

Lessons learned  
A multidisciplinary work experience in STI and HIV/AIDS in Lurigancho  
Prison in Lima, Peru



Lima, December 2005

*"For those who were forgotten even before they died"*  
Cesar, inmate with HIV



Lessons learned. "A multidisciplinary work experience in STI and HIV/AIDS in Lurigancho Prison in Lima, Peru"

Project: Control of STI and HIV/AIDS in the Lurigancho Closed Ordinary Regimen Prison (EPRCOL), Lima, Peru.

This document was created and produced under the editorial coordination of Juan José Arévalo.

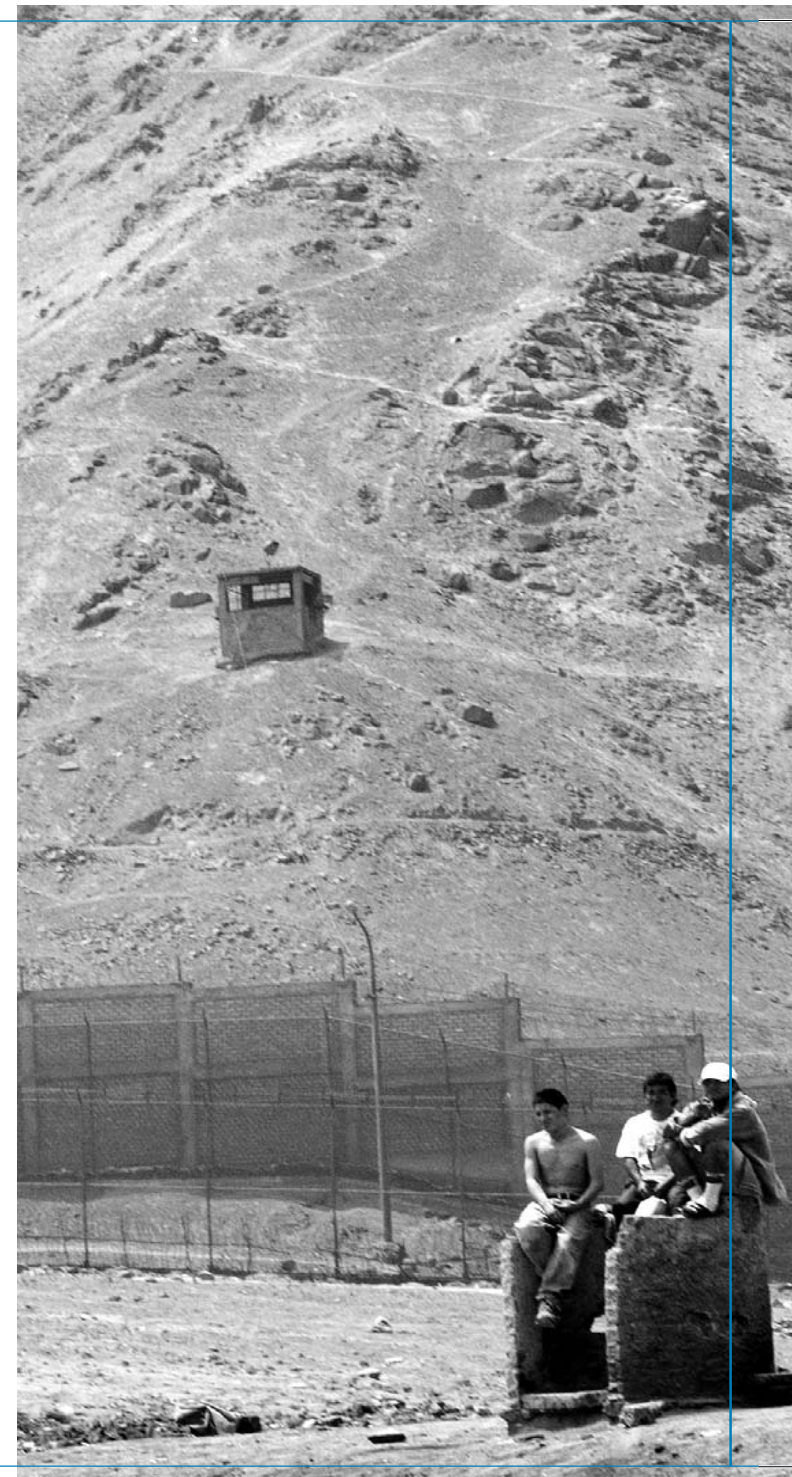
The contents were prepared by Yoni Begazo, Ana Ladera, Vanessa Meneses, Joanna Ladomirska, Katelijn Deknopper, Miguel Villegas, Juan Bernales, Piero Gandini and Juan José Arévalo.

Alessandra Oglino, Julie Latini and Olga Ruiz contributed to revision and editing. Testimonies were compiled by Olga Ruiz. Photographs by Juan José Arévalo (c) (+title page). Design and graphic concept by Juan José Arévalo.

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This edition was printed in December 2005

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# A MULTIDISCIPLINARY WORK EXPERIENCE IN STI AND HIV/AIDS IN LURIGANCHO PRISON

**L**urigancho prison in Peru is one of the most populated in Latin America: more than 8,500 inmates live in a space designed for 1,500. In criminal jargon, it is known as “the university” as the newcomers are in constant contact with inmates with a long criminal background. Its official name is Lurigancho Closed Ordinary Regimen Prison (EPRCOL in Spanish)

Not many know that the risk of contracting the Human Immunodeficiency Virus (HIV) inside the prison is 5 to 7 times higher than in the streets. When compared to the other prisons in the country, Lurigancho prison has a higher prevalence (2,3%) according to 1999-sentinel study carried out by the Epidemiology General Office (OGE) and the National Prison Institute (INPE).

People Deprived of Liberty (PDL) have the same rights to health as free people. Additionally, their health is closely related to many other people such as their parents, brothers and sisters, spouses, partners, friends, sons and daughters. During visit days, an average of 4,000 people enter Lurigancho prison. These include relatives, friends and salesmen who, in turn, contribute to spread infectious or contagious diseases, such as Sexually Transmitted Infections (STI) including HIV and Tuberculosis (TB) among the population.

Mèdecins Sans Frontières (MSF) has developed, together with INPE, a STI and HIV/AIDS control program in Lurigancho prison. The multidisciplinary approach of the joint work with Sexually Transmitted Diseases and HIV/AIDS Control Program (PROCETSS) in the prison made it possible to improve the quality of medical care and treatment of People Living With HIV/AIDS (PLWHA), to train health professionals from other areas (such as psychology, social, educational), support vulnerable groups and in general show that it is possible to offer timely and adequate care for STI and comprehensive medical care to PLWHA in contexts as complex as prisons.

Working in a prison has been a unique experience and a different challenge in preventing HIV/AIDS. During these years (2000-2005), the activities performed have been many, with many the discussions and anecdotes and undoubtedly many will be the books necessary to contain all this experience. In this book, we have tried to summarize the most relevant, the heart of the project. These are our “Lessons Learned”, with mistakes and achievements, but with the hope that they will be useful to all professionals involved in health areas in other prisons. Today, when we are finishing a period of the project, we want to share this experience with you and contribute to the world debate on the fight against HIV/AIDS and STI.

Thank you all.

Mèdecins Sans Frontières



**I**n the PROCETSS of Lurigancho prison, there had been somehow a previous experience. However, the vision of the STI and HIV/AIDS problem was an approach centered on the affected person, with a strong health care component. Efforts were needed to perform health prevention and promotion activities in an institution with small investments in issues such as training, medical supplies and human resources. In 1998, work started in Lurigancho prison PROCETSS with MSF. It was decided to start working in the EPRCOL as this is the most populated prison in the country and because it has the highest number of inmates diagnosed with STI and HIV/AIDS infections.

In Peru, the prison population mostly comes from the poor or extremely poor social strata who have had very little access to the formal educational system or the health system. When looking at the budget allocated to health areas in prisons, it is easy to conclude that the State's efforts to improve quality of life in the prisons are insufficient.

In this context, the presence of MSF acquired real importance as it allowed us to:

- Carry out a situational assessment to have an idea of the magnitude of the problem of STI and HIV/AIDS.
- Consolidate the interdisciplinary teamwork in permanent training, defined a position and responsibility profile and incorporate more organically social workers and psychologists in this intervention.
- Sensitize authorities about the importance of organizing multidisciplinary teams to face STI and HIV/AIDS problems, as well as considering the possibility of keeping the teams for at least 2 to 3 years to give continuity to the project.
- Contribute to the relationship between the work on health prevention and the other areas in the INPE (security, administration, treatment).
- Have available the necessary medicines to treat diagnosed cases of STI, as well as the permanent concern about the treatment of opportunistic infections in people living with HIV/AIDS.

- Incorporate treatment for STI and some opportunistic infections in the list of medicines to be purchased by INPE. Currently we are incorporating condoms as an institutional responsibility.
- Support advocacy work with the Ministry of Health (MINSA) to participate in solving the HIV/AIDS problem in Peruvian prisons. This was also carried out with the Ministry of Justice.

Moreover, some of these interventions centered not only in the EPRCOL but were implemented in other prisons. They tend to be general to all the system, which would imply a higher level of commitment from the authorities at regional and local levels respectively.

Institutional relations with MSF have been horizontal, clear and sincere and we are really grateful for that. We were very pleased with the work environment with the different MSF health professionals, all of them with experience, knowledge and commitment with what they were doing, as well as their capacity to learn about a reality that was strange at first, but then became familiar to them.

Finally, the challenge to our organization is big, even more now that we are growing and organizing INPE's health system. It is important to note that sustainability is a complex issue in countries like ours where HIV/AIDS is not important enough in the minds and hearts of our highest authorities, to the extent that there is not a single speech where they commit to tackling this problem. Many of the challenges involve the struggle against stigma and discrimination that in the case of inmates has a double condition: to be PDL and PLWHA.

We sincerely thank our MSF friends and its different teams that participated in this project in the EPRCOL during these years.



José Best, MD  
General Director, Prison Health National Coordination  
INPE









For a long time, MSF was interested in working in Lurigancho prison, as it is one of the most populated in Latin America, it has a peculiar internal organization and a very critical health situation.

MSF's first contact with prisons and INPE was in 1993 after a visit to Ayacucho prison in the south of Peru. Between 1995 and 1998, MSF in coordination with a local organization<sup>1</sup>, started to work in different prisons in Peru. INPE health personnel was trained in 13 prisons in the Lima region, health programs were developed and a rotatory fund for medicines was created in the women's prison in Chorrillos, Lima.

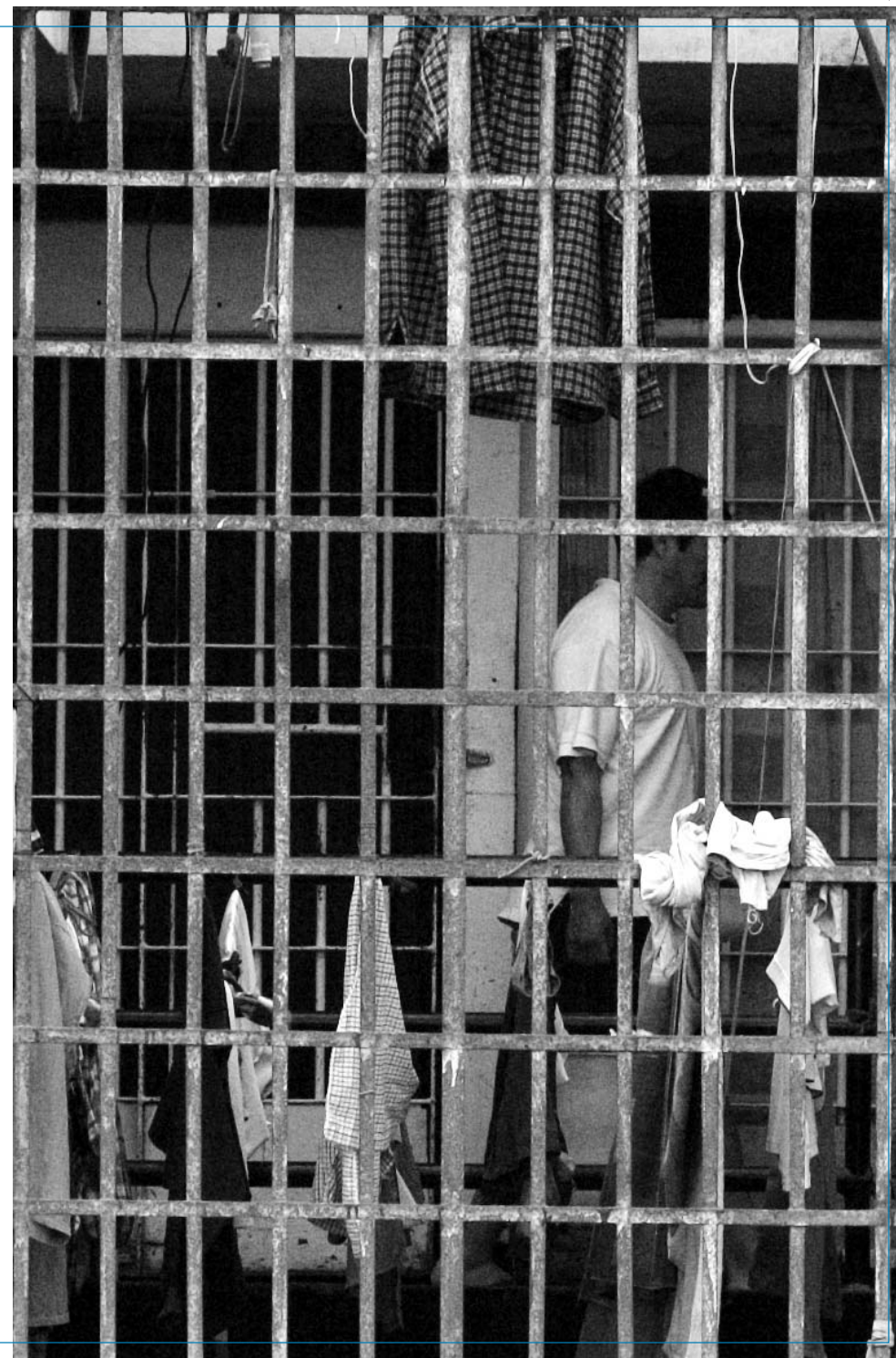
After receiving authorization to enter Lurigancho prison, MSF performed a study on health conditions related to TB, STI, and HIV/AIDS in EPRCOL between September 1998 and June 1999. The results made it possible to understand risk factors for the propagation of these infectious or contagious diseases in prisons, the inmates' health needs and the real situation of medical attention in the prison.

The main conclusions regarding STI and HIV in this study were:

1. There is a high incidence of STI and HIV/AIDS, but it is widely underestimated because there is no sexual education and no access to medical personnel.
2. Risk behaviors are very common: risky sexual practices, tattoos, drug abuse, and sexual violence.
3. STI care does not follow MINSA standards and can be improved.
4. Discrimination and stigmatization make life very difficult for PLWHA. In addition, their care and follow up is insufficient, as the prison PROCETSS capacity and resources are very limited.
5. Interaction with the external world makes PDL a catalyst for TB, STI and HIV transmission to the community outside the prison premises.

The process to establish a transparent and close relationship with INPE authorities and personnel as well as the prison population to carry out this study and later implement the project was a big challenge. The strategy to overcome the lack of confidence from the institutions was to train health personnel in 7

<sup>1</sup> KALLPA, Peruvian Non Governmental Organization devoted to improve life quality of children and teenagers in less favored sectors, strengthening integral health and social skills.





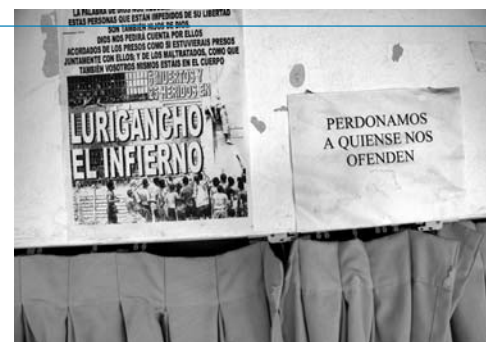
prisons in Lima on the problems related to STI and HIV/AIDS, support different events and special occasions such as the international day against TB and the international day against HIV/AIDS, and supply medicines and other materials (condoms, medical and biosafety material), all this together with the support of Information, Education, and Communication (IEC) materials such as posters, brochures and videos.

The MSF study led to the preparation of the project called “Control of Sexually Transmitted Infections and HIV/AIDS in Lurigancho prison” in order to reduce the transmission of STI, including HIV, and improve the quality of medical services to EPRCOL population.



## LURIGANCHO PRISON

### LURIGANCHO CLOSED ORDINARY REGIMEN PRISON (EPRCOL)



**L**urigancho prison (EPRCOL) is located at the foot of a desert hill in the district of San Juan de Lurigancho, 11 kilometers northeast of Lima's downtown. The prison, opened in 1964, was originally built for 1,500 inmates. In September 2005, the prison had 8,520 inmates, five times the maximum established capacity. There is also a high turnover in Lurigancho prison. EPRCOL inmates represent 25,6% of PDL in the country.

This prison is destined for male inmates imprisoned for common crimes, such as aggravated robbery, murder, unlawful possession of a firearm, sexual crimes and drug trafficking. Primary prisoners are imprisoned together with recidivists and even if this prison receives an inmate to complete his sentence, it is used as a temporary prison because of the increase of crime in the country and because legal processes are very slow (according to INPE statistical bulletin of September 2005 only 14% of inmates were convicted, while 84% were only accused or indicted).

The prison is divided in two well-defined areas: an administrative area and a confinement area for the prison population. The latter is formed by cell blocks and is divided in two sectors: garden (odd cell blocks) and pampa (even cell blocks), divided by a passage (jirón de La Unión). When the inmate arrives, he is assigned to a cell block based on certain criteria. However, this position is not always respected by inmates, who may re-assign themselves to their preferred cell block, for example with people from their neighborhood or district.

Besides prison cell blocks, there are other blocks that were built or fitted to treat, rehabilitate or train inmates. These are the clinic, the chaplaincy, the maintenance and cleaning cell block, the bakery and the industrial workshops. There is also an area for sport, entertainment and events known as the central auditorium. A new clinic is being built with resources from the Global Fund (GF).

The prison has become a large organized community that works as a small city, with neighborhoods, its own particular culture, services and its own economy. The flow of money and goods occurs three times a week; on the days of female visits (Wednesday and Saturday) and male visits (Sunday), as well as on Friday when the prison workshops, restaurants, shops and kiosks are supplied from outside.

The prison population has their own representatives called delegates. These exist at the level of cell blocks as well as central level and comprise health, food, culture, discipline, legal, maintenance and sports areas. In time, this organization has been recognized by the prison authorities, and this recognition, trying to maintain an open dialogue with PDL representatives, has kept the prison in apparently calm.

It seems that power in the prison is exercised by consensus and natural acceptance. Inmates would have the power to elect delegates and to dismiss them if they do not perform their functions. However, the power depends almost exclusively on money and drug dealing. Inmates with the largest criminal record have the managerial positions. This power is vertical and exercised by the so-called general delegate and discipline delegate. Additionally it is said that inside the prison there are



other people that really hold the power. These are called “taitas”. Others mention that “taitas” now prefer to keep a low profile, and the general and discipline delegates are the public figures.

Overpopulation in the prison and the lack of resources have created a particular internal organization where the inmates themselves are in charge of some tasks that should correspond to INPE. Each inmate must contribute with an amount of money with his cell block which is used to maintain it. Inmates with no money, clean or perform other tasks to be able to remain in the respective cell block. Those who refuse to pay or to help and trouble making inmates are expelled from the cell blocks (by the inmates themselves). There are inmates that have some money and may even buy a cell from another inmate who is released or transferred to another prison.

Inmates circulate among cell blocks paying a certain amount of money to the people in charge of the doors in each cell block. This payment, in criminal jargon, is called “taxi”. Additionally, during visiting days there is a direct contact of PDL and their visits for several hours. This has important consequences on public health.

The budget allocated for food remains at around one dollar per person/day, which is clearly insufficient for adequate nutrition. The inmates must also give an economic contribution to improve their food rations. This varies from one cell block to another depending on their economic capacity.

“The more drug you deal, the more power you have...”  
Inmate.

INPE's Treatment Technical Body (OTT) works on inmate rehabilitation, re-socialization and reintegration into society through psychological, social, legal, educational (Occupational Education Center, CEO) and work (industrial cell block, bakery). In the prison, there are other participants, as for example the chaplaincy that keeps a small medicine cabinet, the library and the detoxification center ANDA (Alcohol, Drugs and Associated crime) and other evangelic groups.

## Access to health in EPRCOL

Inside the prison, health care is quite limited and lacks an adequate management of resources, it is a system with a weak structure, with little control by INPE authorities that prioritize security and rehabilitation over health. Evidently, there is no coordination between MINSA and INPE to participate in and supervise public health programs at prison level.

Since 2004, the integral health plan for PDL has been under way in the country's prisons. The aim is to strengthen health areas by applying MINSA's national health policy in the prisons. The creation of the Prison Health General Coordination, recognized in INPE's functional organization chart, is basic to achieve this goal.

In Lurigancho prison, there is a clinic that offers different services such as external medical consultation, health programs (TB and PROCETSS), pharmacy, hospitalization wards, radiology, clinical laboratory, dental, psychological, psychiatric and social services. The clinic infrastructure meets neither the patients' nor the doctor's needs as it was fitted in to an old cell block. The third floor of the cell block, used by the PROCETSS, was rehabilitated by MSF in 2002.

Access to health services in the prison is limited because of several institutional and cultural factors. For INPE authorities and for the Peruvian National Police (PNP), security is more important than health and the allocation of resources and health personnel is insufficient. MINSA does not take a strong enough part in the prison health services and also does not supervise the health programs properly.





Health is not a priority for inmates. For them, their position within the prison according to their own hierarchical power and their legal situation is more important. Besides this, as most of them come from marginal social groups, they tolerate their ailments and seek medical attention only when their situation is severe. Others use drugs and see the clinic as a place where they can get profits: they can pretend they are sick and get free medicines that they can later sell. These two situations are harmful for inmates and create inadequate attitudes in health personnel towards them.

The lack of permanent training of the personnel, their high turnover, an inadequate work environment, the attention of patients with difficult behaviour, and the insufficient understanding of the inmates, damage the relationship between patients and health workers making it difficult and distant. MSF contributed to the organization of health services (organizational chart, job profiles and redistribution of attention quotas<sup>2</sup>, etc) to the improvement of infrastructure (third floor of the clinic, waste areas and an area for the detection of persons with respiratory symptoms) and to training and raising awareness in the clinic's staff, as well as supplying medicines, logistic and laboratory materials.

<sup>2</sup> Amount of inmates that can access the clinic by week and by cell block.

The attention quota system was created to guarantee the inmates access to health, but this is still insufficient, as it excludes inmates without a cell block and limits the access to more populated cell blocks.

Attention in the PROCETSS is not limited by the quota system. The multidisciplinary team was trained, committed and then accompanied during the development of their activities and strategies. Currently, and as a result of the intervention, the inmates are offered quality and respectful attention.

Health delegates are an important element for the inmates' access to health services. They attend to minor health problems inside the cell blocks and are involved in the access to the clinic (they liaise between the health personnel and the prison population). There are also collaborators, inmates that help in the daily activities of the clinic, such as cleaning and patient transport.

*"Health personnel are always respected and protected. In February's riot, we were inside a cell block giving a workshop to promoters. All of a sudden, we heard gunshots but we went on with the activity. When the shots were everywhere, we wanted to go outside but the guardian left. He asked me: Are you staying, miss? I told him I wasn't but he had already left. The inmates told me that they would come with me. They protected me near the wire mesh; they formed a wall around me with their bodies..."*

#### **Lurigancho prison PROCETSS professional**

*"The first difficulty in the clinic is the shortage of staff. There are almost 9 thousand inmates and we are only 45 health professionals. This is very little compared to the very large demand. Doctors attend between 70 and 100 inmates per day of consultation. STI and HIV necessitate a great deal of attention, as well as TB..."*

#### **Lurigancho prison clinic professional**







## Target population

The greatest challenge of a STI/HIV control and prevention program has been the preparation of strategies to be able to achieve our goals. In this sense, it was essential to know the reality of the prison, the identification of vulnerable groups and support groups, the strengthening of relationships between the prison population, INPE and MSF professionals, the knowledge of the prison language or jargon, and the use of qualified human resources.

Although at the beginning of our project our efforts were oriented towards treatment, prevention gradually became more important as a privileged ally to achieve our objectives. Logically, this preventive and promotional component started to develop as the knowledge about the prison and the different beneficiaries of the project increased. In 2003, a clear IEC strategy was consolidated. In this, creativity and imagination were fundamental to give the messages to our target public.

The identification of the target population was indispensable to design a particular strategy for each group and to adapt the messages to the needs of each one.

## VULNERABLE GROUPS

**General population:** The general prison population constitutes a vulnerable group as a whole because of overcrowding, feeling of abandonment, psychological vulnerability, social pressure and physical violence. In the prison, the factors that increase the incidence of STI and HIV transmission are “boosted” as sexual encounters are frequent, varied, diverse and hidden.

According to the admissions to a prison, within the EPRCOL there are two kinds of inmates in the population:

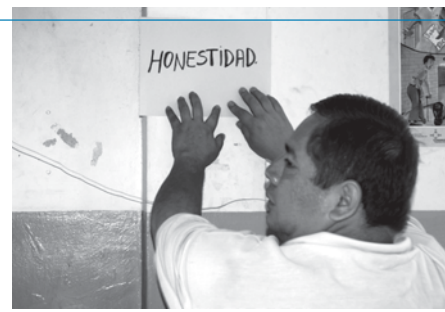
**A primary population:** Who are young firsttimers between 18 and 25. They are mainly classified in cell block 1, but they can also be found in other cell blocks. They were identified as vulnerable, as this is their first time in a prison, and because they particularly face risky situations and risky sexual practices.

*“Here we are a “bridge” population. There are some inmates that have their wife, their mistress and their sissy. It is not weird here to have a sissy. It is just like having an asset, a car. That’s why they are called “little cars”. Sex with men is not forbidden.”*

**Former health delegate**

*“Remember: The risk is not in what we are, but in what we do”*

**Health delegate**



**Recidivist population:** Those inmates with previous admissions to prisons. Considering the figures for 2003 and 2004, six thousand people were admitted to Lurigancho prison, where only 35% represent primary population.

**People with STI symptoms:** Inmates with STI symptoms, whether they attend PROCETSS or not. Inflammatory or ulcerative STI facilitate HIV transmission. This is why people with STI have a higher risk of contacting HIV. In the prison clinic, 30 to 35 new STI cases are diagnosed every month. The most frequent is genital ulcer (55% to 70% of the cases).

**People living with HIV/AIDS (PLWHA) and their families:** PLWHA are those inmates that were diagnosed with HIV in the prison or were admitted with a diagnosis made outside (for medical and legal reasons it is necessary to confirm the diagnosis). In the prison, PLWHA are subject to stigma and discrimination: because they are inmates, because they are HIV positive, many because they use drugs, many because they have homosexual behavior and others because they come from a very poor social strata.

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*"In the cell block they discriminate against you with their eyes, they look at you as if you were dead, as if you were insulting them; that discourages you. They yell at you in front of everyone. "Hey, AIDS man. Make a line to get your dish". They humiliate you and that embarrasses you. Then the people with HIV will not leave their cells, or go to collect their food, as they are afraid. Sometimes they leave the cell block to live outside in the passage or anywhere else. It is hard, but they believe it is better as they are not constantly reminded that they are sick..."*

**Inmate with HIV**

These people are more vulnerable to infectious diseases, which easily lead to complications and the mortality is high. Besides that, their quality of life inside the prison is terrible. Many of them will not tell those near them in the prison about their condition because they are ashamed, afraid or because they lack information. Sometimes they will not tell their families. Some even lack a family structure and others are discriminated against their own families. Within the project, family ties are fostered to help the PLWHA to receive emotional support and help.

In October 2005, there were 97 PLWHA followed up in Lurigancho prison PROCETSS. However, this is a fluctuating population because of the high turnover of admissions to and releases from the program.

People living with HIV/AIDS, as well as their families, were considered as a target group.

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*"In the cell block many are HIV positive but they don't care. I think they should have special consideration: more food, better treatment... Otherwise, they weaken and become exhausted..."*

**Inmate with HIV**

*"When I was told I was positive, I knew what HIV meant as my brother died from that. AIDS can kill you if you don't take care of yourself, so you have to be careful. I have had several relapses and I stay longer in the clinic than outside, but the treatment can only be followed there because life quality in the cell block is no good. There you can't rest, you can't sleep well, there are no blankets, there is vice, the lights are on, they bother you ... and you need lots of rest to recover from this illness..."*

**Inmate with HIV**





**Virgen de la Puerta Community:** This community is formed by a group of inmates self-recognized as homosexual, with transvestite tendencies, who are frequently repressed inside the prison. Most of them are located in cell block 3. Some of them cut hair for a living, but most of them do sexual work at the prison, which make them more in risk of contacting STI and HIV/AIDS. In fact they are the group with the highest HIV and RPR (syphilis test) seropositivity.

This group is very distinct: they are all male that define and acknowledge themselves as transvestites, but they cannot explain their sexual identity. They have a very low cultural and educational level, only very few have finished elementary school, even less high school. This community has an average 25 to 30 members.

The members of this community are perceived, together with Commercial Sex Workers that come to the prison, as transmitters of STI or HIV. The rest of the population never assumes the responsibility of taking care of themselves during intercourse.

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*"In the Virgen de la Puerta Community we speak a lot about many things and we support each other. When I need to cook, I can borrow some rice or if anyone needs some potatoes someone else will lend me some; we also interchange T-shirts...If we were isolated, we would be hanged. There are naughty boys who want to do things to us, they bother us, they touch us, they grope our arse when we walk by and they want to take advantage. That is why I never leave and if I have to, never alone. As we are sissies... MSF has taught us to take care of ourselves. I always come to confidence workshops, with Ms. Yoni, Anita..."*

**Member of the Virgen de la Puerta Community**











**Commercial Sex Workers (CSW):** Among the women that come to the prison on visit days, there are some CSW. Even though this procedure is not openly accepted by the prison authorities, it is a reality that has to be faced within the context of a STI and HIV/AIDS program.

*“Commercial Sex Workers that enter the prison twice a week during female visits, are normal women, single mothers or married, who come to the prison to work and earn some money. Besides sexual work, they come to sell; others also have a source of income outside. There are times when they come more often, for example, for Mother's Day, for Christmas, for their birthday or when they have to register their children at school. They make money for special occasions or they are paid with food or with drugs.”*

#### Lurigancho prison PROCETSS professional

**LASZER Group (Lacras, Sin Zapatos, Refugiados):** This is the name given to a heterogeneous group of inmates that do not belong to any cell block and have no definite place to live. Generally, they are found on roofs, in yards, hallways or any place, outside the cell blocks, where they can spend the night, and this turns them into potential victims of sexual violence and risky sexual practices. Therefore they are vulnerable to STI and HIV/AIDS. As they are heterogeneous, it is difficult to document their specific risk indicators.

As they do not belong to any specific cell block, they have no access to most of the services offered in the prison, such as a food rations or access to the clinic. They generally have no visits and the abuse of drugs is very high among them. Moreover, and because of their living conditions, this population is strongly stigmatized. Among them we can find:

**Sin Zapatos (Shoeless):** Very poor marginal people that live and eat from cell blocks' leftovers or from the garbage. This group moves around the prison and is not aggressive.

**Lacras (marginal, considered as the worst in society):** Similar to the “Sin zapatos”, these inmates eat from leftovers or garbage. Dependence on drugs is

higher in this group. They are considered to be aggressive and they are constantly waiting to steal or to sell their belongings to buy drugs.

**Refugiados (Refugees):** Inmates that have been expelled from their cell blocks for indiscipline or because they have not paid their debts with delegates. Refugees are common in the prison, but in most cases it is a temporary condition.

Within the LASZER group we can also find inmates that live in the so-called Malvinas<sup>3</sup> of cell blocks 6, 8 and 10. They move during the day, and at night they assemble little huts in the yards, in the gardens and in open spaces such as the little farm in front of cell block 21 to sleep in. Other LASZER live on the roofs of their cell blocks, where they work as guards and therefore they are protected by the delegates. There is also a group of inmates that live on the roof of the prison auditorium and look for food in cell block 15.

Cell block 21 was created in 2004 for inmates that did not belong to any cell block. As time went by, this cell block became organized like all the other cell blocks in the prison, achieving rights such as the food ration and a quota for the clinic. The creation of cell block 21 has solved the problem temporarily. However, as it is organized as the other cell blocks in the prison, it does not meet the needs of the LASZER population that is in the same way constantly moving.

The so called LASZER represent 5% of the EPRCOL population.



<sup>3</sup> Collective cells

## SUPPORT GROUPS

**Multidisciplinary team:** A group of health professionals that works on the preventive, promotional and health care activities in the Lurigancho prison PROCETSS. This multidisciplinary team consists of a doctor, a nurse, a psychologist, a social assistant, midwives (as counselors), laboratory and pharmacy staff. MSF joined this team to implement the activities planned in the project. During the first years, the MSF team included only medical staff, but later some psychologists joined the team to carry out all the preventive and promotional strategies.



*"In the INPE, the only PROCETSS that works is the one in Lurigancho. Here we are a team and we offer an integral service. They go hand in hand. A HIV patient may need medical attention, but if he gets depressed and stops taking his medication he will need some advice and that's the psychologists job. Multidisciplinary teams started with MSF, who brought many ideas, together with organization and experience. We should acknowledge that. The negative aspect may be that they overprotect inmates. Everybody consider them human beings, but when the inmates want something they also find a way to obtain it. Over time, they (MSF) also learned not to be so trusting"*

**Lurigancho prison PROCETSS professional**

**Health delegates:** Health delegates are the inmates that represent the prison's different cell blocks on health matters.

Compared with the other delegates, health delegates are not as highly valued. They are perceived to have less power, as they do not have a direct authority on the inmates' life. They offer services only to meet the inmates needs. Besides, the concept of health doesn't have a high value among inmates; therefore it is not one of their immediate priorities.

Health delegates liaise between the clinic and the cell blocks, making inmates' access to health easier, offering primary attention and controlling direct access to the clinic (quota allocation and emergency cases management). Likewise, the health delegates make it possible to transmit the prison population's health related enquiries and needs to the general delegate who will in turn transmit them to the prison authorities.



*"Working in a prison is quite different from working outside, because here they have their own rules which you don't get to know at the beginning. For example, health delegates. Within the prison internal organization, they have responsibility and they are middlemen between the health staff and the inmates. We respect their power, we coordinate with them and we ask for their help to coordinate the activities. The rest of the prison respects them."*

**Lurigancho prison PROCETSS professional**



During a workshop for health delegates, they are taught how to use protection masks when dealing with people with Tuberculosis.





## IEC Component (Information, Education & Communication)

The IEC component is a strategy that offers knowledge and direction to a specific population, to promote affirmative attitudes and behavior with regard to STI and HIV/AIDS prevention. There are many ways to reach the public and achieve the appropriate identification: a brochure, a video, a play, a training workshop and other creative activities to communicate the messages. The preparation and implementation of IEC material requires the participation of all parties involved.

The incorporation of the IEC component made it possible to have a communication program for the prevention of STI and HIV in Lurigancho prison. The final purpose was that of promoting a change in the behavior in the prison population regarding the practice of safe sex, focusing on the correct use of condoms and therefore reducing the incidence of STI and HIV among the internal and external population of the prison. This program was complemented with a strategy that improved the supply of condoms and access to the clinic.

There were informative talks addressed to the prison authorities, PNP, and diverse health and technical professionals to raise their awareness on HIV/AIDS and STI issues and to involve them in the project's objectives.



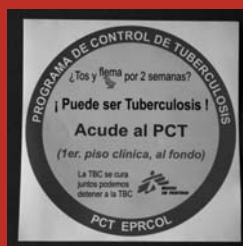
# IEC MATERIAL

The preparation of each IEC material started from the need for relevant information and media, as proposed by the target population itself, the support population and the MSF project team, during meetings and concept focus groups. The inmate population took part in the preparation of the designs and the texts adapted for each group.

The materials designed were diverse and varied, and were prepared and distributed during the addition of the IEC component to the project (brochures, posters, flip charts and their application guide, stickers, calendars, T-shirts, and general graphic material).

INPE and MINSA authorities recognized the materials. Moreover, such material as the flip chart is used by other prisons in Lima and provinces.

All IEC strategies must contain concrete messages, adapted to the prison populations. In addition, the inmates must be involved in the preparation of the material, allowing enough time to validate it, and in this way achieve a balance in the way messages are phrased between the inmate's jargon and what is acceptable to the personnel that will use it. It is also important to raise awareness in the professionals and to involve them in the preparation and validation of IEC materials.





## STRATEGIES FOR THE GENERAL POPULATION

### Intervention in cell blocks

IEC intervention in cell blocks arose from the need and the wish to promote direct access to information about STI and HIV/AIDS prevention. In this way, inmates can perceive themselves as vulnerable subjects, and promote a change in their behavior towards risky situations such as unprotected sex.

This strategy had three basic axis: the first one was to reach or benefit with prevention messages the largest number of inmates without them leaving their cell blocks; the second was to promote access to the clinic and counseling; and the third to offer early screening of STI as a way to prevent HIV infections.

Initially, IEC strategies were designed to intervene in two specific cell blocks: one in the pampa and the other in the garden in order to have a preliminary view that could later be extended to the rest of the prison, as these two blocks had very different characteristics and therefore needed specific interventions for each one.

An activity plan was prepared to raise awareness and knowledge in the population regarding the risks involved in STI and HIV infections, in order to modify risky attitudes and behavior. This activity plan was divided into three stages: rapprochement, mapping, and information and awareness.

**Rapprochement:** Contacts were established with professionals (social assistants, psychologists), internal security (guardians) and cell block delegates (general, health and discipline). Together we coordinated some informative talks to psychological and social therapy groups that worked with them, as well as to other inmates that were considered to be within these therapy groups.

**Mapping:** The characteristics of cell block organization were assessed, which helped us to have a better understanding of the dynamics of the inmates' life. This, in turn, made it possible to adapt and plan our activities based on the timetables, habits and places where our talks would take place. The places and spaces for sexual encounters were identified, but also the infrastructure in each cell block.

**Information and awareness.** Some informative talks were organized to reach the highest number of inmates and to have a good coverage. Additionally, it was necessary to develop different activities such as sports, contests, condom distribution campaigns, exhibition of IEC material, celebration of the International Day against HIV/AIDS, health campaigns and health circuits.

Even though the strategy for the general population made it possible to have a better knowledge and understanding of the context inside the prison, the results have not been as effective as those obtained using strategies directed at specific groups.



## Strategies for newcomers

One of the strategies that has guaranteed the largest coverage of STI and HIV risk and prevention messages has been the one that focused on new admissions. That included both the primary population (that are admitted to the prison for the first time and therefore do not know how it works or the risks for their health) as well as recidivists (those have been previously admitted to a prison).

This strategy offers information to newcomers that allows them to see themselves at risk of becoming infected with STI, HIV or TB, promotes EPRCOL services and allows the early screening of STI and TB and therefore opportune and efficient treatment.

This strategy also includes promotional preventive and treatment components.

The promotional preventive component consists of a talk about the risks of STI, HIV and TB and the ways to prevent them. This information is reinforced by distribution of IEC material, condoms and lubricants.

The medical part consists of the routine medical examination when the inmate is admitted to the prison, where the form “Evaluation and Derivation to Health Programs” is completed. This form was prepared to make it easier to liaise with health services. It is a questionnaire that was designed as a checklist to make it possible to discard several infections, especially STI, HIV and TB. When any disease is suspected, an appointment is made in the prison clinic and at the same time the health personnel is instructed to follow up the case.

More than eight thousand inmates have been reached with this strategy in the last two years (September 2003 to September 2005). Likewise, in 2004, 21% out of the 1486 counseling performed in the prison PROCETSS were for people that had been recipients of this strategy. This percentage corresponds exactly to the increase in counseling sessions between 2003 and 2004.

With this newcomers strategy, it is possible to reach a large amount of the prison population with low investment in time and resources.





### Condom distribution

The availability of condoms within the prison is fundamental for the prevention of STI and HIV/AIDS. The free distribution of condoms is part of PROCETSS preventive promotional activities.

Since 2001, with the support of MSF, there has been a regular distribution of condoms, giving priority to vulnerable groups. Two years later, a condom flooding strategy was introduced. This consisted of the distribution once a month of condoms, lubricants and brochures, in the cell blocks during lunch time (“paila” time), and also during special events, for example New Year, Father’s Day, Independence Day and the International Day Against HIV/AIDS.

Currently this activity is carried out entirely by PROCETSS multidisciplinary team with the support of other professionals from the clinic as well as health delegates.

### The health campaign

The health campaign is performed inside the cell blocks or in the prison central auditorium to reach a considerable number of inmates. This activity mobilizes the health professionals to give integral care to those who have little chance to have access to the clinic, for example inmates who do not belong to any cell block.

There is a promotion area (informative talks about STI, HIV/AIDS and TB and the development of a health circuit), a prevention area (counseling and tests to screen TB, HIV and Syphilis) and a treatment area (medical and dental care), besides artistic activities and haircuts.

### The health circuit

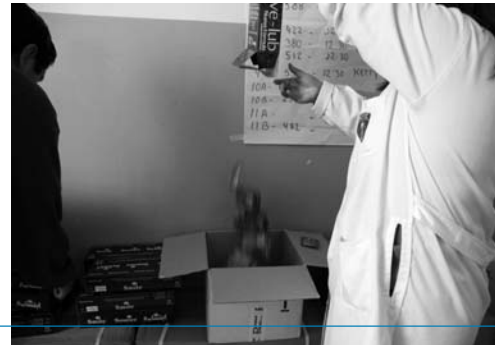
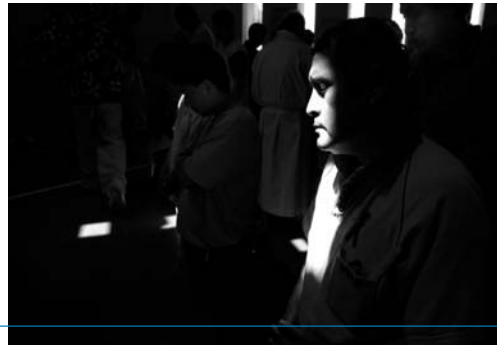
This is a relaxing, educative and competitive activity that makes it possible to identify the participants’ knowledge of STI, HIV/AIDS and offers complementary information about the subject. It was adapted to complement an educational subject with a competition game. The participants must use their knowledge to solve problems with messages related to STI and HIV/AIDS.

The health circuit comprises eight steps, four of which refer to topics related to STI, HIV/AIDS (STI identification, appropriate use of the condom, stigma and discrimination, and risk behavior in HIV/AIDS). The other four steps are games that will enable the participants to relax and compete without any previous knowledge about the matter (sack races, pulling the rope or the egg and spoon race).

This activity can be adapted to any health topic (for example, TB, nutrition and sanitation).

### International Day Against HIV/AIDS

To commemorate the International Day Against HIV/AIDS, different activities are prepared. These are presented in a commemorative act in front of the whole prison population. Artistic contests (dancing, music and drawing), banners and health circuits are organized in order to promote HIV/AIDS prevention messages, to reduce stigma and discrimination against people living with HIV/AIDS inside the prison and to raise awareness in the prison population on these topics. The central activity is on December 1<sup>st</sup>, in the prison auditorium, where the winners of the different contests receive awards.





# STRATEGIES FOR SPECIFIC GROUPS

## Strategy for People Living with HIV/AIDS (PLWHA)

At the beginning, some training and reinforcement courses were carried out on psychological counseling and treatment for HIV cases, addressed to PROCETSS professionals. These training sessions were designed to inform and raise awareness

of this problem to achieve a uniform discourse about STI and HIV/AIDS working on preventive and promotional messages on health, counseling, sexuality, stigma and discrimination and adherence to treatment. At the same time, some work was done with PLWHA through group dynamics to provide information on topics related to the infection. Later, some intensive workshops on self-care were included.

The aim of the workshops was to offer PLWHA a group of useful tools to facilitate understanding of the different

aspects of HIV infection. Among the main topics were: opportunistic infections, risky conduct and behavior for re-infection, current treatments, sexual behavior and other topics such as sharing their diagnosis so that they can improve their understanding about the disease and above all, to ensure their commitment to take care of themselves.

Therapeutic groups were formed where people could, besides sharing a space for a limited time, share their emotions, fears, feelings and worries. Some occupational workshops were also organized, among them the guitar-playing workshop and the handicraft workshop (to manufacture Christmas decorations and blankets).

As part of the collective strengthening strategy, the formation of Mutual Support Groups (GAM) was encouraged. There were some attempts to organize a GAM,

but finally it was not possible to consolidate them, as the environment in the prison is quite complex.

When the Highly Active Antiretroviral Therapy (HAART) arrived at Lurigancho prison in 2005, some workshops were organized as a preparation for treatment, with specific topics about Anti Retroviral (ARV), the different schemes, the importance of CD4, viral charge and adherence.

Another aspect of the strategy with PLWHA has been individual work through support counseling, psychological support, social aspects and periodical medical attention.

During the first years of the project, the third floor of the clinic was highly stigmatized, as it was identified only with people living with HIV/AIDS. To minimize this stigma, activities from other strategies of the project were organized in this space (health delegates, promoters, Virgen de la Puerta Community), as well as celebrations of special dates, trying to attract more groups and people that work directly or indirectly in the prison. The third floor then became a space for socialization and gathering, making it an open place and at the same time dissipating the fear of been there.

Additionally, as part of the strategy, there was direct intervention with the families of inmates living with HIV/AIDS to improve communication channels, raise awareness in the families about the importance of their participation as a supportive network during the evolution of their illness, strengthening their skills



to handle the situation, increasing their capacity to give emotional support to the patient, and decrease the individual and group conflict.

A program was prepared to perform workshops in which the problems of STI and HIV/AIDS were addressed through sharing experiences. A space where to live and express the families' conflicts, fears and worries was encouraged. The workshops also contained theoretical and practical information on topics related to the disease, with workshops on confidence, family and partner relationships to strengthen family ties. Besides receiving information about the necessary measures to take once the inmate returns home, they were informed about the different hospital centers they could access for the continuation of their treatment and control.

The collective strategy for PLWHA within the prison faces more difficulties than outside, especially because of high stigmatization and the lack of commitment by the inmates. The formation of GAM (Mutual Support Groups) is feasible, but unlike what happens outside, in the prison the multidisciplinary team has to make an additional effort in having a full time professional staff.

People's behavior is not only determined by personal elements, but also by social and cultural factors. That's why it is appropriate that interventions with people living with HIV consider individual and collective work. Moreover it is indispensable to know people's knowledge, attitudes, practices, beliefs, and needs about HIV to be able to consider these factors when preparing the topics to be included in training and other interventions.

Inmates can trust a program that guarantees confidentiality. However, it is very difficult to keep strict confidentiality in a prison environment, where the HIV status of inmates is hierarchically requested by the personnel and the officers.





### Strategy with Virgen de la Puerta Community

This is a vulnerable population with the highest risk of contracting and transmitting HIV/AIDS inside Lurigancho prison. The members of the community were identified as a priority for the development of strategies and activities.

The collective approach started by aiming to strengthen them as a group with their own identity. Several workshops were conducted on topics such as group unity, human rights, sex and sexuality, confidence, negotiation and correct use of condom, as well as awareness of STI and HIV/AIDS.

In addition to these activities, several other activities were planned with the Community (hairdressing, rotatory fund), they also received support to participate in several general activities in the prison (artistic and gastronomic contests) trying to promote their skills and reinforce the messages transmitted in the workshops.

For the project, the Community is an important ally for reaching the “encaleta” (hidden) population, those inmates who have sex with men (MSM), but who do not want anybody to know their sexual orientation to avoid being laughed at, prejudiced and discriminated. According to the members of the Community, “more than half of the prison can be classed as an “encaleta” population”.

The participation of the Virgen de la Puerta Community was essential in spreading STI and HIV/AIDS preventive messages, and also in some of the project’s activities such as health campaign, health circuit, and the preparation of IEC material.

Based on the knowledge collected during the first years of the project, in 2002 an individual approach was started by carrying out supportive counseling, psychological support, social services and periodic medical attention. In addition there was also reinforcement of the topics addressed in the group workshops.

Some workshops were carried out with INPE professionals focusing on human rights, sexual diversity, stigma and discrimination.

Today, a change of attitude is perceived among the members of the Virgen de la Puerta Community towards the possibility of assuming less risky conducts, but there is still no visible change of behavior (no continuous use of condoms, multiple sexual partners).



The strengthening of the Virgen de la Puerta Community as a group contributes to their recognition and acknowledgement within the prison by inmates and INPE professional personnel and improves their access to services. However there is still stigma and discrimination against this Community.

### Strategy with Commercial Sex Workers

As this group is external (and clandestine) to the prison and because they are afraid of being discovered, it is difficult to identify and follow-up. Even if only a small group of CSW approach the health service, several external workshops have been conducted on STI and HIV/AIDS, sexual and reproductive rights, periodical medical attention, negotiation and correct use of condoms to keep them playing a proactive role with their health and self-care.

They are periodically offered counseling, condoms and lubricants. They are also encouraged to visit MoH Sexually Transmitted Diseases and HIV/AIDS Reference Centers (CERETS).

### Strategy with LASZER group

Although at the beginning, this LASZER group was identified as being highly vulnerable, it was not predicted as having a high rate of STI or HIV/AIDS that would define them as a target group.

Only by the end of 2004, it was possible to intervene with a health campaign specific for the LASZER group. Preventive, promotional and medical attention activities were organized within the cell block. The results obtained in the campaign were more worrying than in other cell blocks and became the first objective data that enabled us to consider this population as target group.

Today, we know more about this group and its dynamics but a specific intervention for this group has not yet been undertaken.



The search, identification and intervention with specific groups within the prison is necessary, as this helps to define and prioritize strategies, to enhance the available resources and make a better use of the efforts made by health personnel.

## Strategy with health delegates

As health delegates know the health problems and are recognized among the inmates in their cell blocks, they are a strategic ally in winning the confidence of the prison population, to spread the messages and to liaise between the clinic and the cell blocks.

At the beginning the health delegate's organization was incipient and they did not meet periodically. They did not have specific functions backed by the health area and the inmates themselves. Many of them were appointed despite their lack of the necessary qualities (inclination to serve others and of concern for inmates' health), so they had to be given clear functions and work plans based on their vision and mission as health delegates. Another of the limitations was the continual turnover of health delegates, which interfered with their cohesion, showing an uneven commitment and interrupting the flow of activities.

Some workshops were organized to offer training and to build awareness on such topics as STI and HIV/AIDS, first aid, health care, how to become a healthy person and the preparation of health promoters. The topic of stigma and discrimination was addressed as a transversal axis.



Health delegates helped in the preparation, validation and implementation of IEC material addressed to the prison population such as the flip chart “La Firme”<sup>4</sup>, brochures, key messages and others.

In addition, some periodic meetings were organized to debate topics of their own interest, integrate the new delegates and encourage their active participation within the prison health system, involving them in the different prison health service activities (health campaigns and circuits, condom floods, supportive talks in the cell blocks, and in the strategy for new admissions, support in the organization of the international day against HIV/AIDS and others).

The image of the health delegate as a representative, essential for solving inmates' health problems was strengthened. They helped with the reorganization of quota allocations and with the organization of the schedule.

To be aware of the importance of a health delegate's role to the inmates, it is important to consider the underlying risk of an inadequate use of power when implementing strategies.

<sup>4</sup> “LA FIRME”, a flip chart on STI and HIV/AIDS, is a tool used exclusively for penitentiary population, which has illustrations made by two inmates. This flip chart is used in the talk to cell blocks and for first timers. It has a users guide.



### Strategy with Promoters and Educators (Peer)

Peer are people who offer their support, information, orientation, education and counseling to other people (their “peers”) with whom they share one or more characteristics, allowing them to establish horizontal relationships.

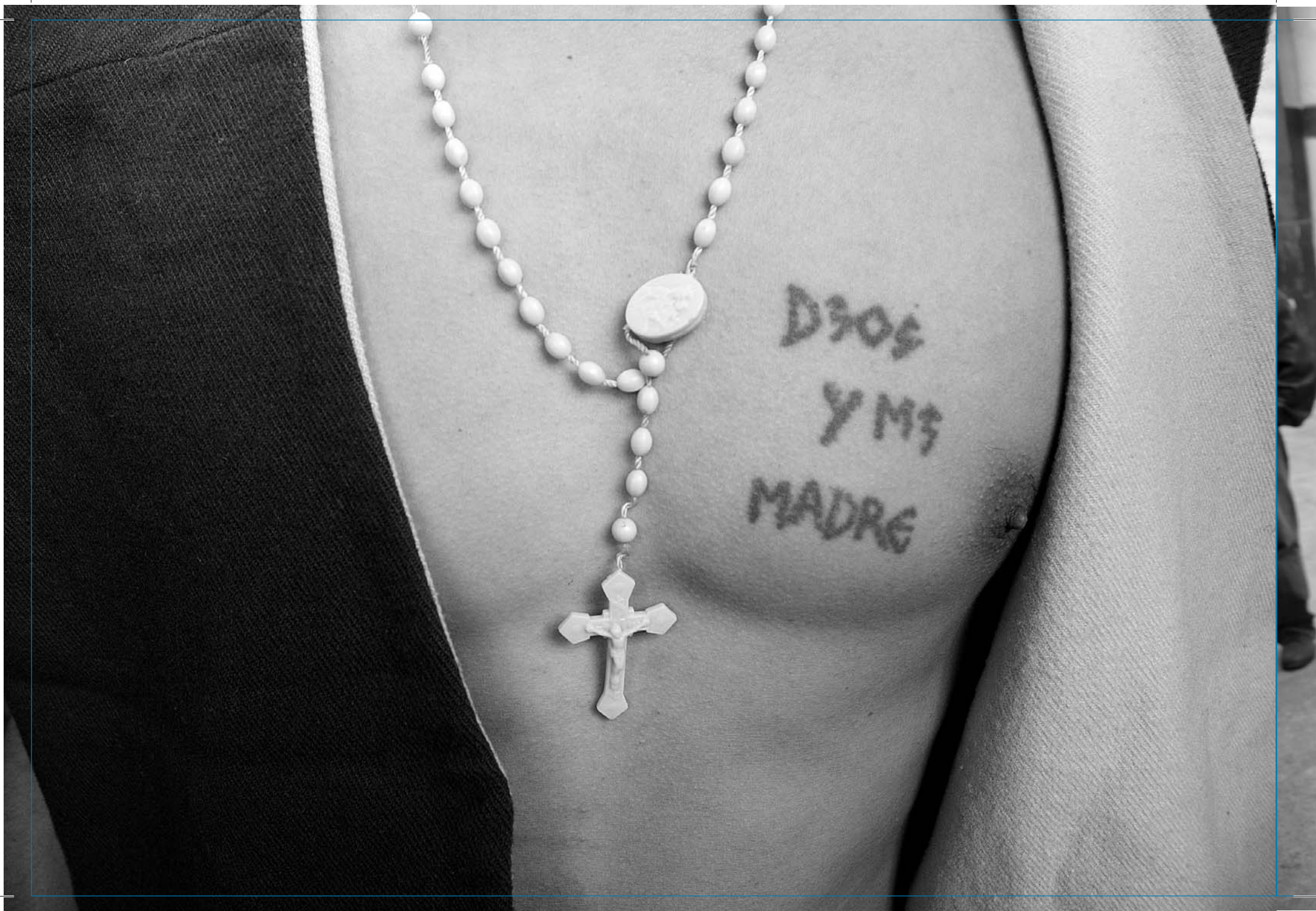
One of the IEC components was a strategy to prepare Peer Promoters and Educators (Peer), offering training in STI and HIV topics to health delegates, members of the Virgen de la Puerta Community and PLWHA.

This strategy could not be carried out, basically because it is very difficult to find a peer within a prison, which is a hierarchical and competitive system, where nobody can be trusted, and where horizontal relationships are not always possible.

In addition, the life style of inmates consists of meeting their immediate needs and expectations, making their interests and motivations short lived before any activity that is not profitable. Therefore a Peer relationship is not attractive to them.

A peer strategy might be implemented in prisons with very specific groups that make homogenous groups where there is no exercise of power and no established hierarchical roles. For other groups, such a strategy is not realistic.











**T**he medical area includes all activities of a multidisciplinary team with regard to diagnosis, treatment and follow-up of patients as a part of comprehensive care of STI and HIV/AIDS in the prison. However, it is important to point out that the medical component is closely related to all preventive strategies.

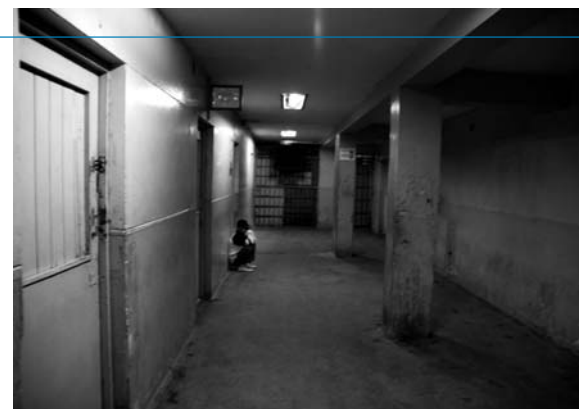
At the beginning of the intervention, during the first stage of the project, it was necessary to reinforce and improve the general care system in the clinic, its infrastructure and the human resources. For this the third floor of the clinic, where PROCETSS is operating, was rehabilitated. Moreover, a waste area was built as well as other improvements to infrastructure.

The improvement in infrastructure offers a motivating work environment for the health staff, and contributes to the improvement of quality and respectful attention.

Another weakness of the program was the lack of human resources. At the beginning of the project, the medical team consisted of 2 persons: a doctor and a counselor. With the development of IEC activities, the demand for the services provided by PROCETSS increased, making it necessary to reinforce the team.

STI and HIV/AIDS constitute an important health problem inside the prison. Their management requires the presence of an adequate multidisciplinary team. Medical services of PROCETSS in Lurigancho prison need the presence of a full-time doctor.

Job profiles for medical staff and the organigram were elaborated. Workshops, awareness-raising talks, socialization activities and in-service training were performed to empower medical staff.



## ACTIVITIES

The main health care activities in PROCETSS of Lurigancho prison are as follows:

**Counseling:** Pre-test, post-test and support, carried out by personnel trained in counseling (midwife, nurse, psychologist and social assistant).

**Medical consultation:** Medical care for patients with symptoms of STI and inmates living with HIV/AIDS.

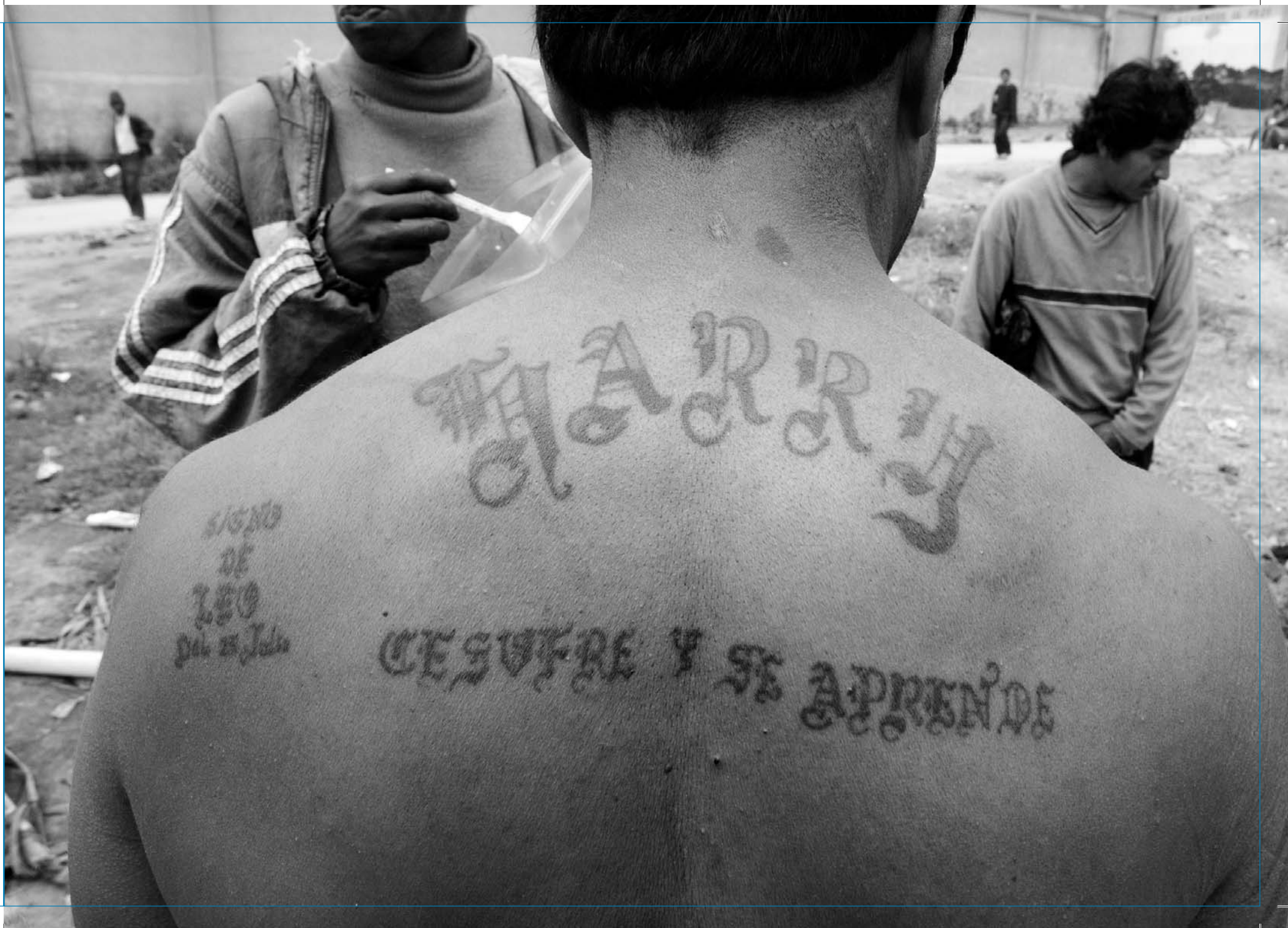
**Supervised treatment:** Permanent supervision of treatment is necessary in the prison. We use the term “supervised treatment” which consists of periodic treatment administration for STI, prophylaxis of opportunistic infections and HAART.

**Laboratory:** Implementation of rapid tests (HIV, RPR)

**Pharmacy:** Management of required medicines and medical material.

**Hospitalization:** Hospitalization of patients in the prison’s clinic or their transfer to the reference hospital (evacuation out of the prison) when needed.

These services are mainly offered to patients with symptoms of STI, people living with HIV/AIDS, people with risky behavior such as the Virgen de la Puerta Community, CSW, the LASZER group and TB patients.







### Medical data

The prevalence of HIV/AIDS in Peru is estimate to be lower than 1%. The estimation was based on the prevalence of HIV/AIDS in pregnant women (47% of total of pregnant women were tested in 2004). These last estimates show a prevalence of 0,21% at the national level and 0,44% for the region of Lima and Callao.

The total of the infected population is estimated at 76 000 persons. From 1983 to June 2005 the accumulated total of HIV/AIDS cases registered in Peru was 22857. Out of this number, 70 - 75% correspond to Lima and Callao Region. There is a problem in notification of cases of HIV and AIDS (counted separately by MINSA) which does not give a clear picture of the situation. HIV incidence is growing in the Amazon area and the coastal region around Chiclayo.

The data collected from different activities performed by the multidisciplinary team (MSF & INPE) shows gradual implementation of different strategies in the prison. There is no data for the first years of the project. At the same time, the 2005 data includes information only up to October, and shows the gradual withdrawal of the MSF team from daily medical activities.

### Counseling, tests and prevalence

Counseling activities were already performed before the project began. With reinforcement of the team, its training and incorporation of adapted tools, counseling activities increased to cover the new demand created by different strategies. In addition since the end of 2002, the implementation of the rapid tests strategy (HIV, RPR) in the clinic of Lurigancho has made possible the sustainability of the counseling system created. It was also necessary to implement a written counseling form adapted to the prisons' reality.

Table 1 shows the gradual increase of counseling and HIV/RPR tests performed. At the same time, it shows a decrease in test acceptance because patients who are better informed about the voluntary aspect of testing are making a free decision. In 2000 and 2001, the total of RPR tests performed was not recorded.



In 2004 and 2005, the total of post-test counseling is higher than the total of HIV tests performed; this is due to the inclusion of RPR testing only in the total of post-test counseling.

Table 1. Counseling and performed tests in PROCETSS/EPRCOL MSF 2000-2005.

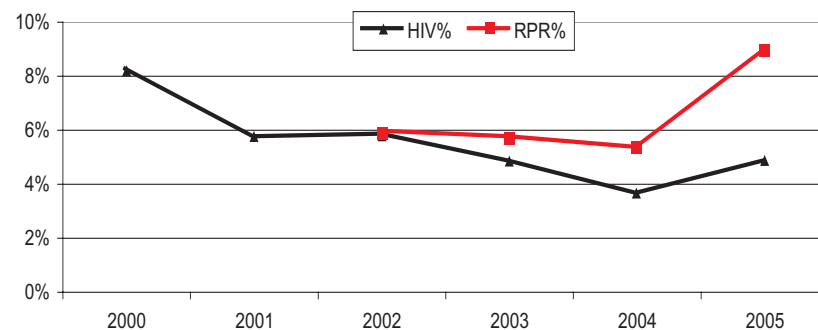
PLWHA	2000	2001	2002	2003	2004	2005
Pre-Test Counseling	416	685	919	1190	1610	1240
Post-Test Counseling	411	656	849	1125	1486	1082
Positive HIV test	34	39	51	56	52	43
Total HIV test	416	685	873	1154	1442	900
Positive RPR tests	12	11	52	67	80	91
Total RPR tests	-	-	873	1178	1495	1018

Source: MSF Annual reports 2000-2005.



HIV seropositives among PROCETSS patients decreased in parallel to the increased coverage of counseling. During the development of the project, counseling was offered to the general inmate population as a result of the intervention in cell blocks and strategy for newcomers, and no longer just to identified vulnerable groups with much higher prevalence of HIV. However, in 2005, there was an increase in numbers of HIV and RPR due to reference to PROCETSS of patients diagnosed with HIV or syphilis (RPR) during a testing campaign performed in April by one of GF actors. In general, among patients of PROCETSS in Lurigancho, RPR seropositive is higher than the HIV one. (See Graph 1).

Graph 1. HIV and RPR seropositivity among PROCETSS/EPRCOL patients. MSF. 2000-2005



Source : MSF Annual reports 2000-2005

According to the sentinel study performed in 1999 by OGE<sup>5</sup> and INPE, the prevalence of HIV and RPR in Lurigancho prison was 2,3% for HIV and 3,5% for RPR. A second sentinel study, funded by the GF, was performed in April 2005, but there are no official results so far.

<sup>5</sup> Oficina General de Epidemiología

## HIV vulnerable and risky groups

HIV/AIDS in Peru is an epidemic concentrated in the vulnerable population, such as men that have sex with men (MSM), with a prevalence of 13% nationwide, and 24% in the region of Lima. Other vulnerable populations have lower HIV prevalence. Nationwide, 0,6% to 2% of commercial sex workers (CSW) are HIV positive, although a higher prevalence has been reported among unlicensed CSW. An OGE study, performed among sexual worker customers ("bridge population") that receive periodic medical attention in coastal cities (Lima, Ica, Chiclayo and Trujillo), found a prevalence of 0,62%.

Among the vulnerable groups identified as target population in EPRCOL we can mention:

**Virgen de la Puerta Community:** This group has the highest HIV seropositivity (41 to 48%) within vulnerable groups in the prison. During the three-year follow-up (2003-2005), an apparent decrease of HIV seropositivity within the Community was observed. The results are influenced by the gradual increase of the Community members during the time of follow up. However, because the total number of integrants in the Community is low (38 to 40 accumulated number per year) each case strongly influences the total percentage.

**TB patients:** HIV seropositivity among TB patients is between 4 and 6%. Tuberculosis is the main opportunistic infection among people living with HIV/AIDS. In EPRCOL, 40% of PLWHA have TB.

**LASZER group:** Although the information about this group is limited, HIV seropositivity is high, being estimated around 6%. More attention should be paid to this group in the future.

**Patients with STI:** The data obtained shows HIV seropositivity around 4% among STI patients. The results can be sub estimated because of possible underreported cases (registration problems).

**Commercial Sex Workers (CSW):** HIV seropositivity among female sexual workers followed by the project is very low. These data show that contrary to general belief, CSW do not represent a significantly risky group.

Table 2. HIV seropositivity in vulnerable groups, PROCETSS /EPRCOL MSF 2003-2005

Year/Group	CVP	TB	LASZER	STI	CSW
2003	48 %	6 %	-	4 %	4 %
2004	40 %	4 %	6 %	3 %	0 %
2005	41 %	5 %	-	4 %	0 %

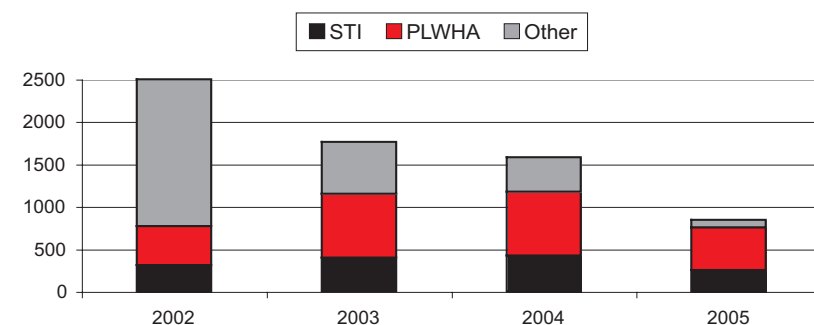
Source: MSF Annual reports 2003-2005.

In Lurigancho prison, the HIV/AIDS epidemic is concentrated in vulnerable groups, and at the same time it is transmitted to the prison's population and to society in general.

### STI case management.

Medical activities were aimed at meeting the need for specialized consultations and in-service training on STI and HIV/AIDS case management for PROCETSS medical staff. However, what started as support from MSF became a substitution, responding to a clear need for a full-time doctor for PROCETSS activities. However, implementation of STI guideline facilitated early case detection, management of STI and data collection.

Graph 2. Total of consultations in PROCETSS /EPRCOL MSF 2002-2005

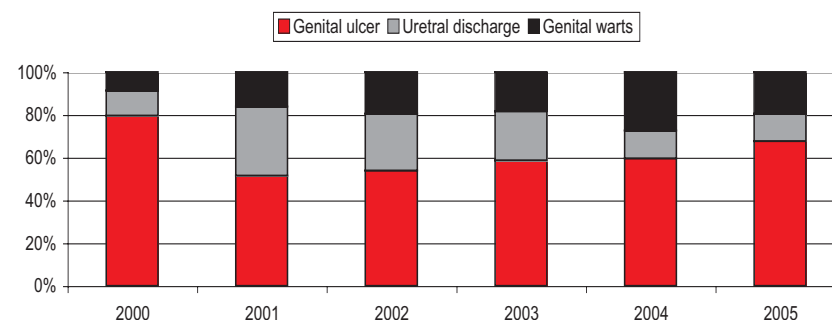


Source: MSF Annual reports 2002-2005

The increase in medical consultations (HIV and STI) during 2003 and 2004 was due to the presence of a full-time doctor in the field. Consultations for PLWHA correspond to an average of 45% of the total consultations and symptomatic STI to an average of 25%. The category of "others" includes general medical consultations performed by the PROCETSS doctor. In 2002, the high number of "other" consultations is related to TB patients who at that time were followed by the same doctor in charge of 2 programs (TB and HIV). (Graph 2).

The main diagnosis of symptomatic STI corresponds to genital ulcer syndrome (55 to 70% of cases). Over the years, an apparent increase of the total number of genital warts is observed (2 to 25% of diagnosed STI cases). This situation shows how important the availability of treatment is for herpetic ulcers (60-80% of genital ulcers) and genital warts in Lurigancho prison. These specific treatments are not considered by MINSA as a part of the PROCETSS program even if their availability allows a proper management of cases and indirectly influences HIV control through better attraction of patients with risky behavior for infection and transmission of HIV.

Graph 3. Symptomatic STI cases among PROCETSS patients /EPRCOL MSF 2000-2005



Source: MSF Annual reports 2000-2005.

As the prevalence of herpetic ulcers and genital warts is high among those diagnosed with STI in Lurigancho prison, the availability of specific treatment (acyclovir and podophyllotoxine) must be considered inside the prison, even if it is not considered in other PROCETSS programs.



## HIV/AIDS case management

In general, the management of HIV/AIDS cases includes ambulatory care and hospitalization in the clinic of the prison or follow-up of cases transferred to a reference hospital (evacuation). Ambulatory care includes medical consultations (with average of 45% of total consultations in PROCETSS) and supervised administration of medicines for prophylaxis (isoniazid, cotrimoxazol), treatment for opportunistic infections and HAART.

In spite of supervised administration of treatments, the inmates' adherence to treatment is not guaranteed for several reasons, drug abuse being the main reason. Therefore, it is necessary to have a program to decrease drug use in the prison, to minimize its potential damage and to guarantee treatment adherence.

Table 3 shows the progressive increase in the number of people living with HIV/AIDS that entered the program. The highest number of patients does not necessarily mean a higher seropositivity (as shown in Graph 1), but better coverage of the program. At the same time, the variation in total exits of the program is influenced by humanitarian discharges from the prison which were very high in 2002 and 2005.

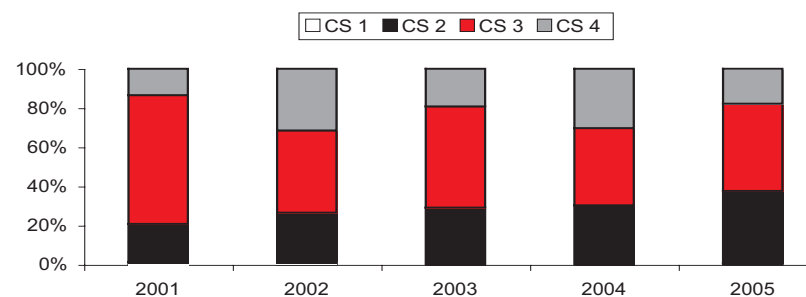


Table 3. Numbers of PLWHA in PROCETSS /EPRCOL MSF 2000-2005

PLWHA		2000	2001	2002	2003	2004	2005
Total PLWHA at beginning of year		44	53	52	63	82	82
ENTRY	New cases	34	40	47	37	38	43
	With previous external diagnosis	-	-	-	13	7	14
	Re-entry to the prison	3	7	9	10	5	7
	Total Entry	37	47	56	60	50	64
EXITS	Exit from the prison (freedom)	19	19	24	32	29	26
	Humanitarian discharge from the prison	4	9	12	0	6	17
	Transferred	0	7	2	4	1	0
	Dead	5	13	7	5	14	6
	Total Exits	28	48	45	41	50	49
Total PLWHA at the end of the year		53	52	63	82	82	97

Source: MSF Annual reports 2000-2005.

Graph 4. HIV infection clinical stages in PROCETSS patients / EPRCOL MSF . 2001-2005



Source: MSF Annual reports 2001-2005.

\*CS: Clinical Stage



PARA SU ATENCION  
PONGA SU FIRMA Y  
HUELLA DONDE  
CORRESPONDA.

Graph 4 shows that the percentage of patients in early clinical stages of HIV infections increased gradually in parallel to the increase in the total number of people living with HIV/AIDS followed by the program (WHO stage 2 passed from 19 to 37% of total cases). This situation demonstrates an improvement in early case detection during the development of the program.

However, the highest number of patients corresponds always to WHO stage 3 (between 42% and 67%). That includes pulmonary TB which usually represents an important public health problem in the context of prisons.

TB prevalence in Lurigancho is very high (in 2004: 342 TB registered cases among 8,242 inmates, which represent more than 4 thousand cases per one hundred thousand people).

TB/HIV co-infection (40% in Lurigancho) represents another important problem. The prison context is usually limited in early case detection and treatment of both diseases, which leads to severe cases, resistant forms and high mortality.



## HIGHLY ACTIVE ANTI-RETROVIRAL TREATMENT (HAART)

Until 2004, people living with HIV/AIDS in Peru had very limited access to treatment which was only provided for members of the Armed Forces and Social Security beneficiaries. In August 2005, the number of public hospitals (MoH) supplying HAART in the country reached 41, among them PROCETSS in Lurigancho prison.

HAART was implemented in Lurigancho prison in July 2005. MSF participated with training of the multidisciplinary team, medical technical support and preparation of patients for treatment.

Even if the first beneficiaries of HAART are only 14 people living with HIV/AIDS with basic schemes, more patients would gradually be included. There are still some issues to be solved (availability of different treatment schemes, handling of drug addiction, proper laboratory follow-up, definition of reference hospitals), and this corresponds to a political decision of the MINSA and INPE authorities to give sustainability to this experience.

Table 4. PLWHA receiving HAART in PROCETSS/EPRCOL MSF 2005

HAART	JULY	AUG	SEPT	OCT	Total
Total HAART started	4	2	6	2	14
Total exist from the program	3	0	1	0	4
Totall on HAART in the program	1	3	8	10	10

Source: MSF Monthly reports July – October 2005.

With the presence of a trained multidisciplinary team and availability of necessary drugs, it is possible to offer a comprehensive HIV/AIDS quality care in the prison







The aim of hygiene within health facilities is to prevent the transmission of infections by implementing barriers to the different elements of the transmission chain, irrespective of the health structure, in order to protect the health of the personnel, the patients and the general community.

Universal precautions refer to the group of procedures that have always to be followed at the time of attending patients to reduce the risk of transmission of the different infective agents that are spread through blood and body fluids.

Lurigancho prison health services do not meet the necessary conditions of a health structure: the infrastructure is seriously damaged, ventilation is not adequate, the electric installation is not working properly, there are leaks and humidity. At the same time beds are insufficient and the existing ones are in a terrible condition.

The health personnel, the inmates, the external visits (relatives, authorities, professionals) and the prison environment are exposed to several etiologic agents.

Through the joint work with EPRCOL health service, MSF promoted several measures that made it possible to substantially improve the quality and respect for biosafety standards. These measures had three main axis: infrastructure, human resources and the supply of medical and non medical materials.

**Infrastructure:** A waste area was built (incinerator and sharp pits) solving the biggest problem and risk due to the lack of a strategy to separate and treat the waste produced by the clinic, which had been deposited in a sector of the prison to which inmates had access.

In addition, the third floor of the clinic was rehabilitated (PROCETSS), a sterilization center was implemented and organized and a module to identify patients with respiratory symptoms was built.

**Human resources:** Training of clinic personnel and the collaborators in charge of cleaning. Topics included the implementation of biosafety techniques such as waste separation, circuit and treatment, sterilization techniques, as well as reorganization of the area and the implementation of protocols according to current standards.

Within all this biosafety work, the creation of a committee for intra hospital infections has been quite important. This committee is in charge of coordinating, evaluating and enforcing all bio-safety standards.

**Supply of medical and non-medical materials:** Giving support to supply the resources necessary to implement biosafety activities. This includes cleaning material, protection barriers (gloves, boots, masks, etc.) and other material specifically used for sterilization.

To complement the tasks performed, a practical biosafety guideline is being prepared. This guideline will be adapted for use by the Lurigancho prison health services.



The knowledge on biosafety and the prevention of infectious or contagious diseases improves the attitude of health personnel and collaborators, leading to positive changes in their behavior .





During these years carrying out the project in Lurigancho prison, in Mèdecins Sans Frontières (MSF) we have learned that:

- To be able to implement any project or strategy inside Lurigancho prison, it is of great importance to understand the social and cultural dynamic within the prison, and to be known and recognized by the inmates as people who want to work with and for them.
- Even if they are in prison, the participation of inmates in planned activities is not guaranteed. Many times they have other activities (social and psychological therapy, meetings with their lawyers, visits to the judiciary or to the Occupational Education Center (CEO) which keeps them away from the cell block or from the activities schedule within the project.
- In a prison, projects happen in slow motion. It is necessary to work firmly but serenely to gain access and the necessary confidence to implement the planned strategies. Also, it is necessary to have a great dose of patience and to be ready to adapt the initial plans according to the prison environment.
- MSF as a humanitarian and somehow horizontal organization has to learn and adapt its culture and approach to be able to work with a very hierarchical institution such as INPE, in order to achieve its proposed objectives.
- Creativity and flexibility are the key elements to work in prisons. Everything has to be adapted to the reality of the prison. No foreign element will work per se.
- Rotation of INPE health professionals does not contribute to the implementation of strategies or their sustainability. Involving them in achieving the project's goals demands time and effort. The processes are interrupted by their rotation.
- Carrying the virus is not the only condition that stigmatizes and dis-

criminate inside the prison: the social condition also does so. Therefore working to reduce stigma and discrimination against people living with HIV in a context such as Lurigancho prison is much more complicated and demands considerable time and effort.

- Permanent communication among all actors in Lurigancho prison is a difficult exercise but it is also vitally important to unify the message given to inmates. At the same time, communication is important to avoid duplication of activities that can produce fatigue or low participation and thus affect the scope of the expected results.







*"Currently, with the support of the international organization Mèdecins Sans Frontières many goals have been achieved in terms of biosafety, as there is permanent training to the health personnel, to inmates who help in the health area, to health delegates from all cell blocks, to health promoters, providing elementary biosafety standards and minimizing the risk of catching a disease and spreading it in the cell blocks and consequently to all the population in the prison."*

**Lurigancho prison health professional**

*"MSF has strengthened and integrated us to keep working with the usual willingness to help the prison population and with the commitment to spread the experience gained throughout the years to other prisons in the country."*

**Lurigancho prison health professional**

*"MSF arrived and listened to a group of INPE professionals who had been working in prisons for many years. These professionals had experience, sensibility and were eager to contribute ideas, projects, to perform changes to improve the quality of the attention given to inmates."*

**Lurigancho prison health professional**

*"I thank Mèdecins Sans Frontières for the great opportunity of making a responsible and professional work, the opportunity of meeting and sharing ideas and projects, dreams and reality. Thank you very much."*

**Lurigancho prison health professional**





Mèdecins Sans Frontières, MSF, is an international humanitarian organization that provides medical and sanitary aid to population with little access to health services or to victims of natural or man-made disasters with no difference of nationality, race, religion or political belief.

Through their humanitarian action, MSF intends to preserve life and relieve suffering, respecting people's dignity, until they are able to take their own decisions. The objective of its activities is to provide medical aid and protect the physical and psychological integrity of the civil population in a precarious situation.

Mèdecins Sans Frontières perform its activities in close contact with the civil population and at their request, with the presence of 15000 doctors, nurses, epidemiologists, laboratory technicians, logisticians and administrators from all over the world that work in MSF projects and interventions in more than 70 countries.

The humanitarian medical mission is protected by the International Humanitarian Rights. MSF members respect the ethical principles of their profession at all times and cannot be compelled to perform activities contrary to them. MSF also demands the respect to the International Humanitarian Rights.

Mèdecins Sans Frontières was awarded the Nobel Peace Prize in 1999 as recognition of their humanitarian work.

MSF has been developing several health projects in Peru since 1985.



## ACKNOWLEDGEMENTS

Carrying out this project along the years has been a learning and commitment journey in the prevention and treatment of HIV/AIDS and STI, where the contribution of different actors that participated in one way or another, has been fundamental to achieve our objectives inside Lurigancho prison.

We are especially grateful to the professionals in PROCETSS multidisciplinary team and the EPRCOL TB team; to INPE staff, and the prison authorities; to health delegates that contributed to improve the access to health of the people deprived of liberty; to the National Director of INPE health area, to the National and Regional Direction of INPE and to the Peruvian National Police.

To all of the inmates, our friends, for their support, participation and confidence. Without your help and interest none of the plans in this project would have been carried out.  
Absolute thanks.

We are also thankful to the different MSF teams that took an active part in the development of this project, as well as the Peruvian MSF coordination team for their permanent support.





## ACRONYMS

ANDA	Alcohol, drugs and associated crime
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-Retro Viral
CEO	Occupational Education Center
CERETS	Sexually transmitted diseases reference center
CVP	Virgen de la Puerta Community
CSW	Commercial Sex Workers
OGE	Epidemiology General Office
EPRCOL	Lurigancho Closed Ordinary Regimen Prison
GF	Global Fund
HAART	Highly active anti-retroviral treatment
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
INPE	National Prison Institute
MINSA	Ministry of Health
MSF	Mèdecins Sans Frontières
GAM	Mutual support group
MSM	Men who have sex with men
OTT	Treatment technical body
PDL	People deprived of liberty
PEER	Peer promoters and educators
PLWHA	People living with HIV/AIDS
PNP	Peruvian National Police
PROCETSS	Sexually Transmitted Diseases and HIV/AIDS Control Program
RPR	Rapid plasma reagent, a blood test for syphilis
STI	Sexually transmitted infections
TB	Tuberculosis
VCT	Voluntary counseling test

## BIBLIOGRAPHY

*Estudio sobre las condiciones de salud con relación a la Tuberculosis, Enfermedades de Transmisión Sexual y VIH/SIDA en el establecimiento Penitenciario de Régimen Cerrado Ordinario de Lurigancho.*

*Mèdecins Sans Frontières The Netherlands. Lic. Claudine Lerho, Lic. Carlos E. Cabezudo Moreno, Lic. Jean Schmitz, Lic. Luís Suárez, Lic. Vania Martínez Jiménez. November 1999*

*Proyecto de Control de las Infecciones de Transmisión Sexual (ITS) y VIH y SIDA en el Establecimiento Penitenciario de Régimen Cerrado Ordinario de Lurigancho, EPRCOL.*

*Mèdecins Sans Frontières Belgium, Annual report 2000.*

*Sexualidad y Salud Sexual de varones internos del penal de Lurigancho.*

*Ernesto Vásquez del Águila. Médicos Sans Frontières Belgium, Noviembre 2000*

*Proyecto de Control de las Infecciones de Transmisión Sexual (ITS) y VIH y SIDA en el Establecimiento Penitenciario de Régimen Cerrado Ordinario de Lurigancho, EPRCOL*

*Mèdecins Sans Frontières Belgium. Annual report 2001.*

*Proyecto de Control de las Infecciones de Transmisión Sexual (ITS) y VIH y SIDA en el Establecimiento Penitenciario de Régimen Cerrado Ordinario de Lurigancho, EPRCOL.*

*Mèdecins Sans Frontières Belgium. Annual report 2002.*

*Programa de Comunicación para la Prevención de ETS y VIH/SIDA en el EPRCOL.*

*Mèdecins Sans Frontières Belgium. August 2002.*

*Proyecto de Control de las Infecciones de Transmisión Sexual (ITS) y VIH y SIDA en el Establecimiento Penitenciario de Régimen Cerrado Ordinario de Lurigancho, EPRCOL.*

*Mèdecins Sans Frontières Belgium. Annual report 2003.*

*Proyecto de Control de las Infecciones de Transmisión Sexual (ITS) y VIH y SIDA en el Establecimiento Penitenciario de Régimen Cerrado Ordinario de Lurigancho, EPRCOL.*

*Mèdecins Sans Frontières Belgium. Annual report 2004.*

*Intervención IEC en pabellones, Informe final.*

*Proyecto de Control de las Infecciones de Transmisión Sexual (ITS) y VIH y SIDA en el Establecimiento Penitenciario de Régimen Cerrado Ordinario de Lurigancho, EPRCOL.*

*Mèdecins Sans Frontières Belgium, Abril 2004.*

*Current status/new perspectives for the AIDS preventive intervention, MSF Peru. Internal review report, January 2003.*

*Manuela Varrasso, Behavior Change Communication Adviser. January 2003.*

*Faites y Atorrantes, una etnografía del penal de Lurigancho.*

*José Luís Pérez Guadalupe. Facultad de teología pontificia y civil de Lima, Centro de investigaciones Teológicas (CINTE). Lima, March de 1994*

*Amor de Machos, lo que nuestra abuelita nunca nos contó sobre las cárceles.*

*Jacobo Schifter. Editorial ILPES, San José de Costa Rica, 1998.*



Lima, December 2005



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