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Protocol on Assessing Drug Use and HIV in Prison Settings

Protocol on assessing
drug use & HIV
in the prison settings

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CONTENT

| | |
|--|----|
| I. Background..... | 5 |
| II. Introduction | 5 |
| A. Characteristics of the prison population: | 5 |
| B. Stakeholders in the response: | 6 |
| III. Objectives | 7 |
| A. Objective of the protocol: | 7 |
| B. Objective of the assessment: | 7 |
| IV. Methodology Considerations..... | 8 |
| A. Ethical considerations | 8 |
| B. Characteristics of the assessment | 9 |
| C. Target groups / Target prisons | 10 |
| <u>D. Inclusion / Exclusion criteria</u> | |
| E. Types of data collection (sources of data) | 11 |
| 1. Secondary (existing) data..... | 11 |
| 2. Primary data (qualitative and quantitative)..... | 12 |
| F. Sampling and considerations due to sampling biases..... | 12 |
| G. Interviewing | 13 |
| H. Data collection team qualifications..... | 14 |
| I. Steps to follow in the assessment | 14 |
| J. Topics to cover in the questionnaire..... | 14 |
| K. Validity and Reliability | 15 |
| V. Final report content | 15 |
| VI. Literature review of previous studies: | 16 |

I. Background

In order to increase access to drug use and HIV/AIDS prevention and care services in the prison settings any response needs to be informed by a sound and proper assessment of the situation. As a minimum, this assessment needs to cover the drug use and HIV/AIDS prevalence, knowledge, attitude and behavior and treatment/prevention infrastructure situation in prisons as well as training needs of staff.

This would ensure that activities and responses are evidence informed, monitored and evaluated (based on a regular assessment of the nature and magnitude of the problem). Reliance on methodologically sound and comparable assessments (undertaken in a comprehensive, systematic and periodic manner, using similar definitions, indicators and procedures to assess the situation) would enhance international exchange of expertise when similar situation arise.

This protocol is developed with the intent of providing guidelines to carrying out these assessments in an effort to harmonize to the extent possible the data collection exercise.

II. Introduction

A. Characteristics of the prison population:

The prison setting population has particular characteristics that set it apart from the general population. Compared to the general population, it has a higher prevalence of psychiatric problems (1), higher level of suicide and self harm (2) and higher level of social pressures of different types (from stress up to, in certain situations, sexual harassment and sexual and physical abuse) (3). Moreover, the criminal justice system is an institution with regular contact with drug dependent users¹. The inmate population and given the aforementioned is at higher risk of drug use whether in terms of initiation of the behavior or continuation (in the absence of proper intervention) (4). Post release information suggests that the drug using population within the prison setting has the distinctiveness of having of higher risk of drug overdose on discharge from prison (high post release mortality) (5).

It is also important to remember that there is a strong relationship between incarceration and transmission of blood borne viruses (such as the Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and syphilis). Injecting drug use is the most commonly reported risk factor for this transmission (5-7). When it comes to drug injection in prisons, the overall injection rates drop substantially upon incarceration because of the high security situation². However the same data suggest that a number of factors within the prison lead to significantly more frequent risk taking injections episodes (such as use in groups and sharing injection paraphernalia) (5,9). Other factors in the prison setting were also identified for higher prevalence of these infections such as previous imprisonment, tattooing and high-risk sexual behaviors. There is growing evidence that the blood-borne virus infections can be

transmitted while individuals are in prison as well as evidence that some had the infection before they got to prison.

The aforementioned probably explains why, the prison inmate population HIV infection rates are significantly higher than those noted in the general population. The data from the Middle East and North Africa indicate that the HIV prevalence in the general population is low; however concentrated epidemics are noted in groups at higher risk of HIV infection and vulnerable groups (particularly the inmate populations)⁷. Some prisoners are infected prior to incarceration and some are likely to get infected inside the institutions. This coupled with a high turn over rate of the inmate population represent a potential threat to further spread HIV outside the prison walls and into the general population.

B. Stakeholders in the response:

Given these characteristics, the prison environment needs to be armed by sound responses to deal with the peculiarities of the drug use and HIV/AIDS situation within its setting. These responses should involve all the key stakeholders in the criminal justice system. Inside the prison setting these stake holders include the prison staff (police, wardens, custodial staff, etc...), the prison management board, the prison health service and/or prevention delivery staff as well as the inmates themselves. The stakeholders Outside the prison setting might differ depending on the country of concern.

In this protocol the stakeholders within the prison setting will be referred to as the “target group for intervention” and those outside the prison setting will be part of what will be referred to as the “National Task Force” (this might include some individuals from the prison management group).

For the purpose of the assessment the role of the National Task Force includes:

- Selection of the prisons to be covered by the situation assessment
- Ensuring representativeness of the country prison population
- Assistance and facilitation in conducting a representative sampling
- Determining data collection needs
- Planning and coordinating national, international, and bilateral agencies' activities and resources to meet those needs.

Moreover it could play a role in identifying the most capable national institutions for implementing the recommended data collection approaches. This as such will facilitate future implementation of activities based on creation of strong interest among the selected national institutions and partners (importance of multi-sectorial involvement).

Members of the task force that are suggested in this protocol include representatives from:

- Prisons Authority / Ministry of Interior
- Ministry of Justice
- National AIDS Control Program / Ministry of Health

- Mental Health Secretariat / Ministry of Health
- Drug Rehabilitation Center / Ministry of Health
- Anti Narcotics General Administration / Ministry of Interior
- Relevant NGOs

UNODC and other relevant international agencies are usually participating in national task force meetings.

It is important to note that these assessments are carried out by the countries themselves through Principal investigators selected by countries' task forces per se and not through independent investigators. The assessments as such represent the point of view of the countries of concern.

III. Objectives

A. Objective of the protocol:

Given that the goal of the assessment is similar in all countries of concern, the general principles, guidelines and core indicators for assessment should be similar across the board. It does not propose the methodology of assessment for the countries. The country specific methodology of assessment could be tailored to the local specificities of the prison condition of each country. However the protocol guidelines and principles from which every methodology will stem will ensure harmonization of the assessment methodologies.

This protocol was developed with the intent of providing the overall *guidelines* through which assessments should be carried out to harmonize to the extent possible the data collection exercise and as such facilitate exchange of expertise when similar problems are encountered. It was developed within the context of a regional UNODC project on improving prison's services to treat and prevent drug use and HIV. On top of suggestions and guidance from UNODC and UNAIDS expertise, it included input generated through a consensus meeting with the principal investigators (and Task Force representatives) from the countries involved in the regional project of concern. This consensus meeting intended at making sure that feedback of the countries involved is taken into account. These countries received methodological toolkits for specific data collection components (such as the UNODC Global Assessment Programme (GAP) toolkits). They also received regional technical support coupled with coordination with country lead investigators familiar with the assessment protocol.

B. Objective of the assessment:

The main objectives of the assessment are to:

- Describe the overall drug and HIV situation in an effort to guide the development of a comprehensive package of response to drugs and HIV/AIDS strategy in the prison facility;
- Gather information on the Knowledge Attitude Behavior and Practices (KABP) on drugs and HIV in all target group of assessment within the prison facility;

- Discuss any major differences in the Knowledge, Attitude, Behaviors and Practices (KABP) profile of various target groups;
- Identify specific risk factors which may be associated with the transmission of HIV that require intervention;
- Identify strengths and weaknesses in the existing strategy to curb HIV/AIDS and drug use in the prisons as well as the feasibility and appropriateness of these interventions per the target groups assessed;
- Identify opportunities for reform and development;
- Assess the available psychosocial, medical and health service resource infrastructure;
- Assess the training needs for the staff (with special emphasis on the health care staff);
- Identify and propose the best method for behavioral change in inmates;

It is important to reemphasize that the direct aim of this assessment is the generation of operational recommendation of intervention aiming at improving access of inmates to drug use and HIV/AIDS prevention and care services in the prison settings. It is as such a targeted and focused behavioral, infrastructure and needs assessment that does not directly intend at *changing* the current prison structure, standards or settings or *assess its compliance* to international humanitarian norms or standards.

IV. Methodology

A. Ethical considerations

The general and overall guiding ethical consideration to be followed in this assessment is ensuring that the basic human rights of individuals are not violated in the course of research. The respondents need to know the objectives of the assessment, how the assessment will be carried out, any possible risk of participation, the benefits of participation (to self, community or science) of participation and how confidentiality will be maintained. Moreover consent (whether written or oral) is completely voluntary and cannot be coerced, the interviewer must acknowledge rights to give or withhold consent at any stage of the assessment. It is also important to note that throughout the assessment, researchers are expected not to raise any false expectations.

Anonymity and confidentiality are crucial during assessment. Moreover arrangements should be made to ensure that respondents are not endangered in any way by disclosing any information. In addition to the safety of the respondents, that of the field workers (given the peculiarities of the setting of assessment) should also be taken in account. More details on ethical considerations in the field are provided through the UNODC GAP toolkit <REFER TO UNODC GAP module 7 – Ethical considerations>.

The main 5 principles to retain are:

1. Beneficence and Non-maleficence
2. Fidelity and responsibility
3. Integrity

4. Justice
5. Respect for people's right and dignity

B. Characteristics of the assessment

Effective response programs should operate from a realistic assessment of current situation behavioral risk and ideally track impact through changes over time. This assessment as such should have the following characteristics:

- Fast;
- Feasible, acceptable and applicable;
- Cost-effective;
- Flexible (plan of action can be revisited anytime based on developing information);
- Multi-method & multi-source;
- Comparable to a doctor's quick assessment in a busy hospital emergency department;
- Inductive;
- Probably not leading to "absolute" truth yet accurate enough to provide decision makers to take appropriate actions;
- Documents problem and propose responses;
- Determines and documents needs and available resources;
- Documents good/best practices initiatives (lessons learned);
- And most importantly it need to be linked to intervention

Assessments of drugs and HIV/AIDS situation within the realm of epidemiological research have particular challenges given the hidden and stigmatized subject matter within the communities. Yet the same assessments within the prison setting might carry even further complications that need to be taken into account. These challenges could be surpassed by development of an appropriate task force involving all the stakeholders outside the prison setting. This is further enhanced through reliance on a well trained data collection team to ensure best outputs. Moreover there is a need for proper data collection tool development, most suitable sampling and collection technique and means to deal with the censorship of some information on many levels.

Given these challenges, the overall assessment need to rely on multi-sources and multi-methods of collection techniques to cross-validate and triangulate the responses. This would rely on both quantitative and qualitative data collection means. The assessment should be designed with the needs of the country of concern in mind. The data collection will be coordinated by the individual country task force while meeting the general guidelines of this research protocol. External technical assistance and training for specific data collection methodology could be provided as and when necessary.

C. Target groups / Target prisons

Given the overall objective of the assessment (to develop a sustainable response to increase access to drug use and HIV/AIDS prevention and care services in the prison settings), the groups to target for data collection should include as a minimum:

- Prison Staff (police, wardens, custodial staff, social workers, etc...)
- Prison management board
- Health service &/or prevention delivery staff
- Prisoners

The sample could include the entire target population or a sample of it depending on the number involved in each of the prison settings. For a more elaborate discussion of the sampling procedures that might be applicable, kindly refer to section E. However it is important to note that the sampling should be made in such a way to make the responses as generalizable as possible, to the prisons on a community or national level as well as the target community within these prisons. The task force should be involved in the entire data collection process to ensure and facilitate the ensuing capacity building exercise.

The number of target prisons selected depends on the local situation (accessibility granted) of each country. In as much as probabilistic randomization of prisons is encouraged to ensure representation, access to prisons is situation specific which would limit the flexibility of probabilistic choice. It is also important to note that unnecessary insistence on access to certain prisons or parts of certain prisons might not be helpful, however the objectives of the assessment should always be emphasized. Mutual understanding with all members of the task force should be ensured. Moreover selection of prisons should take into account the characteristics of the assessment (as mentioned in section B).

Given the fact that probabilistic choice is unlikely, below are guiding principles and factors to take into account to make an informed choice on which prisons (from those given access to) should be given a higher priority of selection:

- Diversity of the inmate population (preference is given to prisons with more diversified inmate population)
- Size of the prison setting (preference for bigger prisons to ensure a larger representation of the overall prison population of the country)
- Representation of female inmates (efforts should be made to have representation of this important section of the inmate community)
- Presence of health care service center (given objectives of the assessment preference is for prisons having health care facilities in house or acting as referral for other prisons).

D. Inclusion / Exclusion criteria

Note the inclusion, exclusion criteria to follow are only suggestive and it could be modified to the discretion of each country, however inclusion of a screening question to ensure the screening out of inmates not meeting the suggested exclusion criteria is a must. This would ensure international comparison of results of assessment while respecting the specificities and needs of each country.

Inclusion criteria: part of the target group of assessment including foreign inmates who speak the language of the instrument.

Exclusion criteria: Juveniles are excluded from this assessment, inmates with a history of impeding mental or physical illness, violent offenders, inmates with death sentences, prisoners that cannot be physically reached (because of legal visits, social visits or court appearance), foreign inmate who don't speak the language of the instrument, political prisoners, inmates in solitary confinement, and too short duration of present stay in prison too short.

E. Types of data collection (sources of data)

1. Secondary (existing) data

The assessment should start with a preliminary assessment of the 'existing' situation. This will include a collection of information on the prisons population, on the number and type of prison staff, on the structure of the prison setting and on the available medical facilities for drug use and HIV in prisons, review of existing studies and data sources in the country, a desk assessment of risk behaviors based on available information, mapping of where the risk is and who is at risk, and formative qualitative work to identify opportunities, barriers, and appropriate approaches to promote behavior change. Available information analysis is an essential first step in the data collection exercise as it would orient all future steps of collection. This information is important to collate and analyze in depth. Secondary (existing) data are available in many forms such as existing statistics and documents (routinely collected). A non exhaustive list of potential secondary data sources would include:

- Policy documents in respect of drug use and HIV/AIDS prevention & treatment
- Ministry of Justice or Ministry of Interior reports
- Penal system reports
- National Human Rights reports
- Reports by prison inspection bodies (national or international)
- Non Governmental Bodies reports
- Drug users arrests figures
- Records of training and qualifications of staff
- Urine test records
- HIV, HBV and HCV screening records
- HIV, STD surveillance data
- Number of people seeking treatment in prisons
- Number of deaths from drug abuse or from HIV, HBV, HCV
- Official reports and government statistics
- Other

2. Primary data (qualitative and quantitative)

Following the secondary data collection and assessment, it will be important to undertake additional research to complement or further validate the information available so far. Depending on the size of the target group population at stake as well as the type and nature of the information sought. The collection of information might rely on a sample of this population or on the entire target population in question. Furthermore, the collection will rely on quantitative as well as qualitative data collection means.

For the qualitative data collection technique, the main two forms of data collection are focus group discussions as well as key informant interviewing. The aim of qualitative data collection is to generate descriptive data, it could be used to plan, pretest questionnaires, monitor effectiveness of some programs in operation and generate hypotheses for quantitative collection. It however requires special qualifications for the data collector and special training

A Focus Group Discussion (FGD) is usually a discussion amongst a group of 6-10 people selected due to a common experience or to common access to information ex: health care personnel within the prison setting with different expertise/training, inmates with different experience, prison staff in a male facility, female prisoners, ex-drug users etc... Details on how to carry on FGD is provided in a separate UNODC GAP training toolkit for this purpose <attach UNODC GAP module 6- Focus Assessment Studies: A Qualitative Approach to Data Collection >.

As for key informants interviewing, they represent one of the most frequently used techniques in assessment studies. They simply represent an interview with an individual that holds key information by virtue of his post or life experience. It is a one-to-one interview that relies on open ended (and semi-structured) questionnaire. The technique of collection technique/qualifications as well as the analysis is more or less similar to the FGD. The aforementioned toolkit as such could be used as a training manual for this purpose.

As for the primary “quantitative” component, the quantitative usually denotes a specific questionnaire with associated close-ended responses. These questionnaires need to be developed and finalized based on the knowledge acquired both from the secondary and primary qualitative collection. As previously mentioned, depending on the size of the target group population at stake, the questionnaire could either be collected from a sample of this population or on the entire target population in question.

To note that biological assessment, whether in regards to drugs or HIV is not part of the current survey method protocol, however whenever available and applicable this information could be used as a supplementary source of data.

F. Sampling and considerations due to sampling biases

In the presence of a small accessible population of assessment it is best to target the entire population with the data collection tool in question. However if the population

size is big sampling might be necessary (given the 'fast / cost-effective' nature of this assessment).

In the presence of a sampling frame, a random sampling that could be stratified to represent different subgroups could take place to ensure overall representation and enriching the inductive conclusions reached and reinforcing our findings. The problem is many a times in prison settings sampling frames are not provided for a variety of reasons. In the absence of sampling frames some non-probabilistic sampling techniques could be used. These alternative sampling procedures could be used so as to meet the characteristics of the assessment as proposed in Methodology Section B. Examples of these techniques are:

- Purposive sampling: a sampling technique that quickly maximize understanding of wider social processes and activities in research setting by selecting and looking for a specific subgroup within the prison (or other target group) population.

- Convenience sampling: a sampling technique where only those available or agree to interview are selected

- Cluster sampling: when "natural" groupings are evident in the population. The total population is divided into these groups (clusters), and a sample of the groups is selected. Then the required information is collected from the elements within each selected group.

- Quota sampling: is a sampling technique where a population is first segmented into sub-groups, then judgment is used to select the subjects or units from each segment based on a specified proportion. ex: an interviewer may be told to go in a prison setting and sample X number of male prisoners arrested for drug charges and Y number of prisoners arrested for other charges etc...

Consideration for biases due to sampling must be taken into account while analyzing and interpreting the data collected. To compensate on sampling biases there is a need to first triangulate the data from the multi-sources (to cross-validate, cross-check from different sources) ex: use qualitative data or secondary data supplementation. Moreover, reliance of interviewers notes of collection might also deemed of importance. It is also necessary to note down participation as well as refusal rates and best to analyze the profile refusals (non response analysis).

G. Interviewing

Confidentiality and anonymity is best served using a self filled questionnaire, however given the fact that illiteracy rate is high among the inmate population at hand it is advisable to use face to face interviewing through qualified and trained field workers.

Given the nature of the setting where interviewing is taking place, it is highly likely that a prison guard will be on premise during data collection. In the event of this happening and in order to minimize sources of bias in reporting, it is highly advisable to keep the prison guard at a distance where he could not hear the interview and add additional insurance for confidentiality to the respondent.

H. Data collection team qualifications

Where feasible and appropriate, it is best to rely on the behavioral research human capacities inherent in an academic setting or an NGO or a non-police based body (in that order) to conduct the actual data collection. This would need to be supplemented by resources or support from other sources.

The team of data collectors should be well trained and specialized epidemiologist/social scientist, well familiarized with the data collection tool & technique. It is preferable if they have a general understanding of the relevant research and drug and HIV/AIDS related issues. The collectors should have good communication and rapport and hold a non-judgmental attitude. The collectors should be trained on observing both verbal and non-verbal cues and taking notes.

I. Steps to follow in the assessment

Below is a suggested listing of steps to follow in carrying out the assessment

1. Partners (task force) development (as suggested in Introduction B.)
2. Assessment coordination body nomination
3. Methodological agreement
4. Tools development
5. Piloting of the assessment tool
6. Data collection team nomination
7. Data collection team training
8. Data collection
 - a. Secondary
 - b. Primary qualitative
 - c. Primary quantitative
9. Parallel data entry data verification and validation
10. Analysis
11. Reporting
12. Endorsement and raising of recommendations
13. Finalization of the report and dissemination

J. Topics to cover in the questionnaire

Below is a suggested list of topics to be included within the questionnaire of assessment:

- HIV screening and seropositivity prevalence
- Knowledge of HIV and other blood borne transmissions
- Level of HIV discrimination
- Attitude towards drug dependence
- Drug use history
- High risk drug use
- HIV history
- Violence in prisons
- Sexual behavior and attitudes
- Tattooing
- Blood sharing rituals

- Access to drug or HIV health and preventive care
- Access and knowledge about VCT
- Availability accessibility to information
- Accessibility to HIV prevention commodities (condoms, lubricants, disinfectants, syringes and needles, etc..)
- Peer support
- Other important diseases: TB, HBV, HCV
- Universal precautions
- Potentially injurious practices
- Other diseases (as deemed necessary by country) ex: leprosy, past surgery, dental disease

K. Validity and Reliability

Without going into the definition of each, the focus here is how to ensure maximum validity and reliability of the assessment. It is widely advisable to operationalize the tools to be used for assessment based on previously used one with tested validity and reliability and minimize on un-tested questions. It is also preferable to be as comprehensive and exhaustive as possible while asking about specific KABP (Knowledge, Attitude, Behavior and Practices) domains.

Another cross validation test to pass is the triangulation of the findings sought from multiple sources of data.

Internal consistency analysis of the response could also be used as a measure of reliability. Official records cross checks could also be used as a method of cross validation.

It is important to note based on previous experience that in a study of prison inmates, more reports of drug use was noted in self administered questionnaires compared to interviewer administered ones. Marijuana use is reported more validly than other substances. Arrestees are more willing to admit to using marijuana, followed by opiates, then amphetamines and then cocaine. Cocaine was noted to be the most stigmatized substance (Lana Harisson).

V. Final report content

Even though the report format might differ from one country to the other based on different factors such as the local context as well as the emphasis needed to be reflected, the guidelines below will highlight the minimum chapter contents to ensure the extent possible to a certain uniformity of content that could facilitate exchange of expertise.

The following chapter contents need to be filled:

- 1- Executive summary with key results, findings and recommendations for further action
- 2- Contextual assessment of prison settings (general facility description, arrest rates, types, etc..)
- 3- Health care resource assessment
- 4- Methodology of data collection

- 5- Drug use and HIV prevalence and knowledge, attitude and behaviour assessment
- 6- Needs and recommendations raised
- 7- Discussion of the results (obstacles faced, recommendations for improvement of collection)
- 8- Conclusion
- 9- Appendix with different instruments used

This report needs to be discussed and validated through a consensus meeting led by the PI who wrote the report in the presence of the different members of the Prison Task Force and other national counterparts having a stake in the drug and HIV response in prison settings.

VI. Literature review of previous studies:

On interviewing, sampling and data collection:

- In Kyrgyzstan the selection of prisoners to be interviewed was done with the assistance of prison authorities and therefore comprised more a “convenience sample” of prison inmates. Each of the prisoners interviewed was given one package of tea, a pack of cigarettes and one kilogram of sugar as compensation.
- In a study of HIV, HBC and HCV in England and Wales, prisoners were interviewed in groups of 10 to 40 depending on groups available at time of study. After a 5 minutes briefing and demonstration, consenting prisoners completed a questionnaire on risk behaviours and provided oral fluid specimens (unlinked and anonymous). Those who chose not to participate played no further role in the study and were not characterized neither demographically nor for risk factors for the infection studied. This was to allay fears of any possible drug testing or security purpose of the study by ensuring that none was coerced to respond. Members of the study group were available to assist when required (particularly when illiterate candidates were unable to read questionnaire). No prison staff took part in the collection(10)
- In a study assessing HIV, HBV and HCV in Ghana, all prison inmates and officers present in the study site were invited to participate. They were informed that the study was confidential and that the information provided by the prisoners will not affect the incarceration status. All individuals accepting to join were interviewed and were administered the questionnaire based on their literacy level. The medical records of each consenting participant were reviewed to ascertain whether they had been previously tested for the infections under investigation. The study was done in a confidential manner and random unique study generated numbers were employed to identify participants(11)
- An interview study on treatment needs on entering prison, in Ohio USA was done to determine the extent of drug use and estimate the number in need of treatment among incoming prisoners. For validation of self reports hair samples of prisoners were taken

and supplemented to the data. In addition their criminal records and urinalysis results were obtained. The study sample included those who had been sentenced to prison and had resided in jail for less than three months. The list of qualified prisoners were provided by jail officials and an identification number was assigned to each participant. They were given assurance of confidentiality and an informed consent form was secured before interviewing each subject. Questions followed the national institute of mental health's diagnostic interview schedule- version IV instrument(DIS-IV) and additional information were drawn from DUF program in the city of Cleveland. To assess treatment need each subject was asked two questions. What was learned from the prisoners perception on their treatment needs was used to predict the prisoners' reaction towards an offered or imposed treatment system. In the assessment of drug independency the researchers used DSM-IV diagnostic tool(12).

- Two case studies. The first one was an ethnographic study of young illicit drug users. The second one was a YAD study(Youth Aids and Drugs). Participants were young illicit drug users who were interviewed on a single occasion in a field office, rented for the study , which was geographically distant from center office. The university solicitors gave the researchers advice which modified their methodological approaches, and provided them with direct and personal access to their advice and 24-hour telephone numbers which could be called for legal assistance. In planning YAD study, it was decided that the researchers would seek some, albeit not total, protection for the study by informing the local Drug Squad about the investigation. Various security measures were taken to keep the address of the field office as secret as possible(13).
- A study about drug use and initiation in prison in the UK : the paper focuses on heroin and cocaine use in a sample of UK prisoners. the objective was to study characteristics of those who ever used or initiated use of this drugs while in prison. The sampling was a probability sampling (systematic sampling, one in 34 male sentenced prisoners, one in 8 remand prisoners and one in 3 female prisoners) among prisoners from all operational prisons in England and Wales as part of a national psychiatric morbidity survey. 88.2% of the selected prisoners completed a face to face interview (with trained staff of Office for National Statistics). Interviews were conducted in private or when necessary at presence of another ONS interviewer. Those who were judged to be too dangerous to be interviewed were prevented from being interviewed. Interviews covered topics including personal, demographic characteristics, social history, psychiatric morbidity and drug use(14).
- A study conducted at Durham prison, a typical male remand and short sentence prison. All new prisoners were screened at reception by a healthcare officer for physical and mental health problems as well as substance use. A standard prison questionnaire (F2169) was used which contained several specific questions about recent drug and alcohol use. This provided useful information for the prison doctor, who assessed each inmate the next working day and decided about detoxification regimens and any other treatment needs. All unconvicted men remanded into custody over seven months from 1 October 1995 to 30 April 1996 were eligible for the study. The research was explained to each man and assurances given that any information he offered was confidential and

would not be passed on to prison staff. Each man gave written consent. Subjects were interviewed by one of two researchers trained in psychiatry. A semistructured interview designed specifically for the study was used. A comprehensive drug and alcohol history was taken, levels of use recorded, and DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, fourth edition) diagnoses of abuse and dependence made when appropriate (18).

- A group of drug-using male prisoners was identified from the 2000 prisoners Criminality Survey. These were divided into samples, based on their sentence length, and two sweeps of interviews were conducted: Sample 1 consisted of interviews with prisoners, most of whom had been in custody for between four and nine months. Respondents were asked about their drug use and experiences of treatment and testing during their current term of imprisonment. Sample 2 involved a separate sample who were interviewed in the community following their release. This group consisted of shorter sentenced prisoners. Respondents were asked about drug use and, treatment and testing during their last term of imprisonment and about drug use and re-offending since release (19).

Some key results and discussions raised:

- Marijuana, cocaine and opiates were the most widely used drugs among which older participants were more likely to use cocaine and opiates and younger participants were more likely to use marijuana. A higher percentage of females showed life time drug dependence in comparison to male participants. Those who were classified as currently or life time substance dependent on cocaine and opiates had a higher likelihood of past treatment as well as perceiving treatment needs in the future. However the generalizability of the study is limited since the study samples were not representative of all general population of USA prisons (12).
- According to ethical guidelines for Australian health research: before research is undertaken the free consent of the subjects should be obtained. Sufficient information about the purpose, methods, demands, risks, inconveniences and discomforts of the study be provided. If it becomes apparent that the research is harmful to research subjects, the investigator should modify or stop the research program. There is a conflict between researchers ethical and legal responsibilities and the ways to address this should be clear. How to maintain research confidentiality and immunity of research data! How to protect researchers from criminal liability! legal protection for researcher and research!(13)
- 26.4% of the life-time heroin users and 9.3% of the cocaine/crack users reported first using these drugs while in prison. As a percentage of those used in prison, 42.8% had initiated heroin use and 38.2% had initiated cocaine use in prison. Those aged 20-30 were more likely to have initiated heroin use in prison than 16-20 year-olds. A childhood diagnosis of conduct disorder more than doubled the odds for having used heroin or cocaine while in prison. A positive association between separation or divorce and cocaine use in prison was observed. Having been in prison before was uniformly

more strongly related to heroin use than cocaine use. A greater number of previous terms in prison significantly increased the odds of cocaine and heroin use as well as life-time use of these drugs. Those with more psychiatric disorder were more likely to have initiated heroin use while in prison. It is possible that low levels of amphetamine and cocaine use is because these are less readily available in UK prisons. However it could be argued that the effects associated with the use of heroin and cannabis are more suited to life in prison than stimulant drugs such as cocaine and amphetamines.(14)

- Increasingly the responsibility for collecting information and disseminating health information falls onto those who are engaged face to face with at risk groups of hidden or illegal subcultures. The use of community outreach workers and peer interviewers reflects broader shifts in health care provision and public health management(Beck, 1992; Lupton, 1995; Rose, 1996) which have come to place more emphasis on community outreach in risk and harm reduction strategies. However there are gaps, one of the most serious is the failure to provide adequate legal and ethical support to sustain confidentiality in such an approach. Because those who are not given assurance of confidentiality might not participate in research. There is need for an ethical balancing to be conducted. On one hand there is a need for discretionary power to prosecute those who are involved in an illegal act and on the other hand the need to know about activities such as illicit drug use such that public health strategies can be initiated to reduce harm. Finding a balanced response that prioritizes these competing interests will not be easy (15)

- To provide prevalence and incidence of drug use surveys were based on self reports. However improved hair analysis and urinalysis techniques show that self report methods miss a lot of recent drug use. Validating self reports requires comparison to some method that is presumably more accurate. Like analyzing drug metabolites in bodily fluids. Other methods used are reports by family members, treatment or criminal records. The DUF study has fairly consistently found that only about half of those who test positive for a drug report use in the past 2 to 3 days. The most common way to interpret the congruence of urinalysis and self-report is to focus on just those with positive urinalysis and determine the percentage who accurately report their drug use. Another way is to compare those who self report for drug use to the percentage who tested positive for that drug.

- The research literature suggests that self-report may be least reliable among criminal clients. A study of prison inmates found that more reports of drug use using self-administered versus interviewer-administered questionnaire (McElrath 1994). Another finding is that arrestees are most willing to admit marijuana use, followed by opiates, amphetamines, and then cocaine (Harrison 1992).But yet, self reports are important to understand the complexity of causal and correlating characteristics of drug use and information about age at which individuals initiated drug use. Attitudes about the risk of harm and past treatments can only be obtained through self-reports. The Hair analysis still has several controversial aspects, one is that it is not clear how drugs enter hair. Another aspect is interpretation of dose and time relationships. However some

studies suggest that hair analysis disclose more recent drug users than can be found through either urinalysis or self-reports (17).

The researchers found that when questioned by prison staff many inmates played down the extent of their substance use, disclosing only what they thought was necessary, as they were not confident of receiving treatment but risked being labelled as drug users. When interviewed by researchers, who were not perceived to be part of the system, inmates seemed more willing to disclose substance misuse. The fact remains, however, that substantial numbers of drug users were missed by prison reception screening. They believe that if drug use in prison is to be tackled effectively greater emphasis needs to be placed on more rigorous clinical screening and provision of drug treatment programmes comparable to those in the community. Without adequate detoxification programmes many inmates will continue to use drugs in prison. In some cases this will be accompanied by the risk of needle sharing (18).

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