

Abstract

This article examines the human rights and public health implications of injection drug use in prisons with a specific focus on HIV and hepatitis C (HCV) viruses. The authors argue that prisoners who inject drugs have a right to access harm reduction measures — those that reduce the harmful consequences of drug use without necessarily reducing drug consumption. Moreover, states that fulfill their obligation to provide prisoners with harm reduction measures such as access to bleach, substitution therapy, and sterile injection equipment implement sound public health policy with a positive impact for a population particularly vulnerable to HIV and HCV. Ultimately, this approach benefits not only prisoners but also prison staff and the public, and does not entail lessening of the safety and security of prisons.

L'article examine les implications, en matière de droits de l'homme et de santé publique, de la prise de drogue par injection dans les prisons, particulièrement pour ce qui concerne les virus du VIH et de l'hépatite C (VHC). Selon les auteurs, les détenus qui s'injectent des drogues ont un droit d'accès à des mesures de réduction des risques — celles qui réduisent les conséquences néfastes de l'emploi de drogues sans nécessairement réduire leur consommation. De plus, les états qui remplissent leur obligation de fournir aux détenus des mesures de réduction des risques (eau de Javel, thérapies de substitutions et matériels d'injection stériles, par exemple) mettent en œuvre une politique saine de santé publique, qui a un effet positif sur une population particulièrement vulnérable au VIH et au VHC. En dernière analyse, cette approche profite non seulement aux détenus mais aussi au personnel pénitentiaire et au public, sans pour autant diminuer la sécurité ni la sûreté des prisons.

En este artículo se examinan las implicaciones para los derechos humanos y la salud pública del uso de drogas inyectadas en las prisiones con un enfoque específico en los virus de VIH y hepatitis C. (VHC). Los autores mantienen que los prisioneros que se inyectan drogas tienen derecho a obtener acceso a medidas de reducción del daño — aquellas que reducen las consecuencias perjudiciales del uso de drogas sin necesariamente reducir su consumo. Asimismo, los estados que cumplen su obligación de suministrarles a los reos medidas de reducción de daños, tales como acceso a blanqueadores, terapia de sustitución y equipos de inyección estériles, implementan una política de salud pública sensata con un impacto positivo para una población que es especialmente vulnerable al VIH y VHC. A fin de cuentas, este enfoque beneficia no sólo a los reos sino que también al personal de las prisiones y al público y no implica reducir la seguridad en las prisiones.



PRISONERS WHO INJECT DRUGS: Public Health and Human Rights Imperatives

Ralf Jürgens and Glenn Betteridge

[B]y entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities.¹

Prisoners have long been identified as a group particularly vulnerable to HIV and, more recently, hepatitis C virus (HCV) infection due to the high prevalence of HIV and HCV among prisoners and the lack of measures within prisons to prevent transmission. In recent years, a handful of countries have responded to the HIV and HCV epidemics in

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prison by introducing HIV and HCV prevention and harm reduction programs, which reduce the harmful consequences of drug use without necessarily reducing drug consumption. Efforts undertaken include implementing pragmatic public health measures such as providing condoms, lubricants, bleach or other disinfectant for cleaning syringes, substitution therapy to treat injection opiate addiction, and needle exchange programs within prisons. Yet, the overwhelming majority of prisoners who require such measures to protect their health do not have access to them, and most prison systems have failed to sufficiently address drug injection-related health problems.

Today, the scale and severity of the human rights abuses and public health crisis attributable to injection drug use in prisons can no longer be ignored. In recent years, several countries have documented HIV or HCV outbreaks in prisons. Surveillance data now unequivocally indicate that injection drug use is fueling the world's fastest growing HIV epidemic in the countries of the former Soviet Union. A number of these countries inordinately rely on prohibitionist laws to address injection drug use, resulting in high rates of incarceration among injection drug users and related harms. The coexistence of significant communities of injection drug users, intense stigma and discrimination against illicit drug users, and politically driven criminalization of drug users is not unique to this region. Many other countries such as Thailand and the United States — countries with radically different socio-economic circumstances — are also exemplary of this phenomenon. The combination of growing prevalence of HIV, HCV, (drug resistant) tuberculosis, and sub-standard prison conditions threatens to significantly increase morbidity and mortality among imprisoned injection drug users and ex-prisoners released into the community. There is now evidence that harm reduction measures can be successfully adopted in prison settings, with proven benefits and none of the feared negative consequences. It is therefore high time that the world wake up to the public health and human rights implications of HIV/AIDS in prison and take action that promotes and protects prisoners' rights and public health.

This article briefly reviews prison HIV and HCV prevalence and evidence of injection drug use and resulting HIV and HCV transmission behind bars. International instruments that set out prisoners' rights and states' obligations are reviewed with a focus on protections that hold the promise of mitigating the impacts of the HIV and HCV epidemics in the prison context. The authors argue that prisoners' right to health includes the right to access measures to prevent HIV and HCV and other drug-related harms. In this context, the article reviews the evidence for harm reduction measures that have proven successful in reducing HIV and HCV transmission in prisons.

Prevalence of HIV and HCV in Prisons

Worldwide, rates of HIV infection in prisoner populations are much higher than in the general population. In many countries, prevalence rates in prison are closely related to two factors: 1) the rate of HIV infection among injection drug users in the community and 2) the proportion of people who injected drugs prior to imprisonment. The jurisdictions with the highest HIV prevalence in prisons (apart from countries with large heterosexual HIV epidemics) are areas where HIV infection in the general community is "pervasive among IV drug users, who are dramatically over-represented in correctional institutions."² Commenting on the situation in the United States, the US National Commission on AIDS stated that "by choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection."³

In western Europe, particularly high rates have been reported from countries in southern Europe — for example, 20% in Portugal and 16.6% in Spain.⁴ In contrast, other European countries, including Belgium, Finland, Iceland, and some states in Germany, have reported lower levels of HIV prevalence.⁵ Relatively low rates of HIV prevalence have also been reported from Australia.⁶ In the United States and in Canada, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. In the United States, many prison systems have rates under 1%;

while in a few, rates have approached or exceeded 10% among men and 15% among women.⁷ In Canada, rates between 1% and 11.94% have been reported.⁸

In the countries of central and eastern Europe and the former Soviet Union, high rates of HIV infection and injection drug use among prisoners are a growing concern. Generally, the available HIV-prevalence data tend to suggest lower HIV prevalence in prisons in Central Europe (for example, Poland, Czech Republic, Hungary, and Bulgaria), and a much higher prevalence in some of the states of the former Soviet Union — in particular, Russia and Ukraine, but also Lithuania, Latvia, and Estonia.⁹ For example, in the Russian Federation, by late 2002 the registered number of people living with HIV/AIDS in the penal system exceeded 36,000, representing approximately 20% of known HIV cases.¹⁰ In Latin America, studies have shown rates of 3 to 41% in Brazil, 2 to 50% in Argentina, and 1 to 7% in Mexico.¹¹ In Asia, numerous studies in Thailand have shown that a history of imprisonment was associated significantly with HIV infection.¹² HCV seroprevalence rates in prisons are even higher. In countries where studies have been undertaken, rates of 30 to 40% are the norm.¹³

Drug Use and Injection Drug Use in Prisons

Illicit drugs are available in prisons despite the sustained efforts of prison systems to prevent illicit drug use by prisoners — by doing what they can to prevent the entry of drugs into prisons, tightly controlling distribution of prescription medications, and enforcing criminal prohibitions on illicit drug possession and use among prisoners. Many prisoners come to penal institutions with established drug habits.¹⁴ In fact, many prisoners are in prison in the first place because of offenses related to drugs.¹⁵ These may be crimes related to drug production, possession, trafficking or use, or crimes committed to acquire resources to purchase drugs. Many prison systems have seen significant increases in their populations (and consequent overcrowding) attributable in large measure to a policy of actively pursuing and imprisoning those dealing with and consuming illegal substances.¹⁶ People who used drugs prior to imprisonment often find a way to continue drug use on the inside. Other

prisoners start using drugs in the penal institution as a means to release tensions and to cope with being in an overcrowded and often violent environment.¹⁷

Studies have shown that injection drug use is prevalent in prisons in many countries. For example, a report prepared for the European Union showed that between 0.3 and 34% of the prison population in the European Union and Norway injected while incarcerated; that between 0.4 and 21% of injecting drug users (IDUs) started injecting in prison; and that a high proportion of IDUs in prison share injection equipment.¹⁸ In Canada, 11% of 4,285 federal prisoners participating in a survey of prisoners self-reported having injected since arriving in their current penal institution. In some regions, up to 23% of prisoners reported injection drug use.¹⁹ More recent studies confirm high levels of injection drug use.^{20,21}

In Australia, between 31 and 74% of IDUs reported injecting in prison, and between 60 and 91% reported sharing injection equipment in prison.²² In Thailand, the first wave of HIV infections occurred in 1988 among drug injectors. From a negligible percentage at the beginning of the year, the prevalence rate among injectors rose to over 40% by September, fueled in part by transmission of the virus as injectors moved in and out of penal institutions.²³ A recent study concluded that "injecting drug users in Bangkok are at significantly increased risk of HIV infection through sharing needles with multiple partners while in holding cells before incarceration."²⁴ In Russia, a study among 1,087 prisoners showed that 43% had injected a drug ever in their lives; that 20% had injected in the penal institution, of which 64% used injection equipment that had already been used by somebody else; and that 13.5% had started injecting in prison.²⁵ In Mexico, a study in two jails found rates of IDU of 37 and 24% respectively.²⁶

Imprisonment is a common event for many IDUs. In a national study in the United States, approximately 80% of 25,000 IDUs had been in prison.²⁷ In a 12-city WHO study of HIV risk behavior among IDUs, between 60 and 90% of respondents reported a history of imprisonment since commencing drug injection, and most had been imprisoned on multiple occasions.²⁸

Risk of HIV and HCV Transmission

For those IDUs who continue injecting in prison, imprisonment increases the risk of contracting HIV and HCV infection.²⁹ This is because those who inject drugs in penal institutions almost always share needles and syringes, which is a very efficient way of transmitting HIV and HCV — much more so than sexual contact. Because it is more difficult to smuggle needles and syringes into penal institutions than it is to smuggle drugs into them, needles and syringes are very scarce. Most often, only a handful of needles will circulate among a large population of prisoners who inject drugs. In contrast to significant risk reduction by IDUs in the community, risk behavior in prisons (with the exception of prisons that have introduced the preventive measures described below) has remained unchanged over the past decade.³⁰ In an Australian study, 6 of the 36 persons who reported injecting and sharing when last in prison also reported that it had been the first time that they had ever shared syringes.³¹ Needle sharing is frequent, and often 15 to 20 people will inject using the same equipment.³² Sometimes, the equipment is homemade, with needle substitutes fashioned out of hardened plastic and ball-point pens, often causing damage to veins, scarring, and severe infections.³³

The high rates of injection drug use, coupled with the lack of access to sterile injection equipment, which leads to increased levels of sharing of equipment among prisoners, can result in the frighteningly quick spread of HIV in penal institutions. There were early indications that extensive HIV transmission could occur in prisons. In Bangkok, HIV infection among IDUs rose from 2 to 27% in 1987 and to 43% by late 1988, following an amnesty and release of a large number of prisoners. Six studies of HIV infection among IDUs in Thailand found that a history of imprisonment was associated significantly with HIV infection.³⁴ HIV outbreaks in prison have been documented elsewhere. Most notably, a study undertaken in Glenochil prison for adult male prisoners in Scotland provided definitive evidence that outbreaks of HIV infection can occur in penal institutions. The study investigated an outbreak of HIV in Glenochil in 1993. Before the investigation began, 263 of the prisoners

who had been at Glenochil at the time of the outbreak had either been released or transferred to another penal institution. Of the remaining 378 prisoners, 227 were recruited into the study. Of those, 76 reported a history of injection and 33 reported injecting in Glenochil. Twenty-nine of the latter were tested for HIV, with 14 testing positive. Thirteen had a common strain of HIV, proving that they had become infected in the penal institution. All prisoners infected in the penal institution reported extensive periods of syringe sharing.³⁵

Another documented outbreak of HIV infection occurred in a penal institution in Australia. Epidemiological and genetic evidence was used to establish that HIV infection had indeed occurred in the penal institution. Attempts to trace 31 injection drug users resulted in 25 being located. Of these, 2 were HIV-negative, 7 were deceased, 2 declined to participate, and 14 were enrolled in the study. It could be proven that 8 of the 14 were infected with HIV while in the penal institution.³⁶

More recently, during random checks undertaken in 2002 by the state-run AIDS Center, 263 prisoners at Alytus prison in Lithuania tested positive for HIV. Tests at Lithuania's other 14 prisons found only 18 cases. Before the tests at Alytus prison, Lithuanian officials had listed just 300 cases of HIV in the entire country, or less than 0.01% of the population, the lowest rate in Europe. It has been said that the outbreak at Alytus was due to sharing of drug-injection equipment.³⁷

Transmission of HCV has also been documented in a number of studies.³⁸ In Canada, a prisoner has sued the federal prison system for allegedly contracting HIV through injection drug use in prison, after being refused methadone maintenance treatment.³⁹

Public Health Implications

Due to the closed nature of prisons, the health of prisoners is an issue that rarely comes to the attention of the public at large. However, the health of prisoners is an issue of public health concern. Prison presents a prime opportunity to respond to behaviors that pose a high risk of HIV and HCV transmission, such as needle sharing, using proven

public health measures such as needle exchange programs. Everyone in the prison environment — prisoners, prison staff, and their family members — benefits from enhancing the health of prisoners and reducing the incidence of communicable disease. Measures to decrease the risk of HIV and HCV transmission, including measures to minimize accidental exposure to these blood-borne infections, make prisons a safer place to live and work. The high degree of mobility between prison and community means that communicable diseases and related illnesses transmitted or exacerbated in prison do not remain there. When people living with HIV and HCV are released from incarceration, prison health issues necessarily become community health issues. The extent to which this is the case cannot be underestimated: for example, a recent US study found that an estimated 25% of all HIV-infected citizens pass through a correctional facility in the US each year; and in Russia, each year 300,000 prisoners, many of whom are living with HIV, HCV, and/or tuberculosis, have been released in the past few years from prisons, a figure likely to increase because of recent drug policy changes.^{40,41}

International Human Rights and the Responsibility of Prison Systems

Together the principle of limited exceptionalism and the rule of law form a mutually reinforcing core and a starting point for the analysis of the human rights of prisoners.⁴² Under international law and related international instruments, prisoners enjoy all human rights except those rights they are necessarily deprived of as a fact of incarceration.⁴³ Arguably, state actors should pay particular attention to the rule of law in the prison context because prisoners are by and large deprived of the ability to affect their own circumstances — in ethical terms, their autonomy and agency are constrained, which increases the likelihood that their dignity will be compromised. Prisoners are under the authority of state officials upon whom they rely for the essentials of life as well as all other entitlements and privileges. In the context of prison health care, a number of domestic courts have determined that states owe greater obligations

to prisoners than to the population at large because prisoners do not have control over their circumstances and cannot access prevention, care, and treatment services available in the community.

International human rights treaties, while general in nature, are relevant to the rights of prisoners in the context of the HIV/AIDS epidemic.⁴⁴ States that have ratified or acceded to these international laws are legally bound to respect, protect, and fulfill prisoners' right to, *inter alia*: equality and non-discrimination; life; security of the person; not be subjected to torture or to cruel, inhuman, or degrading treatment or punishment; and enjoyment of the highest attainable standard of physical and mental health. Specific rules and principles based in international human rights law apply to the situation of prisoners. The following multilateral instruments outline standards regarding the treatment of prisoners and prison conditions: Basic Principles for the Treatment of Prisoners; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment; Standard Minimum Rules for the Treatment of Prisoners (SMR); and Recommendation No. R (98)7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison.⁴⁵⁻⁴⁸

Many of the principles and rules set out in these instruments flow from and are particular iterations of the legal right of prisoners not to be subjected to cruel, inhuman, or degrading treatment or punishment, and the right to enjoyment of the highest attainable standard of physical and mental health. Unlike that legal right, however, none of these instruments are legally binding on states.⁴⁹ Two additional international instruments are relevant to the situation of prisoners in the context of HIV/AIDS: the WHO Guidelines on HIV Infection and AIDS in Prisons; and the International Guidelines on HIV/AIDS and Human Rights.^{50,51}

The WHO Guidelines provide standards — from a public health perspective — that prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by

HIV/AIDS. The WHO Guidelines outline general principles and address issues such as HIV testing; prevention measures; management of HIV-infected prisoners; confidentiality; care and support of HIV-infected prisoners; tuberculosis control; women prisoners; juvenile detention; semi-liberty, release, and early release; community contacts; resources; and evaluation and research.

The International Guidelines on HIV/AIDS and Human Rights identify the following specific actions in relation to prisons:

Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.⁵²

International Human Rights and Harm Reduction in Prison

Harm reduction in relation to drug use means reducing the harmful consequences of drug use without necessarily reducing drug consumption.⁵³ The major harmful consequences of injection drug use include blood-borne viruses such as HIV, hepatitis B, and HCV; overdose; injection site and other bacterial infections; and involvement in criminal and other anti-social activities.⁵⁴ In the prison context, measures aimed at HIV prevention are widely understood to include the provision of educational programs, condoms and water-based lubricants, bleach (liquid or tablets), clean needles (syringes), substitution therapy for opiate addiction (methadone maintenance treatment), and sterile implements for tattooing and piercing. Some or all of these measures also protect against sexually transmitted infections and

blood-borne infections (including hepatitis A, B, C) and other injection-related problems. Yet most of these measures, while they have been successfully introduced in some countries, remain inaccessible to the majority of the world's prison population.

Access to HIV and HCV prevention and harm reduction programs implicates prisoners' right to life, right to security of the person, right not be subjected to torture or to cruel, inhuman, or degrading treatment or punishment, and right to enjoyment of the highest attainable standard of physical and mental health.

The right to health in international law should be understood in the context of the broad concept of health set forth in the WHO Constitution, which defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Like all other persons, prisoners are entitled to enjoy the highest attainable standard of health, as guaranteed under international law. Key international instruments reveal a general consensus that the standard of health care provided to prisoners must be comparable to that available in the general community (that is, the principle of "equivalence" of health services).⁵⁵ In the context of HIV/AIDS and HCV, health services would include providing prisoners the means to protect themselves from exposure to HIV, HCV, and other forms of drug-related harm.⁵⁶

The following international standards are also implicated by HIV and HCV prevention and harm reduction in prisons:

- right to non-discrimination, including the benefit of special rules for sick or handicapped persons [Basic Principles 2; Body of Principles 5(2); SMR 6]
- access to health services available in the country without discrimination on the grounds of their legal situation (a.k.a., the principle of "equivalence" of medical services) [Basic Principles 9; Council of Europe Recommendation R 98(7) 10, 11, 19]
- clinical decisions governed by medical criteria alone, and health care personnel should operate with complete

independence within the bounds of their qualifications and competence [Council of Europe Recommendation R 98(7) 20]

- medical services organized in a close relationship to the general health administration of the community or nation [SMR 22(1); Council of Europe Recommendation R 98(7) 7]
- right to obtain from public sources reasonable quantities of educational, cultural, and informational material, subject to reasonable conditions to secure security and good order [Body of Principles 28].⁵⁷

Under the International Guidelines, countries should consider providing access to HIV-related prevention information, education, and means of prevention (condoms, bleach, and clean injection equipment) [International Guidelines paragraph 15(d)]. The WHO Guidelines contain numerous sections related to prevention and harm reduction [WHO Guidelines paragraphs 14-26]. Regarding education and information, the WHO Guidelines call for HIV-prevention education for staff and prisoners in various formats and at various times throughout their incarceration/employment, including peer education. Participation of inmates and staff in development of educational materials is encouraged; and education on infection-control procedures should emphasize universal precautions [paragraphs 14-19]. Regarding injection drug use, prisons should offer and encourage a variety of drug treatment programs: methadone should be continued for inmates already on it at the time of imprisonment and initiated for prisoners where it is otherwise available in the community; bleach to clean needles and syringes should be made available if it is available in the community; and clean needles/syringes should be considered for prisoners where available in the community.

The World Health Organization's Health in Prison Project continues to support implementation of such measures in prisons and recently published a status paper on prisons, drugs, and harm reduction that concludes that "harm reduction measures can be safely introduced into prisons, that such measures can significantly bolster preventing the transmission of HIV/AIDS in communities and that action in the interest of public health as a whole is required."⁵⁸

Education and Voluntary Counseling and Testing

Education is an essential precondition to the implementation of harm reduction measures. If prisoners are not aware of the modes of HIV and HCV transmission, ways of preventing transmission, and the reasons to do so, harm reduction tools may go unused. The World Health Organization Guidelines on Prevention and Management of HIV Infection and AIDS in Prisons recommend that prisoners and prison staff be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release.⁵⁹ Written materials distributed to prisoners should be appropriate for the educational level in the prison population. Furthermore, inmates and staff should participate in the development of educational materials. Finally, peer educators can play a vital role in educating other prisoners.⁶⁰

The World Health Organization Guidelines on HIV Prevention and Management in Prisons state:

Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre- and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support should be available when prisoners are notified of test results and in the period following.⁶¹

The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others. Counseling and testing are an important part of comprehensive HIV-prevention programs. Voluntary, rather than mandatory, testing is recommended because it fosters the development of trust between patients and health care providers.⁶² A trusting atmosphere facilitates better understanding of what the test means for patients, their partners, and their families.

Education and VCT, separately or together, are not sufficient or adequate responses to HIV/AIDS in prisons,

however. A few evaluations have indicated improvements in levels of knowledge and self-reported behavioral change as a result of prison-based educational initiatives.⁶³⁻⁶⁵ The effectiveness of current educational efforts in reducing HIV transmission among prisoners, however, remains largely unknown.⁶⁶ States do not fulfill their international human rights obligations by implementing such programs in the absence of harm reduction measures such as bleach distribution, substitution therapy, and needle exchange. Education and counseling are not of much use to prisoners if they do not have the means to act on the information provided. States have an obligation to provide prisoners with information about how to protect themselves as well as the means to do so.

Providing Bleach or Another Disinfectant

One strategy to reduce the risk of HIV transmission through the sharing of injection equipment is to provide liquid bleach, together with instructions on correct use, for sterilizing needles and syringes. Making bleach available to prisoners has often been opposed on the grounds that it may be perceived as condoning an illegal act that has contributed to many prisoners being incarcerated in the first place. It has also been argued that making bleach and information on how to clean injection equipment available may encourage non-users to experiment with injection drug use, and that bleach could be used as a weapon against staff.⁶⁷ However, the experience in those prison systems that have made bleach available to prisoners has shown that distribution of bleach has not compromised security within penal institutions.

According to a study undertaken by Harding and others for the World Health Organization, 16 of 52 prison systems surveyed in Europe had already made bleach available to prisoners in 1991.⁶⁸ Significantly, no system that has adopted a policy of making bleach available in penal institutions has reversed the policy, and the number of systems that make bleach available has continued to grow. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made bleach available rose from 28% in 1992 to 50% in 1997.⁶⁹

Bleach is also available in many other prison systems, including in most Canadian prisons and in many prisons in Australia.^{70,71}

Needle Exchange or Distribution

It is important to make bleach available in prisons. However, studies have shown that it is not enough:

- Based on research, bleach disinfection should be considered as a method to reduce the risk of HIV infection from the re-use or sharing of needles and syringes only when no other safer options are available. In addition, bleach is not fully effective in reducing hepatitis C infection.⁷² Sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and syringes.⁷³
- The probability of effective decontamination is decreased further in prison. Injecting is an illicit activity. Because prisoners can be accosted at any moment by prison staff, injecting and cleaning is a hurried affair. Studies have shown that bleach disinfection takes more time than most prisoners can take.^{74,75}
- Even when bleach is provided, prisoners may find it difficult to access it.⁷⁶

Outside penal institutions in many western countries, needle exchange or distribution programs have become an integral part of a pragmatic public health response to the risk of HIV transmission among injection drug users (and ultimately, to the general public). Extensive studies on the effectiveness of these programs have been carried out. For many years, there has been scientifically sound evidence showing that they are an appropriate and important preventive health measure.⁷⁷ For example, a worldwide survey found that in cities with needle exchange or distribution programs HIV seroprevalence decreased by 5.8% per year; in cities without such programs, it increased by 5.9% per year.⁷⁸

In countries where syringes and needle exchanges programs are available in the community, providing sterile needles to prisoners has been recommended, on the ground that

access to sterile drug-injection equipment would ensure that prisoners would not have to share their equipment. A steadily increasing number of penal institutions have established and evaluated needle and syringe exchange or distribution programs. In Switzerland, distribution of sterile injection equipment has been a reality in some penal institutions since the early 1990s. Sterile injection equipment first became available to prisoners in 1992.^{79,80} Since then, needle exchange or distribution has been introduced in penal institutions in Germany, Spain, Moldova, Kyrgyzstan, and Belarus.⁸¹ Ukraine, Poland, and Iran have announced that they will start pilot projects by early 2006.⁸² Experts interviewed for a review of international research on prison-based syringe exchange programs (PSE) reported that they are at the planning stage also in Italy, Portugal, and Greece.⁸³ Canada is also considering introducing PSE. The review by Dolan and others and a more recent report that provides a comprehensive review of international evidence and experience with PSE showed that evaluations of such programs have been favorable.⁸⁴

Only one evaluation reported mixed results. In one prison in Germany, some of the positive effects that were documented in other evaluations could not be observed, primarily because access to needles and syringes (through an automatic dispenser) remained limited and therefore needle sharing continued. In addition, some prisoners reported that the fact that they could obtain clean needles and syringes may have tempted them to go back to injection drug use while they had previously switched to other forms of drug use because of the fear of infecting themselves with HIV and/or HCV.⁸⁵ In contrast, all other evaluations showed that reports of drug use decreased or remained stable over time and that reports of syringe sharing declined dramatically. No new cases of HIV, hepatitis B, or hepatitis C transmission were reported. The evaluations found no reports of serious unintended negative events, such as initiation of injection or the use of needles as weapons. Staff attitudes were generally positive. Overall, the reviews indicated that prison syringe exchange programs are feasible and do provide benefit in the reduction of risk behavior and the trans-

mission of blood-borne infection without any unintended negative consequences.⁸⁶⁻⁸⁸

Methadone Maintenance Treatment

Outside penal institutions, methadone maintenance treatment (MMT) programs have rapidly expanded in many countries over the past decade. There are ample data supporting their effectiveness in reducing high-risk injecting behavior and in reducing the risk of contracting HIV.⁸⁹⁻⁹¹ There is also evidence that MMT is the most effective treatment available for heroin-dependent injection drug users in terms of reducing mortality, heroin consumption, and criminality.⁹²⁻⁹⁴ Further, MMT attracts and retains more heroin injectors than any other form of treatment.⁹⁵ Finally, there is evidence that people who are on MMT and who are forced to withdraw from methadone because they are incarcerated often return to narcotic use, frequently within the penal institutions, and often via injection.⁹⁶ It has therefore been widely recommended that prisoners who were on MMT outside the penal institution be allowed to continue it in the institution.⁹⁷

Access to MMT is supported by international guidelines. Opiate addiction is a recognized health condition. MMT is a recognized therapy for the treatment of opiate withdrawal symptoms and, as such, is part of the standard of care for the treatment of opiate addiction in countries where it is available. In such countries, prisoners who suffer from opiate addiction, and for whom the use of MMT is clinically indicated, have a right to receive MMT as part of the right to enjoyment of the highest attainable standard of physical and mental health. In situations where MMT is available, it should be provided in accordance with guidelines and standards applicable in the community. A significant problem associated with MMT in prison, however, is the failure of some prison physicians to prescribe MMT dosages adequate to treat the effects of opiate addiction. As a result, some opiate-addicted prisoners, even when taking MMT, also continue to inject opiates. This diminishes the potential of MMT to reduce the harms associated with injection drug use.⁹⁸ Arguably, the failure of governments to provide MMT to opiate-dependent prisoners breaches the

right not to be subjected to torture or to cruel, inhumane, or degrading treatment or punishment. The breach is two-fold. First, arguably it is cruel, inhumane, and degrading to let an opiate-dependent prisoner suffer through withdrawal. Second, in the absence of MMT, opiate-dependent prisoners will likely continue to inject opiates in prison, thereby risking HIV and other blood-borne infections.

As in the community, MMT, if made available to prisoners, has the potential of reducing injecting and syringe sharing in penal institutions. The World Health Organization Guidelines on HIV/AIDS in Prisons therefore recommend: "Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries where methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons."⁹⁹ Evaluations of MMT programs in prisons have shown positive results.¹⁰⁰ For example, results from a randomized-controlled trial of the MMT program in prisons in New South Wales in Australia indicate lower rates of heroin use, injection drug use, and syringe sharing among those enrolled in MMT compared to controls.¹⁰¹ In Canada, the federal prison system expanded access to MMT after evaluation demonstrated that MMT has a positive impact on release outcome and on institutional behavior.¹⁰²

Health in Prisons — Whose Responsibility?

All the methods listed above are of vital importance. But there is one structural change that, as UNAIDS has pointed out, could have a great impact in the long run on HIV/AIDS and HCV in prison:

This is to transfer control over prison health to public health authorities. Of course, in making such a move, proper resources must be provided at the same time, and freedom of action of the new prison health authorities guaranteed.

Some countries have already introduced such a change in prison health administration. Norway was one of the first. And in France, where prison health was transferred to the Ministry of Health in 1994, a positive impact is already evident.¹⁰³

Addressing Prison System Concerns

Prison systems and governments have argued that preventive measures such as those described above cannot be introduced in prisons for safety reasons and that making them available would mean condoning drug use in prisons. This section will address these concerns and point out that introduction of such measures in prisons is in the interest of all concerned — prisoners, staff, the prison administration, and the public — and that it does not mean condoning drug use.

The Perceived Conflict of Values Between the Penal System and Medical Care

Correction is a public safety (law enforcement) rather than a public health activity, and prison life is not organized on the basis of care but of coercion. Outside the prison setting, it has long been recognized that coercive interventions are counter-productive in controlling HIV transmission and its consequences, that HIV/AIDS interventions need to be based on respect for persons and their rights and dignity, and that personal responsibility has to be encouraged.^{104,105} Prevention of disease and the provision of medical care in prisons, however, require reconciling or balancing a medical model of prevention, diagnosis, care, and treatment with the correctional requirements of custody and control.¹⁰⁶ The punitiveness inherent in the prison system, and security concerns, have often been seen as obstacles to effective prevention of HIV/AIDS (and HCV) in prisons.

The promotion of health in prisons does not necessarily entail lessening the safety and the security of prisons, however. The interests of prisoners in being given access to the means necessary to protect them from contracting HIV (and HCV) are compatible with the interests of staff in their security in the workplace and of prison authorities in the maintenance of safety and order in the institutions. Any measure undertaken now to prevent the spread of HIV (and HCV) will benefit prisoners, staff, and the public. First, it will protect the health of prisoners who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. Second, it will protect staff in correctional institutions. Lowering the prevalence of infections in prisons

means that the risk of exposure to these infections will also be lowered. Finally, measures to prevent the spread of HIV (and HCV) in prisons also protect the public. Most inmates are in prison only for relatively short periods of time and are then released into their communities. In order to protect the general population, HIV/AIDS (and HCV) prevention measures need to be available in prisons, as they are outside.

Condoning Drug Use or Condoning HIV (and HCV) Transmission?

Many prisoners are in prison because of drug offenses or because of drug-related offenses. Preventing their drug use is seen as an important part of their rehabilitation. In the eyes of many, acknowledging that drug use is a reality in prisons would be to acknowledge that prison authorities have failed. Another argument that is often used is that making bleach or sterile needles available to inmates would mean condoning behavior that is illegal in prisons. Far from condoning drug use in prisons, however, making available to inmates the means that are necessary to protect them from HIV (and HCV) transmission acknowledges that protection of prisoners' health needs to be the primary objective of drug policy in prisons. As the Scottish report *Drug Use and Scottish Prisons* pointed out, "the idea of a drug free prison does not seem to be any more realistic than the idea of a drug free society," and "stability may actually be better achieved by moving beyond this concept."¹⁰⁷

Furthermore, introducing preventive measures such as those described above is not incompatible with a goal to reduce drug use in prisons. Making sterile needles available to drug users has not led to an increase in drug use but to a decrease in the number of injection drug users contracting HIV and other infections.¹⁰⁸ Similarly, making methadone available to some users does not mean giving up on the ultimate goal of getting people off drugs. Rather, it is a realistic acknowledgment that for some users this requires time, and that they need an option that will allow them to break the drug-and-crime cycle, reduce their contact with the black market, link with needed services, and reduce the risk of their becoming infected with HIV.

On the other hand, refusing to make condoms and bleach or sterile needles available to inmates, knowing that activities likely to transmit HIV (and HCV) are prevalent in prisons, could be seen as condoning the spread of HIV (and HCV) among prisoners and to the community at large. As stated by Martin Lachat, Interim Director of Hindelbank Penitentiaries for Women in Switzerland:

... the transmission of HIV or any other serious disease cannot be tolerated. Given that all we can do is restrict, not suppress, the entry of drugs, we feel it is our responsibility to at least provide sterile syringes to inmates. The ambiguity of our mandate leads to a contradiction that we have to live with.¹⁰⁹

Conclusion

Introduction of preventive measures in penal institutions appropriate to the local context is in the interest of all concerned. Prisoners, even though they live behind the walls of a prison, are still part of our communities and deserve the same level of care and protection that people outside prison get: they are sentenced to prison, not to be infected. In the context of the HIV/AIDS and HCV epidemics, when governments fulfill their human rights obligations to prisoners, they also promote positive public health outcomes. Measures undertaken to prevent the spread of HIV, HCV, and other infections will benefit prisoners, staff, and the public.

States have the primary responsibility for respecting, protecting, and fulfilling the human rights of prisoners who inject drugs by providing them with access to harm reduction measures. In implementing such measures, there is a significant role for community and nongovernmental organizations, both national and international. This role, recognized in international instruments, should not be forgotten.¹¹⁰ Where governments fail to recognize prisoners and injection drug users as humans and members of the community, drug treatment becomes punishment, and punishment becomes the sole goal of imprisonment. The goals of rehabilitation and reintegration, and programs designed to achieve them, are denigrated by prison authorities. Human dignity is denied.

Human rights are not respected. And the HIV and HCV epidemics are fueled.

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