Tuberculosis Guide and Airborne Infection Prevention and Control in Correctional Institutions

Lesotho | October 2019
TB remains one of the public health problems in the world, it is among the top ten causes of death worldwide and the leading cause of death among people living with HIV in Africa. Lesotho remains on the WHO list of the 30 high TB burden countries in the world with an estimated annual incidence of 665 TB cases per every 100,000 population and TB/HIV incidence of 470/100,000. The mortality rate in TB/HIV co-infected TB patients is 206 per 100,000 populations. MDR/RR-TB remains a concern with new cases estimated at 4.8%. (Global TB Report, 2018).

The fourth objective of the 2018-2022 TB strategic plan seeks to find, treat and cure 90% of the new TB patients among the vulnerable populations as a targeted approach to find the missing TB cases and end TB. Correctional institutions in Lesotho are identified as high risk areas for transmission of TB among the inmates and corrections staff, this is further worsened by the high burden of HIV in these institutions. Anecdotal evidence shows that rates of TB disease reported from “prison” (corrections) populations are much higher compared rates from the civilian populations (WHO ICRC: 2000). The Ministry of Health (MoH) and the Lesotho Correctional Service (LCS) are working together at National and District Level to ensure that inmates receive comprehensive TB and HIV services equivalent to those provided to the general public.

It is therefore apparent that TB Infection Prevention and Control has to be enforced in correctional institutions and any congregate setting, in particular to strengthen surveillance system, promptly diagnose and treat those with TB disease to prevent further spread. The MoH and LCS have developed this TB guiding document specific to corrections settings to assist in providing practical approaches for reducing the risk and increasing the safety for staff, inmates and visitors of the correctional institutions. It is our greatest believe that this document will contribute immensely towards mammoth task of ending TB by 2030.
ACKNOWLEDGMENTS

Effective Tuberculosis control in correctional facilities requires strategies that protect not only the inmates, but also protects staff, visitors and the general public. However, if unguarded, conditions in these institutions can accelerate the spread of TB and other communicable diseases through overcrowding, poor ventilation, inadequate medical care, poor nutrition, poor sanitation and hygiene to mention a few.

Studies have shown that the levels of TB in prisons are far much higher than levels in the general population. In some instances, TB in prisons may even account for up to 25% of a country’s burden of TB. Late diagnosis and inadequate treatment have been noted as some of the most important factors that have turned correctional facilities into reservoirs undermining all efforts made to protect the general population against TB, as these keep pumping the disease into communities through staff, visitors and inadequately treated inmates being released back into society.

The importance of a close collaboration between the Ministry of Health through the National Tuberculosis Programme and the Lesotho Correctional Service in the pursuit of the end TB strategy cannot be over-emphasised. It is also significant to further underscore the role played by development partners, donor agencies and civil society organizations in the fight against TB, especially in congregate settings.

Lesotho Correctional Service is therefore, greatly indebted to the Ministry of Health–NTP for its leadership and for guiding the development of these important tools. Further, the department greatly appreciates the technical assistance provided by the Centre for Disease Control (CDC) and Eastern, Central and Southern African – Health Community (ECSA - HC). Lastly but not least a pat on the shoulder goes to the LCS health team for collectively putting this important document together.

T. MOTHEPU (MR)
COMMISSIONER
# ACRONYMS AND ABBREVIATIONS

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<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
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<td>ART</td>
<td>Anti-retroviral therapy</td>
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<td>CPT</td>
<td>Cotrimoxazole preventive therapy</td>
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<td>HIV</td>
<td>Human Immune-deficiency virus</td>
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<td>TPT</td>
<td>Tuberculosis Preventive Therapy</td>
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<td>LCS</td>
<td>Lesotho Correctional Service</td>
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<td>LTBI</td>
<td>Latent Tuberculosis Infection</td>
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<td>MDR-TB</td>
<td>Multi-drug resistant Tuberculosis</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NTP</td>
<td>National Tuberculosis programme</td>
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<td>PICT</td>
<td>Provider-initiated testing and counseling</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>RR-TB</td>
<td>Rifampicin-Resistant Tuberculosis</td>
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<td>SOP</td>
<td>Standard Operational Procedure</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TB IPC</td>
<td>Tuberculosis Infection Prevention and Control</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>XDR-TB</td>
<td>Extensively-drug resistant Tuberculosis</td>
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CHAPTER 1: INTRODUCTION

Prisons are not venues holding static populations. They are dynamic communities where at-risk groups congregate in a setting that can exacerbate disease and its transmission, especially airborne diseases like TB. TB in prisons affects the general population through transmission that occurs when prisoners are transferred to another facility or are released back into the community after completion of their sentence. TB can also be transmitted to prison staff and visitors who then bring it into their communities.

A disproportionate number of prisoners come from socio-economically disadvantaged populations where the burden of disease may be already high and access to medical care limited. Prison conditions can exacerbate the spread of disease through overcrowding, poor ventilation, poor nutrition and inadequate or inaccessible medical care.

The incidence of TB in prisons has been reported to be as much as 100 times higher than that in the civilian population. High levels of MDR-TB have been reported from some prisons with up to 24% of TB cases suffering from MDR forms of the disease.

Late diagnosis, inadequate treatment, overcrowding, poor ventilation and repeated prison transfers encourage the transmission of the TB. HIV infection, malnutrition and substance abuse fuel the development of active disease and further transmission.

Specific targets set in the End TB Strategy include a 90% reduction in TB deaths and an 80% reduction in TB incidence (new cases per year) by 2030, compared with 2015. Achieving these targets requires provision of TB care and prevention within the broader context of universal health coverage and multi-sectorial action to address the social and economic determinants and consequences of TB. Therefore, public health strategies to curb TB should be uniform and comprehensive to include prisons, since they are communities that have higher TB prevalence and incidence rates.

TB infection prevention and control in correctional institutions

Why TB infection prevention and control in correctional institutions is important

Box 1: The goal of the TB Guide is to provide practical approaches for reducing the risk and increasing the safety for staff, inmates and visitors of the correctional institution.

Despite the introduction of effective regimens for the treatment and cure of TB, the risk and danger remain high because of failure to diagnose and treat promptly. Untreated TB spreads easily and quickly to anyone with HIV. In addition, there are resistant strains of TB that are more difficult to treat
and can also be transmitted. Reducing the risk of transmission relies on raising Awareness, affecting Attitude, and translating intentions into Action. This requires collaborative and coordinated efforts on the part of policy makers, the Ministry of Health (MOH), Lesotho Correctional Service (LCS). Management teams and staff must work together to improve TB control in correctional institutions. Inmates have the right to at least the same level of medical care as that of the general community, and early detection and treatment will benefit the community at large.

What can be done

Risk of transmission of TB is related to the duration and intensity of exposure and the immune status of those exposed. This can be reduced by limiting the length of the exposure, improving ventilation and separating those at highest risk. Administrative Control Measures (first and highest priority), Environmental Control Measures (second priority) and Personal Protection Equipment (PPE) (third priority) can all contribute to minimizing TB transmission. Early identification, diagnosis and treatment of those with presumptive TB is key. Active screening of inmates and rapid transport of specimens are administrative control measures that must be implemented. Good ventilation in all areas is the crucial environmental control measure and masks and respirators constitute PPE. Although some interventions require planning and resources (such as new construction), many things can be done at little or no financial cost and will result in improved protection of staff, inmates and visitors.

How to use this document and have an impact

The Guide promotes practical approaches to optimize techniques for promoting TB Infection Prevention and Control. Implementation of the Guide is meant to be undertaken as a prioritized, sequential, gradual process to help bring a uniform set of procedures to the correctional institutions in Lesotho.
CHAPTER 2: ORGANIZATION OF TB INFECTION PREVENTION AND CONTROL IN CORRECTIONAL INSTITUTIONS

Lesotho Correctional Service (LCS) and the Ministry of Health National Tuberculosis Programme (MoH-NTP) are working together to create a standardized system, which will facilitate program implementation, evaluation, and scale-up. Management structures such as infection control committees or teams must be created at national and facility level, for oversight and implementation of TB Infection Prevention and Control (TB IPC).

Infection control structure for correctional service at national level

Composition of national LCS infection and prevention control committee (IPC committee)

A multi-stakeholder committee involving the Lesotho Correctional Service (LCS), the Ministry of Health (MoH), and development partners should be established to oversee and coordinate all activities for TB IPC in correctional institutions. The committee should be built-upon the existing collaborations and should be composed of the following members:

1. Senior Assistant Commissioner Health (Chair)- LCS
2. HIV/AIDS Coordinator (Co-chair)-LCS
3. Monitoring and evaluation officer (Secretary)-LCS
4. National Tuberculosis Control officer – MoH
5. Infection control officer - MoH
6. Laboratory Department officer -MoH
7. Nursing officers-LCS
8. Pharmacy technologists- LCS
9. Health Inspectors/Environmental Health Officers- LCS
10. Implementing Partner (NGOs)
11. Civil Society Organisation
12. Representative from Corrections Officers
Roles and responsibilities of IPC committee

The roles and responsibilities of the correctional service national IPC committee include to;

- Develop and disseminate of National Tuberculosis Technical Policies,
- Provide oversight for TB IPC implementation at correctional institution level
- Raise awareness, collaborate and coordinate of stakeholders for TB IPC
- Educate & raise awareness to inmates about TB & importance of ventilation
- Plan, budget, and strategically allocate funding
- Conduct periodic National Assessment of TB IC in correctional facilities
- Develop a Monitoring and Evaluation (M&E) strategy for TB IPC in correctional facilities
- Provide technical support for TB IPC and TB care in correctional facilities
- Develop a strategy for human resource training in TB IPC and
- Provide solutions to issues presented by any facility’s IPC committee
- Supervise the implementation of TB IPC through periodic facility inspection visits

Infection prevention control structure at correctional institution level

Composition of correctional institution IPC committee

Each Correctional institution shall have an IPC committee. Each correctional institution’s IPC committee shall work closely with the District Health Management team (DHMT) and the IPC focal person from MOH when such person has been appointed to address TB IPC issues. The IPC committee shall ensure the implementation of National IPC policies. The IPC committee shall oversee the day-to-day IPC activities in the facility.

The correctional institution IPC committee shall be comprised of:

1. District Commander of the Correctional Institution (Chair)
2. Nurse (Co-Chair)
3. Corrections officer who is responsible for security issues in facility
4. Corrections officer trained on health issues (assigned duties in the clinic)
5. District TB Coordinator from MOH
6. TB Laboratory supervisor from District Hospital
7. Representative of the local NGO providing support to LCS
8. Corrections facility Rehabilitation representative
9. Inmate Peer educator
Roles and responsibilities of the facility IPC committee

The roles and responsibilities of the correctional institution IPC committee include to;

- Conduct correctional institution TB risk assessment 2 times each year
- Write the TBIPC plan for the correctional institution
- Ensure availability of sputum containers for sputum collection,
- Ensure availability and correct use of personal protective equipment (PPE)
- Monitor, supervise, and evaluate IPC activities and prepare documents for quarterly meeting minutes
- Monitor turn-around time of sputum collected: time to arrive in lab; time for results to arrive at institution; time for inmate or staff to be started on anti-TB treatment
- Monitor numbers and location of all inmates and staff diagnosed with TB at the end of each month
- Review progress reports and IPC specific work plan activities
- Promote and coordinate in-service training/education
- Prepare report quarterly for submission to National LCS IPC Committee
- Review budgets for IPC

The Co-Chair of the correctional institution IPC committee will be a Nurse and will appoint and supervise correctional institution teams (IPC teams). There will be 1 team for up to 200 inmates. The IPC teams will be composed at least 5 people comprised of correctional institution staff and inmates.

Roles and responsibilities of the IPC team

The role and responsibilities of the IPC team include to;

- Execute the TB IPC activities as outlined in the IPC plan.
- Document IPC problems and solutions suggested
- Report to the Nurse (Co-chair) of the correctional institution’s IPC committee monthly and more frequently if necessary.

The Nurse Co-chair and IPC team leader will be responsible for maintaining a binder with these written reports and will follow up on issues identified by the team.
CHAPTER 3: TB INFECTION PREVENTION AND CONTROL IN CORRECTIONAL INSTITUTIONS

Managerial controls

a. Establish an infection prevention control (IPC) committee for the correctional institutions

IPC committees must be created at correctional facilities to oversee the implementation of infection control interventions.

b. Develop & implement correctional institution TBIPC plan

See the template for IPC plan in Annex 3

The TB IPC plan must be developed and reviewed twice a year by each correctional institution’s IPC Committee. This plan must be informed by the findings of the risk assessment, to be conducted twice a year by the IPC committee using the TB risk assessment check list (Annex 1). The IPC plan must adhere to the established Standard Operating Procedures (SOPs) from the Lesotho Correctional Service for Tuberculosis screening, isolation precautions, contact investigation and environmental precautions.

Each institution’s IPC plan must have the following included:
1. Coordination of TB IPC;
2. Administrative controls
3. Environmental controls;
4. Personal protection equipment (PPE);
5. Name of the person responsible for each intervention needed;
6. Frequency for conducting the intervention and documentation of this;
7. Budget

c. Promote quality & timely lab services: turnaround time from collection of sputum to start of treatment for positives should not exceed 24 hours
Box 2: Sputum examination is a key to the diagnosis of TB. The cornerstone of TB Infection Prevention and Control includes early diagnosis, and so it is essential that laboratory results are reported as rapidly as possible to the health worker and that the health worker then rapidly follows up with the patient.

d. Ensure that training is conducted for all staff

e. Ensure correctional facility design, construction or renovation promotes TB infection control

An engineer or architect with TB Infection control experience must review all refurbishment plans prior to work beginning.

f. Ensure monitoring & evaluation:

Monitoring should be done quarterly and successes and challenges documented; Evaluation indicators outlined below should be developed and followed;

1. Number of staff trained in TBIPC
2. Number screened for TB (Inmates and staff)
3. Problems and successes with lab turn-around time
4. Numbers of cases of TB identified each quarter
5. Numbers started on treatment
6. Numbers cured
7. Specifics of planned refurbishments with attention to environmental control
8. Availability of PPE and details of any stock-outs

Administrative controls


b. Triage & separation of coughing inmates

Triage
- Promptly identify inmates with cough of any duration
- Separate coughing inmates and bring to health clinic
- Coughing inmates must be identified upon entry to the correctional facility and daily using the peer linkage system (See SOP: Tuberculosis Screening Annex 5)
- Instruct all inmates in respiratory hygiene and cough etiquette (See SOP “Isolation Precautions” Annex 7)
Separation and Inmate Movement

- Explain why any inmate is being selected for special care.
- Do not allow the inmate with cough to remain in the general waiting queue for health services (Fast track).
- Instruct the coughing inmate in etiquette as per SOP “Isolation Precautions”
- The facility should provide tissue (as well as waste bin and hand washing facility after the tissue has been used).
- Inmates’ visitors restriction should be enforced for all newly diagnosed TB patients. Follow SOP for “Isolation Precautions”
- Discuss maximizing inmate flow patterns at entry into facility, whenever evaluated at health clinic, and upon release from facility.

c. Promotion of cough etiquette and cough signage

- Place signs and posters at the exterior entrances, waiting area of health clinic
- Appoint someone from the facility (this does not require a nurse) to explain cough etiquette periodically throughout the day at the health clinic for those with limited reading ability or those who have recently arrived.
- Use Information Education Communication (IEC) materials such as posters and videos at your site in high volume waiting areas.

d. Collection of sputum sample in the correctional facilities:

- Patient sputum collection should occur in outdoor area near health clinic
- Instruct the patient how to produce a sputum sample using the TB Reach sputum collection video in Sesotho
- Give patient sputum container and observe sputum collection outdoors.
- A non-health correctional staff or inmates can be trained as sputum collection observers
- Any person collecting sputum in close proximity to the patient must wear a respirator (N95 or greater)
- The correctional institution nurse or other corrections officer trained in TB IPC who has been identified and designated by the correctional IPC Committee should submit the samples to a nearby diagnostic centre, AND be responsible for ensuring that results are reported within 24 hours and patient treatment is initiated. An up to date register for ALL inmates on whom sputum has been collected, including date of collection, results and date of treatment initiation MUST be maintained in line with MOH NTP Guidelines.

e. Inmate Isolation: Follow SOP “Isolation Precautions”
f. Compulsory Staff Screening For TB Semi-Annually: Follow SOP “Tuberculosis Screening”

Environmental controls: promotion of natural ventilation


b. Position the health staff and inmate appropriately during consultation in the clinic.

c. Keep the windows opened in the cells. Follow SOP as above.

d. Verify and maintain the existing ventilation systems. Follow SOP.

Personal Protective Equipment (PPE): surgical masks & respirators: N-95 or higher

a. Health care provider staff must use PPE equipment, N-95 respirators or higher, in settings that may be at higher risk for TB transmission. These settings include:

- Rooms where infectious TB patients are being isolated
- Areas sputum collection is performed
- While transporting inmates with suspected TB or those diagnosed with TB who have received less than 4 weeks of TB treatment in a closed vehicle

b. Surgical masks must be worn by inmates diagnosed with TB during the first 2 weeks of TB treatment when interacting with staff including selected peer support group members. See SOP “Isolation Precautions”
CHAPTER 4: TUBERCULOSIS TREATMENT

Treatment of inmates with TB must follow the National Guidelines for Tuberculosis

a. Ensure onsite Directly Observed Treatment (DOT).

b. Treatment for Rifampicin resistant or MDRTB: When an inmate’s sputum is Xpert positive for Rifampicin resistance, the nurse will ensure immediate isolation, telephone medical officer within 24 hours to ensure prompt treatment and telephone the TB Coordinator at the DHMT. If inmate is not clinically ill, he will remain in facility and treatment will be initiated in correctional institution according to National TB guidelines.

c. In consultation with the medical officer, the nurse must ensure second sputum sent to National reference laboratory for culture and second line DST.

d. In consultation with the medical officer, nurse will implement monitoring examinations as per the National TB guidelines

Criteria for hospitalization

Inmates with TB must be treated in correctional institutions. Hospitalization is only recommended for the following situations:

- Respiratory insufficiency
- Moderate to severe haemoptysis
- Serious adverse events due to TB medications
- TB meningitis
- Severely malnourished

Candidates for Treatment of Latent TB Infection (LTBI)

Correctional institution staff and inmates in the following high-risk groups should be given treatment for LTBI:

- HIV-infected persons
- Pregnant women
- Inmates with Silicosis
- Health care providers
CHAPTER 5: CONTACT TRACING AND OUTBREAK INVESTIGATION

When a TB case is detected, contact investigation must be promptly initiated. REFER to SOP “Contact Investigation” Annex 6. Nurse will notify District Health Management Team and will help correctional facilities to plan, implement and evaluate all TB contact investigations. Data collection and management is an essential component of a successful investigation.

Principles for Conducting the Contact Investigation

a. Investigation depends on the size and structure of the correctional institution.

b. Wide-scale investigations divert attention away from the high priority contacts.

c. Identified contacts should be stratified by their other medical conditions such as HIV, and the duration and intensity of exposure to the source patient.

d. HIV-infected contacts should be classified as the highest priority group for screening for active TB and initiation of LTBI therapy, regardless of duration and intensity of exposure.

e. Identified groups of contacts with the greatest degree of exposure should be screened immediately, and closely followed-up with repeat screening after 3 months.

f. Corrections and medical staff should be included in the contact investigation depending on their exposure risks.

g. Contact investigation should be made collaboratively with the health centre nearest to the inmate’s home if inmate entered facility within 6 months.

h. When multiple contacts of index case have been released, a wider contact investigation should be considered.

Outbreak Investigation

An outbreak investigation must be considered if more than one inmate from one cell is diagnosed with TB. Multiple outbreaks of TB, including those involving MDR TB, have been reported in prisons and jails, particularly among HIV-infected inmates.

Outbreak investigations must be done in collaboration with the district TB Coordinator and the District hospital.
CHAPTER 6: HIV & OTHER MEDICAL CONDITIONS

HIV testing

HIV Testing Services (HTS) must be offered to all inmates. Participation must be voluntary, and testing must follow the National HTS Guidelines. Anti-retroviral medications will be provided to all inmates with HIV infection as per National Guidelines on the Use of Antiretroviral Therapy for HIV Prevention and Treatment.

HIV Testing must be offered:

- On entry
- During incarceration, provider-initiated testing and counselling (PITC) to be offered as part of an integrated service including: Voluntary Male Medical Circumcision (VMMC), screening and treatment for TB and Sexually Transmitted Infections (STIs)
- HTS campaigns, conducted quarterly in conjunction with the TB screening
- On release

HIV treatment and care

HIV infected inmates should be managed according to the National Guidelines on the Use of Antiretroviral Therapy for HIV Prevention and Treatment.

Education and information

Inmates must be provided with sufficient information about the treatment they are receiving including:

- The regimen, dosage, side effects and the reason for long-term treatment
- The importance of taking treatment exactly as prescribed to avoid ineffective treatment and inducing resistance;
- The importance of scheduled follow up visits and continuous tests as prescribed by the health care providers
• The risks of combining treatment with other substances;
• The importance that they NEVER share their medication with other inmates.

**Support**

There should be groups of inmates created for peer to peer support. Nurses, HTS counsellors and peer educators must be trained on how to run a support group. Once trained, support group leaders must be mentored.

Inmates must be encouraged to disclose their HIV status during adherence counselling. The Nurse and the HTS counsellor should facilitate disclosure processes for all inmates living with HIV prior to release for continuity of care and support.
CHAPTER 7: SCREENING FOR OTHER DISEASES

Universal screening for anal, oral and genital STIs, and chronic diseases should be conducted on all inmates, according to the national guidelines where resources permit. These should be integrated into the general routine and mass screening campaigns.

Non-Communicable Diseases

a. Hypertension: All inmates to have blood pressure checked on entry to facility. Any inmate identified with high blood pressure must be seen by the medical officer on the officer’s next visit to the facility, within 1 week.

b. Diabetes: All inmates to have a finger stick checked for blood glucose on entry to facility. Any inmate with high blood glucose must be seen by the medical officer on the officer’s next visit within 1 week.

c. Health Clinic visits: At every visit to the health clinic, every inmate must have weight and height taken, all vital signs checked, finger stick for blood glucose

For female inmates, a vaginal examination including visual inspection of the cervix with acetic acid (VIA) or pap smear must be done within one (1) month of entry to the facility and annually thereafter. If exam is abnormal, inmate must be referred to nearest district hospital for complete gynaecological evaluation within one (1) week.
CHAPTER 8: COMPREHENSIVE DISCHARGE & REFERRAL PLAN

Objectives

a. To ensure that all inmates released or transferred to another facility are retained within the continuum of TB / HIV care.
b. To ensure that inmates with TB receive community-based TB / HIV care after release.

Discharge Planning

Discharge planning should include the following;

- Collaboration among the public health nurse and the TB Coordinator of the District Health Management Team (DHMT) and the TB nurse in the health centre where the inmate will be referred.
- Ensuring continuity of case-management,
- Evaluating discharge-planning procedures and modifying procedures as needed to improve linkage to care.
- Ascertain transfer dates for inmates on HIV/TB treatment at minimum 7 days prior to release.

Comprehensive Discharge Planning

Comprehensive discharge planning should be done for;

- Inmates with confirmed TB disease
- Inmates presumptive TB disease
- Inmates living with HIV
- Inmates with other diseases

a. Discharge planning should be initiated immediately after monthly discharge list indicates an inmate with TB or HIV will be released.
b. Nurse and/or health team member must interview and document where Inmates with TB disease or HIV will live to enable appropriate referrals after discharge and to follow up that appointment was kept.
c. Nurse must document name of referral health facility for each inmate and date of appointment scheduled so she can confirm appointment kept.

d. Nurse must liaise and communicate with DHMT before the date of release for inmates with TB disease and or HIV.

e. Nurse must notify DHMT within 24 hours if inmate fails to keep follow-up appointment.

f. Nurse must notify DHMT of date of start of TB treatment.

g. Nurse must give inmate referral letter.

h. Nurse must give inmate health “bukana” outlining date of treatment initiation, date treatment should be completed for those with TB disease and details of medications.

i. Nurse must provide a minimum 7-day supply of continuation medication to the inmate.

j. Nurse must facilitate communication for disclosure in order to promote family or caretaker support for treatment adherence.

k. Nurse must encourage inmates to join ex-inmates association for peer support.

SPECIAL ATTENTION SHOULD BE DEDICATED TO INMATES RELEASED ON BAIL OR PAROLE
CHAPTER 9: MONITORING AND EVALUATION

Box 3: Monitoring and evaluation of TB infection prevention and control activities will be integrated into the LCS/NTP monitoring and evaluation and supervision plan. Monitoring will be conducted at all levels, starting at the correctional institution level, regional and national level. At the correctional institution (district) and regional level, monitoring will be done quarterly and annually by the national level.

National level indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Frequency</th>
<th>Monitoring tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and Proportion of correctional facilities with written TB and Airborne IPC plan</td>
<td>Health facility plan</td>
<td>Biannual</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Number and Proportion of correctional facilities that have trained staff (at least 3 members of health service providers ) on IPC which includes topics relevant to TB IPC</td>
<td>Updated Staff training register</td>
<td>Annual</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Number and Proportion of correctional facilities with a person in charge of IPC</td>
<td>Correctional institution plan</td>
<td>Annual</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Number and Proportion of correctional facilities that have conducted a self-assessment or have been assessed on IPC practices including TB IPC in the previous year</td>
<td>Assessment report</td>
<td>Biannual</td>
<td>Supervision checklist/written report</td>
</tr>
</tbody>
</table>
### Correctional Institution level indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Frequency</th>
<th>Monitoring tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of written correctional institution plan including TB IPC activities</td>
<td>Correctional institution plan</td>
<td>Biannual</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Monitoring and evaluation for IPC measures on monthly basis of at least 1 department / area in the correctional institution</td>
<td>Monitoring reports</td>
<td>Quarterly</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Number of staff that are trained on TB IPC (at least 80% of the corrections officers trained)</td>
<td>Updated Staff training register</td>
<td>Quarterly</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Presence of a person in charge of IPC</td>
<td>Written correctional institution plan</td>
<td>Quarterly</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Presence of a (self-) risk assessment report on TB and Airborne IPC practice that was done not longer than 1 year ago (Y/N)</td>
<td>Assessment report</td>
<td>Quarterly</td>
<td>Supervision checklist/written report</td>
</tr>
<tr>
<td>Number and Proportion of corrections staff diagnosed with TB (all forms) in the last quarter</td>
<td>Updated Staff register</td>
<td>Quarterly</td>
<td>TB reports</td>
</tr>
<tr>
<td>Number and Proportion ratio of corrections inmates diagnosed with TB (all forms) in the last month</td>
<td>Quarterly TB reports</td>
<td>Quarterly</td>
<td>TB registers</td>
</tr>
</tbody>
</table>

Monitoring and evaluation tool (annex 4) shall be filled quarterly by the facility level for self assessment and annually by the national and regional level, during supervision visits.