





CARE TO INCARCERTAED PEOPLE WITH HIV/AIDS: LITERATURE REVIEW

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ABSTRACT

Objective: to describe health care provided to people living with HIV/AIDS in the penitentiary system.

Method: a narrative review of the literature that considered publications from 2012 to 2017. The bibliographic survey was performed using controlled descriptors and keywords in the LILACS, PubMed, Embase, Cinahl and Scopus databases.

Result: a total of 215 studies were retrieved that went through three selection stages, including nine. These were grouped according to the areas: HIV prevention, HIV testing and diagnosis, HIV treatment, and articulation between Health Services in addressing HIV.

Conclusion: prisons have the capacity to offer quality health care to persons deprived of their liberty living with HIV, through health promotion and prevention of the HIV virus, as well as early diagnosis and adherence to treatment.

DESCRIPTORS: Acquired Immunodeficiency Syndrome. Prisons. Prisoners. Health care.

HOW CITED: Bossonario PA, Saita NM, Andrade RLP, Santos GP, Nemes MIB, Monroe AA. Care to incarcerated people with HIV/AIDS: literature review. Texto Contexto Enferm [Internet]. 2020 [cited YEAR MONTH DAY]; 29:e20180324. Available from: <http://dx.doi.org/10.1590/1980-265X-TCE-2018-0324>

ASSISTÊNCIA ÀS PESSOAS COM HIV/AIDS NO CÁRCERE: REVISÃO DA LITERATURA

RESUMO

Objetivo: descrever a assistência em saúde prestada às pessoas vivendo com HIV/aids no sistema penitenciário.

Método: trata-se de uma revisão narrativa da literatura que considerou publicações entre os anos de 2012 a 2017. O levantamento bibliográfico foi realizado com a utilização de descritores controlados e palavras chaves nas bases de dados LILACS, PubMed, Embase, Cinahl e Scopus.

Resultado: foram recuperados 215 estudos que passaram por três etapas de seleção, dos quais se incluiu nove. Estes foram agrupados de acordo com os eixos: prevenção do HIV, testagem e diagnóstico do HIV, tratamento para o HIV e articulação entre Serviços de Saúde na abordagem ao HIV.

Conclusão: as unidades penitenciárias têm capacidade de oferecer assistência em saúde de qualidade às pessoas privadas de liberdade que vivem com HIV, por meio de ações de promoção à saúde e prevenção do vírus HIV, bem como do diagnóstico precoce e adesão ao tratamento.

DESCRITORES: Síndrome de Imunodeficiência Adquirida. Prisões. Prisioneiros. Assistência à saúde.

ATENCIÓN DE LAS PERSONAS CON VIH/SIDA EN LA CÁRCEL: REVISIÓN DE LA LITERATURA

RESUMEN

Objetivo: Describir la atención médica brindada a las personas que viven con VIH / SIDA en el sistema penitenciario.

Método: una revisión narrativa de la literatura que consideró las publicaciones de 2012 a 2017. La encuesta bibliográfica se realizó utilizando descriptores controlados y palabras clave en las bases de datos LILACS, PubMed, Embase, Cinahl e Scopus.

Resultado: se recuperaron un total de 215 estudios que pasaron por tres etapas de selección, incluidas nueve. Estos se agruparon según los ejes: prevención del VIH, pruebas y diagnóstico del VIH, tratamiento del VIH y articulación entre los Servicios de Salud con enfoque el VIH.

Conclusión: las cárceles tienen la capacidad de proporcionar atención médica de calidad a las personas privadas de libertad que viven con el VIH a través de acciones de promoción de la salud y la prevención del VIH, así como el diagnóstico precoz y la adhesión al tratamiento.

DESCRIPTORES: Síndrome de inmunodeficiencia adquirida. Cárceles. Prisioneros. Atención de la salud.

INTRODUCTION

The challenges facing the human immunodeficiency virus (HIV), the causative agent of Acquired Immunodeficiency Syndrome (AIDS), is a priority fight for global health, since the epidemic reaches mainly demographics with risk behaviors, which many sometimes lack access to health actions and services such as the prison system¹.

Approximately 30 million people pass through prisons worldwide each year, of which more than 10 million remain incarcerated for a period of time.² These individuals suffer from a higher prevalence of HIV than the general population.³

To ensure the health rights of prisoners with HIV, in 2014, the Brazilian Ministry of Health (MOH) established the National Policy for Comprehensive Health Care for Persons Deprived of Liberty in the Prison System (PNAISP) within the Unified Health System (Revoking inter-ministerial decree 1,777 of 2003. In this policy, the prison units (PU) are reaffirmed as points of primary care within the Health Care Network of SUS, and provides, among others, comprehensive, resolute and health demands, with control and reduction of the most prevalent diseases in the prison environment.⁴

Thus, people deprived of liberty with HIV should be assisted by internal teams that develop actions according to the attributions and functions of Primary Health Care (PHC), and are also referred to other points of care when necessary.⁵ In this context, however, health promotion and prevention actions are insufficiently provided to this population, as well as medical care.⁵⁻⁶

The prison environment is recognized as a structured space capable of promoting continuous care focused on HIV control with the provision of antiretroviral therapy and management of comorbidities, such as drug addiction, tuberculosis and other sexually transmitted infections.⁷⁻⁸

It is believed that for an effective response to the impact of HIV / AIDS in prisons as a public health problem, access to health actions and services aimed at HIV prevention and control by the prison population is equivalent to that offered to the community is essential.⁴

Thus, this work aimed to describe the health care provided to people living with HIV / AIDS in the penitentiary system, by means of a literature review, in order to create a panorama and bring reflections on the proposed theme.

METHOD

A narrative review of the literature was performed. For the development of this, it was intended to answer the following question: "How is the health care provided to people living with HIV/AIDS in the prison system?"

The search for articles was performed in January 2018 in the following databases: CINAHL (Cumulative Index to Nursing and Allied Health Literature), Embase (Excerpta Medica dataBASE), LILACS (Latin American and Caribbean Health Sciences Literature), PubMed (Public / Medline or Publisher Medline) and Scopus (SciVerse Scopus, owned by Elsevier). We opted for the five databases in order to obtain the largest possible number of scientific publications relevant to the theme studied.

The descriptors used were: "health care" and "HIV or acquired immunodeficiency syndrome" and "prisoners or prisons". Which were readjusted according to the database used, including: English-language keywords were used in CINAHL and Embase; English language descriptors found in Medical Subject Headings were used in PubMed; descriptors in Portuguese, English and Spanish identified through research on the Descriptors in Health Sciences (DeCS) were considered in LILACS; In the search performed in Scopus, it was chosen to use the English keywords selected in the other international databases, as there is no structured vocabulary. The Boolean operators used in the databases between the descriptors were AND and OR.

The scientific productions found initially were analyzed from titles and abstracts to identify if they had the potential to answer the question outlined. After such selection, the articles were read in full to verify the pertinence of their inclusion in the study. Next, the data were extracted with the completion of a specific instrument, prepared by the authors themselves, for characterization of the articles, as well as the organization and summarization of the main results.

The inclusion criteria of scientific productions were: studies in article format; studied population aged 18 years and over and corresponding to people living with HIV/AIDS; Portuguese, English and Spanish language; published in the period from 2012 to 2017. We chose to search for articles published in this period because this review was part of the discussion of a study conducted in 2015, thus it was intended to find recent studies in the same period of execution of the study. (3 years before and 3 years after). Articles that did not answer the study question or those that were not found or were not available in full in their online version were excluded.

A total of 215 articles published during the study period were retrieved, 23 of which were excluded due to duplication. After reading the titles and abstracts, 35 materials were selected for full reading, resulting in the inclusion of nine articles (Figure 1).

The organization and summarization of the main findings in the included scientific articles allowed the configuration of the following thematic areas related to care for people living with HIV deprived of liberty: prevention, testing/diagnosis, treatment and articulation with health services. These areas were anchored in the perspective of the Cascade Continuous Care model of HIV, which presents the steps that individuals living with HIV must go from the timely diagnosis to viral suppression,⁸ as shown in Figure 2.

Regarding the thematic “prevention”, the suppression of viral load in the reduction of HIV transmission was considered, as it is an important element within the list of outlined preventive actions for the reduction of new cases of infection.

Likewise, the “testing” area does not constitute itself as one of the stages of the care cascade, however, it was decided to group it with the diagnosis, since they are interrelated.

The possibility of considering the “articulation with health services” thematic was considered, as it enables the transversality of care provided in response to users’ health demands. In this perspective, the importance of the definition and applicability of lines of care as a feasible way of articulating health resources and practices, guided by clinical guidelines, is understood, and overcoming of fragmented responses to the most relevant epidemiological needs, such as the HIV as a prerogative. The lines of care define the responsibilities of the different points of care regarding the provision of health actions and services; express the care flows that are guaranteed to the subjects; allow to outline the therapeutic itinerary of users in the network; have integral care and user-centered care as structuring elements.¹⁰ The implementation of the HIV line of care implies the articulation between points of care in the network, including the PUs, in order to guarantee the concreteness of the steps provided for in of continuous care cascade.

It is also important to highlight a proposal adapted from the classic cascade, called the Continuous Care QualiRede Model (Figure 3), which was reconstructed to incorporate the stages of “promotion of sexual/ reproductive health and specific prevention of STIs/AIDS”, prior to the “diagnosis”. Also, considering the therapeutic guideline of offering antiretroviral therapy (ART) to people with HIV, as soon as the diagnosis is made, the decision was made to relocate the “treatment” stage prior to “retention”. ART “adherence” is also explicitly presented as one of the stages of the model, not just as an element of “treatment” as shown in the classical cascade. This model has been used since 2015 in the state of São Paulo, with the objective of consolidating and qualifying the Care Network in STI/AIDS and viral hepatitis.¹¹

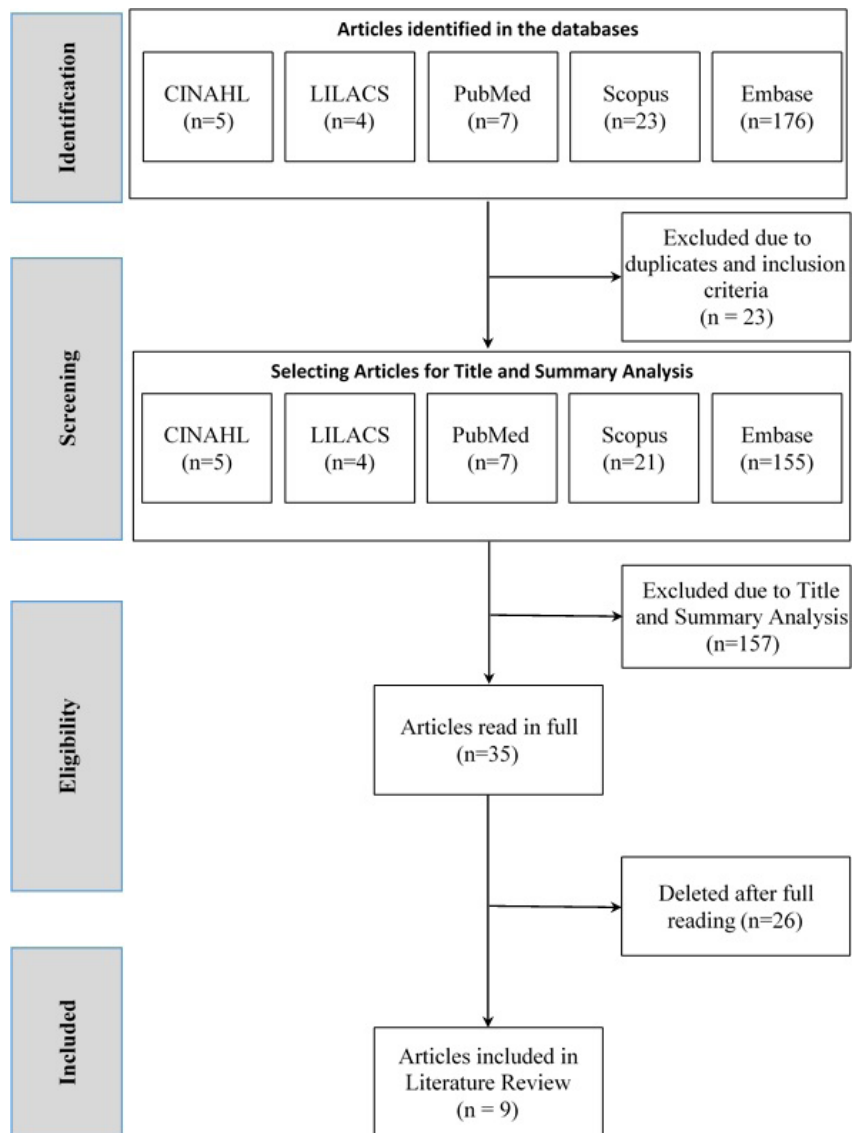


Figure 1 – Flowchart of the number of articles analyzed in each step of the review.

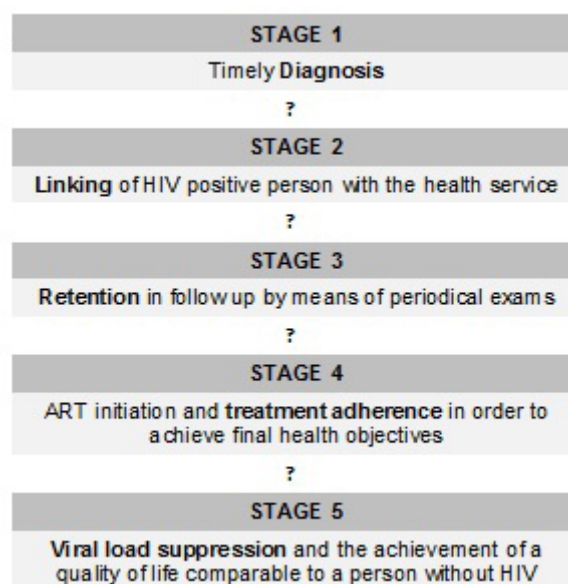


Figure 2 – Steps of the Continuous Care Cascade in HIV
Source: Ministry of Health, 2018.9

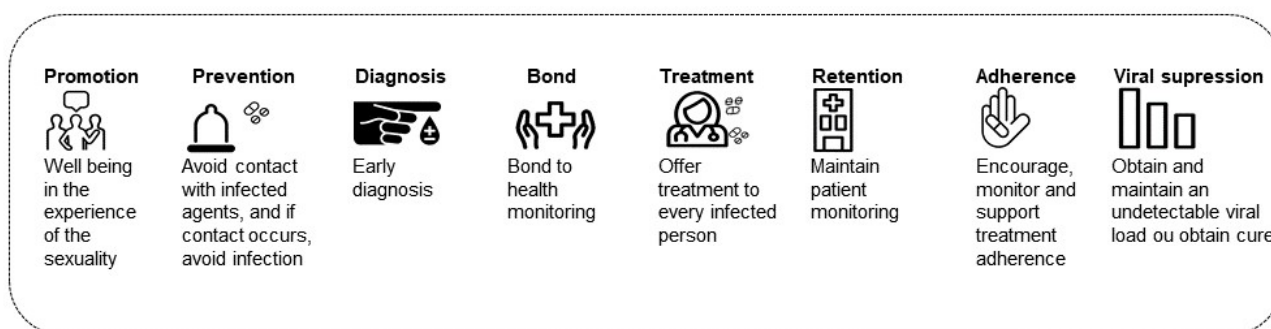


Figure 3 – QualiRede Continuous Care Model: steps and purposes

Source: São Paulo, 2018.¹¹

RESULTS

There were no published studies found for the year 2014. Regarding the research locations, four occurred in the United States of America and the other five in different countries; no studies were identified in Brazil. All materials are published in the English language. Regarding their approach, seven were quantitative (three descriptive, two cross sectional and two descriptive / cross sectional) and two were qualitative (Table 1).

Table 1 – Information on articles included in the review

Authors	Journal	Year	Methodological design	Location
Seth P, Figueroa A, Wang G, Reid L, Belcher L ¹²	HHS Public Acces	2015	Descriptive and cross sectional	United States of America
Monarca R, Madeddu G, Ranieri R, Carbonara S, Leo G, Sardo M, et al. ¹³	BMC Infect Dis	2015	Cross sectional	Italy
Bick J, Culbert G, Al-Darraj HA, Koh C, Pillai V, Kamarulzaman A, et al. ¹⁴	Int J Prison Health	2016	Cross sectional	Malaysia
Spaulding AC, Booker CA, Freeman SH, Ball SW, Stein MS, Jordan AO, et al. ¹⁵	Aids and Behaviour	2012	Descriptive	United States of America
Subramanian Y, Khan MN, Berger S, Foisy M, Singh A, Woods D, et al. ¹⁶	Int J Prison Health	2016	Descriptive	Canada
Simonsen KA, Shaikh RA, Earley M, Foxall M, Boyle C, Islam KM, et al. ¹⁷	J Prim Prev	2015	Descriptive	United States of America
Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, Venters H ¹⁸	Aids Behaviour	2012	Descriptive and cross sectional	United States of America
Chakrapani V, Kamei R, Kipgen H, Kumar J ¹⁹	Int J Prison Health	2013	Qualitative	India
Espósito M ²⁰	Int J Prison Health	2012	Qualitative	Italy

The care provided to people with HIV/AIDS in prison was addressed by the articles regarding the following themes: HIV prevention,^{12,19} HIV testing and diagnosis,¹³⁻¹⁶ HIV treatment,¹³⁻¹⁶ Articulation with health services in addressing HIV.^{12,15,18,20}

In the HIV prevention theme, it was found that the development of such action within the PU can be an alternative to decrease the number of new cases of detainees infected with the virus,¹⁹ however there are prisons that represent a high-risk environment for the HIV transmission. Another study points to the low referral of detainees to health services for the provision of HIV prevention actions, with emphasis on testing and test results, medical consultation after diagnosis of the virus infection and guidelines on exposure of the virus to partner.^{12,19}

In relation to testing and counseling, a study conducted in Italy in 2013 found that all PUs studied offered HIV testing.¹³ Another study conducted in Malaysia found that 66.9% of participants were diagnosed with HIV in a previous incarceration, 56.5% in the current incarceration and 10.5% by compulsory testing during incarceration.¹⁴ It is noteworthy that this last study includes elements of the cascade of care before incarceration and during prison, considering the diagnosis, retention of care (offer of TCD4+) and ART prescription, however, disease prevention, therapeutic adherence and viral suppression were not explored.

Between 2007 and 2011, 877,119 people who entered the prison system in the United States, of which 56.9% were offered HIV testing, 24.2% accepted testing, and 24% actually performed testing. Among the 210,267 people tested, 89.5% received the result; 0.62% were positive; 0.56% received a positive result; 0.39% were new cases and 7.4% declared having the virus themselves.¹⁵

It was also found that while rapid HIV testing is an option to identify people infected with the virus in prisons, institutional barriers such as funding and logistics related to testing were perceived in a study conducted in Canada with 300 detainees.¹⁷ In this study, participants received their test results before leaving the prison, showing the feasibility of offering the rapid test during the procedures prior to the release period. It is noteworthy that 40% of the detainees refused to perform the test.¹⁷

Regarding the HIV treatment theme, one initiative for strengthening and integrating community services/ care and the US prison unit developed with a focus on the distribution and use of ART in persons deprived of their liberty, as well as on retention of care, for at least six months after release from prison, identified that the participating PUs reported adequate capacity to undertake articulation actions for ART treatment to detainees living with HIV.¹⁵

The institutional competence for dispensing medicines to treat people living with HIV was also found in a study conducted in Italy involving 35 PUs. The dispensation of medication by nurses to HIV positive detainees occurred in 70% of the cases in the prison context and the remainder occurred in external medical units.¹⁴ Regarding medication administration, 42.8% had directly observed treatment (DOT), 31.4% were self-administered and 25.7% used both methods. The frequency of ART distribution in prison was "once a day" (17.2%), "twice a day" (31.4%) or "≥3 times a day" (51.4%). The "once a day" ART distribution regime was considered as a facilitator for conducting DOT in the prison context, according to the perception of health teams.¹³

A study conducted in Malaysia in 2012 and 2013, with 221 people living with HIV who were in custody, showed that 73.7% met the criteria for ART indication and 26.2% had viral suppression, however, 34.4% did not receive ART drugs during incarceration.¹⁴

A study conducted to highlight that the resources for the treatment of HIV in detainees are insufficient to meet the complex health needs of this population (presence of comorbidities / co-infections, substance use, mental illness), showing the importance of increasing the number of incarcerated access to drug treatment, prioritizing the achievement of the best health outcomes, the prevention of drug resistance and the transmission of the disease after prison release.¹⁴

The impact of short-term incarceration on ART adherence, viral suppression, and community retention of care after prison release by obtaining data related to periods before, during and after incarceration showed that medication adherence was more expressive during incarceration.¹⁶ During incarceration, there was an increase in viral suppression and T-CD4+ cell counts, as well as a greater insertion of individuals in the post-incarceration health service compared to the pre-period.¹⁶ The authors pointed to the possibility of increasing the outcome of HIV, including adherence to treatment and the insertion of individuals in community health services after incarceration.¹⁶

Regarding the articulation with health services in the approach to HIV, a study in which 19 prisoners living with HIV were interviewed, highlighted the consequences for prisoners' mental health and quality of life resulting from deprivation of liberty, in relation to health care, and showed that the main complaints were about waiting for care and for exams.²⁰

Other issues were poor quality of care, quantity and punctuality of specialized services available to detainees and difficulty in accessing medicines. Thus, partnerships between prisons and health services allow consultations with health professionals to ensure continuity of care for detainees.¹⁵

In relation to the perspective of continuity of care, a survey conducted in the United States of America highlighted the importance of coordinating transitional care, i.e., the one that enables the transition and continuity of care of detainees with HIV/AIDS between PU and the health care service of your home community. In this study, the authors highlighted that after the inmates became aware of the importance of continuity of HIV care, there was an increase from 2,218 to 2,519 for prisoners seeking transitional care coordination between 2009 and 2011, and that primary care medical consultations increased from 941 to 1,336.¹⁸

DISCUSSION

Although they should organize their practices according to PHC attributions Few studies on HIV prevention were found in PUs.⁴ By recognizing the importance of the steps that make up the continuous care cascade, it is realized that there is a need for investments to enable UPs to be able to guide people living with HIV on the importance of combined prevention, early diagnosis of infection and the introduction of ART as a measure to maintain undetectable viral load, and guidelines for reducing disease transmission. Such investments require the availability and qualification of human resources, as well as adequate infrastructure and essential resources. Thus, it would be possible to reduce the referral of detainees to other health services, especially for prevention actions.

The construction of a line of care focused on the prevention of HIV transmission in prison permeates the possibility of achieving access to health, HIV diagnosis and health services when necessary.^{8,21} This involves the distribution of leaflets, placement of posters, educational strategies and health education strategies with active methodologies²² in order to inform and facilitate access to HIV prevention actions in an environment immersed in risky behaviors such as unprotected sexual practice and drug use.

It is important to highlight the broad conception that involves the provision of HIV prevention actions and services, called "combined prevention", based on three interventions: biomedical, behavioral and structural. Biomedical are actions that reduce the risk of exposure to the virus, being divided into classic, such as the application of barrier methods (female condoms, male condoms and lubricating gel), and based on the use of antiretrovirals (ARV), such as Treatment as Prevention. (TasP), offered to all people as soon as the diagnosis is made; Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP). Behavioral actions aimed at broadening information and perception about the risk of exposure to HIV, such as STI counseling, testing support, harm reduction from alcohol and other drug use, enhancement of communication strategies and peer education, among others. Structural actions are related to sociocultural transformations to minimize the vulnerability of key individuals

or populations to HIV. For example, the confrontation with racism, sexism and other prejudices, promotion and defense of human rights, among others. Such interventions can be applied to the general population as well as to key populations such as people deprived of liberty.^{21,23}

The provision of HIV testing, as a component of combined prevention, contributes to the identification of infected individuals, as well as to the initiation of drug therapy aimed at the subjects' quality of life and viral suppression, the latter having significant impacts on transmission of the disease. It is emphasized that, for the effectiveness of such contributions, strategies that guarantee the systematic offer of testing must be undertaken, considering the entire prison path of subjects deprived of liberty.

Offering tests for HIV diagnosis does not mean acceptance to do so. The reasons for refusal to conduct testing in the prison context should be investigated in order to identify existing barriers and implement capable strategies to overcome them. Simultaneously with the organization of the service to offer tests, investments in campaigns / actions to raise awareness and motivation of subjects regarding the early diagnosis of HIV are relevant. If counseling and testing are not offered within the PU, care arrangements are required for referral of subjects to health services suitable for such procedures.

According to a study in India, injecting drug users have been found not to have access to HIV testing in prison, nor are they referred to places offering them.²¹

Despite the difficulties highlighted in studies with the provision of rapid HIV tests, immediate testing at the moment of acceptance and the rapid dissemination of results contribute to the reduction of the chances of refusal and allow the subject to know their serological condition in a timely manner. As the test only takes a few minutes to complete, it is a good option for those deprived of their liberty, including those leaving the prison environment.

Resuming the continuous care cascade,^{10,24–25} between stages of prevention and diagnosis of HIV, there is the offer of rapid testing, fundamental for the knowledge of the serological condition of the incarcerated subjects and the respective care measures in view of the result. However, carrying out testing is equally as important as the need to host and counsel PPLs to raise awareness about their vulnerabilities and identify the interventions needed to minimize the risk of HIV infection/transmission through prevention. including the reduction of damage in situations involving the sharing of needles in jail.

As previously mentioned, promoting disruptions in HIV transmission cycles implies the operationalization of intervention strategies, especially the biomedical measures based on the use of ART, namely TasP, i.e., the provision of ART to people living with HIV aiming at reaching/maintaining an undetectable viral load; PEP, which provides for the use of ART within 72 hours of exposure to a risk of contact with the HIV virus; and PrEP, which presents other strategies that make up combined HIV prevention.²⁶

In Brazil, since December 2013, the Department of STI, AIDS and Viral Hepatitis, through the policy of "Test and Treat" and TasP, has made ART drugs available for free to all people living with HIV, regardless of their lymphocyte levels.

In addition to offering/accessing drug treatment, adherence represents a major challenge for HIV control. It is important to highlight that the path taken by the individual from health promotion, HIV provision and testing, timely diagnosis, early ART, and adequate clinical management directly impacts the reduction of vulnerability to illness, reduction in mortality, increase in survival, expanding the bond and therapeutic success.^{21,24–25}

Given the diagnosis of HIV, the detainee should be referred to the referral service for their first medical appointment, however, a study conducted in the United States with 841 new cases indicates low referral to the health service (37.9%), as well as a consultation up to 90 days after diagnosis (49.7%).

The first consultation with the health team able to care for this newly diagnosed subject is essential for building the professional-person bond with the person living with HIV and for clarifying

doubts about the diagnosis, as it is an essential moment for the realization of the actions offered to control and build knowledge about the individual's quality of life from that moment on. Therefore, the delay in contact between patient and health team can weaken the detainee's mental health due to the stigma and prejudice connected with the disease.

In order to establish the cascade of care it is necessary to think about the continuity of care, involving health promotion until suppression, as well as the articulation between the various actors involved in the care network,^{21,24-25} showing the importance of continuity of care for the control of HIV/AIDS.

Among the limitations of this study, the following stand out: the bibliographic search was not performed by two independent reviewers, as it is not an integrative or systematic review; the possibility of excluding articles pertinent to the review in the selection stage made from the reading of their titles and abstracts; the inclusion of articles only in Portuguese, Spanish and English.

CONCLUSION

In summary, the studies that were part of this review that aimed to describe the health care provided to people living with HIV/AIDS in the prison system demonstrated the importance of rapid tests to identify cases of HIV infection in the prison system, with the objective of establishing early detection and timely treatment, as well as the efforts and articulations necessary to provide comprehensive care, with the following care objectives: the quality of life of the subjects and the suppression of the viral load of PPL living with HIV.

The importance of articulating and coordinating care involving prison health facilities and specialized health services, PHC and even community services was also verified, aiming at the adequate therapeutic approach to detainees, both during the confinement period and after prison release.

Despite the barriers found for HIV prevention and control, it is observed that the prison system has potential to provide care to people living with HIV, as it is an important point of health care which organizes their practices in line with PHC functions and attributes in order to offer comprehensive, integrated and resolute care.

Finally, advancing HIV care provided to people deprived of liberty, anchored in the perspective of operationalizing the steps that make up the continuous care cascade, requires joint efforts and articulation between health services linked to different managing bodies in order to reach internationally agreed commitments in order to confront the AIDS epidemic in key populations, especially in people deprived of liberty.

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NOTES

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CONFLICT OF INTEREST

There is no conflict of interest.

HISTORICAL

Received: September 05, 2018.

Approved: January 28, 2019.

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