HIV and Prisons

in sub-Saharan Africa:

Opportunities for Action

UNITED NATIONS
Office on Drugs and Crime

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Our appreciation to Joao Silva who provided the photographs which starkly depict overcrowding conditions in some prisons in sub-Saharan Africa. These photographs do not show nor are they intended to show, people living with HIV, or the extent of HIV in any specific prison.

Preface

In 2001, Heads of State and Government Representatives of 189 nations gathered at the first-ever Special Session of the United Nations General Assembly on HIV/AIDS. They unanimously adopted the Declaration of Commitment on HIV/AIDS, acknowledging that the epidemic constitutes a "global emergency and one of the most formidable challenges to human life and dignity." The Declaration of Commitment covered ten priorities, including prevention, treatment and funding. It was designed as a blueprint to meet the Millennium Development Goals (MDGs) of halting and beginning to reverse the spread of HIV/AIDS by 2015.

In 2005, recognizing that progress was lagging towards the MGDs, countries and development partners agreed on the urgent need to scale up national efforts to address the AIDS epidemic, leading to a global commitment to moving toward universal access to HIV prevention, treatment, care and support. This move toward universal access was endorsed not only by the UN General Assembly, but also by bodies such as the African Union and the Group of Eight leading industrialized countries (G8).

Of any region in the world, sub-Saharan Africa[1] is the hardest hit by the epidemic with almost two-thirds of all people infected with HIV living in the region.[2]. HIV in prisons is both a public health and a human rights issue that needs to be addressed urgently for an effective response on the Continent Despite this and although there has been a significant increase in national and international funding to control the epidemic, prison settings in sub-Saharan Africa have received surprisingly little attention.

[1] Throughout the document the words "Africa" and "sub-Saharan Africa" will be interchangeably used referring specifically to sub-Saharan Africa.
[2] UNAIDS (2006). AIDS Epidemic Update. Geneva, UNAIDS.

Like all persons, prisoners are entitled to enjoy the highest attainable standard of physical and mental health. This right is guaranteed under international law in Article 25 of the United Nations Universal Declaration of Human Rights and Article 12 of the International Covenant on Economic, Social, and Cultural Rights. The international community has generally accepted that prisoners retain all rights that are not taken away as a fact of incarceration. Loss of liberty alone is the punishment, not the deprivation of fundamental human rights. States therefore have an obligation to implement legislation, policies and programmes consistent with international human rights norms to ensure that prisoners are provided a standard of health care equivalent to that available in the outside community.[3]

This document presents an abridged analytical summary of the inventory of existing information on HIV among prison communities in sub-Saharan Africa, identifies gaps in information and proposes a framework for action. The key finding is that there is insufficient knowledge about the prison community, both in and out of correctional facilities. What is known is alarming and underscores the importance of acting rapidly to fill information gaps in order to better assess national situations, identify good practices and support more effective national policies, programs and service delivery. The document includes a section on next steps, which can be adapted to meet differing country circumstances.

This work is a collaborative undertaking by the World Bank's AIDS Campaign Team for Africa (ACT*Africa*), The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC), the lead organization for the prevention of HIV transmission in prisons, and assisted by the World Health Organization's regional office for Africa (WHO/AFRO). It is based on a desk review of research and

[3] UNODC-UNAIDS-WHO Framework for HIV AIDS Prevention, Treatment and Care in Prison (2006).

analysis of secondary data, and consultations with relevant staff of the World Bank (in and outside the Africa region), some of the country offices and local nongovernmental organizations in Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Mali, Mauritius, Niger and Senegal, representatives of a number of UN agencies such as UNODC, UNDP, UNIFEM, UNFPA, UNICEF, the UNAIDS Secretariat, and prison administration officials in the region.

The purpose of the document is to provide HIV- and prison-concerned communities with information and a way forward in helping to place this underserved population in the mainstreaming of the AIDS response throughout sub-Saharan Africa. It is envisioned as a common platform on which the countries themselves, as well as multilateral, bilateral and nongovernmental partners, can build coordinated policies and programs, and provide services. In conclusion, we consider this a living document, to be revised as new information, experience and resources dictate. We welcome the future contributions of other institutions and organizations for the wider dissemination of this document and also to ensure that the recommendations from this document are implemented.

ACKNOWLEDGMENTS

While many have contributed to the development of this product, much appreciation is due to its principal author, Nilufar Egamberdi (Social Development Specialist, Consultant to ACT*Africa*), who also conducted the research and analysis of the available data. Richard Seifman (ACT*Africa* Senior Advisor) guided the preparation of the document throughout. Elizabeth Lule (ACT*Africa* Manager) provided oversight, support and advice. Fabienne Hariga (HIV/AIDS Expert, UNODC), Reychad Abdul (Regional HIV/AIDS Adviser, UNODC, Kenya), Mickel Edwerd (Project Coordinator, UNODC, Senegal), Claudia Shilumani (Regional HIV/AIDS Advisor in Southern Africa, UNODC, South Africa) and Brian Tkachuk (Africa Regional Advisor for HIV/AIDS in Prisons, UNODC, South Africa) provided valuable comments and substantially contributed to the final draft. Jyothi Raja N. K (UNAIDS Prevention and Vulnerability Adviser) and Innocent Ntaganira (WHO/AFRO Medical Officer, HIV Prevention) contributed in shaping the content, process of review and approval, and development of a dissemination approach. Our thanks also go to the UNAIDS Communication and Knowledge Sharing division and to Ragnhild Johansen (UNODC) who copy-edited the final draft.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Key Lessons Learned

1. Data on HIV in African prisons are limited

Available data on HIV prevalence in Africa have been collected randomly, mostly through studies conducted in individual prisons and often only among those who have been diagnosed with HIV or AIDS. Existing data are not recent or accurate enough to provide a real picture of the current situation in African prisons. More systematic and thorough country and penal institution-based research is needed in order to ascertain the true scope of the problem.

2. High-risk sexual and other risky behavior in prisons increase the spread of HIV and sexually transmitted infections

Common high-risk behavior in the prison environment include unprotected sex (mostly anal and between males), rape, sex bartering and "prison marriages". In addition, unsafe injecting practices among injecting drug users, blood exchange and the use of non-sterile needles and other cutting instruments for tattooing are widespread.

3. Most prisoners come from a high risk segment of the population

Most prisoners are sexually active males between the ages of 19 and 35, representing a segment of the population that is at high risk of HIV infection prior to entering prison, especially in countries with generalized epidemics[4].

[4] According to UNAIDS and WHO, generalized HIV epidemic is an HIV epidemic in a country in which 5 percent or more of women attending urban antenatal clinics are infected; infection rates among individuals in groups with high-risk behavior are also likely to exceed 5 percent in countries with a generalized HIV epidemic. Concentrated or low HIV epidemic is

4. There is a high risk of transmission between prison and non-prison populations

Prisoners and the prison community are not isolated from the general population. The majority of prisoners does leave prisons, and return to the society. In addition, many other persons including staff, volunteers and visitors, live and work amongst prisoners, or visit the prisons on a regular basis.

5. Overcrowding leads to rape and sexual violence in prisons

Prisons in most sub-Saharan African countries are extremely overcrowded. Overcrowding contributes to the deterioration of the physical conditions of prison premises. It also results in poor supervision and safety, which significantly increases the risk of gang activity and violence. Tension, frustration, and idleness among prisoners are often released through sex and sexual abuse.

6. Tuberculosis is more readily spread in prisons

Prisoners are a most-at-risk population not only for HIV and other sexually transmitted infections (STIs), but also for tuberculosis (TB). In prisons, overcrowding, lack of ventilation and poor prevention practices dramatically increase the risks of TB transmission. TB is also the most common opportunistic infection [5] among people living with HIV in Africa. The combination of the high prevalence of both TB and HIV in prisons is responsible for a high mortality rates amongst prisoners.

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an HIV epidemic in a country in which 5 percent or more of individuals in groups with high-risk behavior, but less than 5 percent of women attending urban antenatal clinics, are infected. Nascent HIV epidemic is an HIV epidemic in a country in which less than 5 percent of individuals in groups with high-risk behavior are infected.

[5] People with HIV are vulnerable to various infections and malignancies that are called "opportunistic infections" because the latter develop as an immune system of an HIV-positive person weakens. The most common opportunistic infections include TB, malaria, pneumonia, as well as various fungal and viral diseases.

7. Adequate policies and interventions to address HIV among prisoners are seldom implemented

Worldwide, existing evidence-based policies and interventions to address HIV among prisoners are: condom and lubricant distribution; access to safe injecting equipment and to treatment for injecting drug users; dissemination of information, education and communication materials; and access to antiretroviral (ARV) treatment, and prevention of opportunistic diseases. Guidelines on HIV testing policies for prison communities are rarely followed. Policies that exist at national levels are often inconsistent, inadequate or not implemented, and are mainly available in developed countries.

8. Criminal justice reform could support HIV prevention

Inadequate sentencing and bail practices, poor or no legal representation of prisoners (especially of pre-trial detainees), insufficient facilities for women and juveniles, rape and gang violence call for an appropriate response that must include prison reform in African nations. Appalling prison conditions, including overcrowding, poor food and nutrition, and lack of health facilities and staff present a major challenge for prison authorities and governments at large and contribute to the spread of HIV.

Next Steps

In response to the broad gaps in information and the urgency of reducing the spread of HIV both inside and outside prisons, the following next steps are proposed, to be carried out in selected countries:

- Conduct a situation analysis including sero-prevalence surveillance surveys and behavioral studies.

- Initiate a dialogue with various decision-makers and stakeholders (including non-governmental organizations, national prison administrations, national commissions/committees on HIV/AIDS, line ministries

and donors) based on the findings of the situation analysis and the prevalence surveys conducted. Provide recommendations for interventions, identifying good practices and lessons learned.

- Conduct a legal review, promote advocacy and initiate policy dialogue for the integration of HIV in prisons in national and regional policy instruments.

- Provide technical assistance to local institutions to help develop intervention strategies.

- Encourage networks to promote cooperation and establish integrated work between prison and correctional services, prison health systems, public health systems, national AIDS committees, international and national civil society organizations, to promote good prison and public health and in turn good HIV prevention, treatment and care in prisons.

- Promote awareness and advocacy to seek adequate mechanisms of intervention and document the process.

- Integrate indicators specific to prisons into the national monitoring and evaluation system for HIV and/or reinforce local capacity to do so.

I. INTRODUCTION

1. To better understand available information and raise awareness of the vulnerability of prison communities to HIV/AIDS, as well as those in close contact with them, in May 2006 ACT*Africa* of the World Bank initiated this process of data collection and first round of analysis, which was later joined by UNAIDS, UNODC and WHO. This work should be considered the preliminary phase and a platform for broader undertakings by multiple partners. The topic of HIV/AIDS and prisons, if the groundwork is adequately laid, should become an integral part of costed national AIDS frameworks or plans.

2. Prisons concentrate great numbers of HIV-infected and at-risk populations, while prisoners comprise one of the least represented populations in national HIVstrategies. Prison grounds offer ideal conditions for the transmission of many infectious diseases, including tuberculosis (and now extensively drug resistant TB or XDR-TB), hepatitis (A, B and C), sexually transmitted diseases and HIV[6]. Overcrowded and unsafe premises where injecting drug use and unprotected sex are common make correctional facilities ideal breeding grounds for HIV infection. The majority of prisoners are male; this is especially the case in Africa. Given this, the prison environment is highly conducive to violence and homosexual sex. Heterosexual and homosexual sex in prisons—whether voluntary or forced—is a key factor driving the spread of the infection[7]. Prisoners are not sealed off; they are often in close contact with the general population, thus making the prison

[6] WHO (2001). Health in Prisons. Geneva, WHO
[7] Curtis M (2004). Fighting for Prison Health. Newsletter of the International Harm Reduction Development Program of the Open Society Institute.

population a significant vector of inward and outward transmission of HIV.

3. We found a remarkable lack of data on the number of HIV-positive prisoners, virtually unknown for most of Africa. Available information is relevant only for a limited number of countries; the estimates are mainly based on insignificant samples and are drawn from sporadic surveys. Consequently, there is a significant knowledge gap in understanding the magnitude of the epidemic within the prison communities and its multiplier effect on societies at large. This gap is evident at various levels: (i) institutional, (ii) legislative, (iii) policy and programming, (iv) civil society, and (v) communities and indviduals. International development organizations and donors have yet to pay adequate attention to this issue, while most local governments have neglected to account for what takes place on prison grounds.

II. WHAT DO WE KNOW ABOUT HIV IN PRISONS GLOBALLY?

4. The HIV epidemic has struck prisons and other places of detention around the world with particular severity. Penal institutions have grossly disproportionate rates of HIV infection and confirmed AIDS cases.[8] International data show that HIV prevalence among prisoners is between six to fifty times higher than that of the general adult population. For example, in the USA the ratio is 6:1, in France it is 10:1; in Switzerland 27:1 and in Mauritius 50:1).[9]

5. There are about nine million men, women and children (under 18 years of age) held in penal institutions around the world, with over two million, or 22 per cent, in the USA, which has the highest prison population rate at 714 prisoners for every 100,000 persons.[10] Taking into account the numbers of both new and released prisoners, there are more than 30 million prisoners worldwide every year.

6. On a global scale, the prison population is growing rapidly, with high incarceration rates leading to overcrowding, which largely stems from national law and criminal justice policies. In most countries, overcrowding and poor physical conditions prevail.[11] This phenomenon poses significant health concerns with regard to control of infectious diseases—and HIV prevention and care most of all.[12]

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[8] Human Rights Watch (2006). HIV/AIDS in Prisons.
[9] Macher A, Goosby A. (2004). The Incarcerated: A Report from the 12th World AIDS Conference; Stubblefield E, Wohl D (2000). Prisons and Jails Worldwide: Update from the 13th International Conference on AIDS.
[10] International Centre for Prison Studies (2007). The World Prison Population List. London, King's College.
[11] Walmsley R (2003). Global Incarceration and Prison Trends. Forum on Crime and Society.
[12] Kantor E (2006). HIV Transmission and Prevention in Prisons.

7. Prison populations are predominantly male and most prisons are male-only institutions, including the prison staff. In such a gender exclusive environment, male-to-male sexual activity (prisoner-to-prisoner and guard-to-prisoner) is frequent.[13] The actual number of instances is likely to be much higher than what is reported mainly due to continual denial, fear of being exposed or the criminalization of sodomy and homosexuality.

8. While much of the sex among men in prisons is consensual, rape and sexual abuse are often used to exercise dominance in the culture of violence that is typical of prison life.[14] Inmate rape, including male rape, is considered one of the most ignored crimes. Sexual and physical abuse in custody remains a tremendous human rights problem.[15] Data from the USA show that rape in prison is eight to ten times higher than in the general population.[16] One in five men has been sexually assaulted in prison, while one in ten has been raped. Among prisoners, the rate of sexual abuse is as high as 27 per cent, including rape by prison guards.[17] Prison rape also carries racial overtones.[18] Available data indicate that rape is used as a disciplinary tactic and a control mechanism by prison authorities who not only ignore or do not prevent inmate rape, but encourage it as a punishment tool.[19] Prisoners form alliances, hierarchies and enmities that thrive on creating an atmosphere of fear and control where trade of sexual favors and sexual enslavement is widespread. However, those involved in sexual abuse do not consider themselves to be

[13] Human Rights Watch (2002). World Report; Human Rights Watch (1999). World Report. Special Programs and Campaigns—Prisons.
[14] Human Rights Watch (1991). No Escape: Male Rape in USA Prisons.
[15] Amnesty International (2001). Abuse of Women in Custody: Sexual Misconduct and Shackling of Pregnant Women.
[16] Stemple L (2002). Stop Prison Rape.
[17] US Centers for Disease Control and Prevention (2002). Prison Rape Spreading Deadly Diseases; Lehner E (2001). Hell Behind Bars: The Crime That Dare Not Speak Its Name.
[18] Hogshire J (2004). You Are Going to Prison.
[19] Parenti J (1999). Rape as a Disciplinary Tactic; Gordon N (2001). Rape Used as a Control in U.S. Prisons; Berger V (2002). Sentenced to Rape.

bisexual or homosexual, thus often hindering the dissemination of HIV prevention messages.

9. Given that force is exercised and that condoms are not used, victims of rape and other forms of sexual violence are at higher risk of contracting HIV. The issue of dangerous links between rape and HIV in prisons has been brought to public attention throughout the world. Studies of individual correctional facilities, especially in the USA, highlight HIV transmission occurring through prison rapes.[20]

10. With regard to the gender ratio of those incarcerated throughout the world, according to recently available data, more than half a million women and girls are held in penal institutions.[21] There are significant variations across continents, with the Americas and Asia showing the highest percentage of female prisoners in their total prison populations at over 5 per cent compared to Africa reporting the lowest overall rate at 2.2 per cent.

11. In the closed environment of prisons, women are especially vulnerable to sexual abuse, including rape, by both staff and other prisoners. In many countries, women prisoners are held in small facilities immediately adjacent to or located in male prisons. In rarer instances, women and young girls may not be separated from the male prison population at all. Female prisoners may be supervised exclusively or mainly by male staff. Women in prison are also susceptible to sexual exploitation and may trade or be forced to trade sex for food, goods or drugs with other prisoners or staff.

12. Injecting drug use is one of the principal ways HIV is transmitted in many regions (East and South Asia, countries of

[20] Price J (1995). Inmate's Lawsuit Point Up HIV Infection by Prison Rapes.
[21] International Centre for Prison Studies (2007). The World Female Imprisonment List. London, King's College.

Eastern Europe and Central Asia). A high proportion of prisoners around the world are sentenced for drug-related crimes, including trafficking. Many continue drug use while in prison. Injecting drug use with contaminated equipment accounts for the largest number of HIV cases in prisons on a worldwide basis.[22]

13. Tattooing and other forms of skin piercing are frequent among prisoners and prison staff. Blood brotherhood rituals, involving blood exchange and the mixing of blood also occur, carrying a high risk of HIV transmission.

14. Prisoners are highly prone to TB (including multi-drug and extensively drug resistant TB, the XDR-TB), hepatitis A, B and C, and sexually transmitted infections (syphilis, gonorrhea). Sexually transmitted infections—if not treated— can greatly increase vulnerability to HIV infection.

15. In prisons, health services are generally poor, ill equipped and understaffed, or non-existent. In particular, the quality of sterilization measures for medical, dental and gynecological equipment are largely inadequate. Universal precaution principles are often poorly applied.

16. There is poor or no access to HIV and other STI prevention or treatment services. Access to voluntary counselling and testing and to HIV treatment are often non-existent In many countries evidence-based prevention programmes, prevention commodities (condoms, lubricants, needles/syringes, and/or bleach), drug treatment including opioid substitution treatments are often not made available to prisoners, as they are perceived to be in conflict with drug laws, or laws which prohibit sexual relations between men.

[22] Martin V, Cayla JA, Moris ML, Alonso LE, Perez R. (1998). Predictive Factors of HIV-infection in Injection Drug Users Upon Incarceration.

17. There are high turnover and mobility rates among the prisoners. The average stay is short while the return rates are high. International evidence suggests that most prisoners are eventually released into the general population and return to their communities. If they have contracted HIV, whether outside or inside the prison, they become potential links for transmitting HIV from and into the general population.[23]

18. Lack of knowledge and education among prisoners about the risks of contracting and transmitting HIV coupled with the absence of protective means and proper medical care increase their risks of HIV infection. The risk of infection is also increased for those in contact with members of prison populations such as prison staff and spouses or partners, and by extension, the broader population.

[23] Batterfield F (2003). Infections in Newly Freed Inmates Are Rising Concern

III. WHAT DO WE KNOW ABOUT HIV IN AFRICAN PRISONS?

Overview of Regional Prison Population Statistics

19. About 668,000 men and women are incarcerated in sub-Saharan Africa. South Africa has the highest prison population with 157,402 people behind bars in the region and 335 prisoners per 100,000 of the national population (Table 1); it has the ninth largest prison population in the world. Rwanda has the second largest number of prisoners in the region, with 67 000 incarcerated.[24] Ethiopia and Kenya also report significant prison populations ranging between 65,000 and 55,000 respectively. Many other African nations show high prison population rates, reporting between 120 and 169 incarcerated individuals per 100,000 persons. Overall, West African countries indicate the lowest prison population, with between 2,800 and 6,000 people in penal institutions.

Table 1: Prison Population Data in sub-Saharan Africa—by Country

Country	Prison population (thousands)	Prison population rate (per 100,000 persons)	Total population (millions)
Botswana	6,259	348	1.8
South Africa	157402	335	47.04
Namibia	4,814	267	1.8
Swaziland	2,734	249	1.1
Mauritius	2,464	214	1.2
Lesotho	2,924	156	1.87
Rwanda	67000	152	9.2
Zimbabwe	18,033	139	13
Kenya	47036	130	32.5

[24] It is understood that the majority of prisoners in Rwanda (53000 persons) are held on suspicion of participating in the 1994 genocide.

Country	Prison population (thousands)	Prison population rate (per 100,000 persons)	Total population (millions)
Cameroon	20,000	125	16
Zambia	14,347	120	12
United Republic of Tanzania	43,911	113	39
Madagascar	20,294	107	19
Uganda	26,126	95	28.8
Ethiopia	65,000	92	70.7
Malawi	9,656	74	13
Togo	3,200	65	4.9
Dem. Republic of the Congo	30,000	57	52.8
Ghana	12,736	55	23
Senegal	5,360	54	9.9
Côte d'Ivoire	9,274	49	19.1
Niger	5,709	46	12.5
Guinea	3,070	37	8.4
Mali	4,040	34	11.9
Gambia	450	32	1.4
Nigeria	40,444	30	126
Burkina Faso	2,800	23	12.2

Source: The World Prison Population List - Seventh Edition- Jan 2007, International Centre for Prison Studies, King's College, London

20. In Africa, prison population rates vary significantly between sub-regions and to a lesser extent between countries of the same region. In southern African countries, prison population rates vary from 348 in Botswana to 156 in Lesotho with a median rate of 267. In east Africa, they vary from 30 in Comoros to 205 in Mauritius and 239 in Seychelles. In west Africa, rates vary from 23 in Burkina Faso to 75 in Benin and 178 in Cape Verde. Finally, in central Africa, they range from 35 in Chad to 125 in Cameroon.

21. Data across sub-regions also show that while southern African countries make up about 10 per cent of the total population of

the region, they host one-third of the total prison population of the continent (Table 2), largely due to South Africa having the continent's largest prison population.

Table 2: Prison Population Data—by Sub-Regions

Sub-Region	Prison population	% of total prison population	Population (millions)	% of total population of sub-Saharan Africa
Central Africa	64 665	10	98 489 000	14
East Africa	315 658	47	269 904 250	39
Southern Africa	192 166	29	66 610 000	10
West Africa	95 303	14	252 492 000	37
TOTAL	**667 792**	**100**	**687 495 250**	**100**

Source: The World Prison Population List, 2007, International Centre for Prison Studies, King's College, London

22. A review of the best available data on gender composition of the incarcerated indicates that African countries have among the lowest numbers of female prisoners compared to global figures. In Africa, the number of female prisoners is about 14,000 while in other regions the corresponding figures range from as low as 6,000 to as high as 183,000. Also, with regard to the percentage of female prisoners in the total prison population, African penal institutions indicate ratios of female imprisonment that are relatively lower when compared to international rates.[25] As Table 3 illustrates, they range from 1 percent to just over 6 percent, with an average of 2.2 percent.

[25] Around the globe, the highest percentage of the female prison population is reported in Hong Kong (22%), Myanmar (18%), Thailand (17%), Kuwait (15%), Qatar and Viet Nam (both 12%), Netherlands (11%), Bermuda and Ecuador (both 10%), Macau (9%), USA (8.6%) and Nepal (8.3%), followed by Panama (7%), Venezuela and Nicaragua (6.6 and 6.5%), Uruguay and Canada (5%).

Table 3: Female Prison Population in Africa

Country	Prison population (thousands)	Female prison population (number of women and girls incarcerated)	Percentage of females out of the total prison population
Mozambique	8,812	551	6.3
South Africa	186,739	3,129	6
Mauritius	2,464	137	5.6
Botswana	6,105	306	5
Cape Verde	0.755	38	5
United Rep. of Tanzania	46,416	1,515	5
Swaziland	3,245	148	4
Togo	3,200	64	4
Senegal	22,272	183	3.7
Kenya	61,845	1,254	3.6
Uganda	26,126	901	3.4
Dem. Rep. of Congo	30,000	83	3.2
Madagascar	19,000	650	3.4
Zimbabwe	20,000	602	3.3
Mauritania	1,185	10	2.7
Ethiopia	65,000	N/A	N/A
Rwanda	112,000	2,925	2.6
Cameroon	20,000	N/A	N/A
Zambia	13,200	380	2.6
Côte d'Ivoire	10,355	236	2.3
Ghana	24,379	257	2
Niger	6,000	N/A	N/A
Mali	4,040	80	2
Guinea	3,070	61	2
Nigeria	40,444	756	1.9
Burkina Faso	2,800	25	1
Gambia	450	6	1.2
Malawi	8,566	117	1.2

Source: The World Female Imprisonment List, 2006

23. Data regarding juveniles[26] held in African prisons are limited. In most countries, juvenile prisoners represent between 0.5 and 5 per cent of the total prison population[27] . They are often detained with adults and thus are at great risk of sexual abuse by prison staff and/or older prisoners.[28]

Factors that Contribute to Transmission of HIV Among Prisoners in Africa

24. The existing body of literature points to a number of contributing factors to HIV transmission in African prisons. These range from the weakness of the criminal justice and judicial systems, social stigma, institutional and societal neglect, lack of resources for maintenance of existing penal institutions, poor food and nutrition, lack of health care, overcrowding, mixing of un-sentenced and convicted persons, high-risk sexual and other behavior (such as injecting drug use and blood mixing) and lack of conjugal visits.

25. In male prisons, in Africa and worldwide, homosexual activity is not uncommon – though the reported number of instances is likely to be much lower than the actual numbers due to the denial or criminalization of homosexuality, stigmatization of prisoners by society at large, and underreporting of rape and sexual abuse among male prisoners. [29]

26. Rape and other forms of sexual violence among male and female prisoners are rife in African prisons, between prisoners of the same or different sex, and between staff and prisoners.

[26] Young people under the age of 17 are commonly referred to as juveniles, although for some purposes a distinction is made between children (under the age of 14) and young persons (14–16).
[27] International Centre for Prison Studies (2007). The World Prison Population List. London, King's College.
[28] International Center for Prison Studies (2006). Children in Prison, Guidance Note 14. London, King's College www.kcl.ac.uk/depsta/rel/icps/gn-14-children-in-prison.pdf.
[29] Gear S and Ngubeni K. (2002). Sex and Sexual Coercion in Men's Prisons.

African prisoners have little autonomy to protect themselves. They have minimal control over such factors as overcrowding that contribute to sexual and other forms of violence or injecting drug use.

27. In Africa and around the world, prisons—where socioeconomic barriers break down—offer new norms of dominance and power, particularly between male prisoners. These norms often alter traditional gender identities and roles that become highly sexualized.[30] Same sex relations, including "marriages" between male prisoners, are common, although considered circumstantial. Gang rape and sexual abuse (e.g. exchange of men for favors among gangs and individual prisoners) take place frequently[31]. Consequently, victims of continual rape and sexual abuse often resort to prostitution as a survival or coping mechanism.[32]

28. The appalling physical conditions of African prisons, along with inadequate food and nutrition and almost non-existent health services, seriously exacerbate the prevalence of HIV inside prisons. Prisoners often exchange basic goods (hygiene products such as soap or personal items such as blankets or shoes) for sex as those items may be unavailable for the majority while in prison. In the same way, poor food and nutrition, including low quality and scarcity of food for those incarcerated, drives prisoners towards exchange of sex for food.[33]

29. Health care in most African prisons is usually substandard or nearly nonexistent. There is often considerable disparity between the prison population and the general population in this regard, in contradiction with human rights principles. The

[30] Gear S and Ngubeni K *Ibid.*
[31] Gear S (2006). Your Brother, My Wife: Sex Among Men in South African prisons.
[32] Kudat A (2006). Males for Sale.
[33] http://www.irinnews.org

safety of medical and dental equipment is not always guaranteed. Prevention commodities such as condoms, sterile needles and syringes, disinfectant for tattooing equipment and information are seldom available. Drug substitution approach as a preventive measure is largely absent due to the legal restrictions on drug use.

30. Prisoners are largely dependent on prison authorities for access to information about HIV, any means of protection, and health services as a whole. There are few HIV-related services provided by the public sector to the prisons.[34] The extent to which privileged prisoners (those who have means) can obtain health-care services in Africa is virtually unknown.

31. Tuberculosis is a particularly serious health consideration in African prisons. HIV-positive prisoners with TB can easily transmit TB to those who are not infected with HIV. With new extensive drug resistant TB strains (XDR-TB) appearing in many places, the problem has been further exacerbated.[35]

32. It is very rare that HIV or TB testing, much less HIV antiretroviral treatment, is provided to prisoners. However, if antiretrovirals were available to the prison population without additional nutritional support to malnourished prisoners, treatment success would be significantly affected.

33. Occupancy rates reflect high levels of overcrowding. In Cameroon, Kenya and Zambia, occupancy rates range around 300 per cent–345 per cent above planned levels, followed by Burundi, Malawi, Uganda, United Republic of Tanzania, Rwanda, and Sierra Leone reporting up the rate of 200 per cent Most countries stand at 120 per cent up to 170 per cent rates, including Botswana, Burkina Faso, Ghana, Madagascar,

[34] Goyer KC, Gow J (2002). Alternatives to current HIV/AIDS policies and practices in South African prisons. *AIDS,* Sep 27;16(14):1945–51.
[35] WHO (2001). Health in Prisons. Geneva, WHO.

Mauritania, Mozambique, Namibia, Senegal and South Africa. Overcrowding contributes to further deterioration of the physical conditions of the prison premises. It also results in poor supervision and safety, which significantly increases the risk of gang activity and violence. Tension, frustration, and idleness among prisoners are often released through sex and sexual abuse.

34. Overcrowding also translates into the mixing of prisoners across categories of those incarcerated (pre-trial detainees, convicts, juveniles, men and women). Available data shows very high numbers of pre-trial detainees, those awaiting sentencing or the outcome of appeals (percentage within the prison population) for most African countries, ranging between 50 and 70 per cent. The countries with the highest number of such detainees are Mozambique (72 per cent), Mali (62 per cent), Madagascar and Cameroon (65 per cent), Benin and Nigeria (64 per cent), Burundi (62 per cent), followed by Angola, Burkina Faso, Uganda, Djibouti, Togo and Guinea (over 50 per cent). Many countries have rates as low as 20–30 per cent, including Kenya, Cape Verde, Côte d'Ivoire, Zambia, Senegal, Zimbabwe, South Africa, Ghana and Malawi. A related factor is the long period of pre-trial detention, which also contributes to overcrowding and other problems.

35. Similarly, in some African countries, the number of foreign prisoners is significant. Data concerning the country of origin show that the percentage of foreign prisoners is highest in Gambia (67 per cent) and relatively high in Côte d'Ivoire (30 per cent). Other countries that share relatively high rates include Botswana (13 per cent), Senegal (7 per cent) and Guinea (5 per cent).

36. As is the case in most prisons around the world, prisoners in Africa share unsafe tools and self-made sharp objects for

shaving, as well as tattooing and rituals that involve blood mixing, thus seriously increasing the risk of HIV infection.[36]

37. The issue of injecting drug use among prisoners in Africa has been largely overlooked compared to other regions.[37] Existing data indicate that in the prison community, injecting drug use in sub-Saharan Africa is on the rise in Cape Verde, Côte d'Ivoire, Guinea, Kenya, Mauritius, Nigeria, Senegal and United Republic of Tanzania. It can be expected that the number of injecting drug users in prisons in these countries is also on the rise. Recently UNODC launched a number of small-scale initiatives to obtain more reliable data on African prisons, drugs and HIV. In 2004, one rapid assessment conducted in Mauritius had a prison component (related to HIV in prisons). In 2007, a rapid assessment will be carried out in Cape Verde. However, much more information is needed on this emerging problem.

HIV Prevalence Among Prisoners in Africa — Available Data

38. Most of the available data on HIV among prisoners globally is compiled in developed countries. By contrast, little information is currently available for Africa. The number of HIV-positive prisoners is unknown for most African countries. Existing data suggest high prevalence rates among African prisoners compared with the general adult population. Randomly collected data in a number of countries show HIV prevalence rates in prisons ranging from 2.7 per cent in Senegal and 9 per cent in Nigeria to 27 per cent in Zambia based on voluntary

[36] Simooya O, Sanjobo N, Kaetano L et al (2001). Behind Walls: A Study of HIV Risk Behaviours and Seroprevalence in Prisons in Zambia. *AIDS*, 15 (13): 1741–1744.
[37] National Drug and Alcohol Research Centre, UNSW, Australia, The Centre for Research on Drugs and Health Behavior, UK (2004). Review of Injection Drug Users and HIV Infection in Prisons in Developing and Transitional Countries.

testing and ELISA testing[38]. A study conducted in South Africa indicated that about 40 per cent of prisoners are HIV-positive, while HIV prevalence among adults is estimated at a much lower rate of 25 per cent. For other countries, the corresponding figures show 12 per cent prevalence among prisoners in Cameroon and 28 per cent in Côte d'Ivoire, double or triple the HIV prevalence among the adult population in these countries. Data on Mauritius indicated 5 per cent prevalence among prisoners, which is almost 50 times the prevalence among the general adult population (Table 4).

Table 4: Some Data Regarding HIV Among Prisoners in Africa

Sub-Region/ Country	Total pop. (millions)	HIV prevalence (adults aged 15–49; percent)	Prison pop. (thousands)	Number of prisons	HIV prevalence among prisoners (percent and year)[39]
West Africa					
Côte d'Ivoire	18	7	10,355	33	28 (1993)
Senegal	11.6	0.9	22,271	38	2.7 (1997)
Burkina Faso	12.2	2	2,800	11	11 (1999)
Nigeria	131.5	4	40,444	227	9 (2004)
Central Africa					
Cameroon	16.3	5.4	20,000	73	12 (2005)
Rwanda	17.6	3	112,000	14	14 (1993)

[38] The Enzyme-Linked Immuno Sorbent Assay, or ELISA, is a biochemical technique used mainly in immunology to detect the presence of an antibody or an antigen in a sample for example HIV antibodies. A positive test with ELISA technique has to be confirmed by another test, as it could be a false positive. Stubblefield E, Wohl D (2000). Prisons and Jails Worldwide: Update from the 13th International Conference on AIDS

[39] Data on HIV prevalence present figures gathered through random sampling in a limited number of prisons; therefore, they cannot be treated as representative of a country's prison population.

Sub-Region/ Country	Total pop. (millions)	HIV prevalence (adults aged 15–49; percent)	Prison pop. (thousands)	Number of prisons	HIV prevalence among prisoners (percent and year)[39]
East Africa					
United Rep. of Tanzania	38.3	6.5	46,410	120	5.6 (1995)
Uganda	28.8	6.7	21,900		8 (2002)
Southern Africa					
South Africa	47.4	18.8	186,739	241	45 (2006)
Malawi	12.8	14	8,769	23	75 (N/A)
Zambia	11.6	17	13,200	53	27 (1999)

Source: Data complied from UNAIDS, 2006; Directory of Prisons in Africa, 2005, The World Prison Population List, 2007

39. Existing data are available only for a limited number of countries and there is no provision of systematic data on the magnitude of the pandemic. Countries with the highest HIV prevalence rates, such as those in southern Africa—Botswana, Lesotho, Swaziland, Zambia and Zimbabwe—do not have data available. Furthermore, available data are obsolete as they refer to data collected over a decade ago, e.g. 1993 for Côte d'Ivoire and Rwanda, and 1995–1997 for Senegal and the United Republic of Tanzania. These data are largely random and based on statistically insignificant samples that make such information for the most part unreliable. For example, the study from Malawi shows that 75 per cent of the interviewed prisoners (a sample of 45 people) were HIV positive.

40. There is a considerable knowledge gap in understanding the magnitude of the epidemic in prison communities and its multiplier effect on the non-prison population in the region. Patterns of sexual behavior of men and women prisoners, the

nature of circumstances leading to high-risk sexual activity in prison environments, as well as the risk behaviors associated with the injection of drugs or tattooing, are largely unknown in Africa.

41. Sentenced and locked away, African prisoners have been forgotten by HIV prevention and treatment programs.[40] Many governments prefer to turn a blind eye rather than grapple with the contradictions of the spread of HIV occurring within prison premises.

[40] I. Joshua, M. Ojong: Prisoners: The Forgotten HIV/AIDS Risk Group, 2005

IV. RECOMMENDATIONS

42 There is an urgent need to provide access to evidence based HIV prevention, care, treatment and support in prison settings in Africa. The first step to the development of adequate HIV prevention, treatment, and care programmes in prisons is to build, for each country, better knowledge of the situation, better knowledge of the extent of the problem, and identification of needs to address these problems.

43. There is a need for a combination of sero-prevalence (surveillance surveys) and behavioral studies (knowledge, attitude, behavior and practice studies) to gather data on: (a) HIV prevalence in prison communities, (b) the patterns and nature of sexual behavior in African prisons, and (c) perceptions and attitudes towards HIV of prison populations, prison staff, and partners/families of the incarcerated. These baseline assessments should be collaborative efforts, conceivably involving UNAIDS, UNODC, ILO, WHO, UNFPA, UNICEF, the World Bank, other interested multilateral and bilateral donors, national prison administrations, and international and local nongovernmental organizations (NGOs).

44. National HIV/AIDS guidelines and those on prison management should be reviewed to determine if and how they can realistically address the issue of HIV in prison populations and related concerns. HIV prevention, care, and treatment in prisons should be part of the National AIDS Strategic Plan.

45. Networks should be developed to engage those who know how and those who can do better (e.g. by establishing a network of prison management across countries); promote dialogue and collaboration with national AIDS committees,

and local and international NGOs working on HIV issues; and promote the activities of human rights and advocacy groups, and civil society at large.

46. Legal reforms should be promoted, including those related to the penal codes of individual countries, to develop alternatives to imprisonment as well as to deal with the access to health care in prison in general, and to evidence based HIV prevention and treatment in particular.

47. Awareness about the risks of HIV transmission should be raised among prison populations and those in contact with them (e.g. prison staff, prison service providers, sexual partners) during incarceration and prior to release through targeted information, education, and behavior change communication programs.

48. Peer-based education on condom use and reduction of violence (i.e. conflict prevention tools) among prisoners and prison staff during incarceration and prior to release (pre-release interventions) should be promoted.

49. Access of prisoners to prevention commodities should be promoted in accordance with international guidelines for HIV prevention in prisons, including drug treatment for drug users, condoms, disinfectant for tattooing equipment, and safe needles and syringes.[41] Prevention of mother-to-child-transmission should be available for pregnant women in prison.

50. Prisoners should have access to confidential voluntary counselling and testing. No prisoner should be discriminated or segregated on the basis of his or her HIV sero-prevalence

[41] Guidelines for HIV Prevention in Prisons, WHO,1997 and HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response, UNODC, 2006

status. Those who have been diagnosed with AIDS should have access to antiretroviral treatment, adequate nutrition to enable them to follow their treatment, and prevention and treatment of opportunistic diseases; those with terminal diagnoses should also benefit from compassionate release.

V. NEXT STEPS

51. Given the above recommendations, the following could be undertaken by partners in selected countries:

- **Conduct a situation analysis** including sero-prevalence surveillance surveys and behavioral studies.

- **Initiate a dialogue** with various decision-makers and stakeholders (including nongovernmental organizations, national prison administrations, national commissions on HIV, government ministries and donors) based on the findings of the situation analysis and the prevalence surveys conducted. Provide recommendations for interventions, identifying good practices and lessons learned. .

- **Conduct a legal review, promote advocacy and initiate policy dialogue** for the integration of HIV in prisons in national and regional policy instruments.

- **Provide technical assistance** to local institutions to help develop intervention strategies.

- **Encourage networks** to promote cooperation and establish integrated work between prison and correctional services, prison health systems, public health systems, national AIDS committees, international and national civil society organizations, to promote good prison and public health and in turn good HIV prevention, treatment and care in prisons. .

- **Promote awareness and advocacy** to seek adequate mechanisms of intervention and document the process.

- **Integrate indicators** specific to prisons into the national monitoring and evaluation systems for HIV and/or reinforce local capacity to do so.

52. Selected countries must be prepared to undertake the process of collecting data, assessment and action. For external partners interested in improving regional data, the following factors should be taken into consideration when prioritizing countries for technical and financial support in order to enhance regional perspectives and broaden the common understanding of prison environments in sub-Saharan Africa:

- **Representation of the main sub-regions of Africa (west, central, east and southern)** and the main linguistic and cultural differences (Anglophone, Francophone and Lusophone): these have relevance in terms of judicial, legal and customary traditions for detention facilities, conditions of confinement and legal representation.

- **Varied HIV prevalence rates in the general population and in prisons (where available):** HIV prevalence rates in prisons range from 2.7 per cent in Senegal to 27 per cent in Zambia based on voluntary testing. Better country and regional data would significantly improve the basis for making decisions and monitoring results.

- **Size of the prison population:** Countries have varying prison populations with the highest in South Africa and Rwanda; average in United Republic of Tanzania, Kenya, Nigeria, Cameroon, Côte d'Ivoire; and the lowest in Senegal, Mali and Burkina Faso.

- **Location and number of prisons in the prison system:** Some countries have few prisons while others have many.

The number and types of facilities, whether prisons are located in capital cities and/or outside urban areas, the number of prison managers and size of staff at locations, and the extent to which they are supervised are factors to be taken into consideration.

- **The most vulnerable groups of the incarcerated population:** The number of women, juveniles, elderly and mentally ill and whether they are cohabiting with the rest of the population.

- **Categories of the incarcerated (by type and duration of incarceration):** It is important to look at whether the convicted and the not-yet-sentenced are detained together and for how long.

- **Expressed interest for collaboration by different stakeholders:** Consideration should be given where various local and international stakeholders have expressed an interest in collaboration, including funding.

54. With regards to technical support, UNAIDS offices at country level, UNODC, UNFPA, UNICEF, WHO, national prison administrations, national committees on AIDS, ministries of health and justice, and local and international nongovernmental organizations are potential contributors. Potential partners for funding may include UNAIDS, UNICEF, UNFPA, the Global Fund to Fight AIDS, Tuberculosis and Malaria, USAID, the resources of GHAP (Global HIV/AIDS Programme) and ACT*Africa* of the World Bank, as well as World Bank Trust Funds.

55. The elements of the above described approach would provide the basis for all partners to move forward. For the World Bank, the issue of HIV and the prison community could in future be addressed through investment projects, sectoral

budgetary instruments, as well as mainstreaming, and/or inclusion in the poverty reduction strategy papers process, depending on country demand. Under the technical division of labour among UNAIDS cosponsors, UNODC as the lead agency for HIV prevention and care in prison is committed to support countries by providing technical assistance for legal review, assessment, advocacy, fund raising, capacity building and monitoring and evaluation.

VI. CONCLUSION

56. The HIV situation in prisons in Africa has been a highly neglected area. Available information suggests that the situation is extremely dire in some places and needs urgent attention. Efforts to control the HIV epidemic in Africa that ignore the prison situation are probably doomed to failure.

57. There has been interest expressed by donor and technical agencies to better understand the HIV prison community situation, and to provide financial support for effective and coordinated service delivery to this underserved and vulnerable population. UNODC, as the lead organization, is the appropriate entity to provide coordination and collaborative leadership, to identify countries in consultation with potential partners and country stakeholders to engage in pursuing the approach outlined, and to provide technical support, data collection and reporting. A preliminary work plan and list of countries have been developed, and are available to potential partners on request.

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