



# Guidelines for the Management of Tuberculosis, Human Immunodeficiency Virus and Sexually-Transmitted Infections in Correctional facilities 2013



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA


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## FOREWORD

Tuberculosis and HIV, AIDS are the major causes of morbidity and mortality in the country. It is for this reason that our interventions must focus on prevention of new infections and expand access to testing and treatment services to all South Africans. Correctional facilities are potential areas for spread of airborne infections and therefore require targeted interventions to mitigate the risk of infection.

This document provides the general principles for the management and control of TB, HIV, AIDS and STIs in Correctional facilities. The primary audience is health and administrative staff in the Departments of Correctional Services (DCS) and Health (DOH). It is meant to provide guidance on prevention of new infections, early detection through routine testing and early treatment of those with tuberculosis and human immunodeficiency virus infection and disease. It must be used in conjunction with relevant Department of Health guidelines.

The technical staff of the Department of Correctional Services at national and regional level will be responsible for ensuring that these guidelines are implemented by all health professionals in Correctional Services' facilities. The Department of Health will provide assistance through orientation, training and supervision.

**Dr Aaron Motsoaledi, MP**  
**Minister of Health**



## ACKNOWLEDGEMENTS

The development of these guidelines has been a collaboration between the National Department of Health (NDOH), the Department of Correctional Services (DCS) and partners – the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Office on Drugs and Crime (UNODC), World Health Organisation (WHO), The Aurum Institute, TB / HIV Care Association, Right to Care, and the University Research Co. (URC)

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**Ms M P Matsoso**  
**Director General for Health**

## ABBREVIATIONS

<b>ACSM</b>	Advocacy, communication and social mobilization
<b>AFB</b>	Acid-Alcohol Fast Bacilli
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ART</b>	Antiretroviral treatment
<b>BCG</b>	Bacille Calmette-Guerin
<b>CD4 cells</b>	White T helper cells which are progressively reduced in AIDS
<b>CMV</b>	Cytomegalovirus
<b>CMX</b>	Cotrimoxazole
<b>CSF</b>	Cerebrospinal fluid
<b>DCS</b>	Department of Correctional Services
<b>DoH</b>	Department of Health
<b>DOTS</b>	Directly-observed treatment short-course
<b>EIA</b>	Enzyme immunoassay
<b>ELIZA</b>	Enzyme- Linked Immunosorbent Assay
<b>ETR</b>	Electronic tuberculosis register
<b>HAART</b>	Highly active antiretroviral treatment
<b>HCW</b>	Health care workers
<b>HCT</b>	HIV counselling and testing
<b>HIV</b>	Human Deficiency Virus
<b>INH</b>	Isoniazid
<b>IPT</b>	Isoniazid preventive therapy
<b>IV</b>	Intravenously
<b>LDH</b>	Lactate dehydrogenase
<b>MDR-TB</b>	Multidrug-resistant tuberculosis
<b>MMC</b>	Medical male circumcision
<b>MSM</b>	Men having sex with men
<b>M. tuberculosis</b>	Mycobacterium tuberculosis
<b>NGO</b>	Non-governmental organization
<b>NHLS</b>	National Health Laboratory Service
<b>NSP</b>	National Strategic Plan on HIV, STIs and TB
<b>OIs</b>	Opportunistic infections
<b>PCR</b>	Polymerase-chain reaction



<b>PEP</b>	Post-exposure prophylaxis
<b>PICT</b>	Provider initiated counselling and testing
<b>PJP</b>	Pneumocystis jiroveci pneumonitis
<b>PLHIV</b>	People living with HIV
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>PNP</b>	Peripheral neuropathy
<b>Qid</b>	Four times a day
<b>STI</b>	Sexually transmitted infections
<b>TB</b>	Tuberculosis
<b>tds</b>	Three times daily
<b>T. gondii</b>	Toxoplasma gondii
<b>Tier.net</b>	Monitoring and evaluation system for ART
<b>UVGI</b>	Ultraviolet germicidal radiation
<b>WHO</b>	World Health Organization
<b>XDR-TB</b>	Extensively drug-resistant tuberculosis

## EXECUTIVE SUMMARY

### Why we need these guidelines for correctional centres

- Inmates come from communities with high rates of tuberculosis (TB) and Human Immunodeficiency Virus (HIV). They may have undiagnosed TB or on treatment, which is then interrupted on incarceration, resulting in a high risk of transmission of TB.
- Overcrowding, high inmate population turnover and unhygienic conditions contribute further to the spread of infectious diseases in correctional centres
- Inmates have the right to receive health care, including preventive measures, equivalent to the care available in South African communities as outlined in the following documents:
- Standard Minimum Rules on the Treatment of Prisoners (United Nation Congress on the Prevention of Crime and Treatment of Offenders) Resolution 2076 of 13 May 1977
- Constitution of the Republic of South Africa, Act 108 of 1996.
- Correctional Services Act, Act 111 of 1998 as amended.
- Regulation to the Correctional Services Act.
- Health care Policy and Procedures
- All applicable policies and guidelines of the National Department of Health
- Policies and practices must be put in place **to create a safer environment and diminish the risk** of transmission of TB, HIV and Sexually Transmitted Infections (STIs) to inmates and officials alike.

### Screening and diagnosis in correctional centres

- **Voluntary HIV counselling and testing** must be offered to all inmates at entry, during incarceration, as per request by inmate, as part of routine screening campaigns, as part of integrated primary health care services, and on release. A rapid test is conducted if positive subject to a confirmatory rapid test. In cases of indeterminate or discordant results a blood sample must be sent to the laboratory for an (Enzyme- Linked Immunosorbent Assay) ELIZA test. Inmates whose CD4 count is <350 cells/ $\mu$ L must be started on Antiretroviral Therapy (ART) and all inmates with newly diagnosed HIV must be assessed for TB infection.
- **Symptom-based TB screening** must be conducted on all inmates at entry, during TB screening campaigns, self-reported or peer referred, TB contacts, as part of integrated primary health care services, at least bi- annually and on release. Chest X-ray and GeneXpert<sup>®</sup> MTB/RIF are complementary. An outbreak is defined as more than two inmates from one cell having TB, requiring investigation in collaboration with the Department of Health.

- **Universal screening for anal, oral and genital STIs** must be conducted on- all inmates at entry, upon self-presentation and as part of integrated primary health care services, using specific algorithms based on symptoms.
- **TB diagnosis**, all adult inmates with suspected TB must provide sputum samples. If smear or GeneXpert® MTB/RIF positive, TB treatment is commenced. If both specimens are negative in either test, HIV-negative inmates receive antibiotics treatment for 5 days and are then reassessed after completion of treatment. HIV-positive inmates are referred for assessment, X-ray and TB culture.

#### **Treatment in correctional centres**

- **TB treatment:** Smear- or culture-positive and GeneXpert® MTB/RIF-positive, rifampicin-sensitive patients must be treated according to the National Tuberculosis Management Guidelines, the latter patients further need a second specimen sent for microscopy. GeneXpert® MTB/RIF-positive, rifampicin-resistant patients need to be referred to a multidrug-resistant TB unit for further management. Inmates with pulmonary TB must be admitted in the health facility and isolated for two weeks. Hospitalisation must be considered for diabetes, liver disease, respiratory insufficiency, haemoptysis, serious adverse events of therapy and severe extra pulmonary disease.
- HIV-positive inmates who are not on ART require repeat CD4 testing every 6 months, TB symptom and STI screening during every encounter with a health care provider. These inmates must receive cotrimoxazole, TB prophylaxis and ART as per eligibility criteria. If inmates have TB, ART must be started immediately. They must be screened for cryptococcal disease if CD4<100cells/mm3.
- STIs treatment must be initiated immediately in all inmates with a confirmed diagnosis. The syndromic management flow charts for management of symptomatic STIs outlined in the DoH guidelines must be followed. In addition, HCT must be offered (if not recently tested), condom promotion, adherence counselling and education about the importance of partner notification and treatment must be shared with the inmate. All patients must be reviewed on completion of treatment and referred if not responding to treatment.
- Adherence support must consist of information on the regimen and the reason for long-term treatment including side effects of therapy. Education must emphasise the importance of taking treatment exactly as prescribed. Support provided by nurses, care workers, treatment buddies and support groups must be complemented by pill counts.

#### **Prevention in correctional centres**

- Inmates and correctional centre staff must be informed about TB, HIV and STIs including prevention in their increased risk environment. Peer education as an effective means involves dissemination of correct information by both centre staff and inmates.
- **TB prevention:** Isoniazid preventive therapy (IPT) must be given to all HIV-infected adults who are not on TB treatment; are asymptomatic for TB; have no active liver disease and no history of alcohol abuse, psychosis, convulsions or neuropathy. Isoniazid 300 mg plus Vitamin B6 25 mg daily must be given for the duration of incarceration. Inmates must be monitored for side effects and indications for interruption of IPT. Special considerations apply for infants.

- **TB infection control** consists of environmental and administrative controls and personal protection. These involve an Infection Prevention and Control Committee and Plan, risk assessments, education of staff and inmates, regular screening, isolation of TB patients, coughing etiquette, face masks, safe environments for sputum provision, natural ventilation where possible and ultraviolet germicidal radiation.
- **HIV prevention** requires a comprehensive approach including access to condoms and water-based lubricants; reducing vulnerability to sexual assault; post-exposure prophylaxis with established drug regimens including monitoring of drug safety and potential seroconversion; harm reduction programmes to reduce the risk of HIV-transmission related to substance abuse; education on risk behaviour and preventive measures with a focus on men having sex with men; and Male Medical Circumcision (MMC) with adequate counselling on risk reduction after the intervention.
- **HIV- and TB-related stigma and discrimination must be minimised** through peer education, support groups and information campaigns.

#### **Women and child health in correctional centres**

- All pregnant women must be referred to the DoH health facilities for prevention of mother to child transmission of HIV and follow up.
- To prevent TB in pregnancy, TB symptom screening must be conducted on admission and at every visit to the health facility, regardless of their HIV status. All HIV-positive pregnant women without TB symptoms must receive IPT.
- TB treatment must be given to all women if indicated.
- All HIV-positive pregnant women must receive ART regardless of their CD4 count.
- All women irrespective of HIV and TB status must be encouraged to breastfeed. If active TB has been excluded, all infants living with their mothers in correctional centres must be started on IPT.
- Treatment for prevention of mother-to-child transmission must be completed.

#### **Continuum of care**

- Efforts must be made to retain all inmates admitted, transferred between and released from correctional facilities within the TB/ HIV care.

#### **Recording and reporting**

- Reporting, monitoring and evaluation are paramount and need to strictly follow Department of Health (DOH) policies.

#### **Human rights**

- The rights of inmates, staff and health care workers guaranteed in the *Constitution of the Republic of South Africa* and the *Correctional Services Act* have to be upheld.

## INTRODUCTION

### 1.1 Tuberculosis and Human Immunodeficiency Virus in Correctional Centres

An estimated 360,000 inmates move through the South African correctional centre system annually. The 2011/2012 annual report of the Department of Correctional Services (DCS) states that during this period, the inmate population was on average 158,790. Inmates come from communities with high rates of tuberculosis (TB) and human immunodeficiency virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) prevalence, unemployment and poverty. On incarceration, they may have undiagnosed disease or may be on treatment, which is then interrupted in the process. This poses a high risk of transmission of TB and of selection for resistance in those who default treatment. Overcrowding, high population turnover and unhygienic conditions contribute further to the spread of infectious diseases within correctional facilities. Finally, DCS health care services are not adequately supported, trained or equipped to respond to inmate health care needs, which may lead to worsening of the burden of infectious diseases within correctional centres.

Globally, TB and HIV present major health challenges which are multiplied in correctional centres. A national prevalence survey conducted by the DCS in South Africa in 2006 found that 19.8% of inmates were HIV-positive compared to a national population prevalence of 16.3%. A recent study conducted by The Aurum Institute at Johannesburg Medium B Correctional Centre found a TB point prevalence of 3.4% amongst 981 inmates, more than double the prevalence in the general population of South Africa. Approximately 67% of TB cases in this study had been previously undiagnosed.

High TB/HIV co-infection rates compound the effects of the individual disease. In 2006, 44% of all new TB cases diagnosed in South Africa were found to be co-infected with HIV. The WHO TB Global report of 2012 reported 65% of TB patients in South Africa co-infected with HIV in 2011. TB is the number one cause of death in HIV-positive persons. HIV has a dramatic impact on TB epidemiology and has been implicated as a principal cause for TB resurgence. , , , HIV increases susceptibility to new infections including sexually transmitted infections (STIs), and increases the probability of reactivation of latent TB infection.<sup>5,6</sup>

The DCS has made notable strides in addressing various aspects of health care in South African correctional centres, including provision of TB/HIV and STI screening at entry. Sentenced inmates reportedly have 100 % access to primary health care services with the DCS ensuring access to condoms, TB treatment, isoniazid preventive therapy (IPT) and antiretroviral treatment (ART). Particular attention needs to be paid to awaiting trial detainees in police holding cells who do not have the same access to services. Overcrowding is a major problem in these cells due to delays in judicial processing. On sentencing, these inmates are then transferred to correctional centres where they may transmit disease, or those not sentenced may transmit disease upon release in the communities where they live.

Despite the progress made by the DCS, the burden of TB and HIV in correctional centres is increasing. Reasons include DCS health care staff shortages, late case detection, lack of isolation facilities for inmates with infectious pulmonary TB and inadequate treatment. There is a need for transformation of health care services in correctional centres to prevent new infections among inmates. For effective infectious disease control in correctional centres, a combination of strategies needs to be implemented centred around:

- **Prevention:** implementing strategies that reduce the numbers of new infections, e.g. decreasing overcrowding, putting in place appropriate infection control measures, and initiation of preventive therapy in high risk groups amongst other strategies.
- **Early case detection:** conducting active case finding starting with baseline/ admission screening as part of the mandatory health examination on admission to the correctional centre, followed by bi-annual symptom screening or screening at every encounter with the health services during the stay in correctional centres. Rapid diagnostic tools must be used to reduce delays in confirmation of disease.
- **Prompt initiation of treatment:** standardised treatment must be started within 48 hours of diagnosis. This will require close monitoring of the specimen collection, result reports, recording and filing of results.
- **Effective referral system:** Ensuring that released inmates and parolees with TB are linked to health services for continuity in and management post incarceration

## 1.2 Outline of the National Strategic Plan on HIV, STIs and TB 2012-2016

The South African National Strategic Plan (NSP) on HIV, STIs and TB 2012 – 2016 is driven by a long-term vision for the country with respect to the HIV and TB epidemics. It has adapted, as a 20-year vision, the three zeros advocated by the Joint United Nations Programme on HIV and AIDS (UNAIDS). The vision for South Africa is:

- zero new HIV and TB infections;
- zero new infections due to vertical transmission;
- zero preventable deaths associated with HIV and TB;
- zero discrimination associated with HIV and TB.

The South African NSP (2012-2016) has set the following broad goals to achieve the 20-year vision:

- to reduce new HIV infections by at least 50% using combination prevention approaches;
- to initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation;
- to reduce the number of new TB infections as well as the number of TB deaths by 50%;
- to ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the South African NSP;
- to reduce self-reported stigma and discrimination related to HIV and TB by 50%.

Four strategic objectives form the basis of the collective South African HIV, TB and STI response:

- Addressing social and structural barriers to HIV and TB prevention, care and treatment by influencing societal norms and behaviours through structural interventions to reduce vulnerability to, and to mitigate the impacts of HIV and TB;
- Preventing new TB, HIV, STI infections by ensuring a multi-pronged approach to HIV, STI and TB prevention which includes all biomedical, behavioural, social and structural approaches in order to reduce new HIV, STI and TB infections;
- Sustaining health and wellness by ensuring access to quality treatment, care and support services for those with HIV, STIs and/or TB, and to develop programmes focussing on wellness, inclusive of both physical and mental health;
- Ensuring protection of human rights and increasing access to justice in order to address issues of stigma, discrimination, human rights violations and gender inequality.

### **1.3 Management Guidelines**

HIV, STIs and TB must further be managed in accordance with all relevant existing NDoH guidelines.

## 2. GENERAL PRINCIPLES

### 2.1 Guiding Principles

These guidelines provide standards from a public health perspective which South African correctional centre authorities must strive to achieve in their effort to prevent HIV and TB transmission in correctional centres and to provide care to those most affected by these diseases. The guidelines are specific for the South African context with its extremely high burden of the TB / HIV co-epidemic and based on the general principles defined in the World Health Organization's (WHO) Guidelines on HIV infection and AIDS in Prisons as outlined below:

- a) All inmates have the right to receive health care, including preventive measures, equivalent to that available in South African communities without discrimination as defined in the Bill of Rights in the South African Constitution, in particular with respect to their legal status.
- b) The general principles adopted by the South African NSP (2012-2016) apply equally to inmates and to the community.
- c) The implementation of these guidelines must be through close collaboration among the national and provincial departments of health authorities, correctional centre authorities, and relevant partners, including non-governmental organizations (NGOs). The strategies must be incorporated into a wider programme of promoting health among inmates.
- d) Preventive measures for HIV / AIDS and TB in correctional centres must be complementary to and compatible with those in the community. Preventive measures must further be based on i) the specific conditions in correctional centres conducive to TB transmission and ii) behaviours known to be common in South African correctional centres and increasing the risk of HIV / AIDS such as unprotected sexual intercourse, the sharing or reuse of tattooing and body piercing equipment and the sharing of razors for shaving.
- e) The active involvement of partners and inmates, and the non-discriminatory and humane care of both TB / HIV infected inmates and those with AIDS / active TB are a prerequisites for achieving a credible strategy for preventing both HIV and TB transmission.
- f) It is important to recognize that any correctional centre environment is greatly influenced by both centre staff and inmates. Both groups must therefore participate actively in developing and applying effective preventive measures, in disseminating relevant information, and in avoiding discrimination.
- g) Correctional Services management have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV and TB to inmates and staff alike.
- h) Independent research in the field of TB / HIV among South African correctional centre populations must be encouraged to inform successful interventions in the country.



Independent examination by an ethical review committee must be carried out for research procedures in correctional centres, and ethical principles must be strictly observed. The results of such studies must be used to benefit management, inmates and staff, for example by improving prevention or treatment policies for both diseases in the specific setting of South African correctional centres.

## 2.2 Roles and Responsibilities

### Duties of the medical practitioner

- Diagnose and treat patients appropriately;
- Provide initial education and counselling of patients;
- Clinically assess patients during treatment;
- Manage adverse effects of medicines;
- Refer very sick, complicated and multidrug-resistant (MDR) / extensively drug-resistant (XDR) TB patients to the appropriate level of care;
- Ensure appropriate use and storage of medicines.

### Duties of Professional Nurses or Equivalent

- Plan and budget for HIV, STIs and TB activities;
- Provide appropriate information, education and communication education (IEC) material and conduct group health education activities;
- Provide on-going education and counselling of patients;
- Coordinate awareness campaigns
- Assess, diagnose and treat inmates in accordance with relevant guidelines and protocols and ensure directly observed therapy;
- Maintain updated patient records and registers;
- Monitor adherence and adverse effects
- Provide care and psychosocial support for co-infected patients;
- Establish a proper referral system for patients within correctional facilities and those referred to external facilities;
- Establish and maintain partnerships with all relevant internal and external stakeholders
- Liaise with the laboratory for follow up of results;
- Maintain an adequate supply of drugs, laboratory supplies and TB clinic/ patient cards and registers;
- Ensure tracing and screening of all contacts of clients with infectious TB;
- Coordinate referrals for patients who are released or transferred to another centre while undergoing therapy and follow up on referrals;
- Participate in district quarterly meetings;
- Collect, analyse, consolidate and submit HIV, STIs and TB statistics as required;
- Prepare quarterly reports on case detection, sputum conversion and treatment outcome and submit to the sub-district and district.

### **Duties of the Regional DCS Programme Manager or Supervisor**

- Monitor the implementation of the programmes in correctional centres;
- Liaise with the provincial TB and HIV managers;
- Conduct skills audit and coordinate training for staff;
- Provide technical assistance to the correctional centre health staff;
- Assist with the organization of the health services in correctional centres;
- Assist correctional centres in developing an efficient referral system of patients to ensure continuity of care for patients;
- Ensure sufficient drug supply and supplies in all correctional health facilities;
- Coordinate laboratory services and communication with laboratories;
- Conduct support visits to correctional health facilities;
- Collate and validate correctional health facility data;
- Plan and conduct social mobilisation and awareness campaigns, health promotion and educational campaigns;
- Adapt, develop and distribute relevant IEC material in local language;
- Compile and submit quarterly reports to the provincial and head office levels;
- Evaluate progress with implementation of the programmes;
- Participate in quarterly provincial TB/ HIV meetings.

## **2.3 Operational Issues**

The DCS with the support of the DOH at national, provincial, district and sub-district levels must ensure that the required resources are available to enable relevant staff to operationalize and implement these guidelines. Issues to be considered in the implementation of the guidelines include, but are not limited to:

- Development and implementation of a Health Human Resources recruitment, retention, development and management strategy for the DCS;
- Development of staffing norms specific for the provision of health care services in a correctional environment;
- Provide the required equipment (computers, software, telephones);
- Assessment of drug supply management and drug storage capacity at DCS health facilities (including tracer medicines and supplies);
- Placement of digital x-ray machines within DCS health facilities;
- Consideration of point-of-care testing based on numbers of inmates and access;
- Mapping of laboratory services in relation to DCS health facilities in order to improve diagnosis.
- Explore possibilities of improving current infrastructure for infection control purposes;
- Assessment of DCS health facilities for the possible regional centralisation of MDR-TB and admission of MDR-TB patients;
- Development of a workplace TB Policy for DCS.

## 3. SCREENING FOR TUBERCULOSIS, HIV AND SEXUALLY TRANSMITTED INFECTIONS

### 3.1 Tuberculosis Screening

TB screening must be conducted on all inmates within six hours of admission, biannually for all resident inmates and on leaving a correctional centre. Inmates who present with TB symptoms must be investigated within twenty four hours. A proper history including previous episodes of active TB disease, family history of TB or TB contact and other underlying risk factors such as HIV and diabetes must be obtained from the inmate. A thorough medical examination must be undertaken followed by bacteriological examination using GeneXpert® MTB/RIF and chest X-ray.

TB screening of correctional centre staff must be conducted within the Integrated Employee Health and Wellness programmes and services. The management of staff who acquired TB in the workplace must be outlined in the DCS Workplace Policy and communicated to all staff.

#### Frequency of TB screening

**On entry screening: must be conducted within six hours of admission** to detect undiagnosed active TB and also to identify inmates who are presently on TB treatment in order to ensure continuation and adherence to treatment. It is important that this screening is documented and filed as prescribed.

- **During incarceration:** screening could be part of the following interventions
- **TB screening campaigns:** Bi-annual intensified case finding must be conducted amongst all incarcerated inmates.
- **Self-reported /peer referred TB suspect:** Screening of inmates who visit the health facility at the correctional centre with minor ailments.
- **Contact investigation:** Screening for TB amongst inmates who have shared a cell or spent time with an inmate who has active TB.
- **Exit and transfer screening:** TB screening on release as part of the pre-release programme. This must include symptom screening, bacteriological examination and / or radiological examination as indicated.

#### TB screening and investigation

**Symptom-based screening:** TB symptom screening is recommended for all inmates at the time of entry into the correctional centre. Any inmate who has symptoms suggestive of TB must be immediately isolated and evaluated for TB disease. Inmates are screened using the symptom screening tool for the following symptoms:

- Persistent cough for more than 2 weeks;
- Fever for more than 2 weeks;
- Drenching night sweats;
- Unexplained weight loss (more than 1.5 kg in a month);

They may also present with symptoms suggestive of advanced TB disease such as:

- Chest pain;
- Shortness of breath;
- Haemoptysis.

The TB symptom screening form is attached as Annexe 2.

Inmates must also be asked if they have a history of TB disease or if they have been treated for latent infection or TB disease previously. Other underlying risk factors such as HIV and diabetes must also be identified.

Inmates who have any of the first four TB symptoms must receive a thorough medical evaluation, including sputum examinations or, if indicated, chest X-ray.

**Chest X-ray:** Where indicated, TB suspects must be referred for chest X-ray. If not available within DCS facilities, they must be referred to the nearest public health facility. Inmates with any parenchymal abnormality on their chest X-ray must be followed up with sputum examination. Chest X-ray must not replace symptom screening. However, it can be used together with a symptom questionnaire.

Numerous studies have shown that this screening combination doubles the TB case-finding rate. Cost and logistical barriers in most correctional centres mean that chest X-ray screening might not be readily available.

In addition, for every person who is identified with TB, a chest X-ray is needed to determine the extent of the disease, pre-existing lung damage or scarring, and to exclude concomitant lung disease. This will assist in pre-empting any residual lung impairment that might result from the disease.

**GeneXpert® MTB/RIF testing:** A spot sputum specimen must be collected under supervision from an inmate presenting symptoms of TB and then sent for GeneXpert® testing. The laboratory request form must be completed fully and specify that this is a pre-treatment specimen. The results must be followed up with the laboratory within 24-48 hours. GeneXpert® MTB/RIF is particularly useful as a screening tool for TB in HIV-positive inmates where most patients initiated on ART lack the classical symptoms of TB resulting in missed diagnosis. The test must not replace symptom screening but can be used in combination with symptoms and chest X-ray to increase sensitivity of testing.

**Smear microscopy/ Culture:** A spot sputum specimen must be collected from an inmate with a positive Xpert result for baseline microscopy. This is used to determine the infectiousness of the patient. Where Xpert result is negative, the inmate is HIV positive and TB highly suspected, a culture and Line Probe Assay (LPA) or Drug Sensitivity Test (DST) may be conducted to confirm diagnosis of TB or DR-TB.

**Tuberculin skin test screening:** The Mantoux tuberculin skin testing (TST) is the standard method of determining whether a person is infected with *Mycobacterium tuberculosis*. Reliable administration and reading of the TST requires standardisation of procedures, training, supervision and practise.

## Contact investigation

Prompt and active screening for TB among close contacts of sputum smear-positive (i.e. infectious) pulmonary TB patients must be conducted. Close contacts include, but are not limited to:

- All inmates who sleep in the same cell as the TB patient;
- Infants of women diagnosed with TB.

In addition, for multi drug (MDR-) or extensively drug-resistant (XDR-) TB cases, the following must also be considered for contact investigation:

- Inmates who spend time in closed or poorly ventilated work areas (e.g., carpentry and handcraft shops) that operate inside the same correctional centre as the TB patient;
- Inmates who interact with the TB patient during recreational activities;
- Correctional centre staff who come in contact with a TB patient;
- Visitors who have been in contact with the TB patient.

TB suspects among the contacts listed above must be identified and investigated for active TB.

## Outbreak investigation

An outbreak investigation must be considered if more than two inmates from one cell are found to have TB. This must be done in collaboration with the DoH.

## Managing inmates with TB symptoms

Any inmate who has TB symptoms must be immediately isolated and investigated for TB disease. If TB is not confirmed they can then be transferred back to the cells.

## 3.2 HIV testing

HIV Counselling and Testing (HCT) must be offered to all inmates. Participation must be voluntary.

### Frequency of HCT

**On entry:** HCT must be offered to all inmates except those with known HIV positive status and on treatment.

**During incarceration:** Provider-initiated testing and counselling (PITC) should be offered as part of an integrated service with other health programmes, such as for TB, STIs, prevention of mother-to-child transmission (PMTCT), paediatric care (where applicable), MMC.

**HCT campaigns:** These should be conducted biannually in conjunction with the TB screening or as part of MMC campaigns

**Inmate-initiated HCT:** When inmates present at the health care facility of a correctional centre requesting to be tested.

**On release:** All inmates with negative HIV status or unknown HIV status on exit must be offered HIV testing.

### **How to conduct HCT**

- Written consent must be obtained.
- Pre-test counselling sessions may be conducted in groups or individual sessions.
- Rapid HIV testing must be carried out with a finger prick using an approved testing kit.
- If the first rapid HIV-test is positive, a confirmatory HIV-test (second rapid test) must immediately be performed from a second finger prick using a different rapid test kit product.
- An inmate is considered HIV-positive if the second rapid test is also positive.
- Draw a blood specimen and refer for HIV ELISA antibody laboratory testing if first and second test results are discordant.
- Point-of-care CD4 testing and immediate referral for ART initiation of inmates whose CD4 count is <350 cells/ $\mu$ L.
- Assess all inmates with newly diagnosed HIV for active TB or latent TB infection; including symptom screening, history of exposure, physical examination, and chest X-ray. A tuberculin skin test with 5 mm induration cut-off is recorded as positive.
- When CD4 <200 cells/ $\mu$ L and tuberculin skin test is negative, the patient must have repeat tuberculin skin test after initiation of ART and immune reconstitution.

## **Encourage inmates to request a repeat HIV test after three months to exclude the possibility of the window period.**

### **3.3 Sexually-Transmitted Infection Screening**

Universal screening for anal, oral and genital STIs must be conducted on all inmates. Special focus must be on gonorrhoea, syphilis, chlamydia screening. HIV positive inmates must be regularly screened.

#### **Frequency of screening**

- Upon admission to a correctional centre;
- Upon self presentation or peer-reported suspected STI cases;
- As part of integrated primary health care services;

#### **How to conduct screening for STIs**

- Obtain sexual history on exposure and behavioural risk assessment.
- Make use of specific algorithms for STI screening based on presence of symptoms, e.g. ulcers, lacerations or urethral discharge etc.
- Physical examination of those with symptoms
- Laboratory tests where indicated.

### **3.4 Screening for chronic diseases/ conditions**

All inmates must be screened for the following chronic diseases/ conditions and those with these diseases/ conditions must be screened for HIV, STIs and TB during every encounter with a health care provider:

- Diabetes;
- Hypertension;
- Alcohol and substance use;
- Obesity;
- Mental illness.

## 4. TREATMENT OF TUBERCULOSIS, HIV, AIDS AND SEXUALLY TRANSMITTED INFECTIONS

Treatment of inmates with TB, HIV / AIDS and STI must generally follow the latest Department of Health Guidelines.

### 4.1 Tuberculosis treatment

All patients with drug sensitive TB (New and Retreatment) must be treated with Regimen 1 (2RHZE/ 4RH). Patients diagnosed with Rifampicin resistant TB must be referred to the MDR-TB treatment initiation site for an initial assessment, baseline testing which includes culture and DST for first and second line drugs and initiation of treatment.

MDR and XDR-TB treatment facilities in correctional services

- Ideally there must be one MDR and XDR-TB isolation facility per region:
  - Must include mono/poly-drug resistance specialist advice;
  - Specialist consultation from DOH (outreach team);
  - Ensure access to audiometry
- Correctional centre management must be advised on appropriate prioritisation if inmates need to visit an external MDR-TB facility.

#### Isolation of inmates with infectious TB

Inmates diagnosed with pulmonary TB must be isolated for at least two weeks (if drug susceptible TB) and at least 6 months or when smear and culture negative for MDR and XDR-TB. If they need to leave the isolation area for any reason, they must wear a surgical face mask.

#### Criteria for hospitalisation

Hospitalisation must be considered for TB patients under the following circumstances:

- During the intensive phase of TB treatment for direct observation of treatment
- Diabetes/ liver disease
- Respiratory insufficiency
- Moderate to severe hemoptysis
- Serious adverse events due to TB medicines
- Severe extra pulmonary disease
- Confirmed MDR or XDR-TB



## 4.2 HIV and STI treatment and care

HIV prevalence in correctional centres ranges from 6% in the Western Cape to approximately 34% in KwaZulu-Natal. There is thus sufficient need to warrant on-site HIV care services to improve access to required services.

All HIV-positive inmates require:

- scheduled repeat CD4 testing every 6 months;
- monthly TB symptom screening (see 3.2);
- regular screening and treatment of STIs (see 3.3);
- cotrimoxazole TB prophylaxis if CD4 <350 cells/mm<sup>3</sup>;
- TB and HIV prevention counselling;
- management of other opportunistic infections;
- isoniazid preventive therapy (IPT, see eligibility criteria in 5.2.1);
- cryptococcal screening if CD4<100cells/mm<sup>3</sup>;
- ART in patients with:
  - o CD4 <350 cells/mm<sup>3</sup> or WHO clinical stage IV disease;
  - o Drug sensitive-TB/ Drug resistant-TB patients

## 4.3 Adherence Support

Several measures have been shown to increase adherence with long-term treatment for HIV and TB which may pose considerable challenges to patients. These measures become essential in the demanding setting of correctional centres which provides opportunities for supporting inmates in completing their treatment.

### Education and information

It is critical that inmates are provided with sufficient information about the treatment they are receiving including the regimen, dosage and the reason for long-term treatment. They must be made aware of what side effects they may expect and what action to take if they experience any of these side effects. Education must emphasise the importance of taking treatment exactly as prescribed to avoid ineffective treatment and inducing resistance. Before and during treatment, it is important to continuously remind inmates of the importance of scheduled follow up visits and continuous tests as prescribed by their health care providers. Care takers must explain to inmates the risks of combining treatment with other substances and that they need to avoid sharing their medication with other inmates.

### Counselling

Counselling is a cornerstone of ensuring adherence and must be started on the day of HIV screening. Counselling is aimed at alleviating fears, dispelling myths and eliminating uncertainties patients might have in relation to their diagnosis and treatment. Counselling must be done every time the inmate is seen during follow up in addition to the discussion of acute issues arising from treatment at that particular moment.

## Support

For any patient to adhere to treatment they need support from health care providers, other support staff, family members and / or their peers. In correctional centres, support groups play an important role. Nurses and peer educators need to be trained on how to run a support group and must be mentored until they are fully competent in this important task. Everyone involved in care will have to know about support groups existing at the respective centre so that they can link newly diagnosed inmates to a support group. Health care providers have to build a sound rapport and effective relationship with inmates so that these patients trust them and are encouraged to be open with them. To enhance support, health care providers must encourage inmates to have a treatment buddy, a person who will remind and motivate them to take their treatment as prescribed.

## Pill counts

For all inmates who are new on treatment, health care providers must conduct regular pill counts to improve adherence. This measure complements counselling and education for treatment.

## 4.4 Opportunistic Infections

The common opportunistic infections (OIs) in HIV-infected persons are outlined in the table below.

Condition	Cause/ Aetiology	Clinical features	Action
<b>Pneumocystis jiroveci pneumonitis (PJP)</b>	Fungus called <i>Pneumocystis jiroveci</i>	Tachypnoea, recessions, respiratory distress, sometimes cyanosis, usually very little to hear on auscultation.	Refer for investigation and management
<b>Cryptococcal meningitis</b>	Fungus called <i>Cryptococcus neoformans</i>	Change in mental status (from confusion to lethargy to coma), headache, fever; Nausea, vomiting, papilloedema, focal neurologic deficits neck stiffness and sensitivity to light; <b>Lungs:</b> from mild pneumonia to acute respiratory distress syndrome(ARDS), fever, cough, dyspnoea; <b>Skin:</b> papules, pustules, nodules, ulcers; Bone lesions.	Refer for investigation and management
<b>Mycobacterium avium complex</b>	Mycobacterium avium complex (MAC) <i>M. avium</i> , <i>M. intracellulare</i> , <i>M. aratuberculosis</i> )	Recurrent fever, Weight loss Failure to thrive (children), Fatigue Chronic diarrhoea, Malabsorption; Persistent or recurrent abdominal pain; Lymphadenopathy, hepatomegaly, splenomegaly.	Refer for expert opinion
<b>Cytomegalovirus (CMV) retinitis</b>	Cytomegalovirus	Asymptomatic, or present with floaters, field defects, scotoma, or decreased visual acuity.	Refer for investigation and management
<b>Toxoplasmosis</b>	<i>Toxoplasma gondii</i>	Fever; Headache; Confusion and/or focal neurological deficits.	Refer for investigation and management

<b>Kaposi's Sarcoma</b>	Human herpes virus type 8(HHV – 8)	Skin: Purple or bluish patches and nodules <b>Oral:</b> Usually palate, tongue or gums <b>GIT:</b> Pain, bleeding, or obstruction <b>Lungs:</b> Dyspnoea, cough, wheezing, and /or haemoptysis;	Refer for expert opinion
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#### 4.5 Managing patients who refuse treatment

Treatment is voluntary. Adequate counselling must be provided to the patient to ensure they understand the implications of not taking treatment on their health and that of others. Full knowledge regarding the treatment must be communicated in order for them to make an informed decision. For MDR and XDR-TB treatment, informed consent must be obtained from the patient or family member or designated person in cases where the patient is not in a state to make a decision.

Where all efforts fail to convince the patient to take treatment or when a patient terminates consent, the patient must sign the Refusal of Treatment form.

#### 4.6 Managing awaiting trial detainees

Whilst the rights of the detainees to a fair and speedy trial must be upheld, the appearance of the patient in court may pose a public health risk due to the following;

- transportation of patient to court
- inadequate ventilation in courts
- medical condition of the patient (bacteriological results, severity of disease, response to treatment)

To expedite court appearances for such high risk detainees, court rooms which meet the criteria for airborne infection control or courts with enclosed accused/ witness stands and remote court proceedings through video conferencing may be considered. Appropriate personal protective equipment must be used during transportation of the patients to court.

#### 4.7 Nutrition

There is a vicious cycle between tuberculosis, HIV and malnutrition with one fuelling the other. The availability of safe and healthy food is essential in maintaining and improving inmates' health. Considerable benefits can be achieved when correctional centres work in a complementary manner to promote healthy lifestyles and facilitate healthy eating. Adequate nutrition must be considered one of inmates' basic human rights.

Undernourishment can be considered one of the risk factors in the development of TB, since it is known to adversely affect the immune system and predispose people in high risk settings to acquiring TB infection/ TB disease. Targeting nutritional support to malnourished populations at high risk for TB could potentially reduce the incidence of active TB. Vulnerable groups in correctional centres – such as pregnant and breastfeeding women, substance users, teenagers and elderly people also have specific dietary requirements.

TB / HIV co-infected TB patients present with loss of appetite, nausea and vomiting, diarrhea, weight loss and micro nutrient deficiencies which result in anorexia, weakness and cachexia. Energy requirements are high in TB patients at about 35-40 kcal per kilogram of ideal body weight. This estimate is based on the energy and nutrient requirements for an undernourished and hypercatabolic patient. In TB / HIV co-infected patients, the energy requirements could be increased by 20 - 30%. Mineral and vitamin requirements are higher in TB patients because they are important in maintaining body functions and for different metabolic processes. Therefore, multivitamin and mineral supplements providing 50 – 150% of the recommended daily allowance are recommended.

A healthy meal must mainly consist of starch and a variety of other nutrients such as vitamins and minerals (fruits, vegetables), proteins (beans, milk products, meats, eggs, fish, nuts), sugars and fats every day.

It is recommended that meals in correctional centres must be nutritionally balanced, with low fat, sugar and salt content and high in complex carbohydrates. Meals must include 5-6 portions of fruit and vegetables daily. There must be a set menu consisting of breakfast, lunch, dinner with at least one hot meal per day and approved by a qualified dietician. This menu must be rotated monthly.

It is however important not to recommend routine special diets as these are unnecessary from a medical point of view and could potentially become a perverse incentive.

## 5. PREVENTION OF TUBERCULOSIS, HIV AND SEXUALLY TRANSMITTED INFECTIONS

### 5.1 Education

Inmates and correctional centre staff must be comprehensively informed about TB, HIV/AIDS and STIs, including effective ways of preventing transmission in the increased risk environment within correctional centres. Clear information must be provided on all types of sexual behaviour that can lead to HIV-transmission. Information must also consider the needs of inmates after release. Education material intended for the general public (posters, leaflets and the mass media) must also be made available to inmates.

Inmates must receive TB and HIV/AIDS education on their entry into the correctional centre, during their incarceration and in pre-release programmes. All inmates must have an opportunity to discuss health-related information with appropriate staff.

To enable peer education as an effective means of education, both correctional centre staff and inmates must be involved in disseminating correct information.

Correctional services must train inmates as peer educators so that they are enabled to mobilise and educate their fellow inmates. These peer educators must be educated on TB, HIV/AIDS and STIs with regular updates on new developments with regard to prevention and treatment of these diseases. Health care professionals, social workers and trainers must support, mentor and monitor the work done by peer educators to ensure and improve quality. Even though peer educators must be independent; they need guidance by a professional who can answer their questions and advise them to fully develop their potential and equip them with relevant skills to fulfil their task with maximum effect.

Advocacy, communication and social mobilisation (ACSM) must include:

- Treatment literacy;
- Infection control, e.g. cough hygiene;
- Symptom recognition;
- Rights and responsibilities;
- Stigma assessment and reduction;
- Education, e.g. peer education;
- Behaviour change communication;
- Adherence support.

## 5.2 Tuberculosis Prevention

### Isoniazid Preventive Therapy in Adult Inmates

IPT reduces TB incidence in HIV-infected patients. Despite the fact that ART reduces the likelihood of developing TB disease; TB incidence among HIV-infected patients receiving ART is still 10 times greater than in the general South African population. IPT can be safely given to patients on ART to reduce the incidence of TB in all HIV-infected adults who:

- are not on TB treatment;
- are asymptomatic for TB;
- have no active liver disease/ history of alcohol abuse;
- have no history of psychosis, convulsions, neuropathy.
- have a Positive Tuberculin Skin Test

As there is a high rate of TB transmission in correctional centres, eligible HIV-positive inmates must remain on IPT for the duration of their incarceration.

### Isoniazid Preventive Therapy in Children

All children less than two years of age, whether HIV- positive or HIV-negative, staying with their mothers in the correctional centre and who are asymptomatic for TB must receive IPT to prevent development of TB disease:

- If asymptomatic: start IPT;
- If symptomatic: investigate thoroughly for TB.

### Infection Control

Correctional facilities face inherent difficulties in implementing TB infection control because of the limitations placed on mobility of persons and the need to secure the environment. Infection control strategies therefore need to accommodate these difficulties.

TB infection control strategies aim to address the following:

1. Reduce the production of infectious TB droplets in the local environment. These interventions are referred to as administrative controls.
2. Eliminate infectious TB droplets once they are generated. These are referred to as environmental controls.
3. Decrease or prevent inhalation of infectious TB droplet nuclei by staff and inmates, and minimize the risk of developing active TB. These interventions are referred to as personal protection.
4. Creating an enabling environment to facilitate implementation of TB infection control interventions, referred to as Managerial controls

The above infection control measures are based on an understanding of the biology of the transmission of TB. In order to implement them, several other preconditions to facilitate the creation of an enabling environment in which the respective interventions can be implemented have to be fulfilled:

## 1) Managerial Controls

In as much as political pressure and commitment is required for the implementation of TB control programmes, managerial commitment to the implementation of TB infection control is necessary within correctional centres to ensure success of TB prevention efforts. All correctional facility staff and all persons entering the facility must be aware of the risk of TB transmission, and be committed to reducing the risk of TB through implementation of these measures.

- a. An Infection Prevention and Control Committee must be established to coordinate the development and implementation of the plan in the different areas of the correctional facility. This must be a multidisciplinary group comprising the Head of the Correctional Centre, infection control officer, TB and HIV coordinator, an environmental hygiene supervisor and unit managers. This committee must have the following responsibilities:
  - i. meet monthly;
  - ii. ensure risk assessments are conducted annually;
  - iii. develop and update a TB infection control plan;
  - iv. review the quality of implementation of TB infection control in the centre;
  - v. ensure ongoing staff training regarding requirements of TB infection control;
  - vi. effect any changes necessary to ensure TB infection control is implemented.
  - vii. ensure that finances and budgets allow for implementation of infection control interventions. These may include costs of shelters for outside waiting areas, fans to circulate air and ultraviolet germicidal irradiation (UVGI) units. If immediate funding is not available, donor funds may be sought to effect changes.
- b. A designated infection control officer must be appointed who will be responsible for overseeing the implementation of the infection control plan, training of health care providers, inmates and custodial officials and monitoring the impact of the measures in place.
  - i. Training of correctional centre staff in TB infection control interventions. All staff, including professional nurses, doctors, inmates performing cleaning duties and pharmacists must be aware of the details of the infection control plan. This will ensure that the relevant officials and inmates are informed of TB infection control measures.
  - ii. Education of inmates in TB awareness and TB prevention. Awareness of TB signs and symptoms by inmates leads to better health seeking behaviour and a shorter time-to-diagnosis. This in turn reduces the spread of TB, and improves TB control. Within the centre, health promotion talks, posters and leaflets on TB and HIV must be available and include TB awareness.
- c. The TB infection control plan must be developed annually for each correctional facility. This must be informed by the findings of the risk assessment. It must outline what must be done in case of inmates or staff with TB symptoms and those diagnosed with TB, and precautions to be taken by inmates and staff. The plan must have the following structure: coordination of TB infection control; administrative controls, environmental controls; personal protection. It must also indicate the name of the person responsible for each intervention. The document must be evaluated quarterly and updated whenever necessary to accommodate for changes.



## 2) Administrative controls

These are the most important of interventions to reduce TB infection in correctional centres. The interventions listed below can only be implemented through a coordinated effort of centre managers. Cough etiquette must be emphasized so that few infectious TB droplets are produced and released into the air. The following strategies are recommended:

- a. Screening of inmates for cough as they enter the centre and at regular intervals.
  - i. Screening on entry to the centre is best done within six hours of admission. A poster promoting inmate disclosure of coughing must be placed in a prominent position in the screening area.
  - ii. Screening of inmates for TB signs and symptoms must be conducted during consultation.
  - iii. Inmates must be encouraged to report if their fellow inmates are coughing in order to ensure prompt diagnosis and treatment.
  
- b. Separation of inmates who cough from those who don't (triaging):  
Isolation facilities for inmates who are coughing during investigation must be established to ensure that they are not mixed with non coughing inmates in the cells. In the health facilities coughing patients must be triaged in waiting areas and those admitted in hospitals kept in isolation until sputum investigation results are available.
  
- c. Education of inmates in cough hygiene:  
All inmates must be educated about the importance of cough hygiene and hand washing. Coughing into masks or tissues traps droplets from a cough, and prevents generation of droplet nuclei which can spread TB. Inmates must be asked to dispose of these tissues or masks into appropriate receptacles in waiting areas.  
  
Additional supplies of masks or tissues must be given to custodial officials for this purpose. Regular and timeous ordering of masks / tissues is necessary to ensure an uninterrupted supply.
  
- d. Immediate referral and investigation for TB of inmates who are coughing:
  - I. Active follow up of inmates who are identified as coughing (either by staff or fellow inmates) must be undertaken immediately.
  - II. All correctional centre staff must be familiar with the procedures for screening and investigating inmates for TB.
  
- e. Provision of a safe environment for collection of sputum:
  - I. All sputum collection must be done in a safe environment; the safest environment is out-doors in the sun.
  - II. It is appropriate to give the client access to an appropriate space to cough sputum, and also to give access to running water to wash hands afterwards.

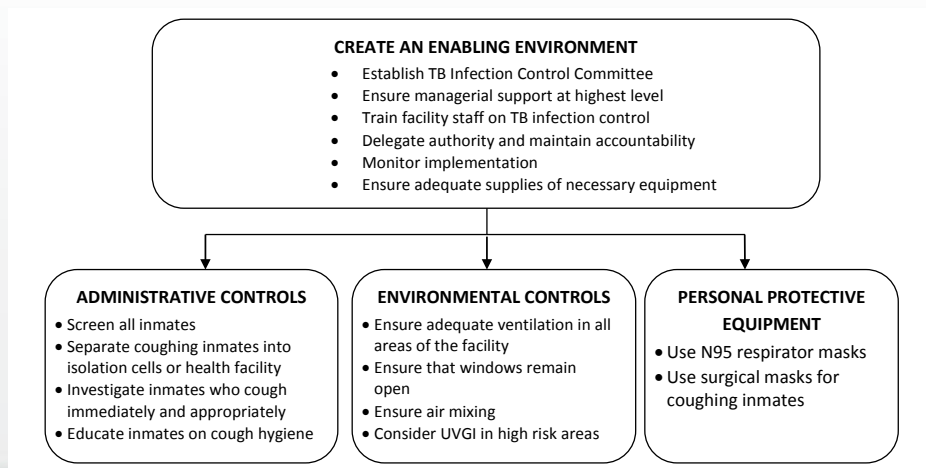
## 3) Environmental controls

Environmental controls can reduce the risk of TB transmission by preventing the spread of M. tuberculosis containing droplet nuclei, decreasing their concentration in enclosed areas, and removing or cleaning contaminated air. The main focus is to attain adequate ventilation to remove all infectious droplet nuclei from the room.



- a. Well-ventilated enclosed facility areas through:
    - I. Natural ventilation is always better than mechanical ventilation. Maintenance of good air circulation by opening windows and use of fans in waiting areas, accommodation facilities and consultation rooms.
    - II. Air mixing must be maintained – this can be done through natural means (air current induced by wind etc.) or mechanically through fans. The mixing of air is critical to ensure that all air has equal chance of being vented to the outside. When air is still, pockets of air may contain higher numbers of infectious droplets, and therefore increase the risk of acquiring TB infection by inmates and officials.
  
  - b. Use of UVGI units:
    - I. If finances permit, UVGI units are a useful companion intervention to administrative controls and ventilation. These must be installed in high risk areas such as admission cells or remand detention facilities where turnover of awaiting trial detainees is high.
- 4) Personal Protective Equipment (PPE)**
- a. Use of N95 masks to prevent inhalation of *M. tuberculosis*:
    - I. N95 masks are useful where strategies to limit production of infectious droplet nuclei are only partially effective. Officials attending to inmates who are suspected of having TB can wear N95 masks. Where risk of TB transmission can be adequately controlled through environmental and administrative means, N95 masks are not necessary.
    - II. Correct use of the masks is essential.
  
  - b. Use of surgical masks is recommended on inmates who are suspected of having TB or confirmed TB patients, in areas where they mix with other inmates/ staff and during transportation. This prevents the spread of infectious particles into the immediate environment following a cough.

Figure 5.1: Principles of TB infection control in correctional facilities



### 5.3 HIV prevention

For the most effective results of HIV-prophylaxis, it is critical that “Combination HIV-Prevention Strategies” which encompass biomedical, behavioural and structural strategies be employed.

The minimum package of HIV-prevention measures in detention facilities must include:

- Education;
- HIV counselling and testing;
- Access to condoms and water-based lubricants;
- Reducing vulnerability to sexual assault any forms of sexual assault;
- Post-exposure prophylaxis;
- Harm reduction programmes to reduce the risk of HIV-transmission and acquisition related to substance abuse (such as injecting drug use);
- Male Circumcision (with adequate counselling regarding risk reduction after circumcision);
- Basic hygiene measures such as soap and disinfectant.

Potential sources of HIV infection in correctional centres include: Sex (consensual or non-consensual), tattooing, sharing of needles, razors, hair clippers, violence, pregnancy, labour and breastfeeding.

#### **Post-exposure prophylaxis**

HIV post-exposure prophylaxis (PEP) is one of several interventions that together make up a package of “Biomedical HIV Prevention Interventions”. Basic principles of PEP in the Southern African context of high HIV prevalence and a generalized epidemic apply equally in the correctional centre setting. These include: a less heightened distinction between occupational and non-occupational HIV exposure; all unknown source exposure must be assumed to be HIV-infected; use of triple ART regimens; minimizing local exposure as far as possible; administration of PEP as soon after exposure as possible (efficacy after 72 hours is unlikely); all PEP regimens must be administered for a minimum of 28 days; a comprehensive infrastructure and support for the exposed individual. Concomitant exposures (such as Hepatitis B virus and other STIs) as well as other consequences (pregnancy, emotional and psychological trauma) must be dealt with appropriately.

Consideration must be given to the effectiveness, simplicity, tolerability and safety of the regimen. Monitoring the safety of the medicines as well as potential seroconversion is an integral part of PEP.

Table 5.2: Monitoring drug safety and seroconversion under PEP

	Source	Exposed				
	Baseline	Baseline	2 weeks	6 weeks	3 months	6 months
HIV	✓	✓		✓	✓	✓
Blood group		✓	✓ if sero converted			
HBV		✓(Unless known immunity)				✓
FBC with diff		If on AZT	If on AZT			
LFT		✓				
ALT			✓	✓		
Cr Cl		✓	✓	✓		

### Men's Sexual Health

The South African NSP (2012-2016) specifically identifies men who have sex with men (MSM) as being at higher risk of acquiring HIV than heterosexual males of the same age, with men older than 30 years having the highest HIV prevalence. Although the law no longer criminalises sex between men, and the *South African Constitution* provides specific protection on the basis of sexual orientation and social attitudes which lag far behind the law. MSM experience stigmatisation in both correctional centres and health settings, and hence are often reluctant to seek help relating health concerns.

MSM in correctional centres have a higher vulnerability for male-on-male sexual assault. MSM who have been sexual assaulted often do not seek health care, nor do they access post-exposure prophylaxis, both of which are key to reducing the high risk of HIV transmission during sexual assault.

Concerted and specifically targeted interventions are needed to address the HIV and TB health needs of this group. The involvement of organisations with specific experience in working with MSM is crucial to ensuring meaningful MSM interventions. Training interventions must focus on;

- training of correctional services staff on stigma and behaviour change towards MSM;
- training of correctional services staff on the health needs of MSM, including their vulnerability to sexual assault, HIV and TB;
- training of health care workers within correctional centres on the provision of MSM-friendly health services;
- training of health care workers within correctional centres on the provision of PEP to MSM, and “marketing” these services to the corrections community

Table 5.3: Activities to be implemented for different target groups

TARGET GROUP	ACTIVITIES
<b>DCS staff</b>	<ul style="list-style-type: none"> <li>• Provide training for staff at all correctional centres regarding stigmatisation of MSM, including their legal and constitutional rights;</li> <li>• Provide training for staff at all correctional centres on MSM and their health needs, including their particular vulnerability to HIV and TB;</li> <li>• Provide training to staff at all correctional centres on the vulnerability of MSM to sexual assault, and the higher risk of HIV and other STIs through sexual assault;</li> <li>• Provide training to HCWs within correctional centres on how to provide more MSM-friendly health service;</li> <li>• Provide training to HCWs within correctional centres on how to provide PEP, particularly for sexual assault.</li> </ul>

### Core indicators for monitoring implementation

The proposed indicators are as follows;

- Proportion of correctional facilities staff trained on stigmatisation of MSM, including their constitutional and legal rights (%)
- Proportion of correctional centre staff trained on MSM and their particular health needs, including their particular vulnerability to HIV and TB (%)
- Proportion of correctional facilities staff trained on the vulnerability of MSM to sexual assault, and the higher risk of HIV and other STIs through sexual assault (%)
- Number of HCWs trained within correctional centres on how to provide more MSM-friendly health services
- Number of HCWs trained within correctional centres on how to provide PEP, particularly for sexual assault

### Condoms

Correctional facilities must make sure that male and female condoms and lubrication for condoms are available and accessible for all inmates. Information and demonstration of correct condom use must form part of counselling.

### Medical Male Circumcision

In keeping with the 2007 WHO/UNAIDS recommendation for countries with generalized HIV epidemics and low circumcision rates to promote medical male circumcision (MMC), and to integrate it into a comprehensive HIV prevention package. South Africa in 2010 adopted voluntary MMC as a preventive intervention, prioritizing males between the ages of 15 and 49. MMC in correctional centres must be integrated into the provinces' programmes.

Factors that need to be considered when integrating MMC into TB / HIV management programmes in the correctional services include access, equity, maximum benefit to recipient, availability of service providers and the security status of the inmates. Some have suggested that inmates who are imminently due for release into society must be prioritised for MMC as this would address the above considerations of access, equity and maximum benefit to recipients. A minimum age of 18 years is recommended for MMC because it eliminates the need for parental consent which will be difficult to receive given the circumstances.

- a. Operational issues: Integration of MMC into the TB / HIV prevention, care and treatment programmes in correctional centres is dependent on the provision of a basic package of services which includes:
- Provider Initiated HIV Counselling and Testing (PICT) and appropriate management of newly diagnosed HIV-positive inmates;
  - TB symptom screening, appropriate investigation and management;
  - Screening and syndromic management of STIs;
  - Provision of condoms and promotion of correct and consistent use thereof;
  - Age-appropriate risk reduction counselling that addresses the risks and benefits of MMC;
  - Harm reduction counselling, including reducing the number and concurrency of sexual partners.

## 6. WOMEN AND CHILD HEALTH

### 6.1 Pregnancy and Tuberculosis

The principles of treating TB in pregnancy are as follows:

- It is very important to prevent and treat TB in pregnancy, both for the mother and the unborn child.
- Always conduct a TB symptom screen at every visit for all pregnant women, regardless of their HIV status.
- All HIV-positive pregnant women must receive ART regardless of their CD4 count
- All HIV-positive pregnant women who do not have TB symptoms must receive IPT

Figure 6.1: Diagnostic algorithm for HIV-positive pregnant women on ART

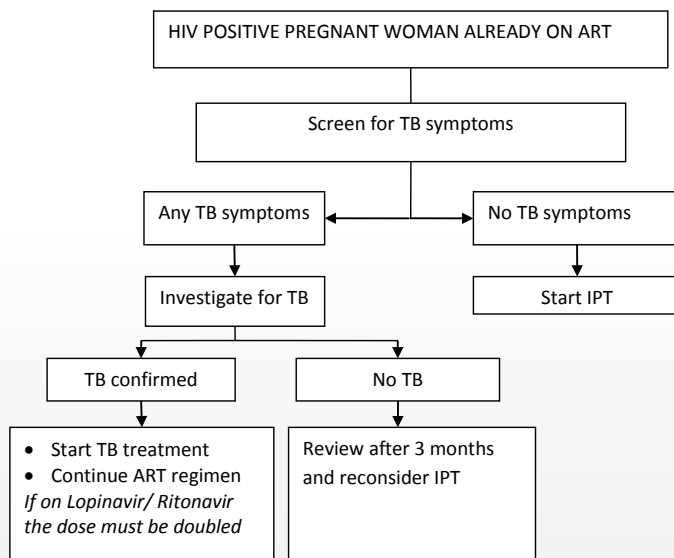
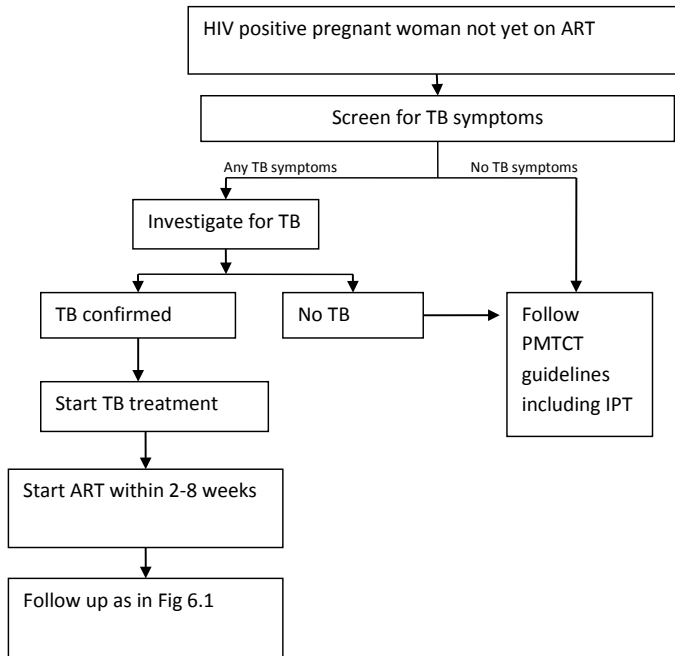


Figure 6.2: Diagnostic algorithm for HIV-positive pregnant women not yet on ART



Close monitoring is required for the following;

- Woman diagnosed with TB in the last two months of pregnancy;
- Woman with TB who has not shown good clinical response to therapy and/or whose smear microscopy has not converted.

All infants born to a mother with TB must be referred for a thorough examination to exclude active TB, if the infant has no TB and living with the mother, they must be started on IPT. All mothers must be encouraged to breast feed.

## 6.2 Infant feeding

The recommendations are as follows:

- All mothers can safely breastfeed.
- Exclusive breastfeeding for 6 months irrespective of HIV status must be promoted.
- Appropriate complementary feeding can be introduced after 6 months with continued breastfeeding for two years and beyond.

## 7. POST RELEASE CONTINUUM OF CARE

### 7.1 Linkage and Retention in Care

The correctional facilities provide an opportunity to test for and treat HIV and TB. Favourable TB / HIV treatment outcomes among inmates in these facilities have been reported (unpublished Aurum data). However, during (a) admission into correctional centres, (b) transfer between centres, and (c) the transition back to their home communities, many (ex-) inmates are likely to discontinue treatment. Once inmates fall out of the care continuum, not only is the health of the inmate at risk, but close contacts and sexual partners are potentially at risk of infection with drug-resistant TB or with HIV.

Health care professionals must develop comprehensive discharge plans for inmates on treatment for HIV / AIDS, STIs and TB who are to be released to ensure continuity of care and post treatment evaluation.

#### Objectives

1. To ensure that all inmates admitted to and transferred between correctional centres are retained within the continuum of TB / HIV care.
2. To ensure successful re-integration of released inmates into the general society by providing information and support to enable them to transition from the correctional facility-based TB / HIV care to community care after release.

These objectives are within the context of the South African NSP (2012 – 2016) which advocates ensuring that 70% of patients initiated on ART are alive and on treatment at the end of five years, and that >85% TB treatment cases are successfully treated.

Groups at high risk of loss to follow up:

- Newly admitted inmates;
- Inmates transferred between correctional centres;
- Detainees attending court;
- Inmates who are discharged or released.

Therefore in order to meet the objectives interventions targeted at these high risk groups must be implemented. These are outlined in table 7.1 below.



Table 7.1: Activities to be implemented for different target groups

TARGET GROUP	ACTIVITIES
Newly admitted inmates	<ul style="list-style-type: none"> <li>• Immediate health screening and needs assessment at the time of admission to determine required level of care.</li> <li>• Implement interventions for the identified health needs.</li> <li>• Rigorous inventory control at healthcare facilities to avoid stock run-outs for HIV and TB drugs.</li> <li>• Accurate and timeous record completion to facilitate follow up and linkage of inmates to appropriate care.</li> <li>• Establishment of inmate’s tangible and perceived barriers that may impede their ability to seek care services within the correctional centre.</li> </ul>
Inmates transferred between correctional centres	<ul style="list-style-type: none"> <li>• Establish communication systems between DCS health care professionals and case management officers in South African Police Services to ascertain transfer dates for inmates on HIV/TB treatment (at minimum 7 days prior notice).</li> <li>• Prior to the date of transfer, health care staff from transferring centre must provide receiving centre with verbal or written notice of the transfer at least 48 hours in advance.</li> <li>• Provide inmates with referral letter at the time of transfer (Patient referral form - GW20/14).</li> <li>• Implement control checks at arrival to ensure that the referral package has been provided.</li> <li>• In case of classified inmates being transferred, the health care officials at the receiving end must obtain records from the transferring centre.</li> <li>• Telephonic follow up by transferring centre up within a period of 7 days to ascertain continuation of care.</li> </ul>
Detainees attending court	<ul style="list-style-type: none"> <li>• Establish communication systems between DCS clinic staff and case management officers to ascertain court dates for detainees on HIV/TB treatment (at minimum 7 days prior notice).</li> <li>• Provide a list of alternative healthcare facilities within the release catchment area.</li> <li>• Provide motivational counselling to detainees in order to create self-efficacy to confidently access community care.</li> <li>• Provide referral letter for detainees to carry to court, in the event of release directly from court.</li> <li>• Provide a minimum 7-day supply of continuation medication to the detainee.</li> <li>• Implement control checks at arrival to ensure that the referral package has been provided.</li> <li>• Inform community TB/HIV district coordinators of the release of the detainee and provide their contact details to facilitate community follow up.</li> </ul>

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Inmates discharged or released

- Establish communication systems between DCS clinic staff and case management officers to ascertain release dates for inmates on HIV/TB treatment (at minimum 7 days prior notice).
  - Establish inmate's expectations and concerns about seeking health care and treatment after release.
  - Establish inmate's tangible and perceived barriers that may impede their ability to seek services upon release.
  - Develop entry-into-care plan with inmate. This must be appended to the release plan.
  - Provide referral letter and supporting documentation.
  - Provide a list of alternative healthcare facilities within the release catchment area.
  - Implement control checks upon release to ensure that the referral package has been provided.
  - Where possible, calling staff at the referral facility to inform them about the referral.
  - Where possible and applicable, an initial 30 day supply of treatment supply must be issued to inmate at the time of release.
  - Use of community corrections services to follow up inmates released with conditions.
  - Telephonic follow up with staff at healthcare facilities where inmates are referred.
  - Telephonic follow up with released inmates where possible.
- 

### **Core indicators for monitoring implementation**

The proposed indicators are as follows;

- Number of offenders released while on TB / HIV treatment
- Number of pre-release counselling sessions per inmate prior to release
- Proportion of released inmates on TB / HIV medication issued with continuation treatment supplies at time of release (%)
- Quantity of treatment continuation supplies issued per participant
- Proportion of inmates successfully followed up at 30 or 90 days after release (%)
- Proportion of inmates entering care within 30 or 90 days after release (%)

## 8. RECORDING AND REPORTING

### 8.1 Monitoring and Evaluation

Programme monitoring and evaluation must be conducted in order to improve accountability, enable ongoing learning and problem-solving, and identify opportunities for improvement.

Measures must be simple and the communication in monitoring and evaluation must focus on:

- ensuring that each suspect and case receives appropriate management;
- describing the TB control programme;
- assessing TB risk and performance of programme;
- collecting and organizing data;
- analyzing data and forming conclusions;
- using the information to improve the TB programme;
- for DCS correctional health facilities, regional offices and the national office, districts and sub-districts to monitor their performance and allocate resources appropriately;
- for DOH to allocate resources appropriately.

Principles for monitoring and evaluation in correctional centres:

- It is important that the standard DOH data collection tools are used within DCS including the electronic tuberculosis register (ETR.net) and the monitoring and evaluation for ART system (Tier.net).
- Duplicate data collection must be avoided and systems must aim to eliminate duplication.
- Important to ensure that management areas are assigned to a specific district for reporting purposes and that the reporting is implemented.
- DOH District support visits to correctional centres are recommended and must be facilitated through a direct link to the district.
  - o Data quality assurance processes for health data must apply to correctional centres.
  - o Correctional centres to participate in training and district programme review.
  - o Important that visit findings are recorded, reported and communicated.
- Correctional services to use of the PHC supervisory manual.

## 8.2 Tools are used for monitoring TB and HIV patients

The following standard tools used by the DOH will be used to monitor performance of the TB programme in DCS:

- **TB symptom screening form:** Used to record screening for TB and STIs at entry to the correctional centre (within six hours).
- **STI screening form:** Used to record screening for STIs within six hours of entry to the correctional centre

It is important that these forms are filed and the records are easily retrievable for legal purposes.

- **Facility TB treatment record (GW 20/12):** The blue clinic/hospital card is used to collect all the information about the patient, treatment and outcomes. It serves as health record information and as any medico-legal documents must be fully completed and stored safely after the patient has been discharged from the correctional centre.
- **Laboratory request form for Sputum Examination:** A specific TB laboratory request form is available from the National Health Laboratory Services (NHLS). This form must be fully completed and accompany any specimen sent to the laboratory.
- **Patient treatment card (GW 20/15):** This is a patient-held green card used to record details of treatment including daily doses taken for all TB patients on treatment. It can be presented by the patient at any facility to access treatment. This card must always be fully completed and up to date.
- **TB identification register (GW 20/13):** Used to record all symptomatic patients identified during the screening. The specimen collection date and results date are also captured in this register to monitor the turn-around time for the results, and time to initiation of treatment.
- **Tuberculosis register (GW 20/11):** Used to summarise key information on each registered patient. It provides an overview of all registered patients and must be used to monitor programme performance. The register needs to be updated on a daily basis.
- **Transfer/ Referral form (GW20/14):** Used to summarise the patient's condition and clinical progress when the patient is referred to another facility for continuation of treatment.
- **Drug resistant TB register for mono and poly-resistant TB, M/XDR-TB:** Used to summarise key information on each drug resistant TB patient started on treatment. The register needs to be updated on a daily basis.
- **TB Notification forms (GW17/5):** Every health care provider across the health sector has a legal obligation to notify all notifiable medical conditions, TB being one of them.

### The electronic TB register

The ETR.net and EDRWEB are programme management tools. The information in the paper registers is captured into the electronic register and collated using this tool. All health facilities at correctional services must have access to the ETR.net and the Tier.Net.

The following reports can be generated by the system for a specified period or as a summary over time:

- Reports on case finding;
- Reports on sputum conversion;
- Reports on treatment outcome;
- Facility profile reports.

The following standard tools used by the DOH will be used to monitor performance of the HIV programme in the correctional services:

- **HCT form (consent and HCT record card):** Used to record HCT information taken during screening and testing at correctional centre.
- **HCT register:** Used to summarise key information on each patient who underwent HCT. All inmates with HCT must be recorded in this register for easy follow up, CD4 count results and other relevant tests. TB screening must also be recorded.
- **Pre-ART register:** Used to summarise key information on each patient tested HIV-positive and not eligible for treatment. It must be used to monitor programme performance.
- **HIV clinic card:** This is a patient-held card used to record details of the visits and the changes in blood results and treatment.
- **ART register:** Used to summarise key information on each registered patient. It provides an overview of all registered patients and must be used to monitor programme performance.
- **New clinical stationery:** Used to capture HIV-positive patients' data (prior to ART and on ART) during consultation. This form can be used as a transfer letter.
- **Tier.net:** Is a programme management tool. The information in the Pre –ART and ART register is captured into the Tier.net.
- **Laboratory request form for monitoring bloods (CD4 count and viral load):** programme for comprehensive management of HIV, care and treatment of HIV/AIDS from NHLS is a form used to request blood test.
- **IPT register:** Used to summarise key information on each patient registered on IPT. It provides an overview of all registered patients and must be used to monitor programme performance.
- **Adverse events reporting form**
- **Referral/Transfer form**

### 8.3 TB Information flow

Paper-based tools are used at centre level to record the clinical information. This information is then entered into the TB register. Completeness of the registers is vital in ensuring good quality data. The registers must therefore be reviewed weekly for completeness and correctness. As soon as each page is completed it must be forwarded for capturing in the ETR as follows:

Form	When to submit
Pink sheets	As soon as it is completed including all fields up to “Pre-treatment sputum results”;
Yellow sheets	As soon as all the fields up to “End of the intensive phase sputum results” (2 or 3 months) are completed;
Green sheets	As soon as all the “End of continuation phase sputum results” (6-9 months), “Treatment outcome” and “all HIV information” fields are completed.
White sheets	Retain in the facility. This page must have complete information on case finding, smear conversion and treatment outcomes for all patients started on treatment. Where this is not clear, it must be rewritten in ink as this serves as the source document for audits.

### 8.4 Key issues to consider when completing the registers

#### TB identification and follow-up register (TB Suspect Register)

- o Use NHLS bar code sticker to document specimen number;
- o If testing was done by Xpert® MTB/RIF, indicate this in the “Comments” section
- NB: Patients diagnosed with Xpert® MTB/RIF also need to have a smear taken to monitor treatment response.
- o Offer all TB suspects HIV testing. An extra column can be added to record HIV result.
- o Remember to complete the monthly summary sheet at the back of the TB Suspect Register.

#### DS-TB Register / DR-TB Register

- o Complete all the fields in the TB register
- o Update HIV and ART data in the TB Case Register.
- o Update follow up sputum results at 2/3 months and on treatment completion
- o Check for completeness before submitting to the next level

#### TB Notification Forms

- o TB is an infectious disease with major public health significance; therefore a notifiable medical condition.
- o TB notifications are reported to the South African Disease Notification System which is a passive surveillance system.<sup>3</sup>
- o Complete and submit a notification form for each newly diagnosed TB case.

**NB: Obtain accurate contact and alternate contact details to ensure follow up in the event of default. Confirm contact details at each visit and update details.**

## **8.5 Coordination**

Existing structures at district, provincial and national must be responsible for the overall coordination of the implementation of these guidelines. TB, HIV, AIDS and STI programme in correctional services must be a standing item in DMT meetings, provincial and national TB and HIV meetings.

Joint supervisory visits to both DOH and DCS facilities must be planned and conducted at least monthly by sub district, quarterly by district and twice a year by province.

## 9. HUMAN RIGHTS AND STIGMA

### 9.1 General rights

- All offenders (awaiting trial detainees, awaiting sentence detainees and sentenced inmates) have rights.<sup>19,20,21</sup> Detainees and inmates with HIV must be treated in exactly the same manner as all others. It is unlawful for an inmate to be treated differently (e.g. housed separately) because of HIV status.<sup>22,23</sup>
- An awaiting trial detainee is a person charged with a crime but presumed innocent; the HIV status of an accused person must not negatively affect the judgement about his guilt.
- The rights of people accused of a crime are protected in that it is unlawful to force a person to make a confession or admission (e.g. whether s/he has tested HIV-positive) that could be used as evidence against the person.
- The statutory rights of detainees and inmates are rights passed by parliament. The Correctional Services Act sets out these rights and the rules that the DCS must follow in running the facilities under its control (e.g. the DCS must ensure a clean and hygienic correctional facility environment).
- In terms of the *Right to Healthcare and Medical Treatment*, the DCS complies with all DOH policies and practices. The right to adequate medical treatment generally means that a detainee or inmate with HIV or TB must have access to the same kind of care and treatment available in the community. The Correctional Services Act states that:
  - The DCS must provide adequate healthcare services to all detainees and inmates so that they can lead a healthy life.
  - All detainees and offenders have a right to medical treatment.
  - Detainees and inmates can ask to be treated by their own doctor at their own cost.
  - A detainee or inmate cannot be forced to have a medical examination, test
- Detainees and or treatment, unless his/her medical condition creates a threat to the health of others, inmates have the right to confidentiality about private matters, including health. If an official knows about the HIV status of a detainee or inmate (or a member of staff), the official may only tell someone else with the consent of the detainee or inmate (or staff member).
- Detainees and inmates face the same risk of HIV infection as other South Africans and they therefore have the same right to protect themselves as those in the community. The DCS has made a commitment to provide HIV education and condoms to detainees and inmates.



- A detainee or inmate who is very ill may be released early. While HIV-infected detainees and inmates do not have any special rights to early release, a detainee or inmate dying of AIDS is likely to be considered for early release. However, with ART and TB treatment, this is unlikely.
- The DCS policy allows detainees and inmates to visit dying relatives, and this includes family members dying of AIDS.

## **9.2 The rights of detainees and inmates with regard to testing, screening and treatment**

It is unlawful for anybody – including a detainee or inmate – to be tested for HIV or screened for TB against his/her wishes.

After admission to the correctional centre, every inmate is given a health examination, which can include testing for contagious or communicable diseases (e.g. hepatitis, TB) if the medical practitioner deems this necessary. Informed consent must always be given for an HIV test or a TB screen, i.e. the person must understand the purpose of the test and what the result may mean for him/her.

Patients need to be fully informed and counselled about their treatment. Individuals have a right to know what is being done to their bodies; therefore patients undergoing TB testing and treatment must receive comprehensive information about the risks, benefits and alternatives available to them. Considerations of informed consent are also particularly relevant when diagnosis is offered although no treatment can be provided.

TB treatment must be provided on a voluntary basis. If a detainee or inmate refuses treatment, this is likely to be due to insufficient counselling, lack of treatment support or fear of disclosure to other inmates. As with any other significant medical intervention, the voluntary and informed decision of the detainee or inmate is necessary to start TB treatment.

## **9.3 The rights of detainees and inmates with regard to isolation and segregation**

Because inmates have a right to privacy and dignity, it is unlawful to segregate those with HIV or TB from the rest of the population. Segregation is only allowed if ordered by the health care professional on medical grounds (e.g. communicable diseases). In such a case, the detainee or inmate must be examined at least once a day by a medical practitioner.

In very rare cases, where all efforts to engage a patient to adhere to treatment fail, the rights of others might justify efforts to isolate the contagious patient involuntarily. However, involuntary isolation must always be a last resort, and it is essential that the manner in which it is implemented complies with applicable ethical and human rights principles.

While contagious TB patients who do not adhere to treatment or who are unable or unwilling to comply with infection control measures pose significant risks to the public, those risks can be addressed by isolating the patient.

It is never appropriate to compel treatment of TB patients over their objection. Isolated inmates must be offered treatment but, if they do not accept, their informed refusal must be respected, as the isolated inmate no longer presents a public health risk. Forcing these patients to undergo treatment over their objection would require a repeated invasion of bodily integrity, and could put health-care providers at risk. Moreover, as a practical matter, it would be impossible to provide effective treatment without the patient's cooperation.

## 9.4 The rights of healthcare workers and DCS staff

HCWs and DCS staff are also at risk for TB transmission from those not yet diagnosed and/or started on treatment. DCS staff in correctional facilities may have higher rates of TB infection and disease than the general population. The infection prevention and control measures must reduce the time persons with undiagnosed TB spend in correctional centre settings and must improve ventilation and thus dilution of any TB droplets in the environment. Nevertheless, the risk to staff will never be zero, and an additional aspect of protecting staff is promoting early recognition of TB disease and standard treatment.

The duty of care in health care provision does not exist in a vacuum, but depends on the provision of goods and services. If these important reciprocal obligations of the healthcare system to the HCWs are not fulfilled, provision of appropriate TB care may not even be possible. For example, unhealthy HCWs will not be able to properly care for patients. The DCS is therefore obliged to:

- provide training, equipment, and protection to those in charge of TB patients;
- provide the skills and information necessary for HCWs to assess their risks and take proper precautions;
- provide access to TB diagnosis, including TB screening, for HCWs living with HIV;
- identify and treat HCWs with active TB, using the best proven treatment (including HCT, ART, and chemoprophylaxis for TB if indicated);
- clearly articulate their expectations about the working conditions for HCWs, the specific roles they are expected to assume, and the risks inherent in those situations;
- appropriately compensate HCWs for their services; this may include danger pay and insurance for themselves and their families, and disability pay for those who become infected.

HCWs and staff have a right to refuse TB screening, but their refusal must be documented and signed (as this may influence compensation).

## 9.5 Stigma

HIV-related stigma has been documented widely since the start of the HIV/AIDS pandemic. HIV stigma refers to prejudice and negative attitudes towards people living with HIV (PLHIV). The consequences of stigma are wide-ranging: deleterious effects on the mental health of PLHIV, including low self-esteem and self-blame; being shunned by family, peers and the wider community; poorer reporting for care and treatment in health-care settings; an erosion of rights; and less favourable outcomes in terms of HIV testing, adherence to ART and TB treatment.

More recently, stigma directed at people living with active TB disease has been shown to have similar effects and less favourable outcomes in terms of treatment completion.

The South African NSP (2012-2016) in its Strategic Objective 1 aims to “reduce HIV- and TB-related stigma and discrimination”. It states that a clear programme of action that covers innovative and established methods of stigma elimination is essential, and that training is key in such programmes to empower and educate communities and individuals.

### Objectives

- To provide peer education training for correctional centre staff, including HIV and TB stigma mitigation;
- To provide peer education training for correctional facility inmates, including HIV and TB stigma mitigation;
- To assist the DCS to run six-monthly campaigns in correctional facilities to mitigate HIV and TB stigma;
- To develop support groups for inmates on ART and inmates on TB treatment, in order to improve treatment outcomes.

*Table 9.1: Activities to be implemented for target groups*

TARGET GROUP	ACTIVITIES
DCS staff	<ul style="list-style-type: none"> <li>• Provide peer education training for DCS staff at all correctional centres regarding HIV and TB stigma mitigation;</li> <li>• Provide on-going support to the DCS to run six-monthly campaigns on HIV and TB stigma reduction, including provision of appropriate posters and audio-visual materials;</li> <li>• Provide training to staff at all correctional centres to run effective support groups for inmates on ART and for inmates on TB treatment.</li> </ul>
TARGET GROUP	ACTIVITIES
Inmates and detainees awaiting trial	<ul style="list-style-type: none"> <li>• Provide peer education training to a specified number of inmates at all correctional centres, enabling such inmates to provide peer education on HIV and TB, including HIV and TB stigma mitigation;</li> <li>• Provide ongoing support and training to correctional centre peer educators to update their knowledge and skills base regarding HIV and TB, including stigma mitigation.</li> </ul>

### Core indicators for monitoring implementation

The proposed indicators are as follows;

- Proportion of correctional facilities staff trained on HIV and TB peer education (including stigma mitigation) (%)
- Number of inmates trained as HIV and TB peer educators (including stigma mitigation)
- Proportion of inmates trained through peer education programmes for HIV and TB (including stigma mitigation) (%)
- Proportion of correctional centres which have run HIV and TB stigma mitigation campaigns at least once every six months (%)
- Proportion of correctional centres providing weekly TB treatment support groups (%)
- Proportion of correctional centres providing weekly HIV treatment support groups (%)

# ANNEXE 1: HUMAN RIGHTS PROVISIONS IN THE SOUTH AFRICAN NATIONAL STRATEGIC PLAN 2012-2016

## DCS Draft Operational Plan

### SO4: Ensure Protection of Human Rights and Increased Access to Justice

SO4.1: Ensure rights are not violated when interventions are implemented and establish mechanisms for monitoring abuses and exercising rights

#### *Targeted interventions*

- Audit interventions to identify potential for human rights abuses;
- Guard against rights violations as part of policy development and programme planning;
- Use existing bodies to monitor human rights abuses and increase access to justice;
- Build capacity within public institutions and civil society to increase access to justice and redress.

SO4.2: Reduce HIV and TB discrimination in the workplace

#### *Targeted interventions*

- Implement a national campaign against unfair discrimination;
- Empower employees in small and non-traditional workplaces.

SO4.3: Reduce discrimination in access to services

#### *Targeted interventions*

- Ensure that oversight bodies receive and address complaints;
- Train social service providers to prevent unfair discrimination.

### Tools and guidelines for human rights

- 1) HIV and AIDS and TB Management Policy for the Public Service and its tools (guidelines and Monitoring & Evaluation plan) 2009 aligned with the South African NSP (2012-2016)
- 2) National Mainstreaming Framework/Guideline for the mainstreaming of HIV and TB in a gender-sensitive and rights-based manner for civil society, business and labour (aligned with South African AIDS Council, Governance & Administration Cluster, National Economic Development and Labour Council and Southern African Development Community)
- 3) Revised Code of Good Practice on HIV and AIDS in the World of Work aligned to International Labour Organization Recommendation 200 of 2010
- 4) DCS HIV and AIDS Policy and Guidelines for Inmates
- 5) DCS HIV and AIDS Policy and Guidelines for Officials (also consider STI, TB)
- 6) All Department of Health Clinical Guidelines/Protocols HIV and TB

# ANNEXE 2: TB SYMPTOM SCREENING TOOL



**health**  
Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## TB SYMPTOM SCREENING TOOL FOR ADULTS AND CHILDREN

### PATIENT DETAILS

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Age: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Patient folder Number: \_\_\_\_\_

### MEDICAL HISTORY

Close contact of a person with infectious TB: 

Yes	No	Unknown
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 (Tick v)

Type of index patient:

DS-TB	Rif Resistant TB	MDR-TB or XDR-TB
Yes	No	Unknown
Positive	Negative	Unknown

Diabetic:

HIV Status:

Other: (Specify) \_\_\_\_\_

### TB SYMPTOM SCREEN

#### 1. ADULTS

Symptoms (Tick v)	Yes	No
Cough of 2 weeks or more OR of any duration if HIV positive		
Persistent fever of more than two weeks		
Unexplained weight loss >1.5kg in a month		
Drenching night sweats		

#### 2. CHILDREN

Symptoms (Tick v)	Yes	No
Cough of 2 weeks or more which is not improving on treatment		
Persistent fever of more than two weeks		
Documented weight loss/ failure to thrive (check Road to Health Card)		
Fatigue (less playful/ always tired)		

*If "Yes" to one or more of these questions, consider TB. If the patient is coughing, collect sputum specimen and send it for Xpert testing. If the patient is not coughing but has the other symptoms, clinically assess the patient or refer for further investigation.*

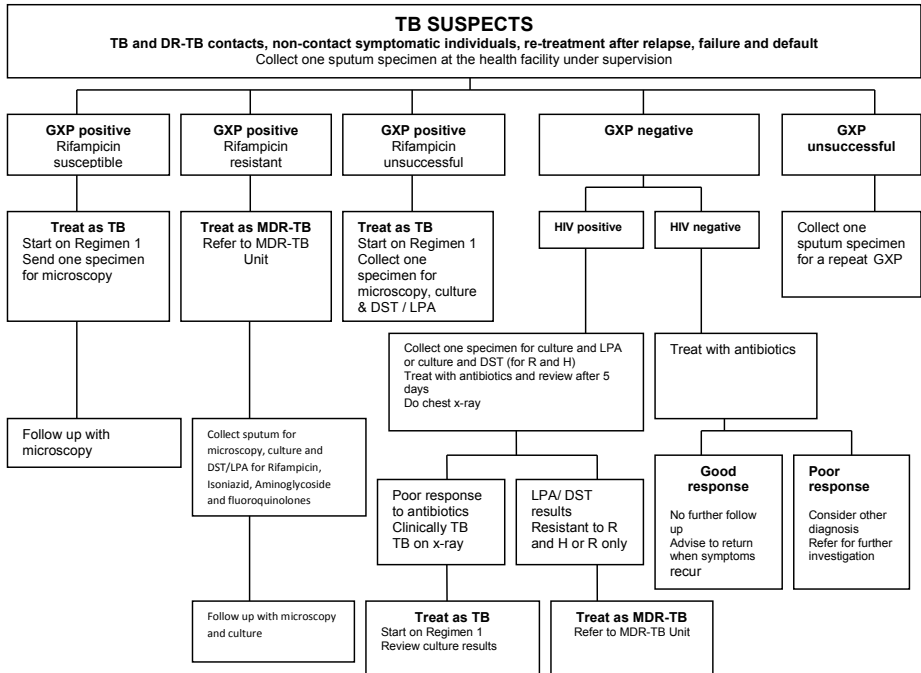
Date of last TB test: \_\_\_\_\_

Patient referred for assessment and investigation:  Yes  No

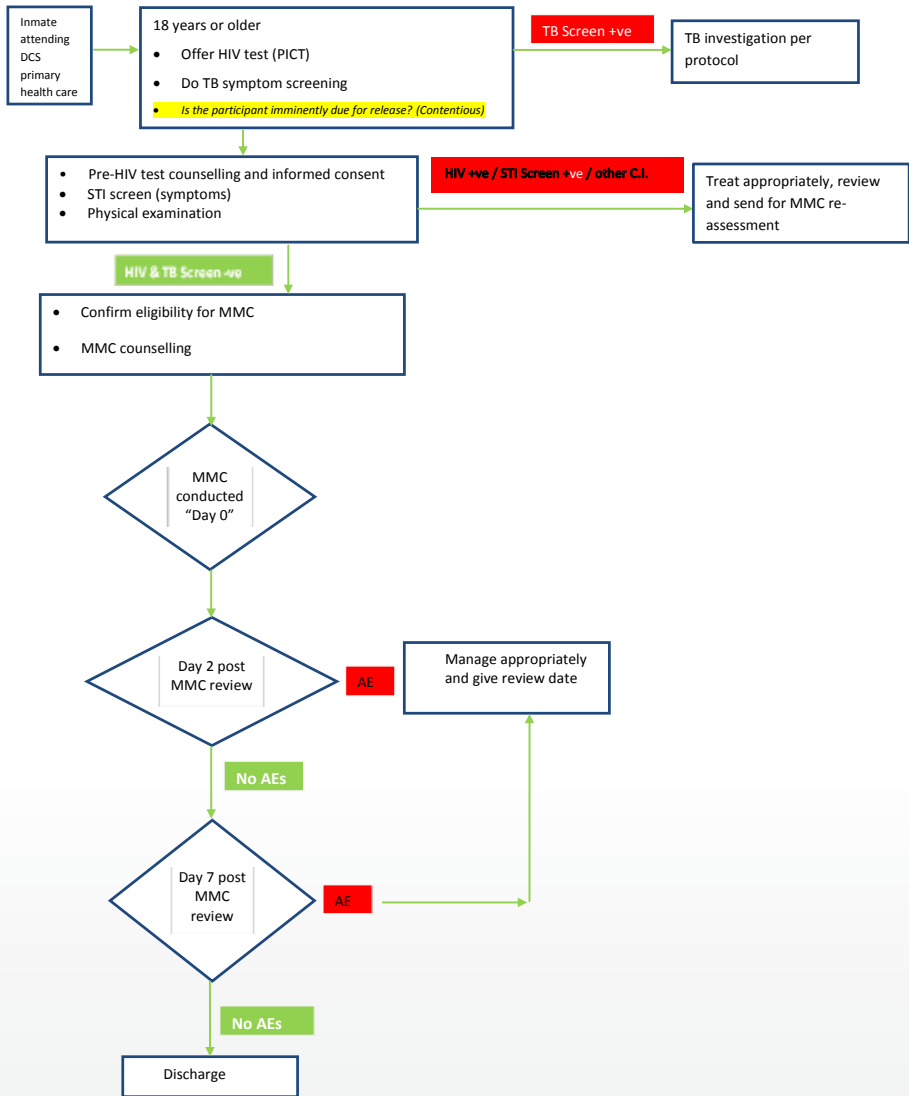
Date of referral: \_\_\_\_\_ Facility name: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# ANNEXE 3: FLOW OF PROCEDURES FOR MMC



# ANNEXE 4: XPERT DIAGNOSTIC ALGORITHM



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<sup>20</sup>WHO Guidelines on HIV and AIDS for Prisons. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS. UNAIDS/99.47/E; 1999.

<sup>21</sup>Andrew Coyle.Human Rights Approach to Prison Management.2nd edition. London, United Kingdom: International Centre for Prison Studies; 2009.ISBN 0-9545444-2-0.

<sup>22</sup>AIDS Law Project and Lawyers for Human Rights: HIV/AIDS and the Law: A Trainer's Manual. First edition, July 1997.

<sup>23</sup>The South African Offenders Organisation for Human Rights Mission Statement.

<sup>24</sup>Correctional Services Act, No 8 of 1959.

The background features a large orange rectangle at the top. Below it, a dark green shape curves from the left side towards the center. A red shape curves from the bottom left towards the center, overlapping the dark green shape. A white shape curves from the bottom center towards the right, overlapping both the red and dark green shapes. The bottom right corner is dark green.

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