentiary Institutions provides some funding to supplement that of international donors, including the Global Fund. In the span of five years of program operations, HIV and HCV prevalence among Moldovan prisoners decreased by more than 50%.



## 4. List of Abbreviations

<b>ART</b>	Antiretroviral treatment
<b>CCM</b>	Country Coordinating Mechanism
<b>HBV</b>	Hepatitis B virus
<b>HCV</b>	Hepatitis C virus
<b>HPV</b>	Human papilloma virus
<b>INPUD</b>	International Network of People who Use Drugs
<b>LAM</b>	Lipoarabinomannan
<b>NGOs</b>	Non-governmental Organizations
<b>NSP</b>	Needle and syringe programming
<b>OD</b>	Overdose
<b>OST</b>	Opioid substitution therapy
<b>PEP</b>	Post-exposure prophylaxis
<b>PrEP</b>	Pre-Exposure Prophylaxis
<b>SRH</b>	Sexual and reproductive health
<b>STI</b>	Sexually transmitted infection
<b>TB</b>	Tuberculosis
<b>TPT</b>	Tuberculosis preventive therapy
<b>UNAIDS</b>	United Nations Joint Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>WHO</b>	World Health Organization

## 5. Resources

### The Global Fund

1. [HIV Information Note](#) (2022)
2. [Tuberculosis Information Note](#) (2022)
3. [Modular Framework Handbook](#) (2022)
4. [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \[2023-2028\]](#)

### Additional technical briefs and guidance notes

5. [Community Systems Strengthening](#) (2022)
6. [Harm Reduction for People Who Use Drugs: Priorities for Investment and Impact in HIV Programming](#) (2022)
7. [Gender Equality](#) (2022)
8. [Equity, Human Rights, Gender Equality and Malaria](#) (2022)
9. [Removing Human Rights-related Barriers to HIV services](#) (2022)
10. [Removing Human Rights-related Barriers to TB services](#) (2022)
11. [Sustainability, Transition and Co-financing Guidance Note](#) (2022)
12. Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools (2022)
13. [Chest Radiography and Computer-aided Detection \(CAD\) Solutions for Tuberculosis Programs](#) (2021)

### Global strategies and commitments

14. UNAIDS (2021). [Global AIDS Strategy 2021-2026](#)
15. UN General Assembly (2021). [Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030](#)
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17. Global HIV Prevention Coalition (2017). [HIV Prevention 2020 Road Map](#).
18. UNAIDS (2016). [Do No Harm: Health, Human Rights and Drugs](#)
19. Stop TB Partnership (2022). [The Global Plan to End TB: 2023-2030](#)

## Programmatic guidance and review

20. Global HIV prevention Coalition (2022). [HIV Prevention 2025: Road Map.](#)
21. UNODC (2022). [Technical Brief: Transgender People and HIV in Prison and other Closed Settings](#)
22. UNODC (2022). [Prevention of mother-to-child transmission of HIV, hepatitis B and C and syphilis](#)
23. WHO (2022). [Simplified service delivery and diagnostics for hepatitis C infection](#)
24. WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)
25. WHO (2022). [Rapid Assessment and Response Guide on Psychoactive Substance Use and Sexual Risk Behaviour](#)
26. Global HIV Prevention Coalition (2020). [Considerations in planning and budgeting for a key population trusted access platform to deliver scaled, quality HIV prevention and treatment services and for addressing critical enablers](#)
27. Stop TB Partnership (2020). [Engage & Empower: Supporting access to TB Health Services for Prisoners and other persons deprived of liberty](#)
28. WHO (2020). Operational handbook on tuberculosis, including modules on [tuberculosis preventive treatment](#), [systematic screening for tuberculosis disease](#), [rapid diagnostics for tuberculosis detection](#), [drug-susceptible tuberculosis treatment](#), [management of tuberculosis in children and adolescents](#)
29. UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions](#)
30. UNDP (2019). [Guidance note for the analysis of NGO social contracting mechanisms](#): the experience of Europe and Central Asia (UNDP, 2019)
31. Stop TB Partnership (2018). [Stop TB Field guide 2: Strategies for Effective TB Case Finding in Prisons and Closed Settings](#)
32. WHO (2018). [Guidelines for the Care and Treatment of Persons Diagnosed with Chronic Hepatitis C Virus Infection](#)
33. UNAIDS (2018). [Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination.](#)
34. UNODC, INPUD, et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)
35. Global HIV Prevention Coalition (2017). [Strengthening HIV Primary Prevention: Five Thematic Discussion Papers to Inform Country Consultation and the Development of a Global HIV Prevention Roadmap \(](#)
36. Global HIV Strategic Information Working Group (2017). [Biobehavioral Survey Guidelines.](#)

37. WHO (2017). [Guidelines on Hepatitis B and C Testing](#)
38. UNODC (2016). [Addressing the Specific Needs of Women Who Inject Drugs: Practical Guide for Service Providers on Gender-responsive HIV Services](#)
39. WHO (2016). [Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection](#)
40. WHO (2016). [Integrating Collaborative TB and HIV Services within a Comprehensive Package of Care for People Who Inject Drugs](#)
41. WHO (2015). [Systematic screening for active tuberculosis: an operational guide](#) and [Etool for assistance in costing and rollout](#)
42. Stop TB Partnership (2015). [Key populations brief: people who use drugs](#)
43. UNODC (2015). [Handbook for Starting and managing needle and syringe programmes in prisons and other closed settings](#)
44. UNODC (2014). [Training manual for law enforcement officials on HIV service provision for people who inject drugs](#)
45. WHO (2014). [Preventing Overdose Deaths in the Criminal-justice System.](#)
46. WHO (2014). [Guidelines on Community Management of Opioid Overdose](#)
47. WHO Euro (2014). [Prisons and Health](#). Chapter 8: [TB prevention and control care in prisons](#)
48. WHO, UNODC et al (2013). [Good governance for prison health in the 21<sup>st</sup> century](#)
49. WHO (2012). [Guidance on prevention of viral hepatitis B and C among people who inject drugs](#)
50. UNODC (2011). [HIV in prisons: Situation and Needs Assessment Toolkit.](#)
51. WHO (2009). [Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence](#)
52. WHO, UNAIDS and UNODC (2007). [Guide to Starting and Managing Needle and Syringe Programmes](#)
53. WHO (2004). [Evidence for Action: Effectiveness of Community-based Outreach in Preventing HIV/AIDS among Injecting Drug Users](#)
54. WHO (1998). [Rapid Assessment and Response Guide on Injecting Drug Use \(IDU-RAR\)](#)

## **Additional resources**

55. APMG Health (2019). [Global Summary of Findings of an Assessment of HIV Services Packages for Key Populations in Six Regions](#)
56. Harm Reduction International [formerly IHRA] (2016). [Monitoring HIV, HCV, TB and Harm Reduction in Prisons: A Human Rights-Based Tool to Prevent Ill Treatment](#)