International Compendium of Current Practices to Address Infectious Diseases in Prisons

The International Centre for Criminal Law Reform and Criminal Justice Policy

in cooperation with

The International Corrections and Prisons Association

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ABOUT THE INTERNATIONAL CENTRE FOR CRIMINAL LAW REFORM AND CRIMINAL JUSTICE POLICY

The International Centre was established in Vancouver, British Columbia, Canada in 1991 at the initiative of the Canadian government. Its founding partners are the University of British Columbia, Simon Fraser University and the International Society for the Reform of Criminal Law. Affiliated with the United Nations, it is one of two interregional institutes in the United Nations Crime Prevention and Criminal Justice Programme. The Centre’s mission is to promote the rule of law, human rights, democracy and good governance. It fulfills its purpose by contributing to local, national and international efforts to support law reform initiatives and to improve the administration of criminal justice. The Centre supports and contributes to the policies and activities of the United Nations Crime Prevention and Criminal Justice Programme, and assists with the achievement of Canadian Foreign Policy objectives.

The International Centre conducts research and policy analysis, undertakes the development and delivery of technical assistance programs and provides public information, consultation and education relating to the international field of criminal law, criminal justice policy and crime prevention issues. Further, the Centre facilitates the exchange of information and expertise to support the government of Canada in both its national and foreign policy objectives in the areas of crime prevention, criminal justice and human rights.

For additional information, please contact the International Centre at:

The International Centre for Criminal Law Reform and Criminal Justice Policy
1822 East Mall, Vancouver, British Columbia, Canada  V6T 1Z1
tel: 604-822-9875  fax: 604-822-9317
e-mail: icclr@law.ubc.ca  website: www.icclr.law.ubc.ca
ABOUT THE INTERNATIONAL CORRECTIONS AND PRISONS ASSOCIATION

The International Corrections and Prisons Association for the Advancement of Professional Corrections (ICPA) is an international membership based not-for-profit association which provides a forum for criminal justice professionals to join in a dialogue and to share ideas and practices aimed at advancing professional corrections. Its mission is to contribute to public safety and healthier communities by encouraging and enabling best correctional practices in prisons and outside communities. Membership is open to all individuals and organizations interested in corrections and prison services and who can further the objectives of the Association.

The ICPA would like to formally recognize the following National Members as major contributors to the advancement of professional corrections:

Corrections Division – Province of Saskatchewan Justice (Canada)
Correctional Service of Canada
Department of Justice of Western Australia
Dutch National Agency of Correctional Institutions
Israel Prison Service
New Zealand Department of Corrections
Prison and Probation Department of Norway
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For additional information about membership, please contact the ICPA at:

International Corrections and Prisons Association for the Advancement of Professional Corrections
340 Laurier Avenue West, Ottawa, Ontario K1A 0P9 Canada
tel: 613-943-3058    fax: 613-943-7844
e-mail: contactus@icpa.ca    website: www.icpa.ca
INTRODUCTION

Infectious diseases, particularly HIV, Tuberculosis and Hepatitis, pose formidable challenges for correctional jurisdictions worldwide. In addition to the obvious health and safety issues these diseases consume a considerable amount of increasingly scarce correctional (prison) resources. Many correctional jurisdictions have responded by developing innovative programs and protocols to face these challenges.

In an effort to share these innovations with colleagues in the Corrections Services from around the world, the International Relations Committee of the American Correctional Association (ACA) undertook discussions and established a Committee which commenced the task of compiling this international compendium of current practices to address the issue of infectious diseases in prisons. With the support of the ACA, early activities of this project were carried out jointly by staff of the Correctional Service of Canada (CSC) and the International Centre for Criminal Law Reform and Criminal Justice Policy (the International Centre). A generous financial contribution from the Open Society Institute (Soros Foundation) ensured continuation of the project under the direction of the International Centre. To ensure that this document reaches as many of our correctional colleagues around the world as possible, it is being published and distributed as a joint initiative of the International Centre and the International Corrections and Prisons Association (ICPA).

Our research began with the distribution of approximately 120 letters inviting jurisdictions worldwide to share their ideas relating to infectious diseases in prisons. Respondents were asked to provide a summary of their innovative programs and practices related to the prevention, screening, treatment of and education about infectious diseases in the correctional environment. They were asked to highlight key aspects of the program so that readers would be able to determine the potential of transferability to their jurisdictions. Respondents were also asked to provide names and contact information for appropriate individuals within their organizations responsible for these programs. From the 120
letters sent out, over ninety responses were received from various correctional jurisdictions worldwide.

The overwhelming number of responses received did not allow for each one to be individually profiled. In many cases there was duplicate information, or at least some similarities, amongst the responses submitted. As a result, there has been significant synthesis and paraphrasing of the responses to establish a uniform and logical structure of the compendium.

The compendium itself presents general and disease-specific practices for screening/diagnosis, prevention and treatment of infected inmates. Where possible, descriptions of practices or programs are followed by the names of the participating jurisdiction/authorities for ease of reference. In addition, a cumulative list of these programs, grouped by jurisdiction, is provided in Appendix I. A contact list comprised of individuals identified by the participating jurisdiction, is also provided as an additional resource in the compendium (Appendix VI). This list invites the reader to consult and/or correspond with colleagues from around the world in an attempt to tackle this most challenging and pressing prison and public health issue. Additional appendices provide program and organizational Internet sites to assist with future research efforts.
DISCLAIMER

The programs, protocols and activities outlined in this compendium are intended as an information resource only and are in no way advocated by the International Centre for Criminal Law Reform and Criminal Justice Policy or the International Corrections and Prisons Association or any of the organizations and individuals involved in the development of this compendium. Moreover, the compendium does not present an evidence based evaluation of practices related to infectious disease control in prisons. This does not purport to contain medical advice that has been approved/sanctioned by medical experts. Rather it is the compilation of only those jurisdictions around the world that responded to our invitation to participate in this project. This limitation obviously introduces a response bias.

The International Centre, the ICPA and the project team would also like to apologize for any errors or misinterpretations that may have resulted either through translation and/or the transfer of information into the compendium.
CURRENT PRACTICES: GENERAL

Screening/Diagnosis

1. Infectious Control Surveillance System

One of the most important strategies to ensure the health of inmates and prison staff is prevention of the transmission of infectious agents. These efforts include, among many other practices discussed further in this document, developing an infection control surveillance and identification system. The program enables personnel to clearly identify the symptoms, trends, treatment and isolation criteria, and other variables of the infectious diseases. Here are some practices that a number of the correctional jurisdictions have followed with some success in their system.

Several jurisdictions reported the development and maintenance of an information chart. The chart includes definitions of infectious diseases and local trends, which are derived from direct observation during surveillance. Such a chart may also incorporate criteria for treatment, stages and patterns of the disease, symptomatic tables, and prevention information. Further, the chart may include possible sources of the infectious diseases and identify potentially infectious materials such as blood, semen, airborne droplets, and others. Along with modes of the transmission of infectious diseases, health authorities may document/cite immediate responses to ongoing infectious outbreaks. Finally, a list of medical definitions can be developed and can serve as a quick reference for all prison employees. An example of such a list is attached in Appendix IV, derived from the Florida Correctional Services Department and Mosby’s Medical, Nursing and Allied Health Dictionary. Valuable definitions include those for Airborne Infection, Antiseptic, Communicable Disease, Disinfectant, Epidemic, Incubation Period, Means of Infection Control, Isolation, STD, and Terminal Disinfection. The Florida Correctional Services Department additionally requires that all ongoing infections be classified as:

- Community acquired infection (CAI): acquired outside of the correctional institution
- Correction community acquired infection (CCAI): acquired within the correctional system and not present prior to the inmate’s reception into the system
- Nosocomial infection (NI): acquired in relation to health care provided in a correctional institution or within the correctional hospital

The incubation period of the infection or communicable disease should be considered when determining the category in which to place each identifiable infection. This classification assists authorities to spot the origin of the outbreak within the correctional institution, and thus, follow procedures of preventing the spread, i.e. testing the immediate contacts, immediate vaccination, or isolation (such as in cases of tuberculosis).

*Jurisdictions that exercise a variation of the “Infectious Control Surveillance System”: Canada (Ontario) and the USA (Florida, North Carolina).*

2. Development of Data Control Management Systems

Data control management typically requires an Infection Control Coordinator. The role of the Coordinator is to identify and manage clusters and outbreaks of infectious diseases. Possible responsibilities for this Coordinator are as follows:

The Coordinator periodically evaluates collected data in terms of patterns and trends of infectious diseases, such as *stable, increasing and decreasing*. To analyze the patterns and trends of infectious diseases, a number of jurisdictions often perform contact tracing. This is often used to investigate an apparent increase in a certain type of infection within the institution by determining the presence or absence of the infection in persons exposed. During the investigation, the Coordinator develops and implements an immediate action plan to prevent and control the infectious outbreak. The employee performing the duties of the Infection Control Coordinator is often also responsible for reporting infectious diseases to the local health authority. The coordinator might also obtain, as part of a monthly routine, environmental specimens of surface and water samples to maintain a clean and safe living area for the inmates.
The Coordinator might further be responsible for obtaining diagnostic specimens when the physician is not present. When signs and symptoms of infection are obviously present, it can be possible for specially trained nurses to collect the specimens.

Jurisdiction that reported the “Development of Data Control Management System”: the USA (Florida).

3. Routine Reception/Prior Release Exam

The “Routine Reception/Prior Release Exam” program is currently applied by many correctional institutions around the world. The purpose of this program is to spot any health abnormalities and potentially hazardous infectious diseases. In some countries the program advocates that all inmates, upon their admission as well as upon their release must undergo a medical examination to determine the presence of infections such as tuberculosis, sexually transmitted diseases, or HIV.

The most basic screening involves a symptom questionnaire and inquiry into past and current medical conditions. This can be done by specially trained correctional staff. Some jurisdictions use much more comprehensive screening including a complete history and physical examination by a physician, laboratory tests, tuberculosis skin testing, chest x-rays, and cultures. Other systems keep incoming inmates isolated from the general population until they have been medically screened and cleared.

Some systems routinely test both female and male inmates for sexually transmitted diseases. Syphilis screening requires a blood test while gonorrhea and chlamydia screening can be performed with a swab test or urine specimen. Microscopy can also assist in the diagnosis of sexually transmitted diseases. A comprehensive evaluation for female inmates would include a pelvic exam and Pap smear.

Note that most inmates, upon admission to most correctional systems, during incarceration, or at the time of their release, are not usually routinely screened for presence of antibodies for HIV. This test is often offered and undertaken voluntarily – that is, with the informed valid
consent of the inmate. This policy is consistent with the World Health Organization’s guidelines on HIV Infection and AIDS in prisons, which also states:

Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited. Voluntary testing for HIV infection should be available in prisons when available in the community . . . Voluntary testing should only be carried out with the informed consent of the prisoner...

As a first step to addressing HIV/AIDS in prisons, voluntary testing and counseling services are often useful (these programs and practices are outlined later in the compendium). This approach has proven to be cost-effective and can simplify resource planning. The goal of testing ought not to be to identify infected inmates for the purposes of segregation, but to inform both non-infected and infected inmates of their results in order to assist them in adopting safer behavior. Therefore, the best program will be one that positively encourages testing. In many countries this issue is solved by making HIV/AIDS testing a confidential procedure so that the inmates’ privacy is not compromised.

Some correctional jurisdictions administer a routine medical examination for all employees prior to their admission to the work place. In this regard, some jurisdictions can find it useful to establish a contractual agreement with the health authority of a province or state to accommodate a designated person to coordinate infectious disease screening of employees. Many then also provide annual tuberculosis screening examinations for both employees and inmates. This could be handled by designating a specific day during the year for inmate/employee testing. Others perform annual tuberculosis screening during the employee’s or inmate’s birthday month, or on the anniversary date of their employment or admission to the facility.

*Jurisdictions that report a variation of “Routine Reception/Prior Release Exam”: Australia (New South Wales), Canada (Saskatchewan), Fiji, Finland, Hong Kong, Hungary, Japan, Lithuania, Philippines, Singapore, Sweden, and the USA (Colorado, Florida, Oklahoma, New York).*
Preventive Measures

This section describes the programs and practices that are currently in use by a number of correctional jurisdictions to prevent the spread of communicable diseases.

4. Implementation of Standard (Universal) Precautions

Implementation of Standard (Universal) Precautions relates to preventative methods which mainly deal with blood-borne pathogens that might be spread from contact with potentially infectious materials. The program involves the identification of potentially infectious materials or fluids, which are implicated in the transmission of infections. It presupposes that all such materials might be contaminated with infectious agents regardless of the source. The program details the management of specific potentially infectious materials and reduces the risk of exposure through the use of vinyl or latex gloves, masks, eye protection, and other appropriate personal protective equipment.

Used inmate/patient care equipment that has been exposed or soiled with blood, body fluids, secretions and/or excretions should be disposed in a manner that prevents contamination of the environment and transfer of microorganisms to other inmates/patients and employees. Equipment must not be reused for the care of another inmate/patient without the use of proper disinfectants or sterilization. One application of this principle involves separating and marking storage for Medication Use Only, for Food Use Only, and for Lab Specimens Only. Ongoing sterilization of medical instruments and equipment is a routine reported from every correctional environment.

As another standard precaution, Florida’s correctional jurisdiction suggests using microshield/pocket masks to minimize the risk of exposure during emergency mouth-to-mouth resuscitation. The masks must be discarded immediately after use. Florida colleagues also propose storage of the unused masks in an area readily accessible in an emergency situation.
Jurisdictions that reported the maintenance of a program similar to an “Implementation of Standard (Universal) Precautions” program: Canada (Ontario), Slovakia, and the USA (Florida).

5. Education/Counseling

A key component of prevention is the education and counseling of inmates. There is a general consensus among most correctional jurisdictions that every opportunity to increase inmate and staff awareness must be acted upon. There is a multitude of practices that are presently in effect within several jurisdictions:

- **Literature**
  
  Literature is an essential component of each educational program and materials are generally provided to all inmates upon their admission. Brochures are distributed with detailed definitions and explanations of infectious diseases, how they are spread, related symptoms, methods of improving recovery, and the necessity of medical examinations. This literature may also include disease profiles including descriptions of symptomatic/asymptomatic patients, drug therapy for each particular disease, and other methods and treatment. Particular attention may be given to sexually transmitted diseases and HIV. For instance, British correctional institutions are currently assigned educational packages on HIV/AIDS. Each contains a video and an accompanying tutor’s manual. Some institutions have created pamphlets for low literacy inmates using cartoon images to describe infectious diseases, transmission risk and the consequences of negligence.

- **Lectures/Educational Sessions**
  
  Aside from the distribution of educational literature, many jurisdictions provide informative lectures. Brazil, for instance, currently presents sessions that cover anatomy, sexuality, hygiene, STDs, HIV/AIDS, family planning and contraceptive methods. Furthermore, many jurisdictions provide personal hygiene items and means of contraception after such educational sessions, so that during intimate/conjugal visits with partners, an opportunity to use protection is provided.
Working with women inmates, the State of Washington specifically deals with female anatomy, pregnancy, family planning, STDs, HIV/AIDS, and preventive methods for numerous infectious diseases. Educational sessions also include topics on the hazards of unprotected or high-risk sexual behavior. Some jurisdictions practice similar educational sessions by identifying potentially high-risk groups, such as alcoholics and drug abusers, and subsequently providing information and treatment programs aimed at reducing recidivism. Changing hazardous behavior patterns and limiting harmful effects resulting from drug and alcohol abuse are often a theme of discussion.

### Inmate Educational Programs

Preventive educational programs take a variety of forms. For instance, Minnesota (USA) has defined a four-step program:

1. Basic educational course upon admission;

2. One-hour briefing session on HIV and other STDs when placed in the facility;

3. Intensive 8-week program for inmates who participate in the chemical dependency or sex offender programs;

4. A pre-release refresher prevention course also designed to introduce them to related community resources.

The approach towards the educational programs may include the following principles:

- Compulsory educational programs for all inmates
- Comprehensive information availability and distribution
- Response to the needs of prisoners with disabilities, different ethnic and linguistic backgrounds, varying language skills, different genders.
- Group and individual sessions
- Programs available immediately upon entering the correctional institution
- Presentation by external community-based HIV/AIDS and health organizations
- Peer counselors and coaches

### Community Educators

There is extensive debate about the effectiveness of information programs. Particularly, it has been suggested that some of these programs do not change the patterns of behavior of the general prison population. In response to this ongoing debate many jurisdictions have attempted to enhance the success of the educational programs by involving recognized community educators. In many cases prisoners distrust prison authorities and are unlikely to participate in prescribed activities, and therefore this approach may be more effective.

### Counseling

One interesting and moderately innovative practice is the involvement of inmates themselves as peer educators. Plays and group meetings are used to educate fellow inmates about STDs and AIDS. This practice can be highly effective since there is usually a sense of “brotherhood”, and therefore increased trust, among the inmates. As such, officials in the State of Wisconsin encourage the development of a peer facilitators network within the correctional environment. The use of the peer educators can also be a cost-saving strategy when a jurisdiction experiences a shortage of staff and resources.

Further, colleagues from Portugal have established a private, specialized program concerning STDs including a description of symptoms, transmission methods, and treatment regimens. In Switzerland, correctional facilitators have commenced an entire range of educational practices including information meetings, group workshops, and consultations led by a prevention team of external experts that evaluate group progress. In Brunei, jurisdictions provide psychiatric counseling to inmates with mental disorders. “Positive Living” counseling for HIV-positive inmates is widely implemented in Zambia. Pre and post-test counseling services, psychosocial
support, clinical monitoring and treatment are provided by correctional officials in London (UK).

In Mantipula, health education/counseling activities are provided by using person-to-person, group, and mass media approaches combined with posters, films, and billboards. To deliver group presentations, provide individual counseling and ensure the effectiveness of these practices, a number of jurisdictions developed a partnership with local health authorities.

- **Rehab/Pre-release Planning**
  Some correctional jurisdictions use educators, psychologists, social workers and non-governmental organizations to implement such programs as drug rehabilitation or pre-release planning.

- **Staff Training**
  In many jurisdictions, particular attention is paid to educating the staff and prison authorities. These education processes mainly include mandatory training on identification and prevention of communicable diseases, with the goal of promoting and encouraging awareness among employees about safe working methods.

  *Jurisdictions that exercise some form of an “Education/Counseling” program:* Australia (New South Wales, Queensland), Austria, Bermuda, Beau-Bassin, Brazil, Brunei, Canada (Ontario, Northwest Territories), Costa Rica, Denmark, New Zealand, Northern Ireland, Philippines, Poland, Portugal, Slovenia, South Africa, Singapore, Switzerland, the United Kingdom, USA (Alaska, Florida, Illinois, Minnesota, New York, Washington, Wisconsin), and Zambia.

6. **Sanitary Precautions: Management of Soap, Antiseptics, Disinfectants, and Other Fluids**

The use of soap, antiseptics, disinfectants, and other fluids is another important component of preventing and limiting the spread of infectious diseases. These practices include
- Thorough washing of hands with soap and water between each patient contact
- Storage of liquid soap in closed containers
- Elimination of the use of bar soap
- Use of diluted chlorine bleach to clean isolation rooms which house or have housed infected persons and to disinfect surfaces contaminated with body fluids
- Cleaning of patient care equipment with disinfectants whenever contaminated. Previously used equipment must be cleaned and disinfected prior to its use for a new patient
- Special attention should be given to equipment and instruments that have rough surfaces or sharp angles which may potentially harbor microorganisms
- Vinyl or latex gloves should be worn during disinfecting and cleaning procedures, particularly if gross contamination is present

Countries that maintain a similar program to “Management of Soap, Antiseptics, Disinfectants, and Other Fluids”: Botswana, Slovakia, United Kingdom (England), and the USA (Florida).

7. Medical Waste Management Program

In the effort to prevent the spread of infectious diseases it is also important to implement the proper management of medical waste. A program developed by the Florida Correctional Services to adequately dispose such waste and prevent the spread of infection, prescribes minimum sanitary practices relating to the management of biomedical waste including segregation, handling, labeling, storage, treatment, and disposal. These regulations apply to all facilities that generate biomedical waste. Once wastes are identified as biomedical they are segregated from

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1 Disinfection destroys or irreversibly inactivates the vegetative cells of infectious microorganisms.

2 Biomedical waste can be defined as any solid or liquid waste which may present a threat of infection to humans, including nonliquid tissue, body parts, blood, blood products; laboratory and veterinary wastes which contain human disease-causing agents. It also includes absorbent materials saturated with blood, blood products, as well as secretions or excretions. Nonabsorbent devices that have been contaminated with blood, but have not been treated with disinfectants are also considered to be biochemical waste.
the general waste stream at the point of origin. Subsequently, all biomedical refuse must be disposed of and appropriately placed into specifically marked containers. The following titles are suggested to be used in conjunction with the international biohazard symbols: “biomedical waste”, “biohazardous waste”, “biohazard”, “infectious waste”, or “infectious substance”.

To ensure the implementation of these suggestions, the Florida jurisdiction developed training sessions for the employees as well as inmates including topics such as:

- the relative persistence in the environment of HIV and HBV
- recognizing needlesticks or other penetrating injuries as a significant risk factor
- proper handling of biomedical waste bags in a safe manner in order to minimize the risk of occupational exposure to HBV and HIV.

8. Environmental Precautions

Much attention has been paid to environmental precautions that help prevent the spread of infectious diseases. These precautions are proven to be effective at little cost. “Environmental Precautions” prescribe daily cleaning of urinals, showers, toilets and lavatories in all the areas of a correctional institution. Correctional institutions in Britain distribute disinfecting tablets to enable inmates to clean their facilities. Generally, inmate workers need to be alert to potential hazards and informed of the proper precautions and protection when cleaning contaminated areas. The Florida jurisdiction developed “standard isolation room cleaning” procedures comprising daily cleaning and disinfecting of isolation rooms. The use of protective equipment (gloves, eye protection and masks), special training of inmates assigned to clean contaminated areas, and the use of a 1/10 solution of bleach as the primary disinfectant in removing blood and body fluid spills.

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3 See Appendix I for term’s definition
In Australia, many jurisdictions promote appropriate cleaning techniques for Inmate Barbers. These programs have a built-in assessment component, to assess quality of service and cleaning.

*Jurisdictions that follow a similar “Environmental Precautions” program: Australia (New South Wales), Austria, Canada (Ontario), UK (England), and the USA (Florida).*

9. *Prevention Practices*

There are also a number of controversial practices used as preventative measures to reduce the harm of narcotic and drug abuse by inmates. It is unrealistic to presume that drug use together with drug injection will cease in a correctional environment although vigilant supervision, drug treatment programs, drug testing and sanctions for use can minimize use. Thus, there are a number of practices used among the penitentiaries that, along with attempts to suppress drug use, also include efforts to make drug usage safe and sterile.

The following practices and programs offer a pragmatic harm-reduction perspective to the misuse of intravenous drugs. This program is based on the premise that if drug misuse cannot be eliminated, at least some of the related problems could themselves be reduced.

- **Distribution of Disinfecting Agents**
  A number of jurisdictions distribute bleach kits and iodophore-based disinfectants to reinforce universal precautions against infection as well as to ensure safe practices for those who may continue to use intravenous drugs.

  Availability of such disinfectants to inmates has often been perceived as contributing to or condoning the use of illegal drugs in prison. It has also been argued that the availability of bleach as well as information on how to clean injection equipment may encourage non-users to experiment with injection drug use. Finally, some believe that bleach could be used as a weapon against the prison authorities. These fears are not reflected in practice; for example, bleach has been available for some time in Canadian prisons without being a threat to
institutional security. Moreover, such measures are considered to be essential in order to reduce HIV/HBV transmission. With regard to making bleach available, the World Health Organization’s Guidelines on HIV Infections and AIDS in Prisons recommends that bleach should be available in prisons where drug injection, tattooing and skin piercing occurs.\(^4\)

**Jurisdictions that maintain a similar “Distribution of Disinfecting Agents” program include:** Australia (Northern Territory), Austria, Canada (British Columbia, Ontario), Czech Republic, Finland, Lithuania, Norway, Slovenia, and the UK (England).

- **Personal Hygiene Practice**

  Personal hygiene plays a key role in the effort to prevent the spread of infectious diseases. In Slovenia, for instance, inmates are provided with latex gloves, condoms and disinfectants. Anonymous distribution of condoms is also currently practiced in many countries, including Eastern European states such as Lithuania and the Czech Republic. In Austria, medical staff provide a "take care set" containing information folders, condoms and lubricants, to all inmates upon admission.

**Jurisdictions that exercise a variation of “Personal Hygiene” practice include:** Australia (New South Wales), Austria, Brazil, Byelorussia, Canada (British Columbia, Saskatchewan, Ontario), Czech Republic, Denmark, Finland, Germany, Lithuania, Portugal, Slovenia, the USA (Wisconsin), and the UK (England).

- **Needle Distribution**

  Reducing the harm from injection drug use must be seriously addressed by correctional authorities. In many countries the spread of infectious diseases is often due to sharing of unclean needles. In response to this problem, Swiss correctional authorities started the practice of needle distribution through automatic dispensers located

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throughout each prison. The automatic dispensers exchange one clean syringe for one used syringe\textsuperscript{5}. Making sterile injection equipment available reduces the risk of being infected with HIV and discourages the use of dangerous handmade syringes. It has been argued that needles should also be exchanged through the prison health services in a confidential manner and inmates should not be accountable to non-medical staff when obtaining needles.

The World Health Organization’s Guidelines on HIV Infections and AIDS in Prisons\textsuperscript{6} recommended that in countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to the provision of clean injection equipment during incarceration. When implementing the practice of syringe distribution, correctional institutions can draw on the experience and resources of needle exchange programs in the community.

Jurisdictions that exercise a program similar to “Needle Distribution” include: Byelorussia, Germany, and Switzerland.

- **Methadone Maintenance**
  
  To reduce the risk of infection many correctional institutions have implemented a methadone maintenance program. It has been suggested that methadone maintenance is effective in reducing high-risk injecting behavior and in reducing the risk of contracting HIV. Moreover, given its effectiveness in reducing the use of narcotics, particularly through injection, methadone maintenance may warrant greater attention as a harm-reducing strategy. Inmates who are forced to withdraw from methadone use because they are incarcerated

\textsuperscript{5} All related issues to this practice can also be found in Expertise: “Legal consequences of denying access to sterile syringes in the prison setting”, Swiss Federal Office of Justice, 1997.

\textsuperscript{6} The information on AIDS prevention strategies can be found at http://www.who.int/inf-new/aids.htm
usually return to narcotic use, often within the prison system, and often via injection.\footnote{More debates can be found in \textit{HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons}, CSC, Feb. 1994.}

\textit{Jurisdictions that currently exercise a variation of “Methadone Maintenance” practice:} Australia (Queensland, New South Wales), Austria, Canada (British Columbia, Saskatchewan), New Zealand, and Switzerland.

- **Heroin Distribution Pilot**

Swiss colleagues, after extensive research, have implemented a heroin distribution pilot project. Swiss authorities argue that not all drug users entering the prison system are willing or able to follow therapy that leads to abstinence, nor are they ready for methadone maintenance. Therefore, drug users who are part of the "PROVE" program for medical prescription of narcotics should be given the opportunity to continue while in the correctional environment. The pilot project has been incorporated in the day-to-day activities of some of the prisons. Most of the Swiss prisons are currently interested in prescribing heroin to chronically dependent inmates.

The authorities in Polish correctional jurisdictions as well as in Australian (Northern Territory) and German jurisdictions prefer an “anti-drug” program which entails mandatory participation in therapeutic sessions as well as psychotherapy. They do not practice the distribution of either methadone or heroin. Rather, they encourage cooperation with experts from public health departments for the development of research. By maintaining direct and constant contact between prisons and public health representatives, Polish correctional authorities ensure not only the availability of medication to cure drug addicted persons, but also the continuity of such care upon their release.
10. Immunization of Inmates

Immunization, or vaccination, against a number of infectious diseases increasingly helps to prevent and control outbreaks of diseases and epidemics. In accordance with the regulations of some correctional jurisdictions, inmates undergo immunization during the reception process. Others concentrate only on the highest risk individuals such as those who are HIV positive or pregnant. Immunization for Hepatitis B is particularly important for inmates with a history of intravenous drug use. Employees are also immunized as a preventive measure against infectious diseases and their spread and are provided with a Hepatitis B vaccine at time of hire.

Jurisdictions that follow a program similar to “Immunization of Inmates” include: Scotland and the USA (Florida, Illinois, Wisconsin).

11. Isolation

Another preventative measure is the practice of medical isolation to prevent direct or indirect transmission of airborne or direct contact infectious agents from the infected to susceptible others or to others that may spread the agent further (including to employees, visitors, inmates, and the community). It is critically important to clean the seclusion rooms and equipment during and after the isolation period. Rooms used for respiratory isolation should meet the standards of air exchange and undergo continuous monitoring.

Jurisdictions that exercise some form of medical isolation program include: Singapore and the USA (Louisiana, New York).

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8 As applied to patients, isolation represents separation, for the period of communicability of infected persons from others in such places and under such conditions as to prevent or limit the direct or indirect transmission of the infectious agent from those infected to those who are susceptible or who may spread the agent to others.
CURRENT PRACTICES: DISEASE SPECIFIC

Tuberculosis (TB): Prevention and Management

TB is a severe and potentially threatening disease that is spread primarily by a person with untreated tuberculosis of the lungs or larynx. One highly infectious person can infect others who share the same air space. Consequently, the residents of correctional facilities are also at risk for TB as many of the correctional facilities have overcrowded environments conducive to disease transmission. In addition to the risk from overcrowding, a number of inmates share other risk factors for development of tuberculosis such as infection with HIV, intravenous drug use, homelessness, and being a member of a lower socio-economic population that has poor access to health care.

This section presents practices for both inmates and the correctional facility for successful TB prevention and control.

1. TB Screening/TB Skin Testing

To prevent the spread of tuberculosis (TB) in prisons, health authorities in most jurisdictions symptom-screen all the inmates during the admission process. Those who have symptoms are examined to determine whether they have (active) TB disease. Symptoms of pulmonary TB include the following: a productive, prolonged cough; a cough lasting for more than three weeks; chest pain; cough accompanied by fever, chills; night sweats; easy fatigue; loss of appetite; and/or weight loss. There may be further medical examination if an inmate experiences any of these symptoms. The evaluation may include a tuberculin skin test (Mantoux Test), a chest radiograph, and, if necessary, sputum analysis. The inmate is generally placed in respiratory isolation during the period to determine presence of the disease. Communities with high prevalence of tuberculosis perform a chest radiograph on each inmate entering the facility. In the United States it is recommended that all prisoners who will be incarcerated long enough to have a TB skin test read should have that test.

In response to the recent development of drug-resistant strains of TB, many jurisdictions are intensifying efforts to properly screen and treat the
disease. Many conduct an annual retest (Tuberculin Skin Testing) of inmates who have previously showed negative results on the Mantoux skin test. The re-examination serves to identify persons who may have had recent contact with the disease and are at significant risk of developing it and infecting others. Those whose TB test shows them to have TB infection can have that TB infection treated to prevent them from developing the disease in the future.

Since the risk of TB infection in prison is heightened for inmates with HIV infection, those diagnosed with HIV or at risk of HIV infection receive a tuberculin skin test and chest X-ray and those who are diagnosed as having TB disease should be offered HIV testing. Individuals who display symptoms such as a productive cough, coughing up blood, weight loss, loss of appetite, lethargy weakness, night sweats or fever are normally subjected to respiratory isolation and sputum smear and culture.

Jurisdictions that maintain TB Screening practice: Canada (Northwest Territories), the Czech Republic, Brazil, Japan, Lithuania, Philippines, Poland, and the USA (Alaska, Florida, New York).

2. TB Transmission Control / Containment

Inmates who have suspected or confirmed pulmonary or laryngeal disease are placed immediately in a TB isolation room. Further transmission control may involve the following:

- isolation in a room with six or more air changes per hour with direct exhaust to the outside;
- anti-tuberculosis chemotherapy regimen during the isolation period;
- investigation of contacts, usually consisting of inmates, staff and visitors in recent contact with the patient;
- examination of contacts, with priority given to symptomatic, high-risk, and close contacts. Subsequent priority must be given to contacts in lesser proximity; examination should include tuberculin skin test and chest x-ray if symptoms suggestive of tuberculosis are present; those contacts who have a previously positive tuberculin skin test should be screened for symptoms but may be excluded from x-ray examination if they do not have symptoms.
Isolation may be discontinued only when therapy effectively causes the patient to improve clinically, and the patient has had three consecutive negative AFB smears from specimens collected on different days. If an inmate requires transportation, he/she is required to wear a surgical mask covering his/her mouth and nose during transport; the vehicle windows should be open to permit airflow. Medical and security staff who are to be in contact with infectious TB patients should wear a personal respirator. The inmate should not be transported in a vehicle with other inmates.

Assessment is an important element in preventing the spread of TB. If inmates are transferred frequently from one facility to another, a retrievable record system is essential for tracking and assessing the status of persons who have active TB disease and TB infection in prisons. The record system should maintain current information about the location, screening results, treatment status, and degree of infectiousness of these inmates.

3. TB Preventive Therapy / Treatment

Often treatment failures are due to noncompliance on the part of the patient and errors in judgment on the part of the provider. Further, successful treatment outcomes require commitment and education on the parts of both the healthcare workers and the inmate.

In the cases of active TB, multiple antibiotics and chemotherapy are administered in order to suppress the disease. For persons who have positive sputum smears or cultures at the beginning of therapy, response to treatment may need monitoring by smear and culture examination at least monthly until the results are negative for the TB bacilli. HIV infected persons who were in close contact with TB-infected persons are often provided with preventive therapy regardless of tuberculosis skin test results, age, or prior courses of chemoprophylaxis.

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9 More information on the treatment medication can be found on http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00042214.htm
All inmates being treated for active TB disease should be on “DOT” (directly observed therapy) to ensure adherence to therapy. This means that each dose is witnessed and documented. When DOT is used, TB medication may be administered either twice weekly, after an initial period of daily medication, or three times weekly from the beginning of the therapy. Inadequate or interrupted treatment for TB can result in relapse, continued transmission, and most dangerously, drug-resistant disease. After effective therapy has begun, continued treatment without interruption is critical until patients complete an entire course of therapy.

**Jurisdictions that maintain a variation of practices outlined above:** Canada (Alberta), Brunei, Byelorussia, Estonia, Ireland, Lithuania, Malawi, and Moldova.

**Hepatitis A (HAV) Virus Infection**

Hepatitis A is a virus that may cause inflammation of the liver. This infection is generally self-limited, i.e. resolves completely over a few weeks. Symptoms of this virus may include nausea, vomiting, and diarrhea. To diagnose HAV, a blood test is usually taken to measure antibodies related to Hepatitis A. Once infected and recovered, the antibodies to the virus provide protection from future infections of HAV.

Ingestion of contaminated food or water can cause hepatitis A. The fecal material of the infected person is highly infectious to others. Methods of transmission are primarily through fecal/oral routes and close person-to-person contact.

Prevention of Hepatitis A most often includes the HAV vaccine or the intramascular immune globulin (IG) for temporary immunity after exposure. Vaccination to prevent HAV infection prior to exposure provides protection against the virus as early as 2-4 weeks after vaccination. Individuals who should be vaccinated include persons engaging in oral/anal sex, users of intravenous drugs\(^{10}\), institutional

\(^{10}\) Although Hepatitis A is not a blood borne infection, outbreaks have been seen among drug users. More information on the subject matter may be found at http://www.intelihealth.com/IH/ihtIH/WSIHW000/9339/10126.html
workers, and individuals with chronic liver diseases. Additional methods of prevention of the disease include washing hands with soap and water after going to the toilet, using bleach to clean surfaces contaminated with feces, and safe sex.

Treatment of HAV, for those who were exposed to the virus, may incorporate a dose of IG no later than two weeks after initial exposure, a healthy diet, and avoidance of alcoholic beverages.

**Hepatitis B (HBV) Virus Infection**

Hepatitis B is a blood-borne virus that causes inflammation of the liver. It can cause liver cell damage, leading to cirrhosis and liver cancer. Symptoms of an acute infection can include flu-like symptoms, dark urine, light stools, jaundice, fatigue and fever as well as yellow coloring of the individual’s eyes and skin.

The blood of a person infected with hepatitis B is highly contagious to those who come into contact with it. Correctional staff, health care workers, and inmates are considered high risk because of the frequent opportunities for exposure to blood. Methods of transmission include contact with infected blood, seminal fluid, vaginal secretions, and contaminated needles, including tattoo and body-piercing tools. HBV can also be transmitted by sexual contact and from an infected mother to her newborn.

Prevention of Hepatitis B can be achieved by safe and effective vaccination, and should be provided to persons at high risk. Hepatitis B Immune Globulin (HBIG) should be administered within two weeks of exposure to non-immune persons who come in contact with blood. It is recommended that all adolescents be vaccinated, since most cases of HBV occur in sexually active young adults. To prevent transmission, individuals should practice safe sex as well as avoid contact with infected blood and other body fluids, either directly or by contact with objects such as needles, razors, toothbrushes, etc. It may also be wise to cover sores with bandages; spilled blood should be removed with the 1/10 bleach-water solution.
Treatment of chronic HBV is complex and may involve a combination of chemotherapy agents. The person must avoid alcohol and other agents toxic to the liver. It is also suggested that patients with chronic hepatitis B be vaccinated against hepatitis A.

**Hepatitis C (HCV) Virus Infection**

Hepatitis C is a blood-borne virus that also causes inflammation of the liver. Like hepatitis B, it too can cause liver cell damage, leading to cirrhosis and liver cancer. Infection by HCV can be determined by a blood test that detects HCV antibodies in the blood. The course of hepatitis C infection is highly variable in different people. A liver biopsy can identify the type and degree of damage as well as determine the severity of the disease, which may gradually progress over a period of 10-40 years. Symptoms are similar to those of HBV.

Methods of transmission include contact with infected blood, contaminated needles, razors, and tattoo or body–piercing tools. Unlike HBV, HCV is less easily spread through sex.

Prevention methods usually include cleaning up spilled blood with a water-bleach solution as well as wearing vinyl or latex gloves when in contact with blood. It is imperative for the infected individuals to practice safe sex and not to share razors, toothbrushes, or needles. Anyone with Hepatitis C should be vaccinated against hepatitis A and B and should abstain from alcohol intake. There is no vaccine against HCV.

In many cases chronic infection develops. Treatment of the disease is complex, currently recommended for only some patients and usually consists of a combination of chemotherapy agents. The necessity for treatment may be determined by biochemical, virologic and when necessary, liver biopsy findings, rather than by the presence or absence of symptoms. Since the treatment may interfere with the production of white blood cells, periodic blood tests are usually performed to monitor any cellular blood changes. It is also necessary to maintain a balanced diet, and exercise regularly.
Most strategies to diagnose, prevent, and treat HBV and HCV are currently designed to reduce risk for inmates, health care providers and other employees with occupational exposure to HAV, HBV, and HCV. As mentioned above, one of the chief routes of HBV and HCV transmission is intravenous drug use. Therefore, continuing the efforts to provide education, support and therapy for intravenous drug users is considered to be of utmost importance.

1. Hepatitis B/C Transmission Control

If an inmate continues to inject intravenously, he/she can be advised:

- to never reuse or share syringes, needles, water, or drug preparation equipment;
- if injection equipment has been shared, to clean the equipment with bleach and water as for prevention of HIV;
- to use only sterile syringes obtained from a reliable source;
- to use sterile water to prepare drugs; and if this is not possible, to use clean water from a reliable source (such as fresh tap water);
- to use disinfected containers;
- to clean the injection site before injection with a new alcohol swab;
- to safely dispose of syringes after one use.

2. Hepatitis B: Preventive Methods / Therapies

Preventive therapy in many correctional jurisdictions often involves vaccination. Vaccination is suggested for health care workers and others exposed to blood and body fluids potentially contaminated with HBV. Post-vaccination testing is performed to confirm immunity.

In the event of a blood or significant body-fluid exposure, an accepted protocol for “Post-Exposure Prophylaxis” should be implemented. This provides immunization, such as immune globulin, and other interventions against the potential infections such as HIV. Following such an exposure, the identification of infected inmates and presumed contact

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11 This practice may further be consulted at http://hopkinss-aids.edu/treatment/treatment.html
persons can help in the prevention of the spread of the disease. The process of identification of potentially infected persons may involve:

- obtaining a blood sample from the exposure source;
- obtaining and reviewing hepatitis B vaccination status and the immune response of the exposed person.

To avoid spread of the disease, it is also common to refer infected inmates to public health centres at the time of release. Prior to this stage, family members and others having significant contact might be encouraged to contact appropriate diagnostic and treatment resources for immunization.

Because treatment for hepatitis B and C is complex and resource intensive, a liver specialist is often consulted. In order to reduce the need to transport the inmate frequently to specialty physician appointments, some jurisdictions have successfully implemented “telemedicine.” This technology allows the inmate to remain in the prison, while the specialist remains at a medical center, and communicate visually and verbally through the computer link. The technology can allow the physician to perform functions such as:

- symptom based diagnosis with the determination of individual need for liver biopsy;
- subsequent individual treatment recommendations;
- monitoring therapy;
- management of recommended therapy.

Prison health authorities often ensure monitoring of therapy for infected inmates as well as design strategies for subsequent treatments. One such treatment has been successfully developed by Australian correctional jurisdictions. A “Vitamin & Herbal Tonic Program” is currently in use as an optional treatment and provided for those suffering from the disease\(^\text{12}\) (although there is no scientific evidence that this is effective).

*Jurisdictions that employ some variation of preventative methods mentioned above include:* Australia (New South Wales, Queensland), Brazil, New

\(^{12}\) A “Vitamin & Herbal Tonic Program” can be found in Australia, New South Wales Correctional Jurisdiction.
Zealand, Poland, South Africa, Sweden, UK (England, Scotland), and the USA (Georgia, Illinois, Iowa, Nebraska, New York, Tennessee).

**HIV-Infected Inmates: Viral Suppression and Prevention and Management of Opportunistic Infections**

A number of practices related to suppression of the HIV virus, and the prevention and treatment of opportunistic infections, have been initiated by a number of correctional jurisdictions. Prisoners are usually provided with the information on treatment options that exist in a community. Similarly, treatment for HIV infection, including highly active antiretroviral therapy and opportunistic infection prophylaxis and treatment, is provided by prison medical services with the same quality and accessibility criteria as in the community.

Continuation of treatment regimens after release from prison is important for persons with HIV infection. Prison medical services often collaborate with community health services to ensure medical and psychological follow-up with consenting HIV infected prisoners after their release. For instance, an HIV aftercare scheme is designed and used to maintain the health of HIV-positive patients. One scheme includes collaboration with several pharmaceutical manufacturers who provide limited medication supplies to inmates just prior to release.

Jurisdictions that exercise some form of a “Prevention and Management of Opportunistic Infections” program include: Brazil, Costa Rica, Denmark, Ireland, and the USA (Georgia).

The following are specific practices that are currently implemented in an effort to manage the health of HIV-infected inmates.

1. **Immunity Clinic**

   The Immunity Clinic maintains optimal immune status, prevents opportunistic infections and reduces medication interactions and untoward reactions. This practice schedules the inmate for frequent and
periodic medical examinations during the entire incarceration. It incorporates:

- Determining HIV status, recording date of testing;
- Review of symptoms and HIV complications;
- Inmate education about the disease and treatment;
- Determining the patient’s general condition including that of the skin, mouth, lungs, heart, abdomen, perirectal area, lymphatics, mental status, and pelvic;
- Monitoring the patient’s immune status often with laboratory tests;
- Ensuring medication adherence;
- Updating immunizations;
- Screening for infections;
- Medication reviews.

HIV-infected women usually undergo a pelvic examination and have a Pap smear done twice in the first year after diagnosis. If the results are satisfactory, tests follow annually. Additional recommended tests include serum pregnancy, gonorrhea and chlamydia.

In order to maintain or improve the current health status of HIV infected inmates some jurisdictions practice follow-up visits every 90 days. Patient weight is also monitored every visit to signal complications of the disease. Patients with declining immune status are seen more often and considered for transfer to a specialized care institution.

*Jurisdictions that perform a variation of “Immunity Clinic” program include:* Singapore and the USA (Florida).

2. Vaccination

Patients with HIV infection often benefit from certain vaccinations. Influenza vaccination is typically provided during season, and Pneumococcal vaccination is administered in order to avoid bacterial pneumonia caused by *Streptococcus pneumoniae.*

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13 Practices such as Vaccination, Isolation, Immunological Deterioration: Methods of Prevention can be further explored at http://hopkins-aids.edu/treatment/treatment.html
3. Special Housing

Inmates with HIV are often housed in areas protecting them from adverse environments. Medical isolation or segregation is not required for HIV-infected inmates unless they also have communicable infections such as tuberculosis. In some settings, support programs are offered to provide psychological support for AIDS/HIV patients. These programs may also include group counseling and self-help training.

4. Immunological Deterioration: Methods of Prevention\textsuperscript{14}

The following practices are oriented towards prevention of specific opportunistic infections in HIV-infected persons. Generally, these practices are designed to prevent immunologic deterioration and to delay the need for many advanced treatments that are resource and time consuming.

In severe cases of immunological deterioration, jurisdictions in Canada adopted a Compassionate Release practice. Consideration for early release on compassionate grounds is often given when:

- an inmate is terminally ill;
- it is necessary to ensure medical treatment or palliative care not otherwise available within the institution;
- an inmate’s physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement;
- an inmate’s continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time of sentencing.\textsuperscript{15}

Numerous clinical and environmental interventions can reduce the risk of opportunistic infections in HIV-infected persons.\textsuperscript{16} Infected inmates are

\textsuperscript{14} More information regarding the prevention of opportunistic infections can be found at http://hopkins-aids.edu/treatment/treatment.html

\textsuperscript{15} Detailed description of the Compassionate Release policy can be found in CSC: HIV/AIDS in prisons: Final Report of the Expert Committee on AIDS and Prisons

\textsuperscript{16} Opportunistic infections include Pneumonia, Toxoplasmic Encephalitis, Cryptosporidiosis, Microsporidiosis, Tuberculosis, Bacterial Respiratory Infections,
normally advised not to eat raw or undercooked meat, particularly undercooked pork, lamb, or venison. Specifically, meat should be cooked to an internal temperature of 150 F (65.5 C). HIV-infected persons should wash their hands after contact with raw meat and after gardening or other contact with soil. Additionally, the patients should thoroughly wash fruits and vegetables before raw consumption.

Other suggestions related to food and water related exposures for HIV-infected persons include the following:

Cross-contamination of foods carries a high risk for HIV+ inmates. Therefore, uncooked meats are not allowed to come in contact with other foods. Hands, cutting boards, counters, knives, and all kitchen utensils are washed thoroughly after contact with uncooked foods. Re-heating ready to eat foods until they are steaming before consumption can reduce the risk of foodborne disease.

To avoid water-borne infections such as cryptosporidiosis and giardiasis, inmates should neither drink water directly from rivers and lakes, nor should they swallow water from swimming pools or any other publicly used water reservoirs during recreational activities. HIV-infected inmates should avoid swimming in water that is likely to be contaminated with human or animal waste.

_Bacterial Enteric Infections, Candidiasis, Cryptococcosis;_ more information about the prevention and treatment of these and a number of other opportunistic infections is available in the “1999 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus”.
CONCLUSION

The International Compendium of Current Practices to Address Infectious Diseases in Prisons has been created in response to the high burden of infectious diseases in correctional environments. As such, the Compendium is an information resource for correctional services worldwide to discover and apply new practices and programs that can effectively meet the formidable challenge of infectious diseases. The Compendium can also be used as a database for those who would like to contact their colleagues from other correctional jurisdictions for more detailed information. The contact list is conveniently placed at the end of the document and includes all jurisdictions that participated in the survey.

To conclude, it must be said that any measure undertaken to prevent the spread of infectious diseases in prisons will benefit not only prisoners and staff but also society as a whole. Society must be cognizant that most prisoners are in correctional institutions for a determinate period of time and will eventually return to the community. Furthermore, prisoners’ human rights must be respected. Prisoners are entitled to be protected from contracting diseases and from any form of discrimination if infected. Consequently, governments and prison authorities need to address the risks of the spread of infectious agents. Lowering the prevalence of infections in prisons means that the risk of external exposure of these infections will also be lowered. Efforts to prevent infection are beneficial to inmates, staff, and the public. Again, most inmates are in prison for a relatively short period of time and are then released into their communities. Therefore, in order to protect the general population and society as whole, infectious disease preventative measures must be available in prisons, at least to the same extent that they are available in the community.
**APPENDIX I:**

**Summary of Responses to the International Survey of “Current Practices to Address Infectious Diseases in Prisons”**

<table>
<thead>
<tr>
<th>Australia</th>
<th>Capital Territory</th>
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<tbody>
<tr>
<td><strong>HIV/HBV</strong></td>
<td>Bleach &amp; condoms available</td>
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<tr>
<td></td>
<td>Priority access to public methadone program</td>
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<td><strong>New South Wales</strong></td>
<td>Peer Support Programs</td>
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<tr>
<td></td>
<td>Therapeutic units</td>
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<td></td>
<td>Free condoms available from vending machines</td>
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<tr>
<td><strong>HBV/HCV</strong></td>
<td>“Vitamin and Herbal Tonic Program”</td>
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<tr>
<td><strong>Northern Territory</strong></td>
<td>Mandatory testing on admission</td>
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<tr>
<td></td>
<td>Ongoing education</td>
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<td></td>
<td>Random blood/breath/urine/drug testing</td>
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<td><strong>Queensland</strong></td>
<td>Voluntary testing upon admission</td>
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<tr>
<td></td>
<td>Bleach available</td>
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<td></td>
<td>Methadone maintenance for drug addicted pregnant females</td>
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<tr>
<td></td>
<td>Distribution of condoms project in 1 prison</td>
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<tr>
<td><strong>HIV</strong></td>
<td>Voluntary test on admission</td>
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<tr>
<td><strong>HBV/STD</strong></td>
<td>Test on request or on basis of clinical indication</td>
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<tr>
<td><strong>HCV</strong></td>
<td>Test on request or on basis of clinical indication</td>
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<tr>
<td><strong>South Australia</strong></td>
<td>Pamphlets for low-literacy inmates</td>
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<td></td>
<td>Methadone maintenance programs</td>
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<td>Country</td>
<td>HIV/HBV</td>
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<td>Austria</td>
<td>Suspended sentence for drug addicts</td>
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<td></td>
<td>Methadone program availability</td>
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<td></td>
<td>&quot;Take care&quot; sets upon admission</td>
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<td>Education on HIV and STD transmission</td>
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<tr>
<td>Bermuda</td>
<td>STDs booklet issued to inmates</td>
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<td>Botswana</td>
<td>Test on admission</td>
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<td>Brazil</td>
<td>Visiting lecturers</td>
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<td></td>
<td>Peer education</td>
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<td>Identification of new cases</td>
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<td>Brunei</td>
<td>Testing on admission</td>
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<td>Referral to a specialized agency upon release</td>
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<tr>
<td>Byelorussia</td>
<td>Anonymous distribution of condoms</td>
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<tr>
<td>General</td>
<td>Educational efforts for all inmates</td>
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<tr>
<td></td>
<td>Disposable syringes available</td>
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<tr>
<td>Canada</td>
<td>Alberta</td>
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<td>HIV/HBV</td>
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<td>Disease specialist</td>
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<td>Management of offenders with HIV/HEP</td>
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</tbody>
</table>
### Costa Rica

**HIV/TB**  
STD WHO Practice  
Seminars and educational sessions for instruction and psychological aid

### Czech Republic

**HIV/HBV**  
Test available on request  
Condoms available

**TB/STDs**  
Adherence to WHO guidelines  
Screening on admission/ x-rays

### Denmark

**HIV**  
Condom available  
Disinfectants available  
Educational efforts

### Estonia

**TB**  
Directly Observed Treatment

### Fiji

**HIV/HBV**  
Testing on admission

**STDs**  
Disease-related education  
Staff examination

### Finland

**HIV**  
Testing on request  
Inmates with HIV sent to outside clinic for treatment  
Free condoms available

**HBV**  
Kit with disinfecting agent and instruction pamphlet: distribution on admission
<table>
<thead>
<tr>
<th>Germany</th>
<th></th>
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<tbody>
<tr>
<td>(No uniform practice in all prisons)</td>
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</tbody>
</table>
| **HIV** | Free condoms available  
Pilot schemes to provide sterilized disposable syringes  
Enforcement of “drug-free” zones (some prisons)  
Counseling available to the infected inmates |
| **Hong Kong** |  |
| **HIV/HBV/TB** | X-rays upon admission |
| **TB** | Health education sessions |
| **Hungary** |  |
| **General** | Oncological screening for female inmates  
Voluntary screening by designated personnel |
| **Ireland** |  |
| **HIV** | Immunity clinics  
Multiple therapy for infected inmates |
| **HBV** | Vaccination for all inmates  
Educational sessions: drug use and sexual behavior |
| **Jamaica** |  |
| **HIV** | Educational sessions and seminars  
Adherence to WHO guidelines |
<p>| <strong>Japan</strong> |  |
| <strong>HIV</strong> | Voluntary HIV-antibody examinations |
| <strong>TB</strong> | X-rays offered on a yearly basis |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Disease(s)</th>
<th>Practices</th>
</tr>
</thead>
</table>
| Lithuania | TB         | Tests on admission and twice annually  
Directly Observed Therapy for active TB cases  
Disinfectants available |
|          | HIV        | Free condoms available  
Health education |
| Malawi   | TB         | Screening on admission with sputum samples  
Testing for inmates with a persisting cough  
Broad-spectrum antibiotic available for infected persons |
| Mauritius| HIV/TB/STD | Testing on admission  
Information and therapy with multi-disciplinary team  
Counseling activities/Health education program |
| Moldova  | TB         | Anti-TB medicines complex cure  
Hospitalization in acute cases of TB |
| New Zealand | HIV/HBV/TB | Full health assessment on admission  
Education including negotiation/conflict resolution and stress management modules  
Bleach available  
Condoms provided |
| Norway   | HIV/HBV    | Chlorine/antiseptics availability  
Administration of hygiene precautions |
### Philippines

| Treponemal Bacteria (TB) | Medical exam on admission  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Daily outpatient department for anti-TB medicine and hospitalization where necessary</td>
</tr>
</tbody>
</table>

**General**

- Health education  
  
  "Person-to-person" and mass media counseling approaches;  
  TB information on billboards

### Poland

**General**

- Preventive efforts:  
  Basic education about protective measures  
  Anti-drug/anti-alcoholism program including AA Mandatory administration of X-ray tests

<table>
<thead>
<tr>
<th>Treponemal Bacteria (TB)</th>
<th>Voluntary tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Possibility of outside hospital treatment</td>
</tr>
</tbody>
</table>

### Portugal

**HIV/HBV**

- Drug-free units in 7 prisons  
  Distribution of condoms/bleach kits  
  Educational efforts

### Romania

**HIV/TB**

- Program on prevention and management of HIV/AIDS/STD cases  
  Epidemiological surveillance system administration  
  Condoms available  
  Counseling  
  Promotion of HIV testing and counseling

### Singapore

**HIV**

- Screening on admission  
  Illness detection programs

| Treponemal Bacteria (TB) | Segregation and treatment in case of active TB |
### Slovak Republic

**HIV**
- Adherence to WHO guidelines
- Anti-epidemic and environmental precautions

### Slovenia

**HIV/HAV/HBV**
- Education, leaflets, condoms and disinfectants available
- Vaccination against all strains of hepatitis

**TB**
- Protective measures and counseling provisions

### South Africa

**HIV/TB/STDs**
- Unit established at national level to coordinate policy development
- Multipurpose clinics within prisons established
- Staff training/education
- Educational sessions for inmates
- Collaboration at national, provincial, and local level
- Use of international days to reinforce awareness e.g. World Aids Day
- Immunization of children and female inmates
- Condoms provided

### Swaziland

**TB**
- Hospital referral system
- Counseling available

### Sweden

**HIV**
- Voluntary testing
- Prophylactic vaccination available
- X-ray testing if symptoms are present

### Switzerland

**HIV/General**
- Distribution of sterile syringes
- Methadone treatment available
- Heroin distribution pilot project
- Awareness enhancement on HIV and health issues
<table>
<thead>
<tr>
<th>Country</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinidad and Tobago</td>
<td><strong>General</strong>&lt;br&gt;Isolation to prevent cross-infection&lt;br&gt;Education literature for STDs</td>
</tr>
<tr>
<td>United Kingdom</td>
<td><strong>England</strong>&lt;br&gt;&lt;br&gt;<strong>HIV</strong>&lt;br&gt;Pilot project on provision of disinfecting tablets&lt;br&gt;Condoms available&lt;br&gt;Pre- and post-test counseling&lt;br&gt;Education video and tutor’s manual available&lt;br&gt;Continuous care&lt;br&gt;&lt;br&gt;<strong>HBV</strong>&lt;br&gt;Intensive immunization</td>
</tr>
<tr>
<td></td>
<td><strong>Scotland</strong>&lt;br&gt;<strong>HBV</strong>&lt;br&gt;Immunization encouraged</td>
</tr>
<tr>
<td></td>
<td><strong>Northern Ireland</strong>&lt;br&gt;<strong>HIV</strong>&lt;br&gt;Segregation of HIV-positive/AIDS inmates&lt;br&gt;Education programs available</td>
</tr>
<tr>
<td>United States</td>
<td><strong>Alaska</strong>&lt;br&gt;&lt;br&gt;<strong>HIV</strong>&lt;br&gt;Anonymous test administration&lt;br&gt;&lt;br&gt;<strong>TB</strong>&lt;br&gt;Standard screening on admission&lt;br&gt;Hepa Filter masks for contact with infected inmates&lt;br&gt;Treatment follow-up upon release</td>
</tr>
<tr>
<td></td>
<td><strong>California</strong>&lt;br&gt;&lt;br&gt;<strong>HIV</strong>&lt;br&gt;Mandatory screening&lt;br&gt;Intensive multidisciplinary approach towards treatment of infected inmates&lt;br&gt;&lt;br&gt;<strong>TB</strong>&lt;br&gt;Tests administered&lt;br&gt;Contractual agreement with the health departments for treatment administration</td>
</tr>
<tr>
<td>United States</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td><strong>Colorado</strong></td>
<td></td>
</tr>
</tbody>
</table>
| *HIV* | Mandatory screening  
Multi-disciplinary case management |
| *TB* | Tests on a yearly basis |
| **Florida** |
| *HIV/TB* | Bulletin on infection control program:  
– infection control procedures  
– data management system  
– surveillance of infections procedure  
– reporting cases to Department of Health  
– HIV program in place |
| *HIV/HBV* | – clustering of seriously ill offenders to afford concentrated level of care  
– medication administered by direct observed therapy  
– HIV / TB bulletin with prevention and management information |
| **Georgia** |
| *HIV* | Test on admission  
HIV aftercare program in collaboration with pharmaceutical manufacturers |
| *TB* | Pre- and post-test counseling |
| *STDs* | Regular testing of staff and inmates  
CDC guidelines followed |
| **Illinois** |
| *HIV* | Voluntary testing/ Educational efforts |
| *TB* | Standard screening |
| *STDs* | Screening for syphilis |
| *HBV* | Testing when symptoms present |
| **Iowa** |
| *HCV* | Initial screening  
Telemedicine program  
Liver biopsy |
<table>
<thead>
<tr>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kansas</strong></td>
</tr>
</tbody>
</table>
| **HIV/TB** | Chronic care program  
Electronic data management  
TB screening on admission |
| **Louisiana** |
| **TB** | Screening on admission  
Prophylactic treatment  
Direct Observation Therapy for active TB infected offenders  
Medical isolation for non-compliance  
Risk assessment for HIV infection |
| **HIV** | Screening on admission  
Medical isolation for non-compliance  
Risk assessment for HIV infection |
| **Syphilis** | Screening on admission  
Direct Observation Therapy for active TB infected offenders  
Medical isolation for non-compliance  
Risk assessment for HIV infection |
| **Maryland** |
| **TB** | Male inmates tested during birthday month  
Females tested during anniversary month of intake |
| **HIV** | Infectious diseases database management  
Database reviewed by infection control office each month |
| **Syphilis** | Screening on admission  
Medical isolation for non-compliance  
Risk assessment for HIV infection |
| **Massachusetts** |
| **TB** | Screening on admission  
Medical isolation for non-compliance  
Risk assessment for HIV infection |
| **HIV** | Infectious diseases database management  
Database reviewed by infection control office each month |
| **Syphilis** | Screening on admission  
Medical isolation for non-compliance  
Risk assessment for HIV infection |
| **Minnesota** |
| **HIV/HBV** | 4 step education process:  
1. Basic course;  
2. One hour education session;  
3. Intensive eight-week program for inmates who are in chemical dependency and sex offender programs;  
4. Refresher prevention course prior to release. |
<p>| <strong>Missouri</strong> |
| <strong>HIV</strong> | Intensive care management program geared towards healthy rehabilitation |</p>
<table>
<thead>
<tr>
<th>United States</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nebraska</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>Two step test on admission</td>
</tr>
<tr>
<td><strong>HAV/HBV</strong></td>
<td>Vaccinations for inmates displaying symptoms</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Mandatory test for all inmates “In-house” counseling for HIV-positive patients</td>
</tr>
<tr>
<td><strong>New Hampshire</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>Infection control program</td>
</tr>
<tr>
<td><strong>New York City</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>Testing on admission Multi-tiered testing Services for employees</td>
</tr>
<tr>
<td><strong>HIV/HBV</strong></td>
<td>Prevention of opportunistic infections and immunization of inmates</td>
</tr>
<tr>
<td><strong>North Carolina</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>Screening on admission Annual screening during anniversary month of admission Co-ordination of infectious diseases control</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Education and counseling by nurses</td>
</tr>
<tr>
<td><strong>STDs</strong></td>
<td>Syphilis screening on admission</td>
</tr>
<tr>
<td><strong>North Dakota</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Mandatory screening on admission and voluntary testing after 6 months</td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>Adherence to the Centre of Disease Control guidelines DOT in treatment of TB</td>
</tr>
<tr>
<td><strong>New York</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>Annual testing of inmates and staff Medication and treatment by directly observed therapy</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Regular live satellite-broadcast staff education program on HIV management</td>
</tr>
</tbody>
</table>
### United States

#### Oklahoma

| HIV/TB/STDs | Testing on admission  
|            | Designated a day in a month where skin testing is performed on all inmates and staff |

#### Pennsylvania

<table>
<thead>
<tr>
<th>HCV</th>
<th>HCV treatment protocol administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Discharge planning project including: education, case referral to a local physician, support groups, assistance with housing</td>
</tr>
</tbody>
</table>

#### South Carolina

| HIV/STDs | Symptomatic screening on admission  
|         | Specialist clinics |
| TB      | Testing on admission and yearly mandatory testing |

#### Tennessee

| HIV | Test for all inmates based on informed consent |
| TB  | Test for all inmates and staff on admission and annually thereafter |
| HBV/HCV | Liver function test on all inmates on admission and at subsequent physical examinations |
| STDs | Test for gonorrhea, syphilis and chlamydia on admission |

#### Texas

| HIV | High HIV peer education encouragement |

#### Vermont

| HCV | Infection control surveillance system  
|     | Confidential HIV testing available |
| HIV | Condoms available |

#### Virginia

| HCV | Intensive treatment including therapy programs |
### United States

#### Washington

| HIV               | Co-operation with community-based organizations  
|                  | Continuous care  
|                  | Promotion of successful rehabilitation in communities  
|                  | Addressing female-related issues  

#### Washington, D.C.

| HIV               | Regional prevention and education program with four components - education sessions, prevention counseling, testing and discharge planning  

#### Wisconsin

| HIV               | Testing on admission  
|                  | Two programs for HIV prevention targeting juvenile inmates  

| HBV/STDs          | Regular testing of staff and inmates  
|                  | Immunization available  

| TB                | Regular teaching sessions on infectious diseases and their control  

#### Zambia

| HIV/AIDS          | Counseling centres with psychosocial emphasis and HIV prevention strategies  
|                  | Rehabilitation services available  
|                  | Peer education  

APPENDIX II:

Directory of Useful Internet Links and Non-governmental Organizations

Sexually Transmitted Diseases/Infections

A Classification on Terminology: Sexually Transmitted Diseases and Sexually Transmitted Infections
http://www.who.int/HIV_AIDS/knowledge/sexually_transmitted_diseases_or.htm

Sexually Transmitted Diseases: Policies and Principles for Prevention

Women and Sexually Transmitted Infections
http://www.who.int/inf-fs/en/fact249.html

HIV/AIDS

STI Control as HIV Prevention
http://www.who.int/dsa/cat98/aids8.htm#Sterilization
http://www.who.int/HIV_AIDS/Overheads/STIcontrolHIV/
http://www.who.int/HIV_AIDS/Nursesmidwivesfs/fact-sheet-12/index.html

Pregnancy and HIV

Women and HIV/AIDS

HIV Vaccine Initiative and Key elements in HIV/AIDS care and support
http://www.who.int/HIV_AIDS/index.html
Key Elements in HIV/AIDS Care

http://www.who.int/HIV_AIDS/knowledge/WHOUNAIDSCAREDOC8Sept00.html

Tuberculosis

http://www.stoptb.org/
http://www.who.int/dsa/cat98/tub8.htm
http://www.who.int/gtb/publications/prisons/preface.html (English and Russian)
http://www.who.int/inf-fs/en/fact104.html
http://www.who.int/inf-fs/fr/am104.html
http://www.who.int/gtb/publications/tbhandbook/introduction.html
http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00042214.htm

TB: DOTS, control strategies, press releases, publications, related links

http://www.who.int/gtb/
http://www.who.int/gtb/policyrd/TBPrisons.htm

TB: vaccine development, safety, policy, research priorities, publications

http://www.who.int/vaccines/intermediate/tuberculosis.htm

Hepatitis

Background Information on HEP A

http://www.who.int/vaccines/intermediate/hepatitisa.htm

Additional information about Hepatitis A can be found on the following web links:

http://www.intelihealth.com/IH/ihtIH/WSIHW000/9339/10126.html
http://www.cdc.gov/ncidod/diseases/hepatitis/a/index.html
Background Information on HEP B

http://www.who.int/vaccines/intermediate/hepatitisb.htm
http://www.who.int/inf-fs/en/fact204.html

Additional information can be found on the following web addresses:

http://www.hepfi.org/Hepinfo/grid.htm
http://www.hepfi.org/Hepinfo/HBVtips.htm
http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm

Background Information on HEP C

http://www.who.int/inf-fs/en/fact164.html

More information on HCV:

http://www.hepfi.org/Hepinfo/grid.html
http://www.hepfi.org/Hepinfo/diagnosis.htm

General Information on Infectious Disease Management

Diseases Preventable through Vaccination

http://www.who.int/home/map_ht.html#Diseases:%20Communicable/
Infectious
http://www.vaccinealliance.org/
http://www.who.int/vaccines/intermediate/vaccprevdis.htm

Environmental Epidemiology/Health/Sanitation

http://www.who.int/peh/
Food Safety and Nutrition

http://www.who.int/fsf/
http://www.who.int/nut/

Health care waste management

http://www.who.int/water_sanitation_health/Environmental_sanit/health_care_waste.htm

About Vaccines and Diseases

http://www.who.int/vaccines-diseases/
http://www.who.int/vaccines/

Epidemiological Information

http://www.who.int/whosis/

Diagnostic and Clinical Technology

http://www.who.int/technology/root/diagn_clin.html

Health Education and Promotion

http://www.who.int/hpr/

Substance Abuse

http://www.who.int/substance_abuse/

Health Technology and Pharmaceuticals

http://www.who.int/technology/
APPENDIX III:

Non Governmental Organizations helpful for research and inquiry

AFRICAN MEDICAL AND RESEARCH FOUNDATION INTERNATIONAL
http://www.who.int/ina-ngo/ngo/ngo001.htm

AGA KHAN FOUNDATION (AKF)
http://www.who.int/ina-ngo/ngo/ngo002.htm

COMMONWEALTH MEDICAL ASSOCIATION (CMA)
http://www.who.int/ina-ngo/ngo/ngo009.htm

FEDERATION FOR INTERNATIONAL COOPERATION OF HEALTH SERVICES AND SYSTEMS RESEARCH CENTERS (FICOSER)
http://www.who.int/ina-ngo/ngo/ngo190.htm

GLOBAL HEALTH COUNCIL, INC (GHC)
http://www.who.int/ina-ngo/ngo/ngo145.htm

INTER-AMERICAN ASSOCIATION OF SANITARY AND ENVIRONMENTAL ENGINEERING
http://www.who.int/ina-ngo/ngo/ngo017.htm

INTERNATIONAL ASSOCIATION OF MEDICAL LABORATORY TECHNOLOGISTS (IAMLT)
http://www.who.int/ina-ngo/ngo/ngo035.htm

INTERNATIONAL COUNCIL ON ALCOHOL AND ADDICTIONS (ICAA)
http://www.who.int/ina-ngo/ngo/ngo056.htm

INTERNATIONAL EPIDEMIOLOGICAL ASSOCIATION (IEA)
http://www.who.int/ina-ngo/ngo/ngo061.htm

INTERNATIONAL MEDICAL INFORMATICS ASSOCIATION (IMIA)
http://www.who.int/ina-ngo/ngo/ngo094.htm

INTERNATIONAL PHARMACEUTICAL FEDERATION
http://www.who.int/ina-ngo/ngo/ngo102.htm
INTERNATIONAL UNION AGAINST SEXUALLY TRANSMITTED INFECTIONS (IUSTI)
http://www.who.int/ina-ngo/ngo/ngo127.htm

INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE (IUATLD)
http://www.who.int/ina-ngo/ngo/ngo126.htm

INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION (IUHPE)
http://www.who.int/ina-ngo/ngo/ngo129.htm

INTERNATIONAL UNION OF IMMUNOLOGICAL SOCIETIES (IUIS)
http://www.who.int/ina-ngo/ngo/ngo132.htm
APPENDIX IV:

Glossary of Terms

The following terms are related to infection control practices. This is not an all-inclusive list of terms. We suggest correctional personnel use a medical dictionary to define words directly related to infectious diseases and pharmaceutical substances.

Airborne

Method of transmission of infection that involves microorganisms entering the air from a source patient who is coughing and sneezing and then being inhaled by the host. Examples of diseases that are spread this way include pulmonary tuberculoses and chicken pox.

Antibody

A special protein formed by the body in response to an antigen (virus cell that causes disease). Antibody tests usually indicate past experience with, and sometimes immunity to the specific virus involved in the process.

Antiseptic

A product that destroys microorganisms on animate surfaces such as the skin. A good example would be any Iodophor product.

Biomedical waste

Any solid or liquid waste that may present a threat of infection to humans. This term includes, but is not limited to, non-liquid tissue and body parts from humans; laboratory and veterinary waste which contains human disease-causing agents; discarded sharps; blood, blood products and body fluids from humans and other primates. The following are also included: used absorbent materials saturated with blood, body fluids or excretions/secretions contaminated with blood. Absorbent material includes items such as bandages, gauzes and sponges.

Biopsy

The removal of a small piece of living tissue from an organ or other part of the body for microscopic examination to confirm or establish a diagnosis.

The definitions are in part taken from “Mosby’s Medical, Nursing and Allied Health Dictionary” Mosby: St. Louis, 1998.
**Blood-borne-pathogen**
Pathogenic microorganism that is present in human blood and disease in humans. They include, but are not limited to, Hepatitis B (HBV) and HIV.

**Communicable**
Able to be transferred, directly or indirectly, from one person to another.

**Contagious**
Can be transferred directly or indirectly.

**Contaminate**
To make unclean or non-sterile with an infectious virus, disease etc.

**Direct Contact**
A method of transmission of infection that involves contact between the source (the place where the pathogenic organism is located) and the host (the person prone to contraction of the disease).

**Disinfectant**
A product that removes an infectious agent. An example is Cidex.

**Disinfection**
The destruction of microorganisms on inanimate objects by physical or chemical means.

**Epidemic**
Occurs when there are significantly more cases of the same disease than past experience would have predicted for that place, at that time, and among that population.

**Immunization**
A process by which resistance to an infectious disease is induced or augmented.

**Immunodeficiency**
Any of a group of health conditions caused by a defect in the immune system and generally characterized by susceptibility to infections and chronic diseases.

**Incubation Period**
The time interval between initial contact with an infectious agent and the first appearance of symptoms associated with the infection.
Indirect contact

A method of transmission of infection involving contact of an intermediate agent (fomite) between the source and the potential host.

Infection

Invasion and multiplication of microorganisms in body tissues, resulting in damage to cells.

Infection control

An organized program including control activities, prevention, and surveillance which involves all personnel in every department of a health care facility and serves to promote quality health care by reducing infections to the lowest possible level.

Inflammation

A tissue response to injury or infection consisting of pain, heat, redness, swelling, and loss of function.

Isolation

To separate or set apart from others; a method utilized for controlling the spread of communicable diseases; segregation.

Microorganism

A minute, usually microscopic living organism. Those of medical interest include bacteria, viruses, rickettsia, molds, yeast, and protozoa.

Opportunistic infection

An infection caused by normally nonpathogenic organisms in a host whose resistance has been diminished by disorders such as diabetes mellitus, HIV, cancer, or immunosuppressive drugs. Long-term use of antibiotics or other drugs also may affect the immune system, creating opportunity for microorganisms not usually pathogenic to become pathogens. People with HIV are particularly susceptible to such infections.

Prophylaxis

Prevention of or protection against diseases involving the use of biologic, chemical, or mechanical agents to destroy or prevent the entry of infectious organisms.

Rehabilitation

The restoration of an individual or a part to normal or near normal function after a disabling disease, injury, addiction, or incarceration.
Respiratory Infections
Infections related to diseases of the lungs.

Sexually Transmitted
A disease usually acquired as a result of sexual intercourse

Disease (STD)
with an infected individual. Includes gonorrhea, syphilis, chancroid, herpes, lymphogranuloma.

Sterilization
A process that destroys all living organisms including viruses and spores.

Surveillance
Systematic collection of information about the occurrence of diseases, infections, and communicable diseases.

Suspect
A person whose medical history and symptoms suggest that he/she may have or may be developing communicable disease conditions.

Terminal disinfection
Disinfection of all surfaces and objects within an area that has previously been occupied by an infected individual; performed at the time that containment precautions have been discontinued.

Vaccination
Any infection of attenuated microorganisms, such as bacteria or viruses, administered to induce immunity or to reduce the effects of associated infectious diseases.
APPENDIX V:

Standard Room Cleaning

Standard cleaning is defined as the daily cleaning and disinfecting of the isolation room.

<table>
<thead>
<tr>
<th>Procedure in isolation room</th>
<th>Points of emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Follow all procedures required in the isolation procedure that is being used until the entire room is cleaned</td>
<td>Wear all the appropriate personal protective equipment such as gloves, gowns, masks</td>
</tr>
<tr>
<td>2. Use a germicidal agent for all cleaning</td>
<td>Follow manufacturers directions for dilution and use</td>
</tr>
<tr>
<td>3. Pick up any debris on the floor using a wet mop</td>
<td>Do not use a dry mop or dry cloth in an isolation room</td>
</tr>
<tr>
<td>4. Pick up the waste in the patient’s room and bathroom</td>
<td></td>
</tr>
<tr>
<td>5. Clean the trash can</td>
<td></td>
</tr>
<tr>
<td>6. Collect the soiled linen in the patient’s room and bathroom</td>
<td>Use a water-soluble bag for collection</td>
</tr>
<tr>
<td>7. Wash all furniture and fixtures</td>
<td>Take special care with the items that have been in contact with the patient</td>
</tr>
<tr>
<td>8. Wash all the bathroom fixtures</td>
<td>Leave ½ ounce of the germicidal agent in the toilet bowl</td>
</tr>
<tr>
<td>9. Wash the floor of the room and the bathroom thoroughly</td>
<td></td>
</tr>
<tr>
<td>10. Sterilize the cleaning equipment</td>
<td>See step #6</td>
</tr>
<tr>
<td>11. Remove personal protective equipment (mask, gown and gloves) immediately after leaving the room</td>
<td>Place items in a lined waste container located immediately outside the room</td>
</tr>
<tr>
<td>12. Wash hands after leaving the room</td>
<td></td>
</tr>
</tbody>
</table>

Except for the steps that are specific to isolation (1,6, and 11), this procedure is appropriate for all cleaning in the medical area.
APPENDIX VI:

International Corrections Health Care Contact List

Members of the participating correctional jurisdictions can be contacted as follows:

**Australia**

*Capital Territories*

James Ryan AM  
Director ACT Correctional Services  
GPO Box 158  
Canberra City ACT 2601  
Ph.: +612 6207 0847  
Fax: +612 6207 0155  
e-mail: James-ryan.act.gov.au

**Queensland**

Dr. Tony Falconer  
Consultant Health and Medical Services Department of Corrective Services,  
GPO Box 1054  
Brisbane, Queensland, Australia 4001  
Ph. 07 322 76501  
Fax: 07 340 56301  
e-mail: TonyFalconer@dcs.qld.gov.au

**New South Wales**

Mr. Gino Vumbuca  
Manager HIV Health Promotion Unit  
NSW Department of Corrective Services  
GPO Box 31  
Sydney N.S.W. 2000  
Ph.: (02) 9289 1468  
Fax: (02) 9289 1563  
e-mail: Hhpu@s054.aone.net.au

**Northern Territory**

Mr. R.D. Moore  
Commissioner NT Correctional Services  
GPO Box 3196  
Minerals House, 66 The Esplanade  
Dartwin NT 0801  
Ph.: +618 8999 5593  
Fax: +618 8999 5580

**South Australia**

Mr. Doreen Rae  
Department for Correctional Services  
GPO Box 1747  
Adelaide, South Australia 5001  
Ph.: 618 8226 9091  
Fax: 618 8231 2465  
e-mail: Rae.Doreen@saugov.sa.gov.au

**Austria**

Prof. Dr. Jorg Pont  
Medical Consultant of the Federal Ministry of Justice  
Schrottg 5/6  
A-1030 Vienna, Austria  
Fax: +43 1 888 55 98  
e-mail: joerg.pont@univie.ac.at
Belgium
Dr. Van Mol
Medical Director
Ministry of Justice
Department of Penitentiaries
Evers St. 2/8
1000 Bruxelles le Belgium
Ph.: (02) 542 76 11
Fax: (02) 542 78 84

Benin
Mr. Lino Kouassi Hadonou
Director
Penitentiaries Administration
MJLDH
BP # 967 Cotonou-Benin
Ph: (229) 31 34 48
Fax: (229) 31 31 47

Bermuda
Mr. Edward L. Dyer
Commissioner of Prisons
P.O. Box HM 264
Hamilton HM AX
Bermuda
Ph. (411) 295-4975
Fax: (411) 295-7718
e-mail: Eldyer@northrock.bm

Bosnia-Herzegovina
Mr. Igor Gaon
Ambassador
Palais de l’Europe, Bureau 1523
67075 Strasbourg Cedex
Ph.: 03 88 41 36 03
Fax: 03 88 41 30 44

Botswana
Mr. E.M. Masire
Commissioner, Dep. Of Prisons & Rehabilitation
Prisons Service Headquarters
Private Bag X02
Gaborone, Botswana
Ph.: 3611700
Fax: 375 398

Brazil
Dr. Edison Jose Biondi
Government of the State of Rio de Janeiro
State Secretariat of Justice and Human Rights
Health Superintendence
Hambi, 60-G2
Batafogo Rio de Janeiro
CEP 22231-000 Brazil
Ph./Fax: ++5521-399-7339
e-mail: supersaude@sej.rj.gov.br

Brunei
Dr. Thomas K. John
Medical Officer
Prisons Department
Ministry of Home Affairs
Jalan Jerudong BG 3122
Brunei Darusalam
Ph.: 673-2-661266/661106/661526
Fax: 673-2-660380/661107
e-mail: Info@prisons.gov.bn

Burkina
Mr. Medard Voho
Le Directeur de l’Administration Pénitentiaire et de la Réinsertion Sociale
Ph.: (226) 30- 48 48 poste 308
Fax: (226) 32-80-05
Byelorussia
Zavadskiy V.I.
Head, Health Committee
Aranskaja St. 1
Minsk, Byelorussia, 222125
Ph.: 375 017 221 15 97
Fax: 221-43-83

Canada
Alberta
Ms. Linda Whitley, HCM, ERC
Infectious Diseases Coordinator
Edmonton Remand Centre
Justice Department of Alberta,
Health Care Unit
9660-104 Av.
Edmonton, AB T5H 4B5
Ph.: (780) 427 1672
Fax: (780) 422 9191

British Columbia
Dr. Diane A. Rothon
Director, Health Services
Corrections Branch
185-911 Yates St.
Victoria, BC V8V 4Y9
Ph.: 250-995-0009
Fax: 250-658-1789
Healthnet@compuserve.com

Northwest Territories
Cheryl Inward-Jones
Institutional Nurse Supervisor
Yellowknife Correctional Centre
Government of the Northwest Territories
Yellowknife, N. W. T.
Canada, X1A 2L9
Ph.: 867-669-8643
Fax: 867-669-8654

Ontario
Dr. Paul Humphries
Senior Medical Consultant
101 Bloor St. West
14th Floor, Toronto, ON
M5S 2Z7
Ph.: (416) 327-2389
Fax: (416) 327-2435

Sandra Black
National Infectious Diseases Coordinator
Correctional Service Canada
Health Services
340 Laurier Av. West, 4th floor,
Section B
Ottawa, ON K1A 0P9
Ph.: 613-995-3098
Fax: 613-995-6277
e-mail: BlackSL@csc-scc.gc.ca

Québec
Mdm. Denise Rouffignat
General Director of Correctional Services
Bureau of Minister’s Associate
2525, boul. Laurier, 11th Floor
Tour du Saint-Laurent
Sainte-Foy, Quebec,
G1V 2L2
Ph.: (418) 644-7678
Fax: (418) 644-5645

Saskatchewan
Mr. Terry Youngman
Senior Standards and Inspections Officer
Corrections Division
Saskatchewan Justice
7th floor, 1874 Scarth St.
Regina, Saskatchewan
S4P 3V7
Ph.: (306) 787-9076
Fax: 306-787-8084
**Yukon**  
Mr. Michael Hanson  
Superintendent, Whitehorse Correctional Centre  
Department of Justice  
25 College Dr.  
Whitehorse, Yukon Y1A 5B6  
Ph.: (867) 393 7253  
Fax: (867) 393 7227  
e-mail: michael.hanson@gov.yk.ca

**Chile**  
Enf. Ingrid Flores  
Coordinadora Nacional de Salud  
Gendarmeria de Chile  
Unidades Atencion Medica

**Costa Rica**  
Victor Salticov, MD, Ph.D  
Infectologist Ministerio de Justicia y Gracia  
San Jose, Costa Rica, America Central  
Post Box: 10965-1000  
Ph.: +(506) 256 6700  
Fax: +(506) 438 1787  
e-mail: Salvicr@hotmail.doc

**Czech Republic**  
Mr. Otakar Michl  
Prison Service of Czech Republic  
Taborska 988  
P.O. Box 3, 140 67 Prague  
Ph.: 02/453751  
Fax: 02/426748

**Denmark**  
Ms. Alette Reventlow  
Adviser  
Department of Prisons and Probation  
Strandgade 100/  
1401 Kobenhavn K. DK 1115  
Ph.: ++ 45 33 11 55 00  
Fax: ++ 45 33 14 03 45  
e-mail: alettereventlow@kriminalforsorgen.dk

**Estonia**  
Mr. Sirje Sepalaan  
Acting Head Physician  
Central Prison Hospital  
Kalaranna 2  
10145 Tallin, Estonia  
Ph.: +372-6-66-38-52  
Fax: +372-6-44-88-67  
e-mail: Sirje@va.ee

**Fiji**  
Lino Matakiloto  
Commissioner of Prisons  
P.O. Box 114, Suva, Fiji  
Ph.: 303512, 302976, 302986  
Fax: 302523

**Finland**  
Dr. Leena Arpo  
Chief Medical Officer of the Prison Administration  
Ministry of Justice  
P.O. Box 319  
FIN-0018 Helsinki  
Ph.: +318 9 1601 8502  
Fax: +358 9 1608 8538  
e-mail: Leena.arpo@om.vn.fi
France
Mr. Pierre Delattre
Penitentiaries Administration
Ministry of Justice
13, Vendom Square 75042
Paris Cedex 01
Ph.: 01 49 96 26 42
Fax: 01 49 96 26 10

Gambia
Mr. David C. Colley
Commissioner of Prisons
Prison Headquarters
Central Prison, Mile 11
Banjul, The Gambia
Ph./Fax: (220) 201 069

Germany
Ms. Tolzmann
Head of Section for the Law Governing in Prison service
Federal Ministry of Justice; Berlin Office
11015 Berlin
Ph.: (030) 2025-70
Fax: (030) 2025-95 25

Ghana
Mr. Richard Kuurie
Directors of Prisons (Administration & Research)
Ghana Service Headquarters
P.O. Box 129
Accra – Ghana – West Africa
Ph.: 233-021-760097
Fax: 233-021-7772865
e-mail: Prisons@ghana.com

Guatemala
Dr. Roberto Castillo
Epistemology Director
Medical Services Coordinator
General Department of Penitentiaries
7 Calle 10-54 Zone 1
Guatemala, C.A.
Fax: 253 44 01 or 232 70 11

Honduras
Dr. Osman Josue Mejia
Asesor Tecnico en Salud
Sub Dirección de Centros Penales Direccion General de Servicios Especiales Preventivo
Tegucigalpa
Fax: 235-6782

Hong Kong
Mr. Cheng Man-wa
Commissioner of Correctional Services
Correctional Services Department Headquarters
24/F Wan Chai Tower
12 Harbour Road, Wan Chai
Ph.: (852) 2582 5180
Fax: (852) 2802 0184

Hungary
Dr. Katalin Heylmann
Head, Department of Health Care
Prison Service Headquarters
Steindl I. U. 8
1054 Budapest, Hungary
Ph.: 36-1-301-8116
Fax: 36-1-301-8198
Iceland
Mr. Sveinn Magnusson MD
Head of Department
Ministry of Health and Social Security
Laugavegur 116
150 Reykjavik
Ph.: 354 555 9165
Fax: 354 560 9700
e-mail: Sveinn.Magnusson@htr.stjr.is

Ireland
Dr. Enda Dooley
Director of Prison Medical Services
Dep. of Justice, Equality & Law Reform
72-76 St. Stephen’s Green
Dublin 2, Ireland
Ph.: -353-1-602-8277/602 8202
Fax: -353-1-662-1180/676 4718
e-mail: enda_M._Dooley@justice.ie

Italy
Mr. Giovanni Tamburino
Head of the Central Office for Studies, Research, Legislation
Largo Luigi Daga 2
00164 Roma
Ph.: 00 39 06 6616 1736
Fax: 00 39 06 6615 4148
e-mail: ufficio6 dap@giustizia.it

Jamaica
Lt. Col. John Prescod
Commissioner of Corrections
Department of Correctional Services
5-7 King St.
P.O. Box 486
Kingston
Ph.: 876-967-1787
e-mail: shaq@cwjamaica.com

Japan
Mr. Takeshi Koyanagi
International Affairs Coordinator
Correction Bureau
Ministry of Justice
1-1-1-Kasumigaseki, Chiyoda-ku
Tokyo 100 – 8977
Ph.: +81-3-3592-7928
Fax: +81-3-5592-7464

Lithuania
Mr. Kestutis Petrauskas
Prison Department at Ministry of Justice of Lithuania
Sapiegos 1, LT-2600,
Vilnius, Lithuania
Fax: 3702 752778

Luxembourg
Dr. Jos Schlink
Medicin des Establishments Pénitentiaires
Boite Postale 35
L-5201 Sandweller
Ph.: 35-96-21-466
Fax: 35-96-21-467

Malawi
Mr. A. E. Yadidi
Prison Medical Officer/Assistant Commissioner of Prisons
Office of the Chief Commissioner of Prisons
Malawi Prison Service
P.O. Box 28
Zomba
Malawi
Mauritius
Mr. Sagar Motah
Principal Hospital Officer
Commissioner’s Office
Mauritius Government Prisons
Service/
Prison Headquarters
Beau Bassin

Moldova
Valeriu Troenco
Vice Minister
Ministry of Justice
35 Titulescu St.
Kishinev
Ph.: 55-90-68
Fax: 55-15-21

New Zealand
Mr. Tony Johns
General Manager
Policy and Service Development
Mayfair House
44-52 The Terrace
Wellington, New Zealand
Ph.: 64-4-499-5620
Fax: 64-4-460-3214

Norway
Jan-Eric Sandlie
Assistant Director General
Statens Helsetilsyn
Postboks 8128 Dep.
0032 Oslo
Ph.: 47 22 24 88 88
Fax: 47 22 24 55 90

Philippines
Mr. Pedro G. Sistoza
Director Bureau of Corrections
Department of Justice
New Bilibid Prison Hospital
Mantinlupa

Poland
Mr. Wlodzimierz Markiewicz
General Director
Central Board of Prison Service
Racowiecka, 37A
02-251 Warsaw
Fax: +48-22-640-8332/8312

Portugal
Manuela Santos Pardal
Medical Officer
DSS-DGSP
Trav da Cruz do Torel, 1
1198 Lisboa Codex
Fax: 351-218 851 522

Romania
Dr. Emanuel Parausanu
Head of Medical Care Office
Romanian Prison Administration
Str. Maria Ghiculeasa nr. 47
72228 Bucharest, sector 2
Ph./Fax: +401.242.60.78
e-mail: office@anp.ro

Singapore
Dr. Chan Khim Yew
Head, Prisons Medical Branch
Prisons Department
407 Upper Changi Road North
Singapore 507658
Republic of Singapore
Ph.: (65) 546 9811
Fax: (65) 5420-425

Slovak Republic
Mr. Anton Farby
Director General of Prison Service
Court Guard of the Slovak Republic
Chorvatska St. 3, 813 04 Bratislava
Ph.: +421.7.5068 3006
Fax: +421.7.5542.4987
Slovenia, Republic of
Ms. Olga Perhavc
Advisor to Director on Health Matters
Prison Administration of the Republic of Slovenia
Tivolska 50
1000Ljubljana
Slovenia
Ph.: (386) 47 85 334
Fax: (386) 478 5770
e-mail: Olga.Perhavc@gov.si

South Africa
Ms. T.M. Magoro
Director Health and Physical Care
Department of Correctional Services
Private Bag X136
Pretoria
0001 South Africa
Ph.: 27 012 307 2308/27 012 324 5255
e-mail: marrym@hqlist.pwy.gov.za

Swaziland
Dr. Nasser Khayyam
Coordinator
Medical Care Section of Correctional Service
P.O. Box 166
Mbabane
Ph.: (09268) 4042476/7/8
Fax: (09268) 4043357

Sweden
Mr. Stefan Skagerberg
Senior Medical Advisor
Swedish Prison and Probation Administration
SE-601 80 Norrkoping
Slottsgatan 78
Ph.: +46 11 19 30 00
Fax: +46 11 19 36 40

Switzerland
Mrs. Priska Schurmann
Swiss Federal Office of Justice
Head of the Section Prison Affairs
Taubenstrasse 16
3003 Bern
Ph.: +41 31 322 41 71
Fax: +41 31 322 78 73

Togo
Mr. Badombina Bigold
Director
Secretariat General
Ministry of Justice
Republic of Togo

Trinidad & Tobago
C/o Mr. Julien Montes
Commissioner of Prisons
Trinidad and Tobago Prison Service, Administrative Offices
8 New Street
Port of Spain
Trinidad & Tobago

United Kingdom
Britain:
Mr. David Hillier, Head of Communicable Diseases Section
Prison Service HQ, Room 834
Cleland House, Page Street
London SW1P 4LN
Ph.: 0171-217-3000
Fax: 0171-217-6412

Northern Ireland
Dr. R.T. Dixon
The Head of Prison
Department of Health and Social Services
4th floor Dundonald House
Upper Newtownards Road
Belfast BT4 3SU
Ph.: 01232-520700
Scotland
Dr. A. Mitchell
Co-ordinator of Medical services
Scottish Prison Service
Calton House, 5 Redheughs Rigg
Edinburgh EH12 9HW
Ph.: 0131 556 8400
Fax: 0131 244 6995
e-mail: amitchell@sps.gov.uk

United States of America
Alaska
Dr. Mel Henry, Ph.D., ACSW
Health Care Administrator
Alaska Department of Corrections
4500 Diplomacy Drive Suite 109
Anchorage, AK 99508 USA
Ph.: (907) 269 7300
Fax: (907) 269 7310
e-mail: Melbourne_Henry@correct.state.ak.us

California
Evalyn Horowitz, M.D., A.B.I.M.
Chief Medical Officer
Public Health Section
Health Care Services Division
Department of Corrections
P.O. Box 942883
Sacramento, CA 94283-0001

Colorado
Joseph T McGarry MD
Chief Medical Officer
Colorado Department of Corrections
e-mail: Adobejoe@juno.com

Florida
Michael W. Moore, Secretary
Florida Department of Corrections
2601 Bliar Stone Road
Tallahassee, FL 32399-2500 USA
Web address:
http://www.dc.state.fl.us

John P. May, MD,
Medical Director of S. Florida
Reception Center
PO Box 02-8538
14000 W NW 41st
Miami, FL 33178
305-592-9567
drjpmay@aol.com

Georgia
Mr. Jerry Buttelwerth, MSN, CFNP,
CCHP, Clinical Services Consultant
Georgia Department of Corrections
Office of Health Services
2MLK Jr. Dr. S.E., 952 East Tower
Atlanta, GA 30334
Ph.: (404) 656-4601
Fax: (404) 651-6414

Illinois
Mr. Donald N. Snyder, Jr., Director
Illinois Department of Corrections
1301 Concordia Court, P.O. Box
19277
Springfield, IL 62794-9277
Ph.: (217) 522-2666

Indiana
Dean Rieger MD, MPH
IDOC Medical Director
Indiana Department of Corrections
e-mail: drieger@coa.doc.state.in.us

Iowa
Paul L. Loeffelholz, M.D.
DOC Medical Director
Iowa Medical and Classification Centre
P.O. Box A, Hwy 965
Oakdale, IA 52319
Ph.: (319) 626-2391
Fax: (319) 626-2141

Kansas
Angela Akerstrom, R.N., M.S.A.
Medical Contract Management
Consultant
900 S.W. Jackson, Suite 451
Topeka, KS 66612-1290
Ph.: 785-296-0045, Fax: 785-296-0045
e-mail: angela@kdoc.dc.state.ks.us

Louisiana
M. Hegmann, M.D.
Medical Director
Health Care Consultant to the
Secretary
Department of Public Safety and
Corrections
P.O. Box 174 St. Gabriel
Louisiana, 70776 USA
Ph.: (225) 319 4344
Fax: (225) 319-4595

Maryland
Joan Armstrong, R.N.-DPSCS
Infection Control Coordinator
Dep. of Public Safety and
Correctional Service
6776 Reisterstown Road, Suite 309
Baltimore, MD 21215
Ph.: (410) 585-3373
Fax: (410) 764-5112

Massachusetts
Mr. John D. Noonan, Director
Health Service Division
Massachusetts Department of
Correction
45 Hospital Road, P.O. Box 317
Medfield, MA 02052-0137 USA
Ph.: (508) 422-3300
e-mail: heajohn@doc.state.ma.us

Minnesota
Jim Losinski, Health Education
MN Dep. of Corrections
1450 Energy Park Drive, Suite 200
St. Paul, Minnesota 55108-5219
Ph.: (651)-603-0012
Fax: (651) 523-7139

Missouri
Dora Schriro, Ed.D., Director
Department of Corrections
2729 Plaza Drive
P.O. Box 236
Jefferson City, Missouri 65102
Ph.: 573-751-2389
Fax: 573-751-4099

Nebraska
Mr. Dan Danaher
Acting Health Care Administrator
Nebraska Department of
Correctional Services
P.O. Box 94661
Lincoln, Nebraska 68509-4661
Ph.: 402-479-5931

New Hampshire
Ms. Arleen Chin
NH State Prison 281 No. State St.
Concord, NH, 03301
Ph.: (603) 271-6061
Fax: (603) 271-5295

New Jersey
Mr. Jack Terhune
Commissioner
Department of Corrections
Whittlesey Road
P.O. Box 863
Trenton, NJ 08625-0863
New York City
Mr. Roger Parris
Assistant Commissioner
Health Substance Abuse and
Forensic Services
60 Hudson Street
New York, NY 10013
Ph.: 212-266 1418
Fax: 212-266-1077

New York State
Lester N. Wright, MD, MPH
Deputy Commissioner/Chief
Medical Officer
Department of Correctional Services
The Harriman State Campus
1220 Washington Avenue
Albany, N.Y. 12226-2050

North Carolina
Faye A. Duffin, RNC, BS
North Carolina Department of Correction
831 West Morgan St./ P.O. Box 29540
Raleigh, N.C. 27626 - 0540
Ph.: 919-733-3226 Ext. 420
Fax: 919-733-1415
e-mail: fduffin@doc.state.nc.us

North Dakota
Kathleen Bachmeier, RNC, MS,
Director of Medical Services
ND State Penitentiary
PO Box 5521
Bismarck, ND 58506-5521
Ph.: (701) 328-6232

Oklahoma
Becky Coffman, RN, MHR
Nurse Epidemiologist
2901 N. Classen, Suite 100
Oklahoma City, OK 73106
Ph.: (405) 962-6158
Fax: (405) 962-6146
e-mail: becky.coffman@doc.state.ok.us

Pennsylvania
Catherine C. McVey, Director
Bureau of Health Care Services
Pennsylvania Department of Corrections
P.O. Box 598 / 2520
Lisburn Road Camp Hill
PA 17001-0598
Ph.: (717) 731-7031
Fax: (717) 731-7000

Gina L. Rolls
Acting Director
Philadelphia Prison System
Office of Contract Administration
Detention Centre
Philadelphia, PA 19136-3407
Ph.: (215) 685-8266
Fax: (215) 685-8267

South Carolina
Nell L. Rochester, R.N.
Nurse Administrator
Infection Control
4542 Broad River Road
Columbia, SC 29210
Ph.: (803) 896-1235
Fax: (803) 896-1221
e-mail: corrections.info@doc.state.sc.us
Tennessee
Mr. Bob Bradford
Director of Health Services
Tennessee Department of Correction
4th floor, Rachel Jackson Building
320 Sixth Avenue North
Nashville, TN 37243
Ph.: (615) 741-2607
Fax: (615) 532-3065
e-mail: Bbradford@mail.state.tn.us

Texas
Ms. Liz Moore
Peer Educator Coordinator
Office of Preventive Medicine
3009 Hwy 30W 164 A
Huntsville, Texas 77340-3009

Mike Pugh, Ph.D.
Assistant Director for Health Services
3009 A Highway 30 West
Huntsville, Texas 77340
Ph.: 936-437-3531
Fax: 936-437-3541
e-mail: mike.pugh@tdcj.state.tx.us

Vermont
Mr. Thomas. Powell, Ph.D.
Clinical Director
Agency of Human Services
Department of Corrections
1103 South Main Street
Waterbury, VT 05671
Ph.: 802-241-2380
Fax: 802-241-2377

Virginia
Vernon Smith, M.D., Ph. D.
Chief Physician
Virginia Department of Corrections
Office of Health Services/
6900 Atmore Drive, Rm #2097
Richmond, Virginia 23225
Ph.: (804) 674 3290
Fax: (804) 674 3551
e-mail: smithmv@vadoc.state.va.us

Washington
Mr. Tony Wright
COCOA Project Manager
Washington State Department of Corrections
P.O. Box 41126
Olympia, WA 98504
Ph.: 360-586-8538
Fax: 360-586-4577
e-mail: tawright@doc1.wa.gov

Washington, D.C.
Ms. Donna Olive
Infection Control Officer
Federal Bureau of Prisons
320 First Street, N.W.
Washington, D.C. 20534
Ph.: (202) 307-2867

Mr. Michael J. DuBose
Department of Corrections
Health Services
1923 Vermont Av., N.W.
Suite N121
Washington, D.C. 20001
Ph.: (202) 673 2248 ext. 124
Wisconsin
Ms. Sharon Zunken
Director, Bureau of Health Services
149 East Wilson St.
Box 7925, Madison
Wisconsin 53707-7925
Ph.: 608 267 1730
Fax: 608 261 7103
e-mail: sharon.zunker@doc.state.wi.us

Zambia
Musheke Kakuwa
Chief Coordinator, Lecturer, UNZA
University of Zambia
School of Education
Department of ISEAS
P.O. Box 32379
Lusake, Zambia
Ph.: (202) 673-2248, ext. 124
e-mail: mkakuwa@edu.unza.zm