HEALTH CARE IN DETENTION

MANAGING SCABIES OUTBREAKS IN PRISON SETTINGS

ICRC

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Dr Raed Aburabi, medical coordinator for the ICRC's health care in detention team, supervised the preparation of this edition.

This guide is dedicated to all those ICRC expatriate and national staff members who died working to save the lives of others.

Foreword

Scabies, a parasitic disease, is a major public health problem in many resource-poor parts of the world, but remains comparatively neglected. Health problems in a community tend to appear in concentrated form in prisons; it is not surprising therefore that in these regions, scabies outbreaks occur frequently in prisons, where overcrowding is a major risk factor. Outbreaks of scabies have been reported in industrialized countries as well – in long-term- care facilities, makeshift refugee camps, nursing homes and less commonly, in acute-care facilities.

Scabies does not usually kill, but it causes great discomfort, often disrupting sleep: "We even scratch in our dreams," sufferers report. And it may cause secondary infections and post-infective complications, such as acute glomerulonephritis. The objective of ICRC action is either to eradicate the disease or to control it, which will ease the discomfort of detainees and reduce the risk of complications.

Coordination amongst the various stakeholders and actors, and teamwork, is of utmost importance during an outbreak of scabies.

This guide is intended for detention teams and health professionals dealing with an outbreak of scabies or case clusters in prisons. There are chapters on the following subjects: conducting an initial assessment; responding to an outbreak; evaluating the measures taken; and preventing further outbreaks. These chapters provide information; the Annexes at the end contain practical tools for use during a scabies eradication/control programme. The Annexes include: protocols for step-by-step scabies treatment; guidelines for estimating the staff and drugs and other materials needed; timelines; and diagrams showing how to set up a scabies eradication/control programme.

Despite the care that has gone into its preparation the guide might contain errors. The authors would be grateful for any corrections that readers might want to send. They would also welcome comments and suggestions for improvement, as the guide should evolve in step with changes in the field. All correspondence should be addressed to:

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Annexes

Abbreviations

BB Benzyl benzoate

BPP Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment (1988)

D Day

HR Human resources

ICRC International Committee of the Red Cross

IPD In-patient department

NGO Non-governmental organization

SMR Standard Minimum Rules for the Treatment of Prisoners (1955)

UN United Nations

USD United States dollar

1. BACKGROUND INFORMATION

1.1. The mite parasite

Scabies is a dermatological disorder, the result of infestation by the mite parasite *Sarcoptes scabiei*, variety *hominis*. The sarcopte is an external parasite (like the louse), an acarid that lives in the human epidermis. It is too small to be visible to the naked eye. Away from its host, it cannot survive very long: 24 to 36 hours at 24°C and 40-80% relative humidity. Lower temperatures and higher humidity levels prolong its survival. At 34°C, mites survive for fewer than 24 hours, irrespective of the level of humidity. The incubation period is two to six weeks in scabies-naive persons, but only one to three days in cases of reinfestation. This early reaction during reinfestation is because of the immune response: that is, the persons in question have an allergy to mites, as it were.

1.2. Reservoir and transmission

Scabies is a communicable disease. Human beings are the only reservoir. Transmission occurs via direct body contact – in 95% of cases – or via contaminated clothes, bedding, bedclothes, carpets, and so on.

Predisposing/Aggravating factors that may contribute to the high prevalence of scabies in certain communities, and especially in detention centres

Overcrowding, poor living conditions, limited access to water, climate favourable for scabies mites, restricted access to health care, delayed diagnosis and treatment, wrong or missed diagnosis, shortage of drugs: all these contribute to high prevalence and the likelihood of outbreaks. The importance of poor hygiene has, however, been exaggerated: mites burrowed in the epidermis are resistant to water and soap, and even to daily showers.

1.3. Clinical features, diagnosis and treatment

Itching, especially at night, is one of the main signs. The primary lesions are erythematous papules, vesicles, bullae and the tunnel or burrow, which is typical but rarely seen. The burrow looks like a short wavy line and is most commonly seen on the anterior part of the wrist, and on the fingers and penis. It is between 1 and 10mm long. The papules are small, may be sparse or numerous, and close-set. Over time, papules can turn into vesicles or even bullae. Common infection sites include the axilla, elbows, finger web, wrists, genitalia, buttocks, waist, knees, toes and navel. The scalp and the face are usually unaffected, except in infants, children and the elderly.

Scratching may cause lesions to develop a secondary infection with excoriation and crust. Coexistence of lesions is quite common; it can sometimes be mistaken for atopic dermatitis or eczema. Crusted scabies, another clinical form of scabies, is highly contagious, with many mites in each lesion. The

skin is hypertrophied, hyperkeratotic or wart-like in appearance and can mimic psoriasis. The risk factors for this form of scabies include old age, diabetes mellitus and immunosuppression (patient under general or topical corticosteroids, HIV infection, haematological malignancy). Fingers and toenails are more significant reservoirs of mites than is often supposed. Skin-scraping is a well-established procedure for diagnosing scabies: the skin is scraped and the scrapings examined under a microscope for mites and their eggs or faeces. However this is of dubious value, being of low sensitivity; in addition, neither microscopes nor trained staff are available in many places of detention throughout the world.

In scabies cases, the patient and his or her bedding and clothes should receive adequate treatment. More details will be found in the chapter on the treatment of cases.

1.4. Associated pathology

Superinfection may occur in approximately 10% of scabies cases. Staphylococci and streptococci are common causes and pyoderma is a typical complication. Acute post-streptococcal glomerulonephritis and septicaemia have also been described.

1.5. Outbreaks

Outbreaks are quite frequent in detention and institutional settings (nursing homes, hospitals, and so on). Outbreaks are underreported and the frequency of their occurrence often underestimated; they are also often not addressed.

2. INITIAL ASSESSMENT OF SUSPECTED OUTBREAK OR CLUSTER OF SCABIES CASES

Ideally, the initial assessment should involve the health authorities in charge, but that should be discussed with the prison director first.

2.1. Confirm the diagnosis and the outbreak

In most prison settings, the diagnosis of scabies cannot be confirmed by microscopic examination. Health professionals will have to rely on their clinical knowledge of scabies lesions. Review the section on "Clinical features, diagnosis and treatment" in Chapter 1 if necessary.

For many outbreaks, 'typical case', 'probable case' and 'contact case' should be clearly defined, usually as done below:

- Typical case: One burrow or tunnel
- Probable case: Itching (especially at night) and several erythematous papules
- Contact case: Someone who has been in prolonged contact with a probable case or someone who shared confined space in close proximity with a probable-case patient for a prolonged period of time.

Usually, when a scabies outbreak or cluster is suspected, the health team will ask to see all the detainees complaining of pruritus, and check the lesions. A diagnosis of scabies may then be confirmed.

Once the presence of scabies has been established, it must be decided whether the cases represent an outbreak (epidemic) or a cluster of cases that is part of a chronic problem (endemic). An outbreak is generally defined as more cases of a particular disease than expected in a given area, or among a specific group of people, over a particular period of time. The cases are presumed to be related to each other or to have a common cause.[1] There is no clear criterion – the number of cases, for instance – for defining a scabies outbreak in the prison setting. In nursing homes and hospitals in industrialized countries, the existence of two

1 This is the definition provided by the United States' Centers for Disease Control and Prevention. Note that the terms 'outbreak' and "epidemic' have very similar definitions and are sometimes used interchangeably. However, 'outbreak' is more commonly used to characterize the situation in smaller areas or groups, such as villages, towns, or specific institutions such as prisons; 'epidemic' tends to be reserved for situations involving large numbers of people dispersed over a wide geographical area.

typical cases (with the burrow/tunnel), together with other probable cases, may constitute an outbreak. In poor communities in the developing world – urban and rural – scabies may be endemic and a few scabies cases may be nothing out of the ordinary. In these contexts, scabies is likely to be a constant presence in prisons; therefore the best criterion for defining a scabies outbreak may be an increase in the number of scabies cases each week.

If it is not an outbreak but a cluster of cases that is part of an endemic problem, the treatment of individuals will help to control the disease but will not eradicate it. While managing an outbreak – as described here – the aim is to eradicate the disease; but, bear in mind that a single case not treated on arrival may lead to cluster cases or an outbreak.

2.2. Epidemiological description

The number of persons affected and their location, together with all defining characteristics (gender, accompanying children, underlying known disease), should be recorded, as well as the names of the contact persons. In overcrowded cells or prisons, especially where there is a lack of fresh air, all the detainees should be regarded as either probable cases or contact cases. Changes in the number of cases can be analysed if a reliable consultation record book is available.

2.3. Living conditions

Living conditions must be assessed in order to decide on the approach to treatment, and to estimate the time needed. The factors to consider are listed below:

- Number and state of showers or shower areas (this will have the greatest impact on the pace of the treatment)
- Quantity of water available, and quantity of hot water available in cold climates, possible availability of water heaters
- Space available for storing belongings securely, space in yard (in the open or protected from sun and rain)
- Space/Room available for application of benzyl benzoate or BB (laundry area, for example)
- Number of detainees in the sleeping area and square metres per person
- Amount each detainee has, in terms of belongings (mattress, blankets, clothing, carpets)
- Capacity and willingness of health and prison authorities to engage in eradication campaigns
- Support from detainees for these campaigns
- Whether detainees go through any medical screening on arrival
- Days on which family visits take place.

The season should be taken into account, as should the weather and how it will evolve.

2.4. Preliminary conclusions

The health team must prepare a report that should answer the following questions:

- Are the skin problems scabies?
- Is there an outbreak (epidemic) or are the scabies cases part of a chronic problem (endemic)? (Compare the prevalence of the disease in the prison setting with that in the community. How has prevalence evolved over time?)
- Who is affected? Any particular groups? Which parts of the prison?
- What are the incidence and the attack rates? (Incidence rate = The number of new cases per population in a given time period; Attack rate = The cumulative incidence of infection in a group of exposed persons over a period of time during an epidemic)
- What is the total number of cases in relation to the number of detainees? (Specify the date of the record)
- What is the proportion of superinfection? (This should be expressed as a percentage of all cases)
- What resources are available (space, water, materials, drugs, personnel/staff)?
- What has already been done? Were these actions appropriate or not?
- Is there a likely specific source (new arrivals from another facility, for instance)?
- What needs to be done and how?

The report should also contain a brief description of the health-care system in prison settings, and at the national and local levels.

3. GENERAL APPROACH TO MANAGING AN OUTBREAK OR CLUSTER OF SCABIES CASES

Managing an outbreak of scabies at a prison is a multidisciplinary team exercise. Also, remember that it is essential to ensure the availability of the resources necessary for an effective response.

3.1. Stage 1: Forming a crisis committee

An outbreak committee with one coordinator should lead the management of the outbreak. It should be created quickly once the outbreak has been recognized. Ideally, the coordinator should be a representative of the prison health authorities (usually someone from the ministry of public health or the doctor in charge of detainees' health). The committee should consist of representatives of:

- the health authorities (prison level and higher)
- the prison authorities
- NGOs or UN agencies already involved in some way with the prisons
- the ICRC (the multidisciplinary detention team)
- the detainee population, when possible. If for security or other reasons detainees cannot be represented on the outbreak committee, they should at least be kept closely informed of all steps taken.

The committee should consist of people with expertise in these areas: health, water and hygiene, logistics, security and coordination.

The members of the committee should first decide upon the objective: whether to eradicate the disease or control it. Depending on the objective, the committee must **choose a strategy and allot tasks** within teams (Table 1). To eliminate the disease, it is necessary to treat the whole population (irrespective of whether individual detainees have skin lesions or not), as well as all the interior of the prison. To *control* the disease, only scabies sufferers and their belongings have to be treated. Another option would be to treat only the block where the outbreak occurred (if only one block was affected) – in elimination campaign mode, as it were – and to control the spread of the disease in the other blocks by treating only scabies sufferers and their belongings. Where overcrowding is an issue,

the elimination mode is preferable. However, if there is no space outside cells or blocks – in the form of prison yards, for example – and if detainees have a lot of belongings (carpets, blankets), the elimination mode will be impracticable. The objective then would be to control the disease, not to eliminate it.

Tasks	Monitoring	Case management	Disinfection of clothing and bedding	Disinfection of environment	Information for detainees
Key steps	Make sure there is agreement on case definition	Agree on a treatment protocol (Annex 1)	Agree on a treatment protocol (Annex 2)	Agree on a treatment protocol (Annexes 2 and 8)	Agree on the messages (Annex 7)
	Count the number of people treated every day in blocks or cells	Estimate the needs, including human resources (Annex 3.1)	Estimate the needs, including human resources (Annex 3.1)	Estimate the needs, including human resources (Annex 3.1)	Ensure supply of requested items
	Make sure that new detainees who arrive during the campaign are isolated in one specific area and not forgotten; do the same with detainees who need to leave the prison during the campaign – for court appearances, for instance	Ensure supply of requested items	Ensure supply of requested items	Ensure supply of requested items	Give detainees all necessary information before starting treatment
		Ensure financial resources	Ensure financial resources	Ensure financial resources	Ensure financial resources
	Keep track of the consumption of renewable supplies				
	Supervise and coordinate the various teams				
	Provide feedback to the prison authorities and detainees				

Table 1

In most instances, the following teams will have to be assembled:

- Cleaning and hygiene promotion: in charge of cleaning the cells when empty, and corridors, latrines and showers at the end. The detainees themselves can be trained for this task. The hygiene promoter(s) will have to conduct one or more sessions for detainees.
- Disinfection of belongings: in charge of putting anti-scabies powder in the bags in which clothes and blankets have been deposited and on bedding and carpets. If the committee has chosen the washing instead of the permethrin strategy, then this team – consisting mainly of detainees – will be in charge.
- Medical: in charge of anti-scabies (topic or oral) treatment and treatment of superinfection.
- Detainee flow control: usually done by the guards and or cell leaders.

The committee should decide **who will pay** for each activity undertaken, and **who will be carry out these activities.** It should also decide on the drugs to be used (topical scabicides, ivermectin, antibiotics for superinfections), the method for treating clothing and bedding (permethrin or something else) and the disinfectant for walls, floors and other surfaces (chlorine, for example). It should also raise the question of treatment for prison guards and their families.

If insects in the prison are also an issue, that may be an opportunity to fumigate the cells in addition to cleaning them. However, if this option is exercised, it must also be borne in mind that detainees will then have to spend more time outside their cells because of the potentially toxic effects of the insecticides.

It is important to decide if detainees should receive new sets of clothing and blankets each or if they may treat existing sets of these before the start of the campaign. New items are the easiest option but, depending on the number of detainees, may add considerably to the budget. Treating existing clothing and blankets will prolong the campaign; it will also require additional bags and permethrin for the treatment as well as more people to treat the bags and put them outside for 24 hours. It will also add to the flow of materials once the campaign is under way; additional manpower will be required as well, to ensure that each detainee receives the correct bag of pre-treated clothing, and at a set time.

The response will be free of charge for the detainees, the guards and their families if they also require treatment.

The committee should draw up a budget with the following in mind:

- Daily workers
- Lunch for any additional personnel from the ministry of public health
- Medicines (scabicides and antibiotics)
- Anti-vectors (permethrin or something else)
- Disinfectant (chlorine or something else)
- Hygiene items: bath soap, laundry soap or washing powder
- Water trucking or water tanks/water pumps/water heaters and source of energy
- Construction materials for temporary showers (if required)
- Renewable supplies: bags for storing treated clothing and bedding (and string for closing the bags), labels and tape, markers (in developing countries, markers often qualify as renewable supplies), dispensing bags for drugs, protective masks for the hygiene team and examination gloves (see **Annex 3.2**)

- Non-renewable supplies: new, clean sets of clothing and blankets (if needed), ropes, brooms, sprayers, boots, rubber gloves, protective clothing and goggles for the hygiene team (see **Annex 3.2**)
- Stationery: notebooks, pens.

The ICRC can carry out all the activities required and pay all the costs if the health authorities are unwilling or unable to do either.

3.2. Stage 2: Preparing a campaign to eliminate or control scabies

After settling on the strategy, make an inventory of the resources available and of those that can be mobilized; the crisis committee should plan the campaign.

The first task is to set up a time frame and draw up a list containing all the activities to be carried out (and when), as well as the persons who will be in charge of each. Planning should take into account visitors' days and national holidays. Ideally, family visits should be forbidden during the campaign, but it is seldom recommended because it may interfere with the well-being of the detainees. A scabies outbreak is not an emergency and it is advisable to take time to assess the situation carefully and plan accordingly. The time frame will also allow the committee to follow the progress of the campaign (see the example in **Annex 6**).

If possible, schedules for court hearings (names and dates) should be acquired in advance, to make sure those detainees will not be forgotten during the treatment process.

The flow of the detainees (packing their belongings, showering, medical treatment, transporting their own bags outside, staying outside until their cells have been cleaned, returning with only clean clothes and carpets) should be very clear to the prison director (**Annexes 5.1 and 5.2**).

3.3. Stage 3: Providing information for detainees

Detainees should be given information on the disease and on what is going to be done to eliminate or control it. They should also know what the crisis committee expect from them.

The information on the treatment should include the flow of people during the period in question and instructions in connection with the treatment (see **Annex 7**). If ivermectin is chosen, detainees should be told that they must not eat or drink anything for two hours before and after the treatment. If BB is chosen, detainees should be shown how to apply it; they should be aware that they may feel a burning sensation and should be encouraged not to take a shower 24 hours before application. If they wash their hands and/or feet during those 24 hours, they should re-apply the BB on their hands and/or feet. It is crucial to draw attention to this in Muslim countries in particular, because of the numerous prayers and ablutions involved. Cultural usage makes it difficult to apply BB correctly in every particular (showering together or in public is not common in a lot of countries). Therefore, the process of application must be explained several times (the steps in the right order, and other matters as well).

3.4. Stage 4: Organizing an elimination campaign

The campaign will vary according to the treatment chosen.

- **Topical anti-scabies treatment** (see **Annex 5.1**)
  Cell by cell, block by block, the detainees put their belongings in bags (see **Annex 9** on the treatment of clothing and bedding). They receive one bar of bath soap and go to the showers wearing their bath towels. They take a shower. Afterwards, wearing their towels, they proceed to the treatment area. They drop their clothing and the towel in their medium-sized plastic bags. Then they receive their treatment. They get a new set of clothing and towels or a clean set (that was washed or treated with permethrin a few days before). They then proceed to the courtyard and stay there until their cells have been disinfected. They have a session on hygiene promotion while they wait. On returning from the yard, they receive new blankets for the night or their own blankets that were treated a few days ago. The next day, they take a shower and receive the second application of BB. Then they go to the courtyard to retrieve their bags and, shake out their clothes, after which they put their cells in order.

- **Oral treatment** (see **Annex 5.2**)
  Cell by cell, block by block, the detainees put their belongings in bags (see **Annex 9** on the treatment of clothing and bedding). They receive one body bar of bath soap and go to the showers wearing their bath towels. They take a shower. Afterwards, they drop their clothes and the towels in their medium-sized plastic bags and get new sets of clothing and towels or a clean set (that was washed or treated with permethrin few days before). They swallow the tablet with some water (direct observed treatment). They then proceed to the yard and stay there until their cells have been disinfected. They have a session on hygiene promotion while they wait. On returning from the yard, they receive new blankets for the night or their own blankets that were treated a few days ago. The next day, they go to the yard to retrieve their bags and shake out their clothes, after which they put their cells in order.

Estimation of needs (materials, drugs and human resources)

Information on the estimation of needs can be found in the chapter on the treatment of cases, bedding, clothing and environment and in **Annexes 3.1 and 3.2.**

Monitoring and follow-up during the campaign

The number of detainees leaving the treatment area should be counted, to make sure no one is forgotten and to order more supplies in a timely manner, in case more people than expected have to be treated. To ensure the availability of water throughout the campaign, its supply should be monitored closely. At the end of each day, the teams should meet to share and consolidate monitoring data on consumption and on the number of persons treated, and to prepare for the next day. What went wrong should be discussed to make adjustments the next day.

3.5. Stage 5: Reporting

After the end of the campaign, a report should be prepared, with the involvement of at least the prison doctor. It will help to pass on information, internally and to stakeholders, on the outbreak and on what was done. It will also be useful for updating the guidelines with the lessons learnt (see **Annex 11** for a template for the report).

4. TREATMENT OF CASES, BEDDING, CLOTHING AND ENVIRONMENT

4.1. Treatment of cases

There is insufficient evidence at present to make a recommendation in favour of either oral or topical treatment. However, its usability favours oral treatment, especially if the number of people to be treated is an important consideration. **Annex 1** sets out the various possibilities.

Daily workers should be treated once they have finished their work; to avoid re- contamination they should be treated on the same day as their cellmates.

BB (topical treatment)

Advantages: Available throughout the world (except in the United States) and economical (less than 1 USD/treatment). However, the cost of transporting it should be considered (as it is much heavier than ivermectin).

Contra-indications, adverse effects, precautions

- It may cause a burning sensation that the detainees should be made aware of; Otherwise, they might be disinclined to go through the second application. As it is an irritant, it might cause diagnostic uncertainty if signs or symptoms recur after treatment.
- Do not apply to mucous membranes (mouth, nose, rectum, vagina).
- Should it get into the eyes, wash with plenty of clean water.
- Never swallow! Ingesting BB is very dangerous, and may cause convulsions. In case of accidental ingestion, refer the person to a doctor who will prescribe activated charcoal.
- In case of breast-feeding, do not apply to the nipples.

Preparation: 25% BB lotion (other preparations might be available, but this one is probably the least unwieldy for prison settings)

Use: Shake before use. For adults, the pure 25% BB lotion should be used. For children, it should be diluted by half (one part BB and one part clean water). For adults, the BB should be left on the skin for 24 hours; for children under the age of two it should be left on for only 12 hours; and for children under six months old, the BB should be left on for only six hours. For children under the age of two, bandages on the hands will help to prevent accidental ingestion. Children and the elderly often have lesions on the face; so BB should be applied on their faces, too. Health staff should apply the BB, using sprayers (five-litre sprayers). BB is sprayed on the body, and each detainee must spread it according to

health staff's instructions. This should be supervised, as people, especially minors, tend not to do it carefully. Detainees can help spread the BB on each other's backs (see **Annex 1** for more information on the use of BB). For pregnant women and children less than six months old, apply the solution only once (one-day treatment). If necessary, a makeshift treatment area can be set up outside the blocks.

Ivermectin (oral treatment)

Advantages: Much easier to use than BB. It is almost impossible to ensure that detainees will apply BB carefully all over their bodies, especially in the genital area. There is also no need to construct a treatment area if ivermectin is used.

Ivermectin has approval, in many countries, only for the treatment of nematode infections (for which also it is effective). However, its off-label use for parasitic skin diseases is common throughout the world.

Contra-indications, adverse effects, precautions

- Transient new-onset pruritus or worsening of existing pruritus may occur.
- It is not recommended for children weighing less than 15 kg (or under the age of five), or for pregnant or breastfeeding women.
- Do not eat for two hours before and after taking ivermectin.

Presentation: Ivermectin is available in 3 mg unscored and 6 mg scored tablets.

Dosage and duration:

Although many persons with classic scabies respond well to a single dose of the drug, its ineffectiveness against nymphal forms and eggs is an argument for a 200 mcg/kg-dose regimen, the doses separated by approximately one week. The tablets should be swallowed in the presence of health staff (direct observed treatment).

Most individuals with crusted scabies will required combination therapy: topical scabicide plus oral ivermectin plus topical keratolytic.

Ivermectin doses according to body weight in kg

Body weight (kg)	Doses: Number of 3 mg tablets	Doses: Number of 6 mg tablets
15 to 24	One	Half
25 to 35	Two	One
36 to 50	Three	One and a half
51 to 65	Four	Two
66 to 79	Five	Two and a half
80 and over	Six	Three

Other possibilities for topical treatment

Malathion (two consecutive nights), sulphur 2% to 10% in white petroleum jelly (three consecutive nights), 5% permethrin cream (one application for 8 to 14 hours and a second one, seven days later), 1% lindane lotion/cream (one application for 24 hours on two consecutive days or a second application one week after the first – also for 24 hours). Permethrin takes effect more quickly and with fewer side effects than BB, but its widespread use is limited by its cost. Lindane can have severe effects on the central nervous system (restlessness, anxiety, trembling and convulsions), especially when applied on broken skin or to epileptic or underweight adults; as broken skin and epileptic or underweight adults are common features of places of detention, this topical drug should be avoided.

Additional treatment in case of superinfection

Usually, oral anti-streptococci and anti-staphylococci are required to treat cases of superinfection. Ideally, a seven-day treatment with macrolide (for adults, 2 g/day of erythromycin, divided into two doses) or cloxacillin (for adults, 3 g/day divided into three doses) should be started one or two days before the anti-scabies treatment. However, in heavily populated prisons, it is seldom possible to screen all the inmates for superinfection. Therefore, cases of superinfection will be discovered during the application of BB, or detainees will have to be checked for it when or before they are given ivermectin. When BB is being used, the medical team in charge of spraying detainees with it should check for superinfection and give tokens to those who need antibiotics; these detainees will then be referred to the medical staff in charge of treating the superinfection. When ivermectin is used, the medical team can examine detainees when they get out of the shower and give tokens to those who need antibiotics.

Contact-case management

A 'contact person' is someone who has had prolonged skin contact with a scabies sufferer. The contact case should receive the same treatment as people suffering from scabies. Ideally, in overcrowded blocks or cells, all the detainees should be treated whether they are affected or not, as it should be assumed that they are all contact cases or scabies sufferers. However, because of the lack of space it might not be possible to treat all of them with all their belongings.

With regard to treatment for guards and their families, the crisis committee should decide whether to treat them, based on the type of contact they have with the detainees.

4.2. Treatment of clothing, bedding and the environment

Whenever possible, for each detainee, a set of clothes, a large towel and a blanket should be washed at 60°C (at least) or in boiling water, and ironed, or treated with permethrin in advance and kept safe, out of range of re-infection, before the campaign starts. The additional time and resources required must be taken into account during the planning phase. In spite of such planning and preparation, some detainees may still find themselves without a spare set of clothes, a towel or a blanket. These things should be provided to them on the first day. They should be given their towels before they go to the showers, and the clothes and

blankets just after the treatment (see **Annexes 2, 5.1 and 5.2**). Even when most of the detainees have spare sets of clothes, there will always be some without. It would therefore be prudent to buy a few sets of new clothes in advance. The same may apply for towels and blankets. Disinfection of clothing and bedding should be done on the same day that the detainees receive treatment (see protocol in **Annex 2**). Permethrin should be put into the bags outdoors, as it is toxic. Daily workers should wear masks. If rain is forecast and the yard has no roof, a tarpaulin should be set up. Bedding and clothing should be left in the bags with the permethrin for 24 hours.

The cells should be disinfected on the same day as the detainees; the corridors, common rooms, showers and latrines should be disinfected on the last day. (See protocol in **Annexes 2 and 8**)

4.3. Estimation of needs

Drugs

Estimation of needs is based on the initial assessment and on the number of cases. Experience shows that when BB is used, each patient or contact person will require between 150 and 200 ml of it (for the two doses). If ivermectin is used, between 8 and 12 tablets of 3 mg will be needed for each person (for the two doses). Most of the time, about 10% of all those affected also have superinfections. There should always be a stock of these drugs in reserve, as new cases will have been registered or new detainees will have arrived by the time the campaign gets under way. This reserve stock should be bigger when treating cluster cases (where there may be more uncertainty about the number of cases) than when conducting an elimination campaign. As a rule, while treating cluster cases, reserve stocks should run to 25%, and while conducting an elimination campaign, to 10%.

Example: **For a scabies elimination campaign (treatment for all whether affected or not) using BB**

Number of detainees	1,200
Reserve 10%	120
Total amount of BB (150 ml/person)	198 litres

Example: **For a scabies elimination campaign (treatment for all whether affected or not) using 3 mg ivermectin tablets**

Number of detainees	1,500
Reserve 10%	150
Total number of tablets (10 tablets/person)	16,500

Example: **Mixed approach using BB (combining elimination and treatment of cluster cases)**

Elimination in Block A: Number of detainees	120
Cluster cases treatment of affected and contact cases in other blocks	41
Reserve 10% for Block A treatment	12
Reserve for other blocks treatment 25%	11
Total (150 ml/person)	28 litres

Example: **Estimation of needs for cluster-case treatment of superinfection with 250 mg of cloxacillin (adult dose of 3 g/day divided into three doses for seven days) or 500 mg of erythromycin (adult dose of 2 g/day divided into two doses for seven days – for use in case of allergy to penicillin)**

Number of scabies-affected cases and contact persons	150
Estimated superinfection rate of 10%	15
Not allergic to penicillin - 90%	14
Allergic to penicillin - 10%	1
Reserve 25%	4
Total number of cloxacillin (250 mg) capsules	1,428
Total number of erythromycin (500 mg) tablets	56

Example: **Estimation of cloxacillin (3 g/day for seven days) and erythromycin (2 g/day for seven days) needs for elimination campaign**

Estimated scabies-affected detainees (see initial assessment)	456
Estimated superinfection rate of 10%	46
Not allergic to penicillin - 90%	*42*
Allergic to penicillin - 10%	*4*
Reserve 10%	5
Total number of cloxacillin (250 mg) capsules	3,864
Total number of erythromycin (500 mg) tablets	140

Water, showers, and soap

As far as we know, the consumption of water during an elimination campaign has never been measured. We may assume that the quantity of water requested, per person treated, is comparable to that for an IPD facility: 40-60 litres per person per day. As each person will undergo two days of treatment, we may assume the amount of water to be 80-120 litres per treated person, or 40-60 litres/person/day for two days. Sometimes water trucking has to be organized.

The more showers that are available, the faster the pace of the campaign. Although the ICRC recommends one shower per 50 persons, this is often impracticable. But if it is available, it will be possible to treat 35-40 detainees per hour per team. Makeshift showers can be set up in the yard. With one shower per 27 persons, the pace of treatment can be as much as 70 detainees per hour per team. Where there are more showers, more teams will be needed. When hot tap water is not available in a cold country or during cold weather, water will have to be heated. Temporary water boilers will have to be installed, and buckets for carrying the hot water made available. More daily workers will be needed (see **Annex 3.1** for HR needs)

Each detainee will receive one bar of bath soap when going to the showers. A reserve stock of soap should be considered. If BB is being used (with two doses), it might be better to give detainees one bar of soap on the first day and a second on the second day. Some detainees will lose their bar of soap between the first and second days of treatment. Giving them two bars of soap will also provide hygiene materials for after the campaign: in some contexts, soap is a rare commodity in places of detention.

Permethrin

Experience shows that 150 g of permethrin are needed per detainee, for both medium-sized and large bags. A reserve stock of permethrin should be set aside (10% for elimination mode, 25% for control mode). It is helpful to have a plastic cup marked with a line, to let daily workers know how much powder to put in each bag. It will be a rough estimate but will ensure that enough, but not too much, permethrin is used; and it will also reduce the possibility of running out of it.

5. EVALUATION

The evaluation of the campaign will analyse its quality, effectiveness and reactivity, as well as resources, safety and costs. It should be carried out one month or six weeks after the end of the campaign, as itching can last for a few weeks after treatment. A report should be prepared and the findings communicated to the prison director and to all those interested parties who were involved in the campaign.

Indicators	Data necessary for indicators	Data: Sources and collection methods	Comments
Effectiveness and quality			
People still itching at night	Pertinent questions: Are there still people itching at night? If so, are they newcomers or are they among those treated during the campaign?	Feedback from cell leaders	If possible, meet the detainees who are still itching (Scabies? Other skin disease?)
Scope of the campaign	Number of detainees who received the two doses Number of targeted detainees	Tally sheet (see **Annex 10**) Prison registrar Decisions of crisis committee	All those targeted should have received the two doses
Number of new cases registered at the health facility	Number of new cases registered at the health facility Are there any new-comers?	Consultation record book	After an elimination campaign, we expect only newcomers to have scabies. After a control strategy we assume that people can catch scabies (new cases) even if they were in the jail during the treatment
State of stock (depleted/ exhausted)	Ran out of which item (duration of unavailability)	Daily meetings during the campaign Stock cards for all items and daily consumption (see **Annex 4**)	Exhaustion of the stock would be an unexpected occurrence
Reactivity			
Waiting period between an increase in number of cases and treatment	Date on which the increase was reported Date on which the treatment began	Internal report Minutes of meetings Health facility registrar	Gap between increase in cases and response should be two months or less
Waiting period between decision to take action and treatment	Date of decision Date on which treatment began	Crisis committee report Minutes of meetings	Gap between decision to act and doing so should be one month or less
Number of people treated/day/team	Number of people treated Number of medical teams	Tally sheet (see **Annex 10**) Decision of the crisis committee	If one shower for 50 detainees, 35-40 detainees/team/day should be treated

Indicators	Data necessary for indicators	Data: Sources and collection methods	Comments
Resources			
Consumption of BB or ivermectin	Number of empty BB bottles Number of cases treated	Stock cards and inventory at the end (number of bottles or tablets remaining in stock) Tally sheet	Consumption of BB should be between 150 ml and 200 ml per detainee
Consumption of antibiotics	Number of drugs distributed Number of cases referred for treatment	Stock cards and inventory at the end Tally sheet for treatment with antibiotics	
Proportion of adequately staffed teams (in terms of qualifications and numbers)	Number of persons per team and their qualifications	Decision of the crisis committee Supervision grid (presence of member of team)	100% is expected
Safety			
Proportion/Number of health staff affected by direct BB contact with the eye	Number of health staff affected by direct BB contact with the eye Number of personnel	Medical team	Check if the persons affected received the proper treatment
Number of other incidents and their impact on the campaign (delays, etc.)	Number of other incidents Impact	Prison director Medical and hygiene teams	
Cost			
Cost per treated person (medical treatment and treatment of bedding and clothing)	Number of people treated Cost	Bills (including transportation costs) Receipts from daily workers Tally sheet	
Cost of treating the environment	Number of blocks treated Cost	Bills Receipts from daily workers	
Total cost per person	Number of people treated Total cost of treatment (environment, clothing, bedding, cases)	Sum of all the costs	

6. PREVENTION OF OUTBREAK

Certain things are needed to prevent scabies outbreaks in prison settings: medical screening of detainees upon arrival, good topical treatment and supply chain of disinfectants, fair access to health care, and a health staff that is familiar with scabies. Their absence will increase the likelihood of outbreaks. And certain things will put detainees at more risk: overcrowding, lack of water and hygiene, and lack of fresh air and exercise.

6.1. Medical screening upon arrival

A single detainee can, without proper and prompt treatment, contaminate a lot of other inmates. The SMR[2] and numerous domestic laws require that every detainee be examined by a medical professional as soon as possible after his admission to a place of detention (Rule 24 of the SMR). The BPP[3] states the same (Principle 24). The latter states also that the examination must be provided free of charge. When those principles or rules are respected, the detainee can be treated promptly on arrival, which can also help to prevent a scabies outbreak.

6.2. Availability of treatment and health staff

Shortage of drugs can result in widespread infection. International rules, especially the SMR, require that the quality of care in prison be at least equivalent to that in the community. The BPP states also that drugs should be provided free of charge. In many countries, scabies is a public health problem and health facilities are supplied with topical scabicidal agents, but so should health facilities in places of detention. It should also be noted that most of the time, topical treatment is provided for people but their bedding and clothes are left untreated. In a prison setting, it is of the utmost importance to treat patients *and* their belongings, because of people's proximity to one another and, often, the overcrowded conditions.

6.3. Access to health care

Both the SMR and the BPP state that detainees who complain that they are feeling unwell should have access to medical care (Rule 25 and Principle 24). An effective system is one that allows sick people access to health facilities.

2 The Standard Minimum Rules for the Treatment of Prisoners were adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva in 1955, and approved by the Economic and Social Security Council through Resolution 663C of 31 July 1957 and Resolution 2076 of 13 May 1977.

3 The Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment was adopted by UN General Assembly Resolution 43/173 of 9 December 1988.

6.4. Health staff: Familiarity with scabies

Wrong or missed diagnoses can lead to the high prevalence of infection. Too often, scabies is not recognized and confused with other pruritic dermatoses: eczema, tinea and atopic dermatitis. Pyoderma could hide a scabies infection and crusted scabies can resemble psoriasis. Health personnel should receive training in this area, to prevent new outbreaks; the training should be a combination of lectures and discussion of cases (illustrated by photographs). On-the-job training, where possible, is also very useful.

7. ANNEXES

Annex 1: Therapeutic protocols

Standard treatment procedures

At	BB 25% (topical)		Ivermectin (oral treatment)
D0	Information for detainees		Information for detainees
D1	Shower with hot water and soap, rinse and dry moderately Apply BB with a sprayer over body, avoiding face and scalp, but taking special care to cover lesions and on armpits, genitalia, behind ears, knees, hands and anterior part of wrist, toes, navel, and folds of the skin and the body; scrub areas with a lot of hair Identify individuals requiring antibiotic treatment for superinfection (if not already done) The BB should remain on the skin for 24 hours, including on the hands and feet Put on clean clothes Take a clean blanket (or bed sheet and blanket, depending on the context) Wait outside cells while they are being disinfected; while waiting, take part in a discussion on hygiene promotion Disinfection of belongings, bedding and carpets (see **Annex 2)** Disinfection of cells (see **Annex 2**) Keep BB readily available to apply after washing hands or feet		Shower with soap, rinse and dry Identify individuals requiring antibiotic treatment for superinfection (if not already done) Put on clean clothes Take a clean blanket (or bed sheet and blanket, depending on the context) Single oral dose of 200 mcg/kg (see table on page 15) under direct observation, on stomach that has been empty for two hours; no food or drink for two hours more Wait outside cells while they are being disinfected; while waiting, take part in a discussion on hygiene promotion Disinfection of belongings, bedding and carpets (see **Annex 2**) Disinfection of cells (see **Annex 2**)
D2	Shower only	Or same as D1 with shower and BB	-
D3	-	Shower only	-
D9	Same as D1 with shower and BB	-	Single oral dose of 200 mcg/kg under direct observation (if not possible on D9, it should be done no later than D16)
D10	Shower only	-	-

Annex 2: Protocol for treatment of clothing, bedding and environment

Standard treatment procedures

At	Disinfection of clothing and bedding	Disinfection of environment
D 0	Distribute three bags to each detainee: 110-litre bag for blankets, 35-litre bag for clothing, and a small plastic bag, of a different colour if possible, for things that will not be treated (books, watch, toothbrush, etc.) Distribute one piece of string to each detainee to close small bags, and take great care over the handling and placement of these bags as they may contain religious materials Distribute labels and markers for the bags (to mark with names and cell numbers)	Information for detainees
D1	Cell by cell, detainees should put their belongings in labelled bags They should keep only one large towel, to wrap around themselves when they go to shower and to dry themselves afterwards The towel should then be dropped into the 35-litre bag Hygiene team bring bags outside and pour the required amount of permethrin into them, seal them with the strings and shake them Sealed bags remain outdoors for 24 hours	Cell by cell, sweep the floor, remove dust from the bars, the doors, the beds, the pillars, and the walls up to a height of one metre With a wet brush, clean the things mentioned above – only with water or with water and detergent; remove excess water with mop To disinfect, spray an active 0.2% chlorine solution or chloroxylenol all over the floor, the doors, the beds, the bars, the pillars, and on the walls up to a height of one meter (from top to bottom) When everything is dry, the detainees may return to their cells If fumigation has to be done at the same time, the detainees will have to be out of their cells for two hours; this needs to be considered while planning
D2	Each detainee opens his bags and shakes out his belongings, outdoors Detainees come back to their cells and rearrange them	-
End of the treatment/ campaign	-	Sweep, clean with wet brush, remove the excess of water with mop and disinfect the common areas, corridors, showers and latrines with an active 0.2% chlorine solution

Preparation of an active 0.2% chlorine solution using the most easily available products

Remember that the concentration of chlorine solutions declines over time (1% per day). To avoid corrosion, never use a metal container.

Calcium hypochlorite, active 70% chlorine powder or granules (HTH)	**Sodium dichloroisocyanurate, active 70% chlorine**	**Chlorinated lime, active 30% chlorine powder**	**Liquid bleach, active 5% chlorine**
30 grams/10 litres or 2 tablespoons in 10 litres of water	30 grams/10 litres or 2 tablespoons in 10 litres of water	66 grams/10 litres or 4 tablespoons in 10 litres of water (allow the sediment to settle and use the supernatant)	400 ml in a 10-litre container and fill with water (the dilution error is insignificant)

Annex 3.1: Estimation of human resources (1 shower for 50 detainees)

Topical treatment

Duties	Number of persons	Comments
Medical team		
Applying topical scabicides and giving referrals for antibiotic treatment	2	At least one should speak the language spoken by detainees
Antibiotic treatment	1	
Counting number of treated cases	1	
Cleaning and hygiene team		
Cleaning cells, preparing and applying chlorine solution	2	May be detainees – after training and under supervision
Supervision, monitoring	1	Should speak the language spoken by detainees
Promoting hygiene	1	Should speak the language spoken by detainees
Carrying water (for makeshift showers)	2/Makeshift showers	Detainees
Distributing soap	1/Cell	
Permethrin team		
Pouring permethrin into bags, installing rope	2	May be detainees – after training and under supervision
Carrying bags	1/20 detainees	Detainees
Supervision	1	Should speak the language or work with an interpreter
Monitoring team		
Stock management	1	
Coordination	1	

Annex 3.1: Estimation of human resources (1 shower for 50 detainees)(continued)

Oral treatment

Duties	Number of persons	Comments
Medical team		
Treatment and counting	1	Should speak the language or work with an interpreter
Checking for superinfection	2	At least one should speak the language spoken by detainees
Cleaning and hygiene team		
Cleaning cells, preparing and applying chlorine solution	2	May be detainees – after training and under supervision
Supervision, monitoring	1	Should speak the language or work with an interpreter
Promoting hygiene	1	Should speak the language spoken by detainees
Carrying water (for makeshift showers)	2/Makeshift showers	Detainees
Distributing soap	1/Cell	
Permethrin team		
Pouring permethrin into bags, installing rope	2	May be detainees – after training and under supervision
Carrying bags	1/20 detainees	Detainees
Supervision	1	Should speak the language or work with an interpreter
Monitoring team		
Stock management	1	
Coordination	1	

Annex 3.2: Estimation of drug and material needs

				Option Ivermectin	Option BB
	Quantity per detainee	**Quantity per hygiene team (2 persons)**	**Quantity per permethrin team (2 persons)**	**Medical team (3 staff)[4]**	**Medical team (3 staff)[5]**
Medical supplies and drugs					
BB 25% 1 litre	150 to 200 ml	0	0	0	0
Cloxacillin - 250 mg	9% of detainees (84 capsules)	0	0	0	0
Plastic cups for measuring permethrin	0	0	2	0	0
Dispensing bags	10% of detainees	0	0	0	0
Drinking water (ivermectin)	0	0	0	100 ml/ Detainee	0
Erythromycin - 500 mg	1% of detainees (24 tablets)	0	0	0	0
Examination gloves	0	0	0	3 pairs/day	3 pairs/day
Ivermectin - 6 mg tablets	10 tablets (according to body weight)	0	0	0	0
Notebook	0	0	0	1	1
Pen	0	0	0	1	1
Five-litre hand-held sprayer (BB)	0	0	0	0	2
Tally sheet	0	0	0	Ad hoc	Ad hoc
Water container (for drinking water)	0	0	0	50 litres	0
Cleaning materials					
Rubber boots	0	2 pairs	0	0	0
Brooms	0	2	0	0	0
Brush	0	2	0	0	0

4 Two will check for superinfection and one will hand out ivermectin and antibiotics if needed.

5 Two will spray BB and check for superinfection, and one will hand out antibiotics if needed.

Annex 3.2: Estimation of drug and material needs (continued)

	Quantity per detainee	Quantity per hygiene team (2 persons)	Quantity per permethrin team (2 persons)	Option Ivermectin Medical team (3 staff)[4]	Option BB Medical team (3 staff)[5]
Cleaning materials (continued)					
10-litre plastic bucket for chlorine	0	2	0	0	0
50-litre plastic bucket for chlorine	0	2	0	0	0
20-litre plastic bucket (for makeshift shower, if needed)	0	1/Makeshift shower	0	0	0
Paint mask	0	2/Day	0	0	0
Flipchart for providing information for detainees/guards	0	0	0	2	2
Rubber gloves	0	2 pairs	0	0	0
Overalls	0	2	0	0	0
Protective goggles	0	2 pairs	0	0	0
Bars of bath soap	1 or 2	0	0	0	0
Washing powder/ Laundry detergent	1	0	0	0	0
10-litre plastic sprayer (chlorine solution)	0	2	0	0	0
Wide-brimmed hat	0	2	0	0	0
Mop	0	2	0	0	0
Materials for disinfecting clothes, bedding					
110-litre plastic bag	1	0	0	0	0
35-litre plastic bag	1	0	0	0	0
Small plastic bag	1	0	0	0	0
Plastic cups for measuring permethrin	0	0	2	0	0

4 Two will check for superinfection and one will hand out ivermectin and antibiotics if needed.

5 Two will spray BB and check for superinfection, and one will hand out antibiotics if needed.

Annex 3.2: Estimation of drug and material needs (continued)

				Option Ivermectin	Option BB
	Quantity per detainee	**Quantity per hygiene team (2 persons)**	**Quantity per perme-thrin team (2 persons)**	**Medical team (3 staff)[4]**	**Medical team (3 staff)[5]**
Materials for disinfecting clothes, bedding					
Protective mask	0	0	2/Day	0	0
Label or paper	3	0	0	0	0
Tape for attaching labels	1 roll/ 60 detainees	0	0	0	0
Permanent markers (check quality before using)	1/Cell	0	0	0	0
Permethrin	150 g/ Detainee	0	0	0	0
Rope	0	0	Ad hoc	0	0
String (to seal plastic bags)	3 pieces/ detainee	0	0	0	0
Tarpaulin	0	0	Ad hoc	0	0
Clothing, towels, blankets					
Blankets	1	0	0	0	0
Clothing	1 set	0	0	0	0
Large towels	1	0	0	0	0

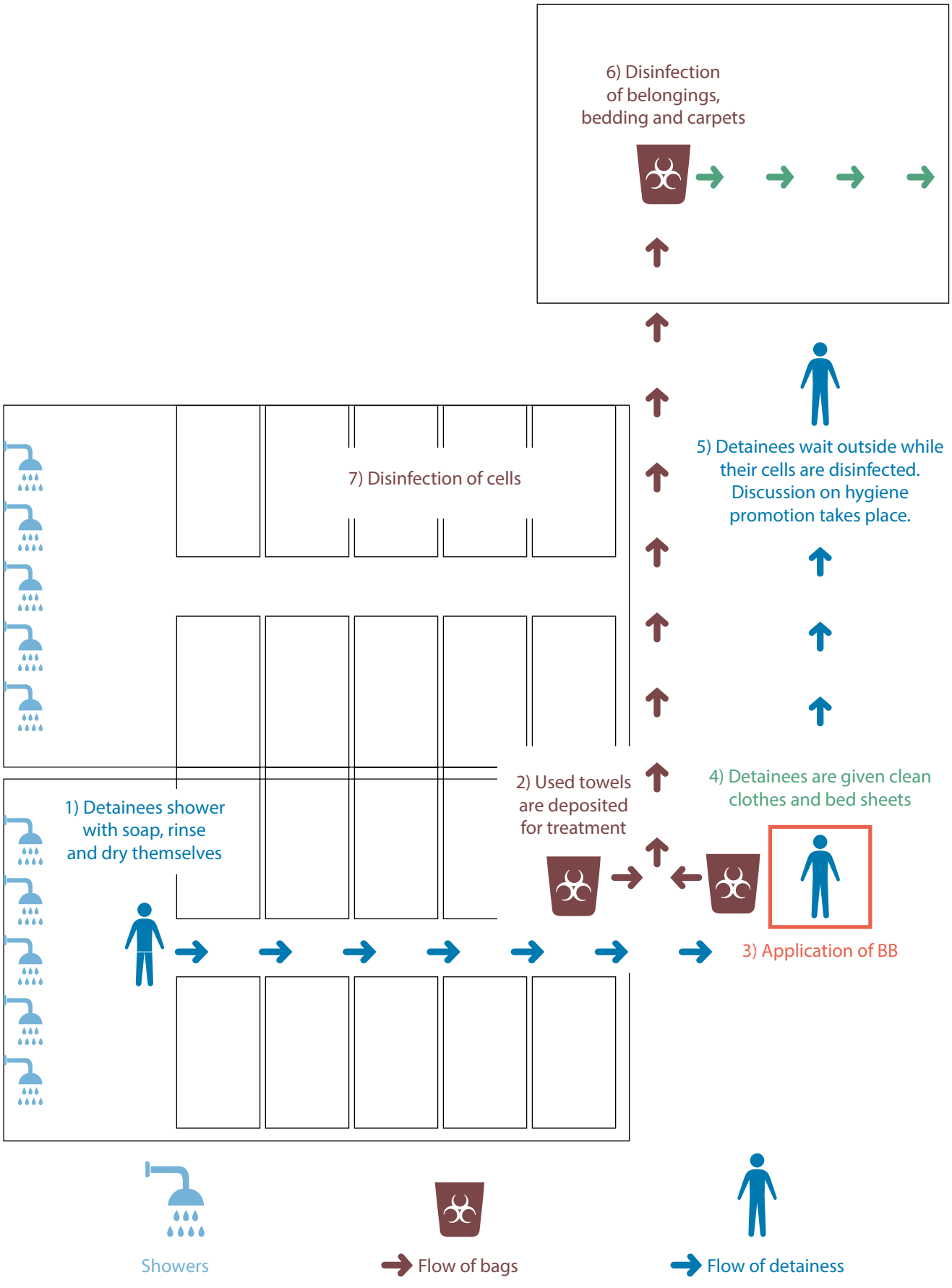
4 Two will check for superinfection and one will hand out ivermectin and antibiotics if needed.

5 Two will spray BB and check for superinfection, and one will hand out antibiotics if needed.

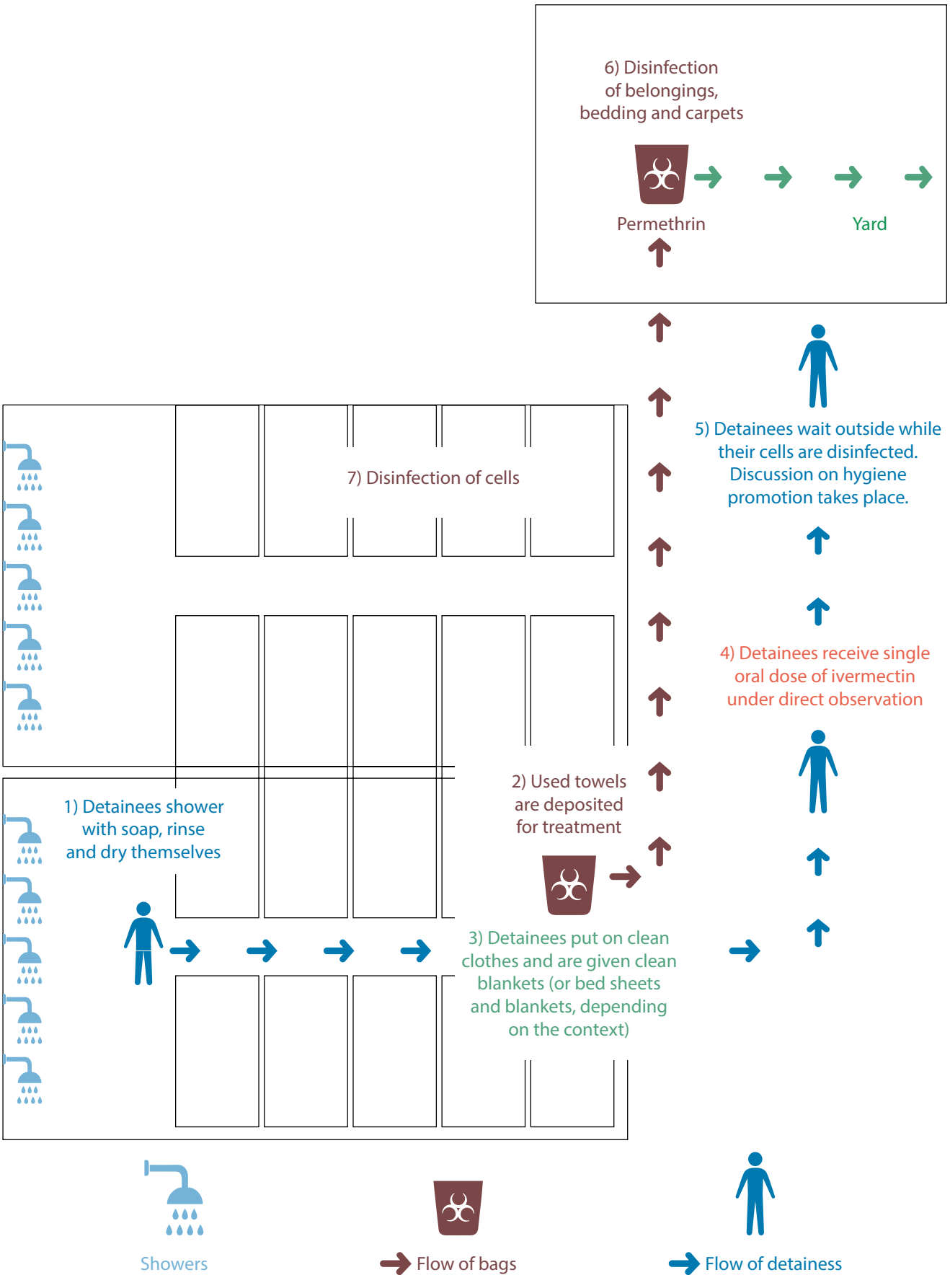
Annex 4: Consumption sheet

	Balance	D0	D1		D2		D3		D4		D5		D6		D7		D8		D9		D10	
		Stock	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry
Medical supplies and drugs																						
BB 25% 1 litre	0																					
Cloxacillin - 250 mg	0																					
Plastic cup (ivermectin)	0																					
Dispensing bags	0																					
Erythromycin - 500 mg	0																					
Examination gloves	0																					
Ivermectin - 6 mg tablets	0																					
Tally sheet	0																					
Cleaning materials																						
Paint mask	0																					
Bars of bath soap	0																					
Washing powder/ Laundry detergent	0																					
Materials for disinfecting clothes, bedding																						
110-litre plastic bag	0																					
35-litre plastic bag	0																					
Small plastic bag	0																					
Protectective mask	0																					
Label or paper	0																					
Tape for attaching labels	0																					
Permanent markers	0																					
Permethrin	0																					
Rope	0																					
String	0																					
Tarpaulin	0																					
Clothing, towels, blankets																						
Blankets	0																					
Clothes	0																					
Large towels	0																					

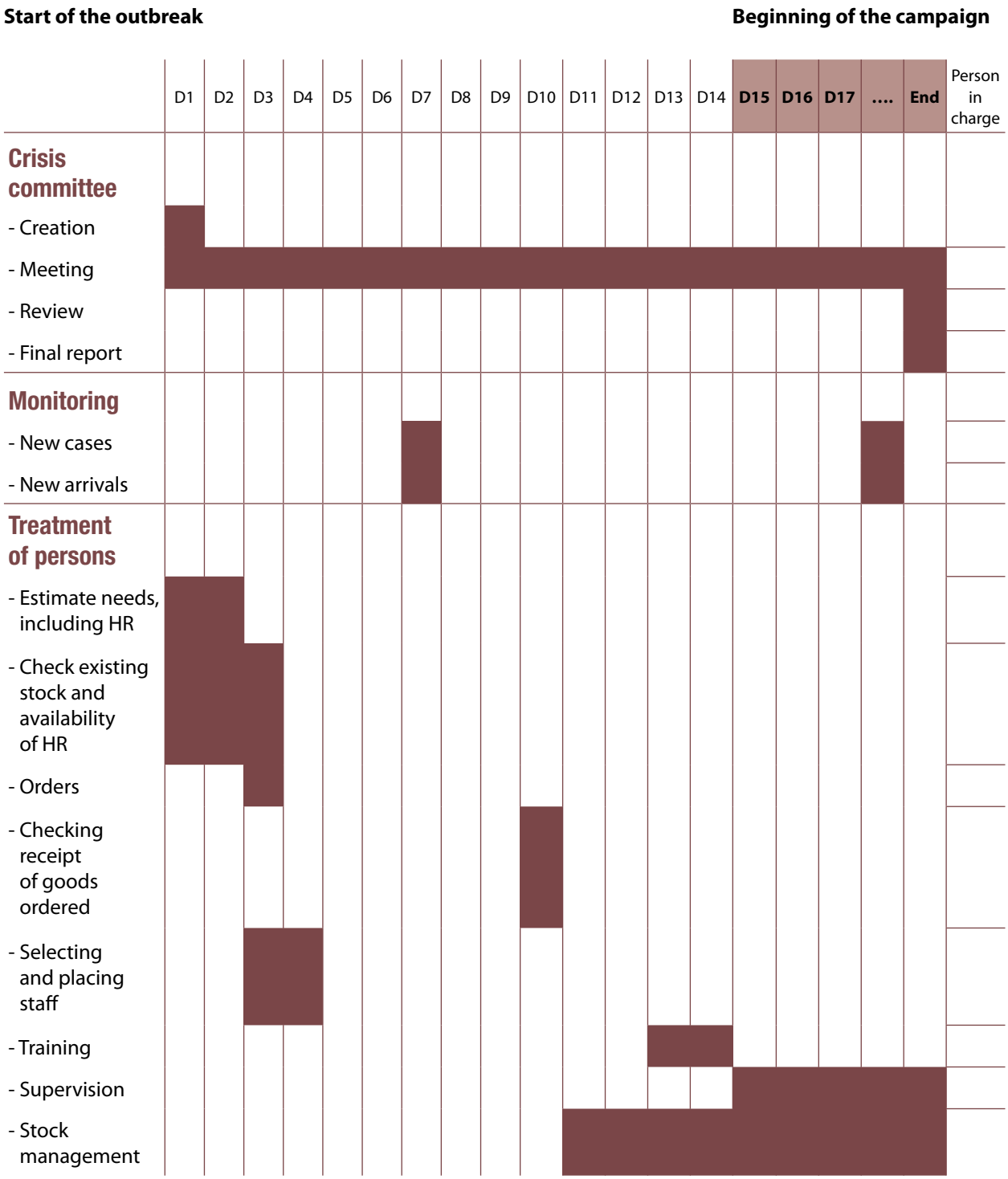
Annex 5.1: Flow of detainees receiving *topical* treatment



Annex 5.2: Flow of detainees receiving *oral* treatment

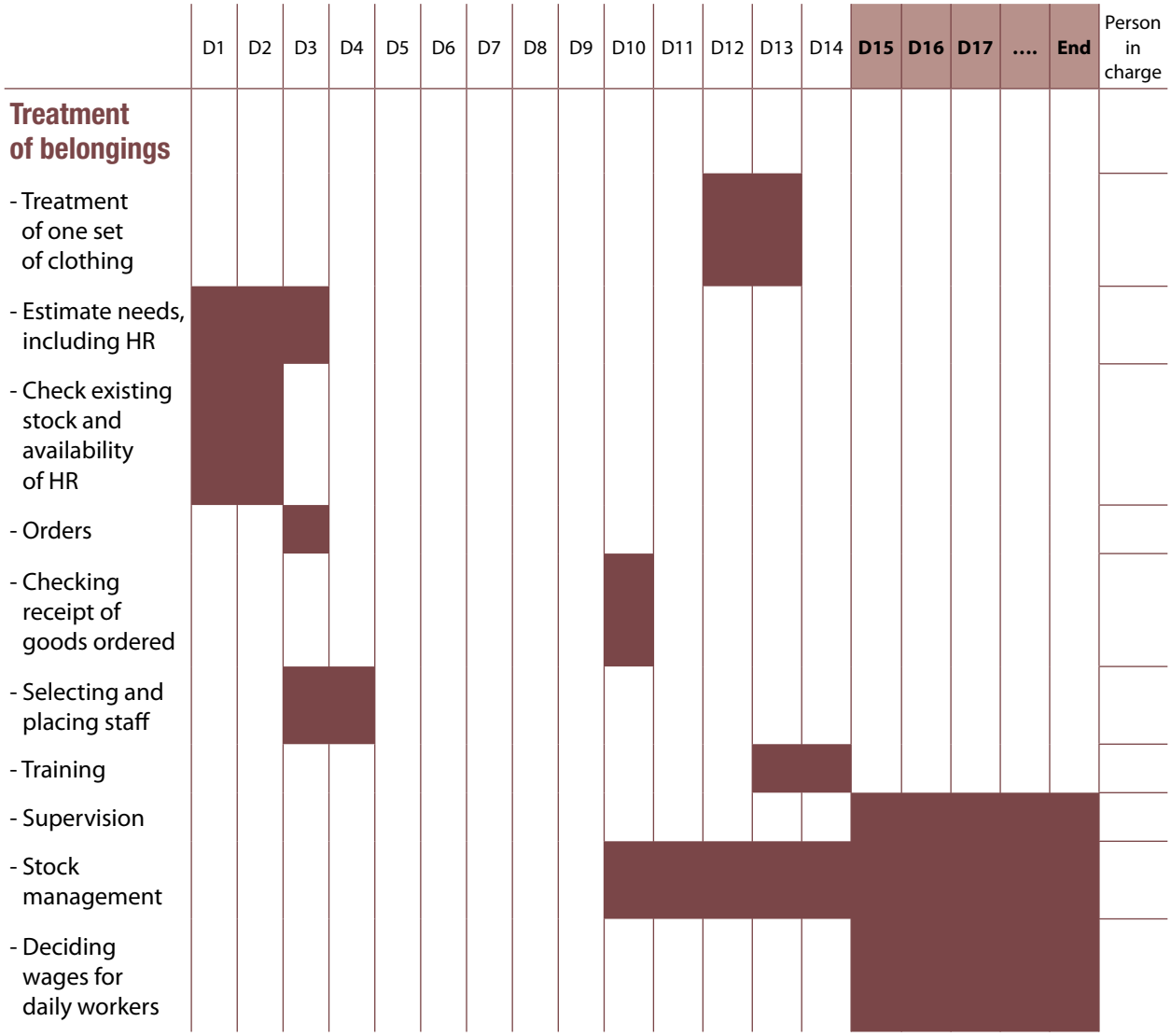


Annex 6: Timeline: Example

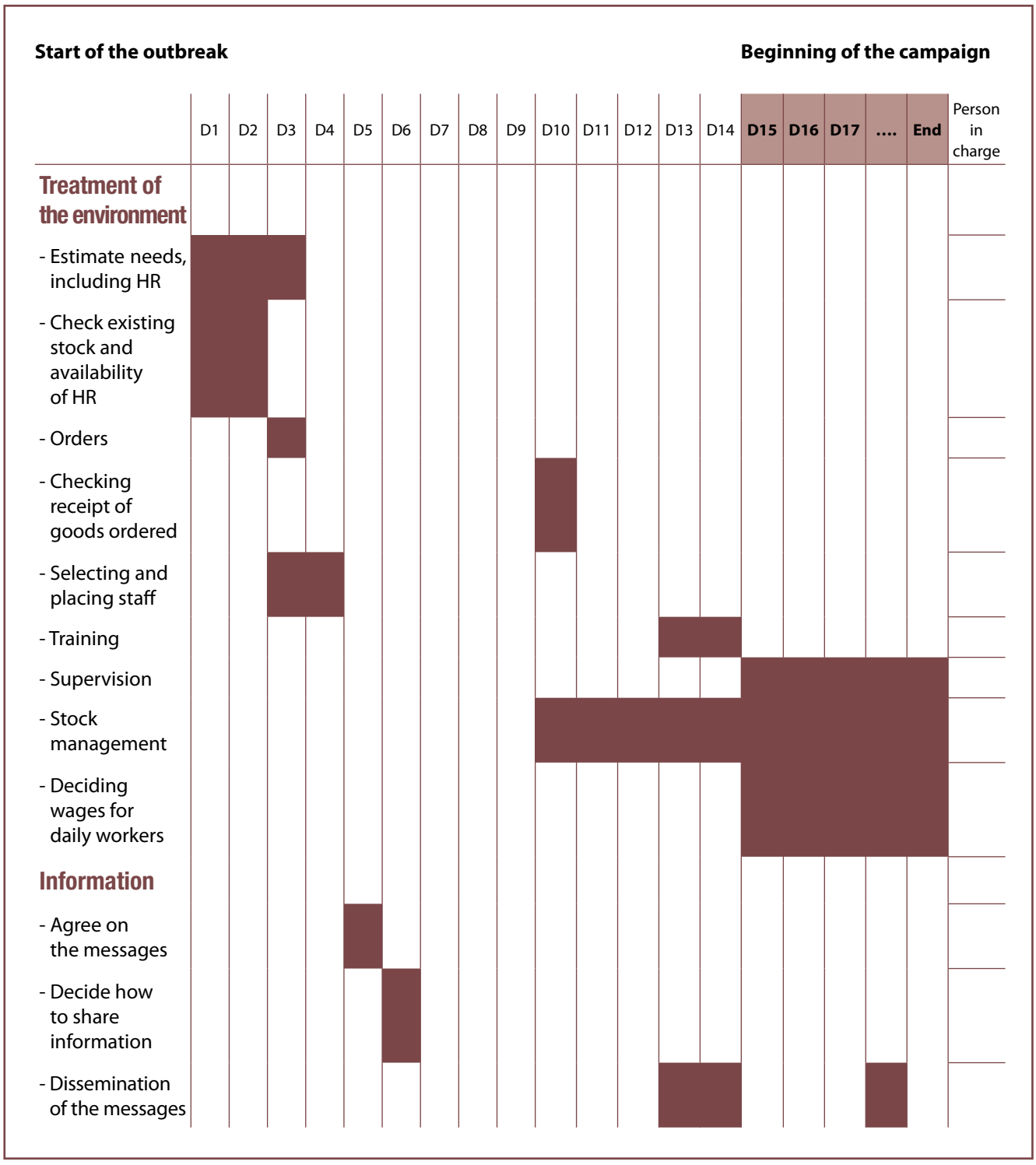


Annex 6: Timeline: Example (continued)

Start of the outbreak **Beginning of the campaign**

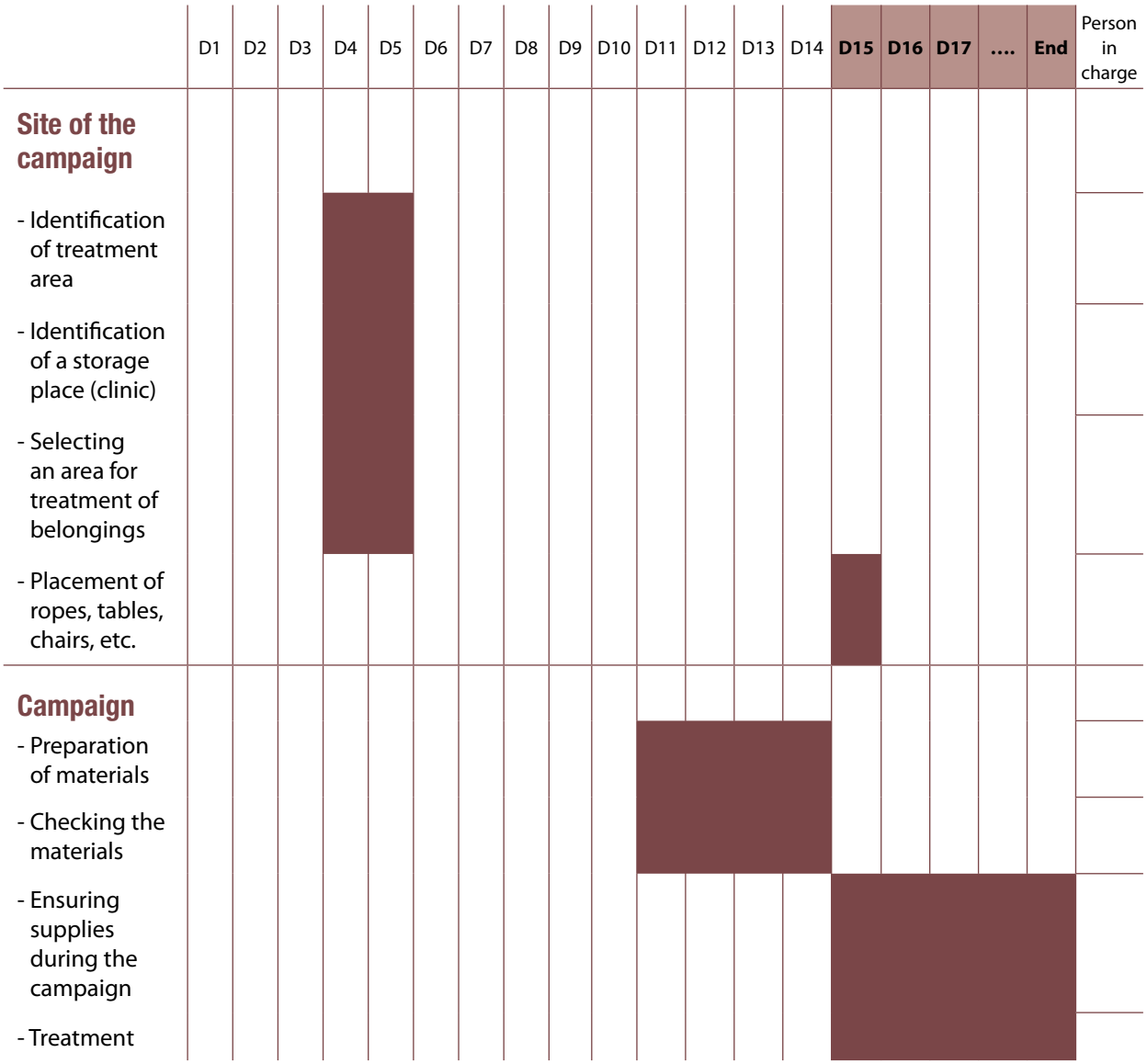


Annex 6: Timeline: Example (continued)



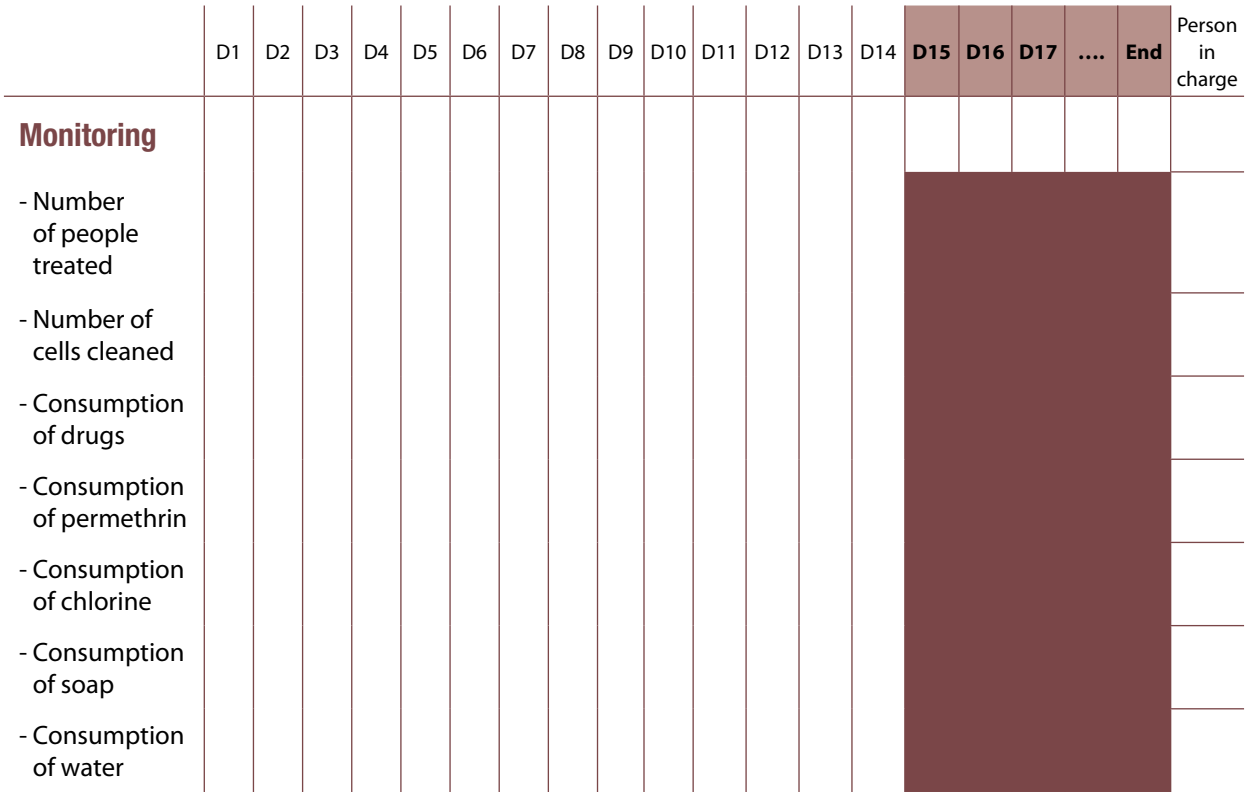
Annex 6: Timeline: Example (continued)

Start of the outbreak **Beginning of the campaign**

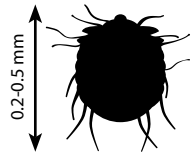


Annex 6: Timeline: Example (continued)

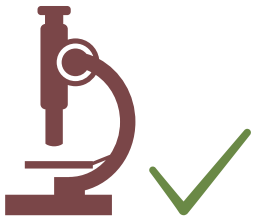
Start of the outbreak **Beginning of the campaign**



Annex 7: Information for detainees



Scabies
(Sarcopotes scabiei)



The mites that cause scabies cannot be seen with the naked eye. They are about 1/4 of a millimetre in length and can be seen only with a microscope.

Scabies mites, unlike fleas, cannot jump from one person to another. However, they can be spread by direct body contact between people. Also, scabies mites may be transmitted through clothes and bedding, and when people live in close quarters.

Preventive measures

Good personal hygiene

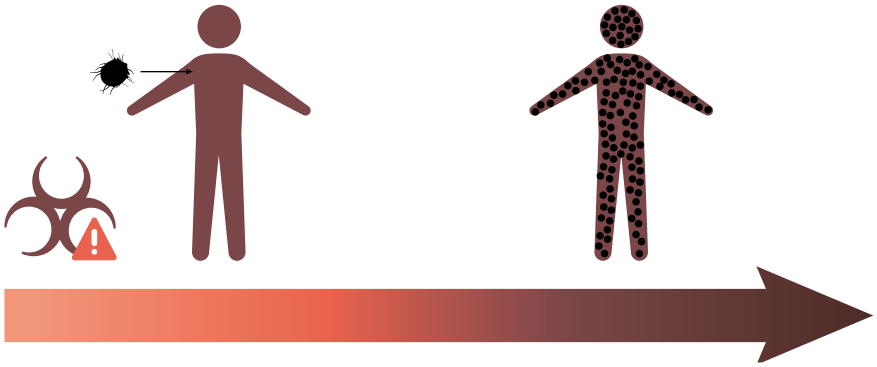
Frequent cleaning of clothes, bed linen and ironing

Daily cleaning of premises

Well-ventilated premises

Main localizations of the signs of the disease

Be sure that all these areas are covered
with the benzyl benzoate lotion



Few days to few weeks before symptoms, **but you are already contagious**

Explain the treatment chosen and what it will involve

The symptoms may persist for two to four weeks after the treatment; the mites will be killed; **and you will no longer be contagious**.

Annex 8: Information for cleaning team

1. Sweep dust and food off the floor with a broom.

2. With a wet brush clean walls, floors, pillars, bars and doors.

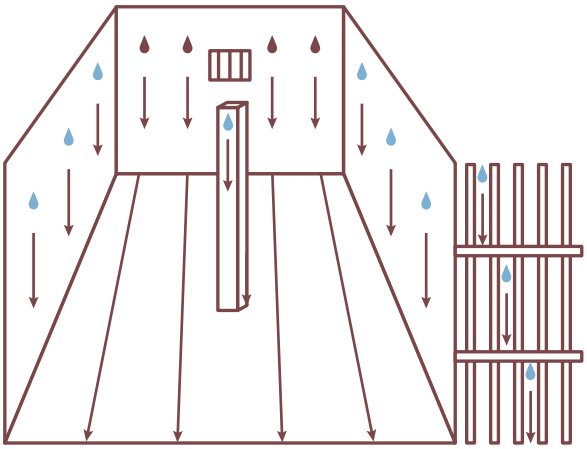
3. Mop up the excess water.

Liquid bleach
(5% active chlorine)

Water

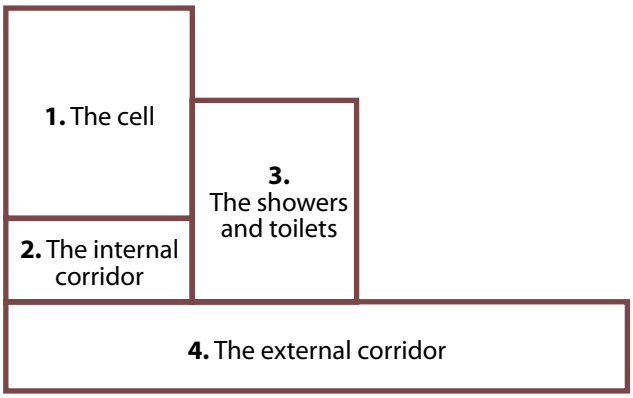
4. Pour 400 ml into a 10-litre container and fill with water.

Clean cells in this order:

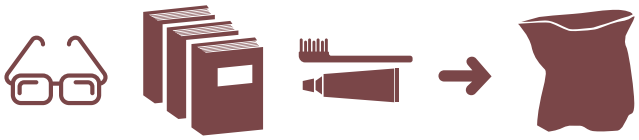


1. Clean from up to down.
2. Clean from the back to the front.

Clean in this order: the cell, the internal corridor, the showers and toilets, and the external corridor.

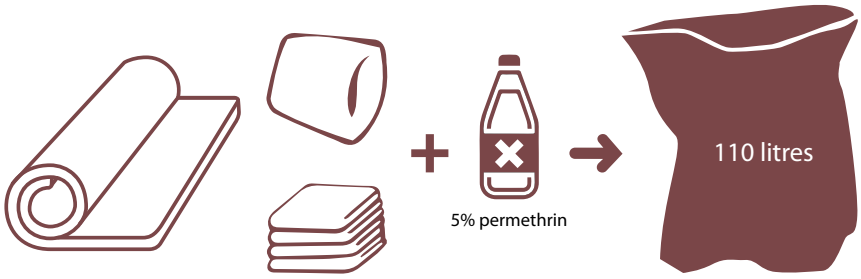


Annex 9: Information for permethrin team



Small plastic bag

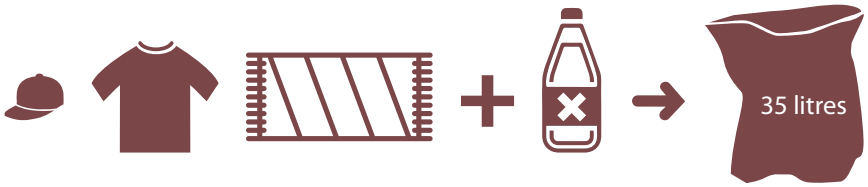
It is especially important to place inside the bag all items that usually come in contact with the mouth. Such items, and others not thought to contain the mite, are placed in the bag and not sprayed. No permethrin should be put in these bags.



5% permethrin

Big plastic bag

Permethrin team: Wearing masks, pour 80 mg into bag (outdoors, if possible).
1. Roll up mattress and put it in the bag
2. Place the pillow inside the bag
3. Place blanket and small carpet inside the bag

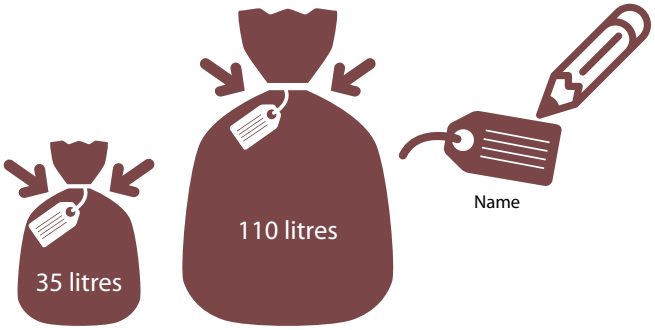


Personal clothes: (pullover, hat, towel, etc.)

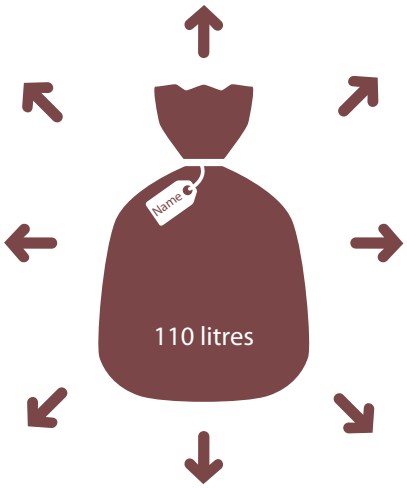
5% permethrin

Medium-sized plastic bag

Permethrin team: Wearing masks, pour 40 mg into bag (outdoors, if possible).



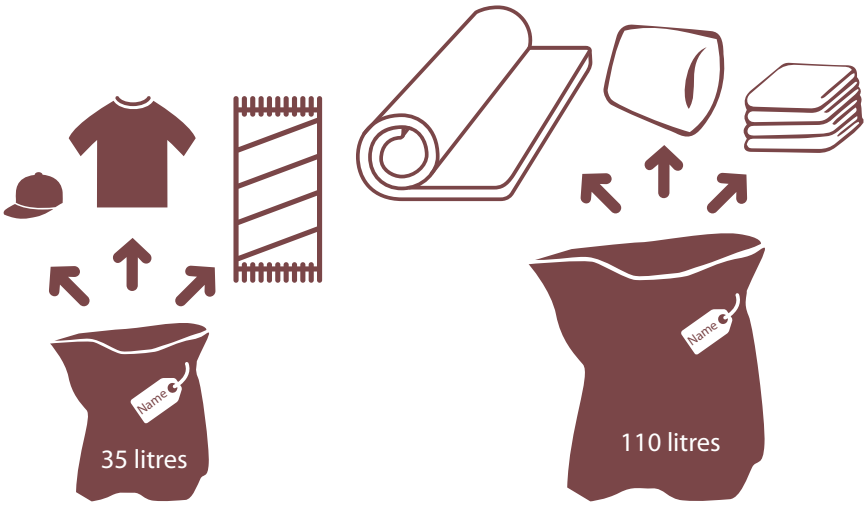
1. Close both bags tightly with the cords.
2. Attach a label – with a name on it – to each bag.



Shake thoroughly, up and down and from side to side, the 110-litre bag containing the mattress, pillow and permethrin.

Put the bags in the indicated place outside under the sun.

Wash your hands thoroughly with soap. Permethrin is poisonous if ingested.



Personal clothes (pullover, hat, towel, etc.)

Mattress, pillow, etc.

When you are given permission to do so, open the bags in the courtyard and shake them vigorously, to remove the permethrin powder from your personal effects. Discard the plastic bags and return to your cell with your belongings.

Wash your hands thoroughly with soap. Permethrin is poisonous if ingested.

Annex 10: Tally sheet

Scabies treatment: First dose

Location:

Prison:

Block:

Date:

Total number of persons to be treated in the block:

OOOOO	5	OOOOO	10	OOOOO	305	OOOOO	310
OOOOO	15	OOOOO	20	OOOOO	315	OOOOO	320
OOOOO	25	OOOOO	30	OOOOO	325	OOOOO	330
OOOOO	35	OOOOO	40	OOOOO	335	OOOOO	340
OOOOO	45	OOOOO	50	OOOOO	345	OOOOO	350
OOOOO	55	OOOOO	60	OOOOO	355	OOOOO	360
OOOOO	65	OOOOO	70	OOOOO	365	OOOOO	370
OOOOO	75	OOOOO	80	OOOOO	375	OOOOO	380
OOOOO	85	OOOOO	90	OOOOO	385	OOOOO	390
OOOOO	95	OOOOO	100	OOOOO	395	OOOOO	400
OOOOO	105	OOOOO	110	OOOOO	405	OOOOO	410
OOOOO	115	OOOOO	120	OOOOO	415	OOOOO	420
OOOOO	125	OOOOO	130	OOOOO	425	OOOOO	430
OOOOO	135	OOOOO	140	OOOOO	435	OOOOO	440
OOOOO	145	OOOOO	150	OOOOO	445	OOOOO	450
OOOOO	155	OOOOO	160	OOOOO	455	OOOOO	460
OOOOO	165	OOOOO	170	OOOOO	465	OOOOO	470
OOOOO	175	OOOOO	180	OOOOO	475	OOOOO	480
OOOOO	185	OOOOO	190	OOOOO	485	OOOOO	490
OOOOO	195	OOOOO	200	OOOOO	495	OOOOO	500
OOOOO	205	OOOOO	210	OOOOO	505	OOOOO	510
OOOOO	215	OOOOO	220	OOOOO	515	OOOOO	520
OOOOO	225	OOOOO	230	OOOOO	525	OOOOO	530
OOOOO	235	OOOOO	240	OOOOO	535	OOOOO	540
OOOOO	245	OOOOO	250	OOOOO	545	OOOOO	550
OOOOO	255	OOOOO	260	OOOOO	555	OOOOO	560
OOOOO	265	OOOOO	270	OOOOO	565	OOOOO	570
OOOOO	275	OOOOO	280	OOOOO	575	OOOOO	580
OOOOO	285	OOOOO	290	OOOOO	585	OOOOO	590
OOOOO	295	OOOOO	300	OOOOO	595	OOOOO	600

Total

Annex 10: Tally sheet (continued)

Scabies treatment: Second dose

Location:

Prison:

Block:

Date:

Total number of persons to be treated in the block:

OOOOO	5	OOOOO	10	OOOOO	305	OOOOO	310
OOOOO	15	OOOOO	20	OOOOO	315	OOOOO	320
OOOOO	25	OOOOO	30	OOOOO	325	OOOOO	330
OOOOO	35	OOOOO	40	OOOOO	335	OOOOO	340
OOOOO	45	OOOOO	50	OOOOO	345	OOOOO	350
OOOOO	55	OOOOO	60	OOOOO	355	OOOOO	360
OOOOO	65	OOOOO	70	OOOOO	365	OOOOO	370
OOOOO	75	OOOOO	80	OOOOO	375	OOOOO	380
OOOOO	85	OOOOO	90	OOOOO	385	OOOOO	390
OOOOO	95	OOOOO	100	OOOOO	395	OOOOO	400
OOOOO	105	OOOOO	110	OOOOO	405	OOOOO	410
OOOOO	115	OOOOO	120	OOOOO	415	OOOOO	420
OOOOO	125	OOOOO	130	OOOOO	425	OOOOO	430
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OOOOO	195	OOOOO	200	OOOOO	495	OOOOO	500
OOOOO	205	OOOOO	210	OOOOO	505	OOOOO	510
OOOOO	215	OOOOO	220	OOOOO	515	OOOOO	520
OOOOO	225	OOOOO	230	OOOOO	525	OOOOO	530
OOOOO	235	OOOOO	240	OOOOO	535	OOOOO	540
OOOOO	245	OOOOO	250	OOOOO	545	OOOOO	550
OOOOO	255	OOOOO	260	OOOOO	555	OOOOO	560
OOOOO	265	OOOOO	270	OOOOO	565	OOOOO	570
OOOOO	275	OOOOO	280	OOOOO	575	OOOOO	580
OOOOO	285	OOOOO	290	OOOOO	585	OOOOO	590
OOOOO	295	OOOOO	300	OOOOO	595	OOOOO	600

Total

Annex 11: Report template

Country

City, place of detention

Start and end dates of the campaign

Context

Describe the context in which the outbreak occurred

Detainee population (number and kind)

Protective factors

Aggravating or leading factors

Background of outbreak in the country or area or place of detention

Epidemiological surveillance system in the country and in the place of detention

Was there a contingency plan for responding to an outbreak?

History of the epidemic

Information on the first case

Epidemic investigation

Crisis committee (composition, decision-making process, decisions taken)

Case definition

Annex 11: Report template (continued)

Description of the epidemic: Duration and persons affected

Number of cases by date

Attack rate

Mapping

Persons affected: Gender, age, other specific details

Characteristics peculiar to the place, if any

Hypotheses regarding the cause of the epidemic

Steps taken by the ICRC

Coordination and actions taken by other organizations and prison authorities

Case management (qualitative and quantitative data)

Hygiene

Communication about the outbreak and the campaign

The pace of the process

Difficulties/Incidents

Practical considerations for future action

Cost and budget

Conclusions and recommendations for preventing recurrence

8. REFERENCES

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MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.

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