Indonesian Prisons and HIV: Part of The Problem, Part of The Solution?

Erni Juwita Nelwan*, Aly Diana**, Reinout van Crevel***, Nisaa Nur Alam****, Bachti Alisjahbana***** Herdiman T. Pohan*, Andre van der Ven***, Ilham Djaya****

*Department of Internal Medicine, University of Indonesia - Cipto Mangunkusumo Hospital. Jl. Diponegoro no. 71. Jakarta 10430, Indonesia. **Health Research Unit, Faculty of Medicine, Padjadjaran University/Hasan Sadikin Hospital, Bandung, Indonesia. ***Department of Internal Medicine, Radboud University, Nijmegen Health Centre, The Netherlands. ****Department of Justice and Human Rights, Banceuy Narcotic Prison, Bandung, Indonesia. *****Department of Internal Medicine, Padjadjaran University/Hasan Sadikin Hospital, Bandung, Indonesia.

Correspondence mail to: ejnelwan@yahoo.com.

ABSTRACT

Around the world, HIV-prevalence rates among prisoners are high compared to the general population. This is due to overrepresentation of injecting drug users (IDUs) in prison and possible HIV-transmission inside prison. Limited health services in penitentiary institutes, stigma, policy issues, and budgetary constraints may hamper delivery of appropriate services for HIV in prison. Prisons may, on the other hand, enable the access to a high risk population for HIV-prevention and care. IDUs are namely hard to reach outside prisons, while in prison targeted interventions for IDUs can be used repeatedly and economically. Also, harm reduction and HIV-treatment can be supervised and monitored carefully.

This paper reviews HIV-prevention and care in prison, and describes the experience in one particular prison in West Java, Indonesia. Based on the literature and local experience, one can conclude that effective and widespread HIV-testing and treatment can be established in prisons if there is commitment from prison authorities, endorsement of services by prison staff and inmates, and collaboration with health care providers from outside prison. Essential components of HIV-services in prison include appropriate health care services, a suitable environment for HIV-counseling and -testing and tailored services for injecting drug use. By partner counseling and linking HIV-services in prison with continued care afterwards, prisons may contribute significantly to HIV-control in the general population, especially in settings where HIV is often due to injecting drug use.

Key words: Indonesian prisons, HIV, injecting drug users.

INTRODUCTION

Indonesia has one of the most rapidly growing HIV-epidemics in Asia, which is in most parts of the country largely fuelled by injecting drug use (IDU).1,2 Drug use is illegal and imprisonment is, therefore, a common and recurrent event for most injecting drug users (IDUs). Reports from outside Indonesia indicate that the risk of being infected in prison, specifically through the sharing of contaminated injecting equipment, is high.3 Similar to many other countries, prisons may thus contribute to the growing HIV-problem in Indonesia. Based on literature review and experience in one particular prison in Indonesia, this paper reviews the epidemiology of HIV in prisons, and the barriers, possible benefit as well as practical aspects of delivering effective HIV-prevention and care in prison.

EPIDEMIOLOGY

In many countries, higher rates of HIV-infection are reported among prisoners compared to the general population.3 Injecting drug users (IDUs) are overrepresented in prisons and many of them are repeatedly incarcerated.3,4 Sharing of contaminated injecting equipment possesses a high risk of transmission of HIV and outbreaks of HIV-infection in prisons have been documented from several countries.5,6 Apart from that, prison populations in general are dynamic with inmates going in and out of the prisons all the time. The high proportion of IDUs and high turnover rate may contribute to the spread of blood borne viruses such as HIV among prisoners and to the general community.3
Also in Indonesia, higher prevalence rates of HIV-infection have been reported from prisons. Official reports put the overall HIV-seroprevalence in prison at 15%, with rates up to 22% in Jakarta and 56% in Bali. A recent survey among more than 600 incoming inmates in Banceuy prison in Bandung, West Java, showed that 7.2% were infected (Nelwan EJ, submitted for publication). The different rates that are reported from Indonesia may be due to selection bias, for instance differences in the proportion of IDUs that were included in serosurveys.

DIFFICULTIES RELATED TO HIV PREVENTION AND CARE IN PRISON

Ideally, prison provides comprehensive programs for HIV that includes voluntary counseling and testing as well as care and treatment for those that are infected. In addition, interventions for drug dependence and injecting drug use should be operational. However, the implementation of such measures may be difficult for various reasons. First, prisons are no health institutions, and health programs in prison encounter many technical and budgetary constraints, such as a limited number of staff, the unavailability of laboratory testing or radiological examination, and inadequate supply of medication.

Second, prison and prisoners face many health challenges besides HIV. Possibly, due to the poor sanitation and overcrowding in prison, skin diseases like scabies, tuberculosis, and acute diarrhea are commonly found among inmates. Additional problems include management of co-morbid conditions, remoteness from HIV-care sites, and organizational and budgetary constraints.

An additional problem which may further complicate HIV-prevention and -care in prison is the stigma that is surrounding HIV/AIDS among prison staff and prisoners. Being a very sensitive issue, HIV/AIDS programs and services must be responsive to the unique needs of vulnerable or minority populations within the prison. Knowledge, attitudes and beliefs among prison staff also need to be considered since discrimination among that group may hamper adequate HIV-prevention efforts. Illustrative is a study that was carried out in an Indonesian prison and that showed that the attitude of prison staff towards inmates was strongly influenced by their knowledge of HIV/AIDS-transmission (Hinduan ZR, submitted for publication). Stigma also exists among prisoners themselves. HIV-seropositive inmates may be exposed to isolation due to fear of getting infected by sharing rooms, using the same food utensils or body contact.

Finally, prison policy and specific technical issues in prison may hamper the implementation of programs focused on HIV-prevention and -care. For instance, prison authorities may be reluctant to introduce needle exchange because of security reasons. Condom distribution may suffer from fear among inmates to be identified as being sexually active with other (male) prisoners. In Indonesia, distribution of condoms, bleaching of needles and methadone were well accepted in some prisons such as in Kerobokan prison in Bali, but especially for needle-exchange program, the actual implementation is still modest.

WHY IS IT IMPORTANT TO PROVIDE HIV-PREVENTION AND -CARE IN PRISON?

Despite the many problems facing HIV-prevention and -care in prisons, every effort should be made to provide services for prisoners, as a basic human right. Article 25 of the United Nations Universal Declaration of Human Rights states that everyone has the right to adequate health care. One should realize that prisoners that are facing a medical problem can only rely on the availability of health services inside prison, or referral by that same prison clinic to health institutes outside.

Besides our moral obligation to provide HIV-prevention and -care for prisoners, there may also be a strategic reason to establish services in prison: effective HIV-prevention in prison can make a substantial contribution to control of the HIV-epidemic in the general community. Imprisonment is a common and recurring event for IDUs in Indonesia. Inmates’ contact with the prison health care system provides an opportunity to offer HIV-screening to a population that is very difficult to reach otherwise.

A final reason to provide HIV-prevention and -care in prison is its cost-effectiveness. The high prevalence of HIV-infection and over-representation of IDUs in prisons create unique opportunities for interventions which can be very delivered efficiently. Experience from Banceuy Prison, Bandung, West Java show that targeted interventions can indeed be used repeatedly and economically.

DELIVERING HIV-SERVICES IN PRISON-PRECONDITIONS

From our experience, several issues should be considered when implementing HIV-prevention and -care in prison. The first and probably most important precondition is commitment from prison authorities, which is crucial and mandatory to implement and sustain any activity. Next, support from prison staff is crucial since
these professionals will be in direct contact with the target population. All too often, HIV-prevention activities as well as HIV-counseling and testing are delivered in Indonesia by non-governmental organizations (NGO) or outside institutes without adequate involvement of prison staff. In these situations it may occur that advantages that are created by one party are undone by the other.

The second precondition is a good collaboration with local health care providers. Prisons are not equipped to deliver specialized medical care and partnership with facilities for referral of patients and analysis of blood samples is needed to support the medical staff of the prison. These specialized facilities also need to be consulted after a diagnosis of HIV is made although most of case management can usually take place within the prison setting. In Bandung, a memorandum of understanding was made between Hasan Sadikin Hospital and Banceuy prison in order to facilitate consultation of medical specialists inside prison and referral of patients or samples from prison to hospital. In collaboration with a primary health care center, diagnosis and treatment of tuberculosis was established (Table 1).

**Table 1. Banceuy narcotic prison – implementation**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
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</table>
| 2006 | MOU between Banceuy Prison and Hasan Sadikin Hospital  
Weekly consultation by hospital specialists  
Patients referral to Hasan Sadikin Hospital |
| 2007 | KAP study of prison staff related to stigma  
Improved general health care  
Health screening for incoming inmates  
Blood sampling for HIV, HCV, HBV-serology, CD4  
Methadone Maintenance Treatment |
| 2008 | General health services linked with counselling and HIV testing  
Screening for tuberculosis  
Improve prison staff’s knowledge about HIV-AIDS  
HIV-care and treatment established, viral load  
Peer support group HIV-positive prisoners  
Adherence and family counselling  
Advocacy - World AIDS Day in prison |
| 2009 | Need assessment addiction care  
Linking HIV-service inside prison with rehabilitation after release |

MOU, memorandum of understanding; KAP, knowledge, attitude and practice;  
HCV, hepatitis C virus; HBV, hepatitis B virus; CD4, CD4+ T-lymphocytes

Another issue to consider is the endorsement of HIV-services by the prison staff and prisoners. There is a hierarchic relationship between inmates and prison staff that access to interventions may therefore be limited by prison staff. An important motive for the prison staff may be (sometimes legitimate) concerns about their own health, in terms of transmission of HIV or other diseases. There is, however, generally a low level of knowledge on HIV and its transmission among Indonesian prison staff and improvement of knowledge is known to improve the tolerance of staff towards HIV-infected prisoners.

The involvement of prisoners is equally important. Their help-seeking behavior and compliance with HIV-prevention and care depends on their trust. Experience in Banceuy prison has shown that inmates are willing to comply with services to improve their health. Not less than 94% of incoming inmates counseled for HIV, agreed to be tested (Table 2). Peer support proved instrumental for HIV-seropositive inmates to deal with psychological and practical issues related to testing, disclosure of HIV-status and starting antiretroviral treatment. In Banceuy prison, seventeen HIV-seropositive inmates voluntary meet on a weekly basis in a peer-group.

**Table 2. Banceuy narcotic prison – overview**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Capacity</td>
<td>450 inmates</td>
</tr>
<tr>
<td>Number of inmates</td>
<td>960; 48 new inmates/month</td>
</tr>
<tr>
<td>Number of hospital beds</td>
<td>15 beds</td>
</tr>
<tr>
<td>Prison health staff</td>
<td>4 GP, 2 dentists, 4 nurses, 3 support staff, 1 psychology consultant, 1 laboratory technician</td>
</tr>
<tr>
<td>History of injecting drug use</td>
<td>17.3% of incoming inmates</td>
</tr>
<tr>
<td>HIV-counseling and testing</td>
<td>818 inmates</td>
</tr>
<tr>
<td>Major Health Problems</td>
<td></td>
</tr>
</tbody>
</table>
Upper respiratory tract infections (33.7%)  
Skin diseases (23.5%)  
Diabetes (3.6%) |
| HIV-positive | 63 inmates; 7.2% of incoming 539 inmates |
| Anti-retroviral treatment | 21 inmates |
| TB-treatment | 26 inmates |
| Methadone Maintenance Treatment | 9 inmates |

GP (general practitioner), during study period additional of 2 GP, 3 nurse, 2 supporting staff, psychology and laboratory technician, since August 2007, diagnosis of 784 prisoners visiting the clinic, 

**COMPONENTS OF HIV-CARE IN PRISON**

Prisoners do not directly benefit from anonymous serosurveys, and may lead to distrust and further stigmatization. Non-anonymous HIV-testing may be limited because inmates may fear the negative consequences of having certain illness inside prison, or because confidentiality is not secured. Improvement of testing inside prisons may be achieved when general
health care and voluntary counseling and testing (VCT) are integrated. In addition to that, offering VCT to all incoming inmates is a method to enable early diagnosis and timely treatment of HIV and may help to establish good relationships between prisoners and health care providers. Similarly, health services for resident inmates, for instance, through outreach to prison blocks, will help to build trust and provide appropriate care.

As mentioned above, confidentiality is a major concern for inmates who want to be tested or who were already found to be HIV-seropositive. Some issues should be carefully addressed, such as the attitude of prison staff, appropriate facilities, such as closed rooms for consultation, locked rooms for medical records and approach toward the medical history of inmates.

So far, anti-retroviral treatment (ART) has been underprescribed in prisons. Although many barriers exist to treat all eligible HIV-infected prisoners, treatment reduces the costs associated with HIV-related complications and may encourage linkage to HIV-care in the community. One crucial issue in Indonesia is that prisons so far are not authorized to manage ART inside prison. Until now, all treatment has been supplied from hospitals or other health institution outside prison, often via NGO’s. In the future, it may be necessary to have the capacity to manage ART separately in prison clinics. Besides ART, care for those that are terminally ill should be improved, as well as possibilities for referral of patients to hospital or consultation of hospital specialists in prison.

HIV-treatment in prison may actually be more effective than outside prison. In Banceuy prison in Bandung, so far 21 prisoners have been started on ART (Box 1). Prisoners receive their treatment daily under direct supervision, which allows for continuous monitoring and counseling. No single inmate has dropped out from treatment, and 16 from 17 patients (94%) examined had an undetectable plasma HIV-RNA after six month treatment. As a comparison, in hospital as much as 12% had dropped out from treatment after six months, and virological failure was detected in around 10% of patients. Possibly, good results can be achieved at a much lower costs in prison than outside, but so far this has not been examined.

Harm reduction measures for prisoners such as access to bleach, substitution therapy and sterile injection equipment have a positive impact for a population, particularly those vulnerable to HIV and HCV; states that fulfill these measures have implemented crucial public health policy. Ultimately, this approach benefits not only prisoners but also prison staff and the public, and does not entail lessening of the safety and security of prisons. Kerobokan prison in Bali has a successful story especially by implementing methadone substitution therapy to reduce HIV-infection.

HIV-SERVICES IN PRISON - ISSUES TO BE RESOLVED

Although HIV-prevention and -care can be implemented successfully in prison, many challenges are remaining. The most important issues which should be addressed are harm reduction, continuation of care for prisoners after release, and up-scaling and sustainability of HIV-prevention and care for all prisoners in Indonesia.

Opioid substitution with methadone has been implemented successfully in many prison environments in the world. In Indonesia, Kerobokan Prison in Bali was the first prison to provide methadone which has enrolled 322 clients since August 2005. Methadone has also been introduced in Banceuy Prison, Bandung, since August 2007. However, only nine inmates have been registered so far, while some have also stopped while still in prison. Current policy in Banceuy prison does not allow other forms of harm reductions, like provision of condoms and clean needles, or needle bleaching. The disparity between the apparent success of methadone in Bali and the low uptake and success in Bandung indicates that we need to understand more about addiction care for prisoners in Indonesia.

The second issue which should be addressed is continuity of care after release from prison. HIV-prevention through harm reduction and HIV-treatment should be continued after inmates are released from prison. In practice, this may be difficult. Often, there is no established collaboration with health care providers outside prison, and logistic issues (costs, distance) may limit the accessibility of services.

Establishing effective links between services in prison and in the community is essential. Such collaboration can improve the standards of care in prisons, support prison staff (including providing opportunities for training), ensure that prison services reflect current national best practice, ensure the sustainability of prison programmes, and improve continuation of care for after release from prison. The main problem that remains is budget. More cost-effective ways for providing general health care and early detection of HIV in prison should be identified. From these experiences, we recommend the establishment of other referral prisons, to help ensure equal access to care for as many prisoners as possible.
CONCLUSION

Prisons may fuel HIV transmission, but also may act as an appropriate place for HIV-prevention and care, which may contribute significantly to control HIV in general community, and which may be very cost-effective. Based on the experience in several prisons, a comprehensive and stepwise approach should be taken to establish HIV-care (Figure 1). Preconditions for HIV-services in prison include strengthened policy and commitment, collaboration with health facilities outside prison, and endorsement of services by prisoners and prison staff. Good general health care should be established first, as a starting point for widespread HIV-testing and treatment. Antiretroviral treatment can be delivered successfully, but continuation of care for prisoners after release is a matter of concern. Other issues which need further research or discussion are harm reduction strategies in prison, as well as up-scaling and sustainability of HIV-prevention and care for all prisoners in Indonesia.

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