HIV/HCV community based counselling and testing in prison a pilot intervention

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Content

- Importance of HIV/HCV counselling/testing in prison
- Easy-to-reach highly vulnerable populations in „hard-to-reach" medical settings
- Challenges: community-based testing campaigns
- Standards VCT / prison
- pilot model project: ingredients, first steps
- Brake isolationism: Prison Health = Public Health

Background HIV/HCV prison

- 110.000 incarcerations / year in Germany (high turnover rate)
- Chronic HCV: up to 17,6% (32-fold higher compared to general population (2010)
- HIV: up to 1,2% (24-fold higher compared)
- HCV among PUD : 57,6% with HCV antibodies (2014)
- Higher prevalence of HIV/HCV in prison (PUD, migrant populations e.g.)

DRUCK Study among injecting Drug Users (2011-2015)

- Up to 86 % at least once in prison
- Up to 40% report i.v. Drug consumption/prison
- 3% started i.v. drug consumption / prison
- High rate of new HIV diagnoses (up to 32%! testing among PUD?)
- Only 65% among those with known HIV status ever received HIV treatment (!)
- Only 56% among those interviewed were on ARV treatment (!)
- HBV vaccination prevalence 15-52 % (!)

Prison Health realities
90-90-90 / 90-95-95 targets

- DRUCK Study carried out by a National institution
  - Time of denial over?
  - Window of opportunity?
- Prison offer space for Public Health Interventions
- How to achieve the 90-90-90 targets?
- How to integrate Prison Health and close the gap?
  - Germany: Federal State structure
  - Prison Health = Stewardship of the MOJ (16 different ministries)
  - Prisons have their own budget for health interventions
- Lack of commonly shared Public Health standards, cooperation, funds, knowledge
  - Some prisons offer VCT at entry and release
  - Vaccination, treatment, counselling, prevention, harm reduction varies

Realities prisoners face prisons fit for purpose?

- Health examination at entry: may or may not include testing + basic information
- Tests carried out may or may not be voluntary
- Doctor – patient relationship certainly different (no free choice)
- Reality sometimes confusing: treatment part of punishment?
- How built up trustworthy relationships in a punitive system?
- What a combination: high risk behaviour combined with lack of prevention methods
  - needle sharing, piercing
  - OST, NSP, condoms (!), vaccination, access to information
- Prisons are a "closed" environment, a whole universe with its own rules, mechanisms and high level of testosterones
  - "security" - "control" -

Testing: prisoners/staff face challenges

- VCT difficult
  - time, language barriers, work overload, budget …
- Often no pre- and post-test counselling
- Test results with prisoners often only shared if positive
  - Insecurity, confusion, false sense of security
- Counselling not used to address risk behaviour + prevention
- Lack of confidentiality
  - Test result may lead to stigma, pressure among prisoners, bullying,
  - impact on status and hierarchy
- Prison based discrimination
  - Test results may have impact on job options, sport and leisure activities
- HIV/HCV one topic among many other health related issues
  - HCV+ test results may not lead to treatment (!)

Is there a perfect times for HIV testing in prison?

- incarceration emotionally extremely challenging
  - panic, depression, isolation
- Not at entry, better 3-4 weeks after the orientation phase
  - capability to digest new information
- After risk behaviour
- Upon release
  - throughcare", release preparation,
  - new substances, overdosing e.g.
- At entry: to diagnose acute symptoms

Community-based testing campaigns in prison?

Pro:

- In principle good treatment options
- Positive for prevention, security
- Prison setting can secure compliance (safe space, time)
- Testing offers counselling options (risk reduction, awareness)
- Prisons = places of a “easy-to-reach” and highly vulnerable people

Contra:

- Violation of testing standards, costs
- Anonymity (negative consequence)
- Test results may lead to stigma/discrimination but not necessary to access to treatment
- Imprisonment as a stressful experience (depression, isolation)
- Doctor-patient relationship difficult (no freedom of choice, what if there is no follow up?)

Aims: concept community based intervention

- Support Prison Health system (and work of its physicians)
- To safe costs (tests, diagnostics covered by DAH)
- To close the gaps
  - Discover unknown HIV/HCV infections
  - Reduce rate of late presenters
- Counselling on risk situations, risk behaviour and risk reduction (past and present, including prison-related risks)
- Capacity building / empowerment (safer use, safer sex)
- To realise prisons as a place for Public Health interventions
- To demonstrate the value of community based interventions

Preconditions for participation

- Cooperation between all actors (authorities, prison health care workers, external physician, prison staff, community workers, prisoners)
  - Agreement signed (procedures, conditions, standards)
- Training of all parties involved
  - Prevention, transmission routes
  - Prison related risk factors, risk reduction
  - Drug consumption in prison
- Advertisement among prisoners (leaflets, radio e.g.)
  - It is secured that prisoners participate voluntary, no pressure taken
- Safe and clean space guaranteed (anonymity, counselling)

Appointments

- 14 days basis a 3 hours
  - One external doctor, two trained community counsellors
- Prisoners announce their will to participate to prison staff
  - reason not mentioned (!)
- More then one appointments are likely
  - a) pre-test counselling and testing,
  - b) result delivery/post-test counselling
- No personal identification necessary
  - Special codes are used for follow-up appointments
- Identity of prisoners and content of test-result is confidential
  - Community workers and external doctors have confidentiality agreement towards the prisoner

First appointment pre-test counseling (20 minutes)

- Questionnaire to discuss and evaluate risks / reactions (community worker)
  - HIV, HCV Status, test behaviour, vaccination (HAV, HBV)
  - drug consumption, risk situations (last 6 months)
  - Risky sexual behaviours, safer sex, STIs
  - Risk behaviours: tattoo, piercing
  - Detailed information on safer use
  - Other risk factors (blood transfusions, fights, wounds e.g.)
  - Symptoms?
  - expected reactions should the HIV/STI test be positive
  - Availability of social contacts

First appointment - medical information

- HIV/HCV
  - Treatment options, new HCV regimens
  - Vaccination (value, procedure)
  - Treatment as prevention.
  - PeP
- Information testing procedure and tests used
  - Rapid or antibody test?
  - meaning of reactive test results
  - follow up should the test be reactive (prisoner takes decision, new appointment possible)
  - Confidentiality: who gets the information should an infection be confirmed?   Name to local health authorities, code to National surveillance institute
  - Confidentiality towards the prison health authorities
  - Is the prisoner able to give consent?

Testing (role of the physician)

- Prisoner decides upon tests performed
  - HIV/HCV rapid test or (immediate result)
  - HIV/HCV laboratory test (result, next appointment)
  - If anonymity has absolute priority: only rapid tests possible (registration procedures)
- If laboratory test for HCV/HIV is positive:
  - PCR test performed with the same blood sample (HCV might not be chronic: 20%)
  - HIV: confirmation test done in the lab with the same blood sample

Post-test counseling

- Explain test result and identify next steps
  - diagnostic tools,
  - procedures,
  - treatment options,
  - vaccination
- Any other health- or harm-reduction related question?
- The prisoner decides if he wants to get in contact to the physician in prison
  - Meeting between prison health doctor, external physician and prisoner can be initiated

Costs

Rapid tests

- HCV rapid test: 17,73 €
- HIV rapid test: 7,08 €

Laboratory test

- HIV Antibody: 6,25 €
- HIV confirmation: 33,30 €
- HCV Antibody: 8,32 €
- HCV PCR: 45,76 €

Human Resources

- Ca. 370 € staff costs for each appointment (fee, travel expenses)
- funds from the BZgA and German AIDS Federation

Hard-to-reach health care settings It took one year ….

- Pilot project started January 2017
- 16 MOJ approached
- 2 prisons reacted
- 1 signed the agreement (prison/DAH)
- Prison with a turnover rate of 554 persons in (2015)
- One physician and social workers of two HIV service NGOs included

Reasons low response rate

- Work in isolation is convenient
  - Prisons secure “survival of the unfittiest”
- Power and status (“control freakanism”)
  - Might be limited should observations leak to the outside world
- Lack of political support
  - Prison Health used for political propaganda
- Lack of understanding of the role prisons could play (public health)
  - “why should we take responsibility for all failures of the health cares system outside?”
- Lack of trust
  - Shame and blame
- The mosquito-effect
  - Community participation painful and troublesome
- Expected work load
- Expected costs
  - follow up: treatment, vaccination, prisons have limited budget (!!!)
- Communities contribution not highly valued

Findings and first results

- Pilot intervention is a learning experience for everyone involved
- Results based on figures of test results and risk evaluation will be presented and shared at conferences etc. when available
- Intermediate results will be shared with the prison involved
- For the time being confidentiality between DAH and prison agreed
- If we want have Prison health integrated into Public Health more is needed than this intervention

Thank you!

Special thanks to the prison authorities , the physicians involved and the community workers that help us to realise the intervention!

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Acknowledgement:

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