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Control of epidemics by jails: lessons for COVID-19 from HIV

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 See [Articles](#) page e807

Of the 10·2 million people incarcerated worldwide, an estimated 3·8% of individuals are HIV-positive, a proportion that varies widely by region.¹ To achieve the ambitious UNAIDS 90-90-90 target,² strategies must address incarcerated people with HIV, as well as those at liberty. Universal test-and-treat (UTT) interventions represent an important step towards achieving these goals; through earlier linkage to antiretroviral therapy (ART) and wider ART coverage among people with HIV, the spread of HIV could be prevented and potentially, the HIV/AIDS epidemic could be ended.³ However, progress towards the HIV/AIDS 90-90-90 targets has not been equally distributed across subpopulations, demographics, or regions. Incarcerated people are especially disadvantaged and at risk.⁴

In *The Lancet HIV*, Michael Herce and colleagues⁵ report the clinical outcomes of a prospective cohort study at three correctional facilities in South Africa and Zambia, which show that UTT implementation is feasible and effective in prison settings. Over a 1 year period, the authors introduced a UTT intervention in adult correctional facilities and tracked time to ART initiation and viral load suppression at 6 months and 12 months follow-up visits. Herce and colleagues found rapid HIV testing could be followed by on-site, rapid initiation of ART care. 835 (86%) of 975 eligible participants enrolled initiated ART with a median time from enrolment to ART initiation of 0 days (IQR 0–8). The high rates of loss to follow up at the correctional facilities was a major limitation of the study. 415 (50%) of the 835 participants who initiated ART had left their initial facility at 6 months. However, 327 (95%) of 346 participants who remained incarcerated at 6 months were retained in care. Furthermore, of the 269 participants eligible for the 6 month follow-up analysis who had at least one viral load result documented, 262 (97%) had achieved viral suppression (<1000 copies per mL) at 6 months. Through early linkage to ART and high retention in care, the proportion of the prison cohort who achieved viral load suppression was similar to that observed in other African community-based trials for treatment-as-prevention (up to 88% of individuals achieved suppression).⁶

Our own experience has shown that rapid testing for HIV can also be successfully implemented in US jails. Our study done in Atlanta (GA, USA), using routine, rapid opt-out screenings at a county jail, showed that the strategy was both feasible and cost-saving compared with sporadic, laboratory-based tests. A higher number of individuals received new HIV diagnoses in the rapid screening group than did those who had sporadic laboratory-based screening (89 vs 15). All individuals who had rapid screening received their test result; and most could start treatment in jail.^{7,8} Compared with the sporadic, laboratory-based screening, rapid screening resulted in a reduction of US\$2·8 million in US health-care costs, when considering HIV diagnoses averted when a higher number of people were aware of their HIV status.⁷ Rapid ART initiation, which Herce and colleagues achieved, was not part of the Atlanta jail programme. The findings from Herce and coauthors might lead to replication of rapid UTT implementation in jails globally. Despite the evidence that UTT can be feasible and effective, such measures to end the HIV epidemic are rarely implemented in correctional facilities, often as a result of prejudice, disdain, and ignorance,⁴ whereby the needs of incarcerated people are often overlooked. When will the health and well-being of incarcerated people no longer be ignored?

The COVID-19 pandemic first affected incarcerated individuals in China, and now the same pattern has been observed globally, including in the USA.^{9,10} Herce and colleagues implemented the same standard of HIV care practised in the community into correctional facilities.⁵ In the same way, as new approaches for managing the coronavirus epidemic in the community are developed—aggressive testing of symptomatic and asymptomatic people with contact tracing—the same standard of care will be needed in correctional facilities. Only by doing so can the role of prisons and jails as reservoirs of viral infection be minimised. Failure to control and prevent the spread of viruses within prisons and jails will undermine population-level targets, which could cost lives and result in health-care costs similar to that observed with COVID-19 disease in the past 3–4 months and the ongoing HIV epidemic for the past 3–4 decades. The idea of health

for all must be adopted universally to prevent disease and to uphold human rights to health and dignity for individuals within and outside of prison walls.

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Gender-affirmative systems needed for PrEP implementation



There is an emerging recognition of transgender women as a priority population for HIV intervention in South Africa and elsewhere in sub-Saharan Africa. Despite evidence of alarming HIV infection rates among transgender women in multiple sub-Saharan African countries, transgender women throughout the continent have profound barriers to accessing the continuum of HIV services because of structural stigma, discrimination, and limitations in health services capacity.¹ South African activists and researchers have called for the prioritisation of transgender women in HIV prevention and human rights campaigns.² Their efforts contributed to the recent expansion of South Africa's National Strategic Plan for HIV, tuberculosis, and sexually transmitted diseases, which currently includes explicit recommendations for customised interventions for transgender women. Sustained investments are now needed to implement pre-exposure prophylaxis (PrEP) programmes for transgender women in South Africa as a pillar of the country's HIV prevention agenda.

In *The Lancet HIV*, Tonia Poteat and colleagues³ reported modest rates of PrEP awareness (45%) and willingness to use PrEP (55%) among a sample of 129 HIV-negative transgender women in South Africa. Current use of PrEP in the sample was even lower (11%).

The more common reasons for PrEP disengagement and non-use reported by transgender women in this study were similar to those found in research with non-transgender women populations: cost, inconvenience, perceived side-effects, and medical mistrust.⁴ Poteat and colleagues' findings also corroborate previous literature on trans-specific barriers to PrEP engagement including internalised transphobia, scarcity of transgender-competent providers, and concerns about negative interactions between PrEP and hormone medications.⁵ Notably, Poteat and colleagues found that high community connectedness with other transgender women was associated with lower willingness to use PrEP, which warrants further investigation in light of prior research on the benefits of community engagement in promoting PrEP for transgender women.⁵ The authors posited that the marketing focus on PrEP for cisgender men might have contributed to views by some community-involved transgender women that PrEP is less relevant for women.

The study emphasises the call to situate PrEP programmes in the broader agenda for transgender-affirmative care.⁶ Given the minimal representation of transgender women in PrEP trials and in PrEP marketing campaigns, there is a need to improve inclusion of transgender women as participants in clinical research

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See [Articles](#) page e825