

ADVANCE COPY

HIV/AIDS in places of detention

A toolkit for policy makers, managers and staff

The United Nations Office on Drugs and Crime
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About this toolkit

This toolkit on HIV/AIDS in prisons aims to provide **information** and **guidance** primarily to **individuals and organisations with responsibilities for prisoners**, and to **people who work in and with prisons**. In addition, it will assist everyone who has anything to do with prisons.

It is written for use primarily in **low- and middle-income countries**, but will be useful also for individuals and organisations in resource-rich countries.

Its **focus is on HIV/AIDS**, but it recognises that other diseases – in particular **hepatitis** and **tuberculosis** – are linked to HIV/AIDS and also represent serious problems in prisons.

It is based on the requirements of **international law** and standards, **scientific evidence** and best practice **experience**.

It complements a series of **other documents** produced by UN agencies, and refers to them, and to other documents, for additional information on HIV/AIDS in prisons.

How does the toolkit relate to other UN documents on HIV/AIDS in prisons?

This toolkit is part of a set of documents by UN agencies aimed at providing up-to-date, relevant, and authoritative information and guidance on HIV/AIDS in prisons.

- **HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response.** This document provides a framework for mounting an effective national response to HIV/AIDS in prisons, based on the evidence reviewed in the *Evidence for Action Technical Paper* and on accepted international standards and guidelines, and reflecting principles of good prison management. It sets out 11 principles and 100 actions. Available at www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf
- **Policy Brief: Reduction of HIV Transmission in Prisons.** This document provides a 2-page summary of the evidence related to HIV prevention programmes in prisons. Available in English and Russian via <http://www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html>.
- **Evidence for Action Technical Papers on Effectiveness of Interventions to Address HIV in Prisons.** These papers provide a comprehensive review of the effectiveness of interventions to address HIV in prison settings. They contain the most detailed and rigorous analysis of the evidence related to HIV/AIDS in prisons undertaken to date, with hundreds of references. They are essential background documents for everyone interested in HIV/AIDS in prisons, and serve as companion pieces to the toolkit and framework document. They are available via <http://www.who.int/hiv/pub/en/>.

Another document (*HIV/AIDS and HCV in Prisons: A Select Annotated Bibliography*) was prepared for the 3rd International Policy Dialogue on HIV/AIDS in Prisons, hosted by the Government of Canada and UNAIDS. It contains the references and short summaries of hundreds of documents dealing with issues related to HIV/AIDS in prisons. It aims to increase *knowledge of and access to* the literature on issues related to HIV/AIDS and HCV in prisons; and to increase the *capacity* of governments, prison systems, non-governmental organizations, and researchers to respond effectively to the challenges posed by HIV/AIDS and HCV in prisons. It was updated in 2007 and is available in English and French via http://www.hc-sc.gc.ca/ahc-asc/pubs/int-aids-sida/hiv-vih-aids-sida-prison-carceral_e.html.

Detailed references for all statements made in this toolkit are provided in the 'review of the evidence on interventions to address HIV in prisons' published in the Evidence for Action series (WHO/UNODC/UNAIDS, 2007) available at <http://www.who.int/hiv/pub/en/>.

The toolkit is divided into five modules.

Module 1 is for **anyone who has anything to do with prisons** and **should be read in conjunction with the other modules**. It provides essential background information about HIV/AIDS, how it is transmitted, tests for HIV, the worldwide epidemic of HIV/AIDS, why HIV/AIDS is such a serious problem in prisons, and explains why and how addressing HIV/AIDS in prisons is linked to the wider questions of prison reform and to human rights.

Module 2 is intended primarily for **policymakers, politicians** and **legislators** who are **responsible for creating policies and laws** on prisons, criminal justice, and health. We hope it will be useful to

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- **ministries of justice** and **ministries of interior** or other ministries that have oversight of prison issues, but also **ministries of health** (since prison health is public health)
- **parliamentarians** with interest in justice, corrections, and health
- **senior government officials** in departments of justice, interior, corrections, and health
- **judges, magistrates, prosecutors** and other state actors in the criminal justice system
- **civil society organizations** with an interest in prisons, HIV/AIDS, and human rights of prisoners
- **donors** who fund activities aimed at strengthening governance, the rule of law and adherence to human rights, as well as activities aimed at promoting and protecting health.

Module 3 is intended primarily for those who have responsibilities for the **management of prison systems and individual prisons**. We hope it will be useful to

- **heads of** national and provincial or regional **prison administrations**
- **prison directors and managers**
- **judges and inspectors** with responsibilities for external scrutiny of prison conditions.

Module 4 is intended primarily for people who work in prisons and provide security or programmes for prisoners on a day-to-day basis. We hope it will be useful to

- **prison officers and guards**
- teachers and instructors
- civil society, including volunteers, non-governmental organizations, and members of religious groups who visit prisons and undertake activities there.

Module 5 is intended primarily for **medical staff who work in prisons**. We hope it will be useful to

- medical doctors
- nursing staff
- paramedical and ancillary workers.

Each module takes a similar approach and discusses the same issues, but identifies the issues that are of particular relevance for the different audiences and what those audiences can and must do to address HIV/AIDS in prisons. **Although much can be**

done by individuals committed to particular parts of the overall task of managing HIV/AIDS in prisons, an appropriate response can best be achieved if all are involved and active.

Why a toolkit on HIV/AIDS in prisons?

HIV/AIDS is a serious health threat for prison populations, and presents significant challenges for prison and public health authorities and national governments.

Worldwide, the levels of HIV infection among prison populations tend to be higher than in the populations outside prisons. This situation is often accompanied and exacerbated by high rates of other transmissible infections such as hepatitis B and C and tuberculosis.

In many countries, the groups most vulnerable to or affected by HIV/AIDS are also groups at increased risk for criminalisation and incarceration, as many of the same social and economic conditions that increase vulnerability to HIV/AIDS also increase vulnerability to imprisonment. As a result, in some countries the populations with the highest rates of HIV infection are also disproportionately represented within the prisons. In countries where the injection of drugs is present, the prevalence of injecting drug users in prison will be important.

In prison, the risk of transmission of HIV and other infections is increased. Prisons are frequently overcrowded. They are often characterised by an atmosphere of violence and fear. Even where sexual relations are forbidden, there is sex in prison. As within the community, despite the control measures implemented, illicit drugs are circulating. Tensions abound, including sexual tensions. Release from these tensions, and difficulties of prison life, is often found in the consumption of drugs or in sex. Often condoms are not available. When drugs are injected, needles and syringes – being scarce, illegal and difficult to hide – are almost always shared, carrying with them a high risk of transmission of infectious diseases. Tattooing is most common in prison, part of the subculture, but in the absence of clean equipment can also be a factor of transmission. Health, dental and gynaecological services are often poorer and not always safe as it relates to the risk of transmission of infections.

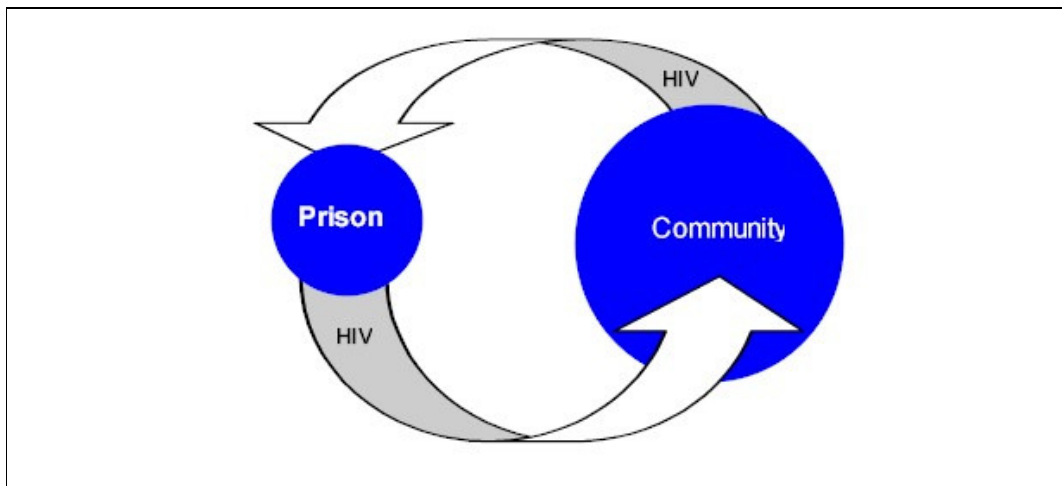
Prisoners are at greatest risk, but prison staff shares this high-risk environment with the prisoners. Because HIV is spread only through contact with blood or other body fluids, prison staff can adopt simple and routine practices to greatly reduce the likelihood that they will become infected with HIV as a result of an occupational exposure, practices that are called “universal precautions”.¹ However, other infections that are much more easily spread than HIV – in particular tuberculosis – pose a real threat to staff.

¹ Universal precautions are simple infection control measures that reduce the risk of transmission of blood borne diseases through exposure to blood or body fluids among patients, health care workers and other staff. Under the “universal precaution” principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or supposed status of the person. Improving the safety of injections is an important component of universal precautions.

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In addition, prison health is public health. The prison system is in continuous contact with the community. Prisoners come from the community and most go back to the community, often after serving short sentences. Prison staff, visitors, and suppliers also go in and out of prisons. This means that whatever is done – or is not done – to promote health in prisons and protect prisoners and staff from contracting infections will ultimately have an impact on the health of the public outside prisons. Prison health issues necessarily are community health issues (see figure 1).

Figure 1: Prisons and communities – how HIV spreads



Implementing effective HIV/AIDS prevention and care and treatment programmes in prisons is therefore good public health practice.

There is strong evidence about what can be done in prisons to reduce the risk of HIV transmission and to provide adequate care, support, and treatment to prisoners living with HIV or AIDS, and there is growing awareness and widespread concern about HIV/AIDS in prisons. For example, in April 2005, at the 11th United Nations Crime Congress, attended by most countries of the world, governments noted that “the physical and social conditions associated with imprisonment may facilitate the spread of HIV in pre trial and correctional facilities and thus in society, thereby presenting a critical prison management problem.” **The Bangkok Declaration issued at the Congress called upon states to develop and adopt measures and guidelines to ensure that the particular problems of HIV/AIDS are adequately addressed in such facilities.** International law requires states to promote health in prisons and therefore to do everything they can to reduce the risk of spread of infections.

Despite this, **many countries have yet to implement comprehensive HIV prevention programmes in prisons**, or to achieve a standard of prison health care equivalent to the standard outside of prison, thereby jeopardising the health of prisoners, prison staff, and the wider community.

Some politicians and prison administrations may find it hard to accept that injecting drug use and/or sexual activity take place in their prisons. But evidence indicates that **drug use and/or sex occurs in virtually all prisons in the world.** Others may fear that measures to reduce the potential harm from these activities – such as making

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condoms and sterile needles and syringes available to prisoners – will undermine security and control, or further encourage such behaviours. Again, there is evidence that this is not the case.

This toolkit is designed to assist countries in their efforts to mount an effective national response to HIV/AIDS in prisons and to improve and, if necessary, reform their prison systems. It offers, based on evidence from scientific research and evaluation and experience around the world:

- practical advice on what **measures countries need to take in the short term to prevent the spread of HIV** (and other infections) among prisoners and to provide them with care, treatment, and support; and
- advice on the **reforms necessary in the medium and longer term** to facilitate such measures.

This toolkit is not a guide to respond to all health and security related issues in prison. The health of prisoners and their access to services is a wide and complex issue. Very often people arrive in prison with many health problems such as drug addiction, infectious diseases, mental or psychiatric diseases, infectious diseases, malnutrition, dental problems, and skin diseases. Not all of these issues could be addressed in this toolkit.

A Note about Terminology and Scope

In some jurisdictions different terms are used to denote whether places of detention hold people who are awaiting trial, who have been convicted or who are subject to different conditions of security. Similarly, different words are being used for various groups of people who are detained.

In this toolkit, the term “**prison**” has been used for all places of detention and the term “**prisoner**” has been used to describe all who are held in such places, including adult and juvenile males and females detained in criminal justice and correctional facilities during the investigation of a crime; while awaiting trial; after conviction and before sentencing; and after sentencing. Although the term does not formally cover persons detained for reasons relating to **immigration or refugee status**, those **detained without charge**, and those sentenced to **compulsory treatment and rehabilitation centres** as they exist in some countries, nonetheless most of the considerations in this paper apply to them as well.

Module 1: Introduction: HIV/AIDS – What is the problem?

This module:

- provides basic information about HIV/AIDS (“Basic information about HIV/AIDS”);
- shows that HIV/AIDS is a major problem in countries around the world (“Living in a world with HIV/AIDS”);
- shows that worldwide, the levels of HIV infection among prison populations tend to be much higher than in the population outside prisons; and explains why this is the case (“HIV/AIDS in prisons: A serious problem”); and discusses the links between HIV/AIDS, human rights and prison reform (“HIV/AIDS, human rights, and prison reform”).

Basic information about HIV/AIDS

What is HIV?

HIV stands for “human immunodeficiency virus”. HIV is a virus that infects cells of the human immune system and destroys or impairs their function. Infection with HIV results in the progressive destruction of the immune system, leading to “immune deficiency”.

People with immune deficiency are much more vulnerable to a wide range of infections than other people because the body is unable to fight these infections. Diseases associated with severe immunodeficiency are known as “opportunistic infections” because they take advantage of a weakened immune system. In the prison context the most significant of these is tuberculosis, which can spread very quickly in overcrowded conditions.

What is AIDS?

AIDS stands for “acquired immunodeficiency syndrome” and describes the collection of symptoms and infections associated with deficiency of the immune system resulting from HIV infection. The level of CD4 cells in the body and the appearance of certain infections or cancers are used as indicators that HIV infection has progressed to AIDS.

CD4 refers to a kind of cell in the blood that contributes to the defence system of the human body. HIV attacks and kills CD4 cells. When there are not enough CD4 cells, it is easier for germs that attack the body to make people sick.

What are the symptoms of HIV infection?

Most people infected with HIV do not know that they have become infected, because no symptoms develop immediately after the initial infection. Some people have a fever-like illness (with fever, rash, joint pains and enlarged lymph nodes) that can occur at the time when antibodies to HIV develop – usually between 6 weeks and 3 months after an infection has occurred.

Despite the fact that HIV infection does not cause any initial symptoms, an HIV-infected person can transmit the virus to another person. The only way to determine whether HIV is present in a person's body is by taking a test for HIV.

What is an HIV test, and how should it be done?

HIV testing is a procedure by which a person's blood or body fluids is analysed in order to determine the presence of antibodies that are produced as a response to an HIV infection. There is a "window-period" inherent in the testing technology, which means that it may take up to 14 weeks – and perhaps longer – for a person infected with HIV to develop HIV antibodies in sufficient concentration to trigger a positive test result.

An HIV test should be

- accompanied by **pre- and post-test counselling**;
- conducted with the **informed consent** of the person being tested (meaning that people should be informed about the benefits and risks of testing, and voluntarily consent to testing); and
- **confidential** (meaning that the test result is only communicated to the patient and otherwise kept secret).

In prisons, HIV testing usually involves a number of different steps. A prisoner is offered HIV testing or asks for an HIV test. A doctor, nurse, or trained counsellor will provide information about the test and discuss HIV-related issues with the prisoner, and the prisoner can ask questions (pre-test counselling). If the prisoner consents to have the test, a nurse or an aide will draw blood from the arm using a needle. The blood sample is then tested for signs of HIV. If the first test is positive, the blood will be tested again to confirm the result.

When test results are available, a nurse or counsellor will share the results only with the prisoner, and provide post-test counselling. If the test shows that the prisoner has HIV infection (is HIV-positive), referral to care, treatment, and support should follow.

Pre- and post-test counselling are important components of HIV testing. The counselling process should address issues such as the risk of HIV transmission, facilitation of preventive behaviours, the evaluation of coping mechanism should one be confronted with a positive result, and referral to care, treatment and support. Counselling should take place before and after the HIV test and should be done regardless of whether the result is positive or negative.

Module 1: Introduction: HIV/AIDS – What is the problem?

In some countries, **rapid HIV tests** are also available. Rapid HIV testing can be performed more quickly than the standard HIV test and can provide a result within 10 to 30 minutes. Many rapid tests are relatively easy to use and can be conducted and read by non-laboratory personnel such as clinical doctors and nurses. All rapid tests, however, are subject to error if the testing protocol is not strictly followed. In addition, as with standard tests, a confirmatory HIV test is recommended for all people who test positive on the rapid test. Confirmatory tests are not necessary if the test result is negative or if there are signs of immune deficiency.

How is HIV transmitted?

HIV is transmitted when infected blood, semen, vaginal fluids, or breast milk enter another person's body. This most often occurs during unprotected sex or during injection drug use (when needles are shared). Anyone who is infected with HIV can transmit it, whether or not they appear sick, have an AIDS diagnosis, or are taking effective treatment for their infection. Infected women who become pregnant can transmit HIV to their newborns during **pregnancy** or **delivery**, as well as through **breast-feeding**.

Unprotected sexual contact

Worldwide, **unprotected sexual contact**, primarily through unprotected vaginal or anal intercourse with an infected partner, is the leading mode of HIV transmission. Oral sex is much less likely than vaginal or anal intercourse to result in the transmission of HIV.

Exposure to infected blood

The most efficient means of HIV transmission is the introduction of HIV-infected blood into the bloodstream, particularly through transfusion of infected blood. Most blood-to-blood transmission now occurs as a result of the use of contaminated injecting equipment during injecting drug use. Use of improperly sterilized syringes and other medical equipment in health-care settings can also result in HIV transmission. It is always a good idea to avoid direct exposure to another person's blood—to avoid not only HIV but also hepatitis and other blood-borne infections.

Overwhelming evidence indicates that people **cannot** become infected with HIV in any of the following ways:

- shaking hands
- coughing or sneezing
- visiting a hospital or medical wing
- opening a door
- sharing food or eating or drinking utensils
- using drinking fountains
- using toilets or showers
- being bitten by a mosquito or other insect
- working, socializing, or living side by side with HIV-positive prisoners or staff.

When does a person have AIDS?

The term AIDS applies to the most advanced stages of HIV infection. The majority of people infected with HIV, if not treated, develop signs of AIDS within 8 to 10 years. Antiretroviral therapy (see below) can slow down the progression of the disease by decreasing the amount of HIV in an infected body.

How can I tell if someone has HIV?

You cannot. A fraction of people infected with HIV develop symptoms early in the course of infection, while others remain without symptoms for 15 or more years after they become infected. Because most people with HIV do not appear sick, it is impossible to tell if a person is living with HIV just by looking at, or talking to, him or her. Prisoners or fellow staff with HIV look just like people without HIV infection.

Is HIV infection always fatal?

Not necessarily. Without treatment, HIV infection almost invariably leads to AIDS, which almost invariably leads to death. Today, however, there are treatments that slow the progression of HIV infection and allow people infected with the virus to live healthily and productively for many years.

What treatments exist for HIV/AIDS?

Anti-HIV medications are medications that slow down the growth of the HIV virus. Because HIV is a special type of virus called "retrovirus," the medications are usually called "**antiretrovirals**."

There are different types (or classes) of anti-HIV medications. Each type of anti-HIV medication works by blocking a different protein that the HIV virus needs in its reproduction. Currently two major classes of anti-HIV medications are available:

- medications that block the protein "**reverse transcriptase**," known as **reverse transcriptase inhibitors** or **RT inhibitors**
- medications that block the protein "**protease**," known as **protease inhibitors**

Several different types of drugs exist to treat HIV infection. These drugs attack various aspects of the process used by the virus to replicate itself. Because HIV quickly mutates to become resistant to any single drug, patients must take a combination of drugs to achieve maximum suppression of HIV.

Combination anti-HIV therapy is known as antiretroviral therapy, or ART. ART changes the natural course of HIV infection, significantly extending the period between initial infection and the development of symptoms. To achieve these results, it is important to initiate therapy before AIDS symptoms develop, although even patients who start on therapy after being diagnosed with AIDS often receive major and long-lasting health benefits. Although effective in slowing the progression of HIV-related disease, **ART is not a cure**. In addition to treatments for HIV infection itself, therapies exist to prevent and/or treat many HIV-related opportunistic infections. In

Module 1: Introduction: HIV/AIDS – What is the problem?

both developing and industrialized countries, ART generally leads to significant improvement in the health and well-being of people living with HIV.

Box 1: Treatment works!

In **Brazil**, approximately 125,000 people received ART between 1997 and 2002. Officials estimate that access to treatment averted 90 000 deaths that would have occurred during this period had treatment not been available.

In the **United States of America**, where ART has been widely available since the mid-1990s, AIDS mortality declined by 66% between 1995 and 2002.

What does HIV/AIDS have to do with tuberculosis?

The emergence of the HIV pandemic has seriously threatened tuberculosis (TB) control efforts globally. HIV weakens the immune response and dramatically increases the risk of developing active TB. TB is the biggest single killer of people with HIV. Where TB and HIV co-exist, such as in prisons, the risk of developing active TB disease is estimated to be 5 to 15% *per year*, as opposed to 10% *lifetime* risk in the non-HIV infected.

Box 2: Basic information about tuberculosis

Tuberculosis is a contagious disease, transmitted by the inhalation of droplet nuclei. These are produced when a person with the active form of the disease coughs. Exposure on the order of days to weeks is necessary to acquire a tuberculous infection. Only about 10% of those who acquire this infection will go on to develop the active disease, tuberculosis, although some groups such as those with later stages of HIV infection, are at greater risk. Crowding, poor ventilation and certain characteristics of the contagious individual increase the likelihood of becoming infected with TB.

Preventative treatment of infected individuals (as defined by a positive tuberculin skin test) with isoniazid can be 70 to 90% effective in preventing these individuals from developing active disease.

Early detection and isolation of contagious persons with active TB is the key to disease control. A constant state of alertness is necessary to find such individuals sooner rather than later.

With appropriate treatment, active tuberculosis is 98% curable, except in the case of multiply-drug resistant (MDR) TB, where the cure rate is lower.

➤ For more information about the basics of HIV/AIDS, see <http://www.thebody.com/basics.html> or <http://www.cdc.gov/hiv/topics/basic/index.htm>

Comment [ad1]: shouldn't we add a UN webpage as well?

Comment [f2]: There is no info on WHO nor on UNAIDS. Here the CDC website that is good also.

Living in a world with HIV/AIDS

HIV/AIDS is one of the most serious health problems in the world. **About 33 million people are estimated to be living with HIV**, with **2.5 million new infections in 2006**. During that year, **2.1 million people died of AIDS**. Almost two thirds of people with HIV/AIDS live in sub-Saharan Africa, but every region of the world is affected by the epidemic. The fastest growing epidemics are currently observed in Eastern

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Europe and Central Asia. HIV/AIDS is a global problem, affecting people in every country.

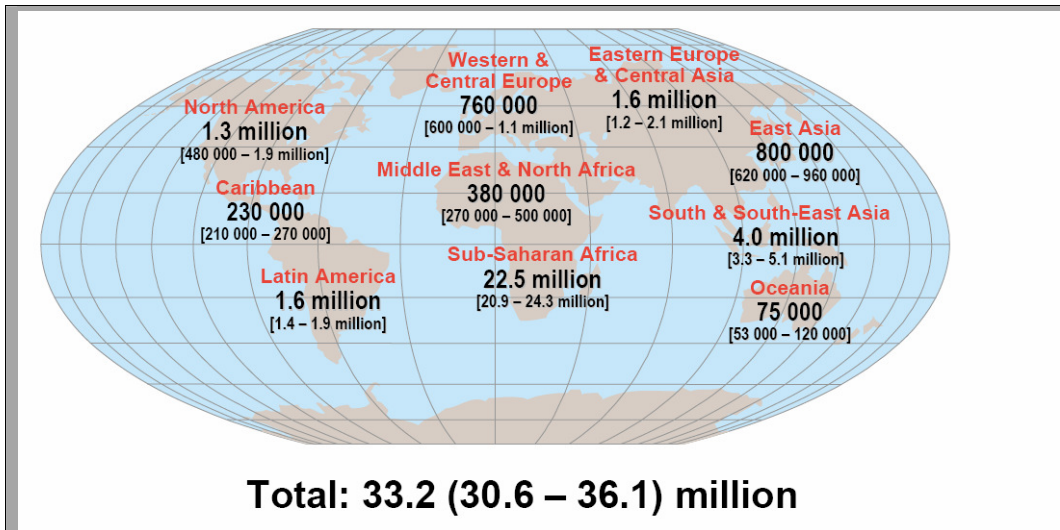
Comment [ad3]: Need to be updated as well as the next pages

Do you know how many people with HIV/AIDS live in your country?

➤ For information about HIV prevalence in countries around the world, see: **UNAIDS. Report on the global AIDS epidemic, 2007.** Available at http://www.unaids.org/en/HIV_data/2007EpiUpdate/default.asp.

Comment [ad4]: Update and add reference group?

Box 3: Adults and children estimated to be living with HIV/AIDS, end of 2006



HIV/AIDS in prisons: A serious problem

HIV/AIDS is a serious health threat for the **10 million people in prison across the world**. In most countries, levels of HIV infection among prison populations are much higher than in the population outside prisons, but the prevalence of HIV infection in different prisons within and across countries varies considerably. In some cases, the prevalence of HIV infection in prisons is up to a hundred times higher than in the community. Even in countries with large heterosexual HIV epidemics, such as in Africa, studies have shown that rates of HIV infection in prisons are higher than outside prisons.

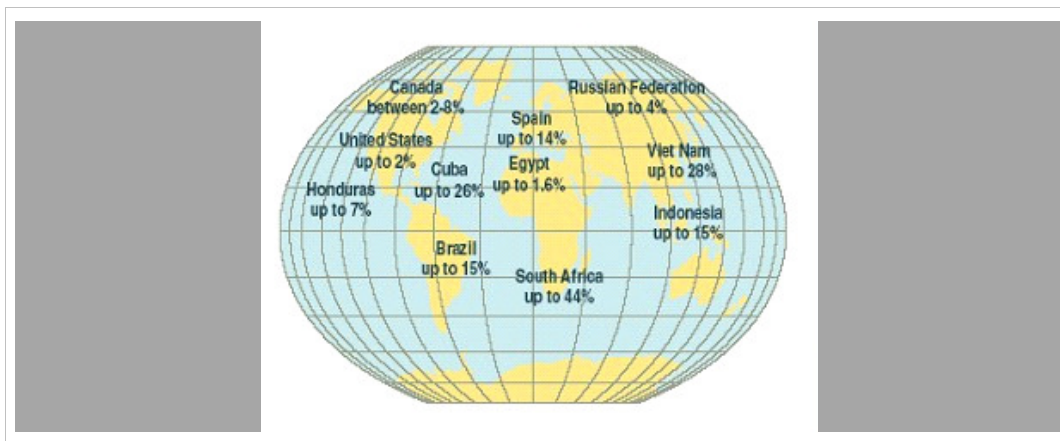
The following are some examples of what we know about how big the problem of HIV is in prisons:

- In the **Russian Federation**, by late 2002, the registered number of people living with HIV or AIDS in the penal system exceeded 36,000 (4% of the prison population), and accounted for about 20% of known cases of HIV/AIDS in the country.

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- In **Latvia**, it has been estimated that prisoners comprise a third of the country's HIV-positive population. In a 2003 study, HIV prevalence was found to be 6.2%.
- **Estonia** reported four studies of HIV prevalence with rates of 8.8 to 23.9%.
- In **Indonesia**, nine studies found HIV prevalence rates of 4% to 22% in 2001.
- In **Vietnam**, data reported in 2000 indicated a total of 22,161 prisoners had tested positive for HIV, for a prevalence of 28.4%.
- In **Brazil**, in several studies, prevalence rates ranged from 3.2% to over 20%.
- **Honduras** reported a prevalence of 6.8% among 2,028 prisoners in 1998/99.
- In **Zambia**, four studies revealed HIV prevalence rates ranging from 16.1 to 27.2%.
- In **South Africa**, according to one estimate, HIV prevalence in prisons was 41.4% in 2002.
- In **Western Europe**, particularly high rates have been reported from countries in southern Europe – for example, 14% in Spain.
- In the **United States**, 1.9% of prisoners are known to be HIV-positive. In a few jurisdictions, however, rates are much higher, particularly among women. In New York, for example, 7.3% of male and 14.6% of female prisoners were known to be HIV-positive; and in Florida, 3.7% of male and 7.3% of female prisoners.
- In **Canada**, in a large number of studies published between 1989 and 2005, rates between one and 11.94% have been reported.

Box 4: Data about HIV/AIDS prevalence in prisons in selected countries



Hepatitis C seroprevalence rates in prisons are even higher than HIV rates. The World Health Organization estimates that about 3% of the world's population has been infected with hepatitis C virus (HCV), but the prevalence of HCV in prisons has been reported to range from 4.8% in an Indian jail to 92% in two prisons in northern Spain.

Box 5: Basic information about hepatitis C

Hepatitis C is a liver disease that is caused by the hepatitis C virus (HCV). The virus enters the liver cells, uses the cell's inner genetic machinery to make copies of itself, which then infect more cells. In about 15% of cases, hepatitis C infection is acute,

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meaning it is cleared spontaneously by the body and there are no long-term consequences. Unfortunately, in the majority of cases (85%), the infection becomes chronic and slowly damages the liver over many years. Over time, this liver damage can lead to cirrhosis (or scarring) of the liver, end-stage liver disease, and liver cancer.

Like HIV and hepatitis B, HCV is spread through contact with the blood (or body fluids containing blood) of infected people. This can happen if a person:

- ever, even once, shares needles, straws used for snorting drugs, pipes, spoons and other drug-related equipment
- gets a tattoo or has body piercing or acupuncture where the operator uses unsterile or homemade equipment or unsterile techniques
- is pricked by a needle that has infected blood on it
- is born to a mother who has hepatitis C
- shares personal household articles such as a shaver or toothbrush with an infected person.

HCV has been shown to live much longer outside the body and in a dormant state, even on dried surfaces, than HIV. Activities that would be negligible risks for HIV transmission, such as sharing toothbrushes or shavers or straws to snort cocaine, are much higher risks for HCV transmission. This is because they often involve exchanging small amounts of blood and the external exposure (to air, temperature and light) that kills HIV may not kill HCV.

The risk of contracting HCV through sexual contact is not as well-established. Recent studies show that there is little to no HCV present in vaginal fluids and semen. However, this area is still being researched and no final conclusions have been made on the assessment of risk for transmission through sexual activities that do not involve the presence of blood.

HCV is NOT spread by casual contact, such as hugging, kissing or shaking hands, or by being around someone who is sneezing or coughing.

Within prison populations, certain groups have higher levels of infection. In particular, rates of **HIV and HCV infection among women** tend to be higher than among men. It is believed that this is due to a higher concentration of females in prison for drug-related offences.

High rates of HIV and HCV in prisons are often accompanied by high rates of tuberculosis (which may include resistant and multi drug resistant cases), sexually transmitted infections, drug dependence, and mental health problems.

➤ For more information about HIV rates in countries around the world, see the chapter on « evidence of the prevalence of HIV in prisons » in: WHO, UNODC, UNAIDS (2007). *Effectiveness of Interventions to Address HIV in Prisons. Evidence for Action Technical Papers*. Available via <http://www.who.int/hiv/pub/en/>

Why are rates of HIV so high in prisons?

First, **many people come to prison already infected**.

In many countries, HIV rates are high in prison because HIV infection rates are high among injecting drug users in the community, and injecting drug use is treated principally as a criminal rather than a health issue – meaning that many injecting drug users spend years of their lives going in and out of prison.

In other countries, rates are high because of high rates of HIV in the general population.

Everywhere, the groups most vulnerable to or affected by HIV/AIDS are also groups at increased risk for criminalisation and incarceration, as many of the same social and economic conditions (such as poverty, lower level of education, and living in medically underserved and minority communities) that increase vulnerability to HIV/AIDS also increase vulnerability to imprisonment.

Second, **people become HIV infected in prison**. This is because high-risk behaviours are prevalent (particularly sexual relations, both consensual and non-consensual, and injecting drug use), but many prisons still do not provide the tools, such as condoms and sterile needles and syringes, that could decrease the risk of infection from such activities. In addition, the risk of transmission is increased by environmental factors such as overcrowding and violence.

What about staff in prisons?

Properly trained and equipped prison staff are not at high risk of being infected with infections like HIV that are spread only through contact with blood or other body fluids. Just like health care workers, prison staff can adopt simple and routine practices to greatly reduce the likelihood that they will become infected with HIV as a result of an occupational exposure, practices that are called 'universal precautions.' Prison staff need to be properly trained concerning the use of universal precautions and given the tools to observe them.

In contrast to HIV, other diseases that are prevalent in prisons and that are much more easily spread than HIV – particularly tuberculosis – pose a real threat not only to the staff directly, but also to their families and to the wider community.

Where prison staff are not properly trained, they more likely react with fear to people with HIV/AIDS. This can lead to stigma and discrimination against people living with HIV/AIDS and those perceived to be at risk of HIV/AIDS. Ignorance of HIV, as well as

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fear and stigma, greatly hamper efforts to stop the spread of HIV. It is therefore essential that prison staff are properly trained on matters pertaining to HIV/AIDS.

Prison staff also play a crucial role in HIV/AIDS prevention and care and treatment programmes in prisons. Their cooperation can help programmes achieve their goal of reducing the spread of HIV among prisoners. Prison staff also benefit from such programmes. Lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered, and will ultimately result in a less stressful workplace.

What does HIV/AIDS in prisons have to do with the community outside prison?

There is a constant flow of people between the community and prison. With **30 million prisoners released back into the community each year**, increased rates of illness in prison have serious consequences for society as a whole. Reducing the extent to which prisons contribute to the HIV (as well as hepatitis C and tuberculosis) epidemics is a central concern of public health policy. Unless action is taken urgently, prisons will continue to fuel and refuel epidemics causing enormous social and financial costs. **Prison health is public health.**

- For a good explanation of why prison health is public health, and suggestions about what should be done to protect both: Irish Penal Reform Trust (2004). *Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia: Prison Health is Public Health*. Available in many languages via www.iprt.ie.
- See also the “Moscow Declaration” that recognizes the need for a close link between public health and the provision of health care to those in prison: World Health Organization (Europe) (2003). *Moscow Declaration: Prison Health as part of Public Health*. Available in English, French, Russian, and German via www.euro.who.int/prisons/publications/20050610_1.

HIV/AIDS, human rights and prison reform

Addressing HIV/AIDS in prisons effectively cannot be separated from wider questions of human rights and prison reform. People in prison are vulnerable to human rights violations and they are vulnerable to HIV. Prison conditions, the way in which prisons are managed, and national policy all impact on the issue of HIV in prisons.

Overcrowding, violence, inadequate natural lighting and ventilation, and lack of protection from extreme climatic conditions are common in many prisons of the world. When these conditions are combined with inadequate means for personal hygiene, inadequate nutrition, lack of access to clean drinking water, and inadequate medical services, the vulnerability of prisoners to HIV infection and other infectious diseases is increased, as is HIV-related morbidity and mortality. Sub-standard conditions can also complicate or undermine the implementation of effective responses to HIV/AIDS by prison staff. Therefore, action to prevent the spread of HIV infection in prisons and to provide health service to prisoners living with

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HIV/AIDS is integral to – and enhanced by – broader efforts to improve prison conditions. This is why efforts to stop the transmission of HIV in prisons must start with making prevention measures available, but should include reforms aimed at addressing these underlying conditions.

Every country's response to HIV/AIDS in prisons is influenced by economic and social conditions, as well as by cultural, social, and religious traditions. However, these national and local conditions do not reduce or negate government obligation to meet recognised international prison, health, and human rights standards. International law is clear that a lack of resources does not excuse a state from its obligations to provide proper and humane prison conditions.

There are a number of international instruments and covenants, both legally binding and normative, that are particularly relevant to HIV/AIDS in prisons. According to them:

- All persons deprived of their liberty have the right to be treated with respect and dignity and not to be subjected to cruel, inhumane or degrading treatment or torture.
- Prisoners must not be discriminated against, but must be separated according to their sex, age and whether or not they have been convicted.
- Accommodation in which prisoners live must be conducive to maintaining good health, provide access to bathing and sanitary facilities and have adequate lighting, ventilation, heating and floor space.
- Prisoners must have a diet sufficient for health and be provided with drinking water.

More generally, the international community has generally accepted that prisoners retain all rights that are not taken away as a fact of incarceration. Loss of liberty alone is the punishment, not the deprivation of fundamental human rights. Like all persons, therefore, prisoners have a right to enjoy the highest attainable standard of health. In the context of HIV/AIDS, this includes a right to HIV/AIDS prevention tools.

➤ For a list of relevant human rights instruments, see: A Coyle. **A Human Rights Approach to Prison Management. Handbook for prison staff.** London: International Centre for Prison Studies, 2002. Available in many languages via <http://www.kcl.ac.uk/depsta/rel/icps/publications.html>.

Two additional international instruments are relevant to the situation of prisoners in the context of HIV/AIDS: the World Health Organization ***Guidelines on HIV infection and AIDS in prisons***, which provide standards 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; and the ***International Guidelines on HIV/AIDS and Human Rights***.

The *Guidelines on HIV infection and AIDS in prisons* were issued in 1993. They confirm that “[a]ll prisoners have the right to receive health care, including preventive

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measures, equivalent to that available in the community without discrimination” and that “the general principles adopted by national AIDS programmes should apply equally to prisoners and to the community”.

The *International Guidelines on HIV/AIDS and Human Rights*, released in 1998 by the Joint United Nations Programme on HIV/AIDS and the Office of the United Nations High Commissioner for Human Rights, identify the following specific action 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.

For various reasons, only relatively few prison systems have implemented all measures necessary to curb the spread of infection in prison and to provide prisoners living with HIV or AIDS with the care, treatment, and support they need. This may be due to lack of knowledge or awareness, negative attitudes against people with HIV or vulnerable to infection, or other barriers such as inadequate funding for prisons generally and prison health care specifically. It is hoped this toolkit will assist prison systems worldwide to introduce comprehensive HIV/AIDS programmes, and to scale them up rapidly, acting for the benefit of public health and human rights.

➤ **For further information on HIV/AIDS, human rights, and prison reform, see:**

- **Office of the United Nations High Commissioner for Human Rights and UNAIDS (re-issued, 2006). *HIV/AIDS and Human Rights: International Guidelines*. New York and Geneva: United Nations. Available via <http://www.ohchr.org/english/issues/hiv/guidelines.htm>. See, in particular, recommendation 29(e).**
- **World Health Organization (1993). *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva: WHO (WHO/GPA/DIR/93.3). Available via www.unaids.org. These 10-page guidelines, written from a public health perspective, propose standards for prison authorities in efforts to prevent HIV transmission and provide care to those with HIV/AIDS in prisons, and emphasise that prisoners have a right to HIV care, including HIV prevention, equivalent to that available in the community outside prison.**

Module 2: Issues for policy makers, legislators, and parliamentarians

This module is intended primarily for **policymakers, politicians** and **legislators** who are responsible for creating policies and laws on prisons, criminal justice, and health. We hope it will be useful to

- **ministries of justice, ministries of interior**, or other ministries that have oversight of prison issues, but also **ministries of health**
- **parliamentarians** with interest in justice, corrections, and health
- **senior government officials** in departments of justice, interior, corrections, and health
- **judges, magistrates, prosecutors** and other state actors in the criminal justice system
- **civil society organizations** with an interest in prisons, HIV/AIDS, and human rights
- **donors** who fund activities aimed at strengthening governance, the rule of law and adherence to human rights, as well as activities aimed at promoting and protecting health.

Ultimately, we hope it will equip policy makers, legislators and parliamentarians with **knowledge** about how best to address HIV/AIDS in prisons; increase **commitment** to address this important issue; and lead to **action**.

The module first provides some background information on HIV/AIDS in prisons. It then highlights **four ways in which policymakers, politicians and legislators can make a difference**:

- addressing the specific risk factors for HIV/AIDS transmission in prison by introducing comprehensive prevention measures;
- providing health services in prisons equivalent to those in the community;
- improving prison conditions through reforms to the prison system; and
- reducing prison populations.

It then lists **three priority actions that policy makers, politicians and legislators should take:**

1. providing political leadership;
2. reforming laws and policies;
3. advocating for increased funding.

Background

HIV/AIDS has had a significant impact on the health sector, the economy, the education system, social welfare, armed forces and uniformed services in many countries. Places of detention are no exception: HIV/AIDS rates are usually higher in them than in the general community. In addition, prisoners are at increased risk for acquiring HIV as well as HCV and TB in prisons and, once released, may transmit the infections to others outside prison.

Therefore, it is essential that each country develop and implement policies and action plans on HIV/AIDS in prisons, based on the requirements of international law and standards, scientific evidence and best practice experience. To do this, **the first requirement is that governments acknowledge the realities of how prisons contribute to the problem of HIV/AIDS** (and HCV and TB) and agree to take the necessary steps to address the problem. Reluctance to do this would represent a failure to accept that prisons have an important role to play in HIV prevention and provision of care and treatment.

What are the realities in prisons related to HIV/AIDS?

In general, those groups of people who are more at risk of contracting HIV while in the community are over-represented in prison. As a result, the percentage of people with HIV in prisons is often much higher than in the community.

Inside prison, people may use drugs and have sex, with reduced access to prevention measures (such as condoms and sterile injecting equipment) and health education that are available to people outside prison.

Unsafe sexual behaviour is widespread, with prisoners having sex (forced or consensual) with each other and, at times, with prison staff.

Drug use is also widespread in prisons in most countries, including injecting drug use and the sharing of contaminated injecting equipment.

Even countries with huge financial resources have not been able to eradicate drug use in prisons. Indeed, some of the measures introduced to deter drug use can increase rather than reduce the risk of HIV infection.

Additional risk factors include the sharing or reuse of tattooing and body piercing equipment, the sharing of razors for shaving, blood sharing/'brotherhood' rituals and the improper sterilisation or reuse of medical or dental instruments.

Factors related to the prison infrastructure and prison management contribute to HIV vulnerability indirectly. They include overcrowding, violence, gang activities, lack of protection for weak or young prisoners, prison staff that lack training or may be corrupt, and poor medical and social services.

As a result, the risk of HIV infection in prisons is high. Serious outbreaks of HIV infection have occurred in prisons in a number of countries.

You can make a difference!

Four elements are key to preventing and responding to HIV/AIDS and other infections such as hepatitis B and C and tuberculosis in prisons:

- introducing comprehensive prevention measures;
- providing equivalent health services in prisons to those in the community, including provision of antiretrovirals;
- improving prison conditions and undertaking other prison reforms;
- reducing prison populations.

Introducing comprehensive prevention measures

Governments should urgently adopt or expand programmes for preventing HIV transmission in prisons. Such programmes should include all the measures against HIV transmission that are carried out in the community outside prisons, including

- HIV/AIDS education;
- voluntary HIV testing and counselling;
- condom provision and prevention of rape, sexual violence and coercion;
- drug- dependence treatment, particularly substitution treatment;
- measures that reduce the demand for, and supply of, drugs in prisons;
- provision of needles and syringes and, as a second-line strategy if provision of needles and syringes is not yet possible, provision of bleach or other disinfectants and
- programmes for the detection and treatment of sexually transmitted diseases.

All these interventions contribute to reducing the risk of HIV transmission in prisons, and some of them also reduce the risk of hepatitis C transmission. They have been shown to have no unintended negative consequences. The available scientific evidence suggests that they can be reliably expanded from pilot projects to nation-wide programmes. Ultimately, since most prisoners leave prison at some point to

Module 2: Issues for policy makers, legislators, and parliamentarians

return to their community, implementing them will benefit not only prisoners and prison staff, but also society in general.

In addition to HIV/AIDS and hepatitis C, programmes to prevent the spread of hepatitis B and tuberculosis are also important.

Information and education

Education is an essential precondition to the implementation of HIV prevention measures in prisons. The World Health Organization *Guidelines on HIV infection and AIDS in prisons* recommend that both prisoners and prison staff be informed about ways to prevent HIV transmission. Written materials should be appropriate for the educational level in the prison population. Furthermore, prisoners and staff should participate in the development of educational materials. Finally, peer educators can play a vital role in educating other prisoners.

However, information and education alone are not sufficient responses to HIV/AIDS in prisons. A few evaluations have indicated improvements in levels of knowledge and self-reported behavioural change as a result of prison-based educational initiatives. But education and counselling are not of much use to prisoners if they do not have the means to act on the information provided.

➤ **For more details (and full references) on information and education programmes, and on all other interventions in this module, see:**

➤ **WHO, UNODC, UNAIDS (2007). *Effectiveness of Interventions to Address HIV in Prisons. Evidence for Action Technical Papers*. Available via <http://www.who.int/hiv/pub/en/>.**

HIV counselling and testing

Counselling and testing are important for two reasons:

- as part of an HIV prevention programme (it gives those who may be engaging in risky behaviours information and support for behaviour change); and
- as a way to diagnose those living with HIV and offer them appropriate care, treatment and support.

In practice, HIV testing in prisons is often available only on demand of prisoners, but in some systems voluntary testing and counselling is easily available. In some other systems, HIV testing is undertaken routinely or is even compulsory (or mandatory). The World Health Organization *Guidelines on HIV infection and AIDS in prisons* state:

10. Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited.

11. 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.

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12. Test results should be communicated to prisoners by health personnel who should ensure medical confidentiality.

There is evidence suggesting that mandatory HIV testing and segregation of HIV-positive prisoners is costly, inefficient, and can have negative health consequences for segregated prisoners. Therefore, HIV testing in prison should always be voluntary and everyone being tested should give informed consent and receive pre-and post-test counselling.

Box 6: The negative effects of mandatory testing and segregation

Mandatory testing and segregation can have negative health consequences for segregated prisoners. In a prison in South Carolina, United States, segregating HIV-positive prisoners contributed to a tuberculosis outbreak in which 71% of prisoners residing in the same housing area either had new tuberculosis skin-test conversion or developed tuberculosis disease. Thirty-one prisoners, and 1 medical student in the community's hospital, subsequently developed active tuberculosis.

Prison systems should **routinely offer** voluntary HIV counselling and testing to prisoners upon entry. In addition, because entry is a stressful time and many prisoners may not want to have an HIV test at that time, HIV testing should be available to prisoners at any time during imprisonment, so that prisoners can learn their HIV status, and prisoners with HIV can benefit from access to care, treatment (including antiretroviral treatment), and support.

HIV testing and counselling should be closely linked to access to care, treatment, and support for those testing positive, and be part of a comprehensive prevention programme that includes access to prevention measures. As mentioned above, many prisoners, including prisoners who are aware of their HIV status, engage in activities that carry a risk of HIV transmission. Knowledge of HIV status alone is not sufficient to prevent HIV transmission when the means that would enable a person to take steps to reduce that risk are not accessible in prison.

➤ **For more details and further references, see WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: HIV Care, Treatment and Support. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_ea_hiv_treatment_df.pdf**

Provision of condoms and prevention of rape, sexual violence and coercion

Recognizing the fact that sexual activity occurs in prisons and given the risk of disease transmission that it carries, providing condoms has been widely recommended. As early as 1993, the World Health Organization, in its *Guidelines on HIV infection and AIDS in prisons*, recommended that condoms be made available to prisoners “throughout their period of detention” and “prior to any form of leave or release”.

As early as 1991, 23 of 52 prison systems surveyed by the World Health Organisation provided condoms to prisoners. Today, many more systems make condoms available, including most systems in Western Europe, Canada, and Australia, some prisons in the United States, parts of the Eastern Europe and Central Asia, and countries like Brazil, South Africa, Iran and Indonesia.

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There is evidence that condoms can be provided in a wide range of prison settings – including in countries in which same-sex activity is criminalised – and that prisoners use condoms to prevent infection during sexual activity when condoms are accessible in prison. No prison system allowing condoms has reversed its policy, and none has reported security problems or any other relevant major negative consequences. In particular, it has been found that condom access represents no threat to security or operations, does not lead to an increase in sexual activity, and is accepted by most prisoners and correctional officers once it is introduced.

However, in some countries where legal sanctions against sodomy exist in the community outside prison, and where there are deeply held beliefs and prejudices against homosexuality, introduction of condoms into prisons as an HIV prevention measure may have to be particularly well prepared through education and information about the purpose of the introduction of condoms, as well as initiatives to counter the stigma that people engaging in same-sex activity face.

Finally, while providing condoms in prisons is important, it is not enough to address the risk of sexual transmission of HIV. There is evidence that violence, including sexual abuse, is common in many prison systems. In many prisons, it would be counter-productive not to realize that HIV prevention depends as much or more on prison and penal reform, than on condoms. Prison and penal reform need to greatly reduce the prison populations, so that the few and underpaid guards are able to protect the vulnerable prisoners from violence – and sexual coercion.

The *Guidelines on HIV Infection and AIDS in Prisons* and the *International Guidelines on HIV/AIDS and Human Rights* highlight that prison authorities are responsible for combating aggressive sexual behaviour such as rape, exploitation of vulnerable prisoners and all forms of prisoner victimization by providing adequate staffing, effective surveillance, disciplinary sanctions, and education, work and leisure programmes. Structural interventions such as better lighting, better shower and sleeping arrangements are also needed.

Box 7: Potential liability of prison systems for not providing condoms

The potential liability of correctional authorities that do not make condoms available to civil action was illustrated by an out-of-court financial settlement achieved by a **South African** former prisoner. The former prisoner claimed he contracted HIV through sex while in prison between 1993 and 1994. Condoms were introduced in South African prisons in 1996. He contended that the authorities did not warn prisoners about the risks of unprotected sex or supply condoms. The South African Department of Correctional Services denied any liability under the settlement.

Legal action was also taken by 52 prisoners in **New South Wales (Australia)** in 1994, challenging the Departmental policy which at the time prohibited condom provision. Before the court action reached conclusion, a pilot distribution of condoms was introduced. Following the successful distribution of condoms in three New South Wales prisons, a state-wide distribution began and was evaluated, showing positive results.

➤ For more details and references, see: WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: Prevention of Sexual Transmission. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_ea_sexual_transmission_df.pdf.

Substitution treatment and other drug dependence treatment

As shown above, many prisoners in countries around the world use drugs while in prison, including by injecting. At least in part this is due to the fact that a substantial proportion of prisoners are drug dependent.

In the absence of effective drug dependence treatment, it is likely that a high proportion of these prisoners will continue using drugs and persist in crime – and many will be at risk of contracting HIV, during imprisonment or outside.

All forms of drug dependence treatment have some impacts on risks of HIV transmission, but substitution treatment programmes have the greatest potential to reduce injecting drug use and the resulting risk of spread of infection. Such programmes, which entail prescribing a drug with a similar action to the illegal drug used, but with a lower degree of risk, have been established in prisons in a growing number of countries around the world, including in a number of prison systems in Eastern Europe or in countries like Indonesia or Iran. Studies have shown that, if dosage is adequate and treatment is provided for the duration of imprisonment, they reduce drug injecting and needle sharing and the resulting spread of HIV and other bloodborne infections. In addition, they have additional and worthwhile benefits, both for the health of prisoners participating in the programmes, and for prison systems and the community. For example:

- substitution treatment has a positive effect on institutional behaviour by reducing drug-seeking behaviour and thus improving prison safety;
- re-incarceration is significantly less likely among those prisoners who receive substitution treatment.

“Substitution maintenance therapy is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families and society at large by reducing heroin use, associated deaths, HIV risk behaviours and criminal activity. Substitution maintenance therapy is a critical component of community-based approaches in the management of opioid dependence and the prevention of HIV infection among injecting drug users.”

UNAIDS, WHO, UNODC, 2004

Various other drug-dependence treatment modalities are being implemented in prison settings, including therapeutic community methods and group counselling. Although there is much less evidence about their effectiveness in preventing HIV, some such programmes have also yielded promising results, particularly if there was good release planning and follow-up after imprisonment. However, while imprisonment provides an opportunity to deliver other drug-dependence treatment, treatment in prison will never be a viable alternative to treatment in the community, because of the high cost of imprisonment. Studies suggest that alternatives to incarceration, such as treatment of addiction in the community, may be more cost-effective at reducing health, social, and economic harms of illegal drug use.

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Ultimately, reducing the number of people who are in prison because of problems related to their drug use must be a priority (see below, the section on reducing prison populations).

➤ **For more details and references, see WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: Drug Dependence Treatments. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_ea_drug_treatment_df.pdf**

Drug demand and drug supply reduction strategies

In addition to drug dependence treatment, adopting other strategies to reduce the demand for, and the supply of, drugs in prisons can also assist efforts to prevent HIV transmission in prisons. However, it is important to note from the outset that such efforts are unlikely to eliminate drug use in prisons. In fact, even prison systems that have devoted large financial resources to such efforts have not been able to eliminate drug use. Therefore, such efforts cannot replace the other measures described above, but rather should be undertaken to complement them.

Drug demand reduction strategies

Research shows that one of the reasons why a relatively large number of prisoners in many prison systems take drugs when they are in prison is to combat boredom, alienation, and stress, and to promote relaxation. This suggests that, in addition to drug treatment, one of the most effective ways to reduce the demand for drugs is to improve prison conditions (for more details, see the section below entitled “improving prison conditions – the need for prison reform”) and to offer more purposeful activities in prisons. Providing prisoners with opportunities to work and/or study while in prison, or activities such as sports, theatre and spiritual and cultural enhancement aimed at providing people with challenging and healthy ways to employ their time, can have a positive effect on risky behaviours, particularly when complemented by appropriate drug use prevention education.

Another strategy to reduce the demand for drugs used by an increasing number of prison systems, mainly in resource-rich countries, is to establish so-called “drug-free” units. Typically, “drug-free” units or wings are separate living units within a prison that focus on limiting the availability of drugs and are populated with prisoners who have voluntarily signed a contract promising to remain drug free. In some instances, they focus solely on drug interdiction through increased searching, while some systems provide a multi-faceted approach combining drug interdiction measures with treatment services. “Drug-free” units could assist efforts to combat the spread of HIV in prison if they resulted in decreased drug use, particularly injecting drug use. There is some evidence from a small number of studies that so-called “drug-free” units do indeed significantly reduce levels of drug use among residents in these units. Such units appeal to a large number of prisoners, including prisoners who do not have any drug problems and want to live in a “drug-free” environment. However, the studies do not say anything about whether “drug-free” units appeal to, and are successful in retaining, the most problematic users, in particular prisoners who inject drugs.

Module 2: Issues for policy makers, legislators, and parliamentarians

Currently, there is therefore no data on the effectiveness of drug-free units as an HIV prevention strategy.

Drug supply reduction strategies

A broad range of search and seizure techniques and procedures can be used in an attempt to reduce the availability of drugs in prisons. These supply reduction measures include: random searches by security personnel; staff and visitor entry/exit screening and searches; drug detection dogs; closed-circuit monitoring; perimeter security measures (netting over exercise yards, higher internal fences to prevent projectiles, rapid response vehicles patrolling the prison perimeter); purchasing of goods from approved suppliers only; intelligence analysts at every institution; drug detection technologies (such as ion scanners, x-ray machines, etc); modifications to the design and layout of visiting areas (use of fixed and low-level furniture); and drug testing (also called urinalysis).

Many prison systems, particularly in resource-rich countries, have placed considerable emphasis on these measures to reduce the supply of drugs. While such measures are not aimed at managing HIV/AIDS in prisons, they may result in unintended consequences for HIV (and HCV) prevention efforts. Drug interdiction measures may assist HIV prevention efforts by reducing the supply of drugs and injecting in prisons. At the same time, they could make such efforts more difficult.

For example, many resource-rich prison systems regularly or randomly test prisoners' urine for illegal drug use. Prisoners who are found to have consumed illegal drugs can face penalties. From a public health perspective, concerns have been raised that these programmes may increase, rather than decrease, prisoners' risk of HIV infection. There is evidence that implementing such programmes may contribute to reducing the demand for and use of cannabis in prisons. However, such programmes seem to have little effect on the use of opiates. In fact, there is evidence that a small number of people may switch to injectable drugs to avoid detection of cannabis use through drug testing. Cannabis is traceable in urine for much longer (up to one month) than drugs administered by injecting, such as heroin and other opiates. Some prisoners choose to inject drugs rather than risk the penalties associated with smoking cannabis simply to minimise the risk of detection and punishment. Given the scarcity of sterile needles and the frequency of needle sharing in prison, the switch to injecting drugs may have serious health consequences for prisoners.

Box 8: Impact of drug testing on drug use: the example of Canada

A 2001 study by the Correctional Service of Canada found that between 1996 – when the drug testing programme was implemented nationally – and 2000 the percentage of samples testing positive for drug use remained largely unchanged (11% to 12%). At the same time, the percentage of prisoners refusing to submit a sample for random drug testing increased significantly, from 9% to 14%. In particular, in maximum-security institutions, the refusal rate increased from 16% in 1996 to 29% in 2000, although regulations stipulate that the sanctions for refusing to provide a sample are identical to those incurred when a sample tests positive for drug use.

Generally, despite the fact that many prison systems make substantial investments in drug supply reduction measures, there is little solid and consistent empirical evidence available to confirm their efficacy in reducing levels of drug use. In particular, there is no evidence that these measures may lead to reduced HIV risk.

Prison systems facing resource constraints should therefore not implement costly measures such as drug detection technologies and drug testing that may use up a substantial amount of resources that could otherwise be used for managing HIV/AIDS in prisons. Instead, they should focus on the proven and cost-effective HIV prevention measures described above and on efforts to improve prison conditions and working conditions and pay for prison staff, without whom other drug supply reduction strategies are unlikely to be successful.

Box 9: Implementation, cost, and evaluation of drug supply reduction strategies

An Australian study examined the implementation, cost, and evaluation of drug supply reduction, drug demand reduction, and harm reduction strategies in Australian prisons (Black, Dolan, & Wodak, 2004). It concluded that “supply reduction strategies [drug detection dogs and urinalysis] were relatively expensive, had not been evaluated and possibly had unintended negative consequences.” In contrast, it found that demand reduction strategies and harm reduction strategies “were relatively inexpensive and evaluation had been favourable.”

➤ **For more details and references, see WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: Drug Dependence Treatments. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_ea_drug_treatment_df.pdf**

Bleach and decontamination strategies

One strategy to reduce the risk of HIV transmission through the sharing of injecting equipment is to provide bleach or other disinfectants for sterilizing needles and syringes. Bleach programmes have received support particularly in situations where opposition to needle and syringe programmes has been strongest, including in prisons.

Bleach is available in many prison systems, including in Western Europe, Canada, Australia, Indonesia, Iran, and some systems in Eastern Europe and Central Asia.

Evaluations of bleach programmes in prisons have shown that distribution of bleach is feasible in prisons and does not compromise security. However, studies in the community have raised doubts about the effectiveness of bleach in decontamination of injecting equipment, and conditions in prisons further reduce the

“Prisoners are highly unlikely to spend 45 minutes shaking the syringes to clean them while waiting to inject in some hidden corner of the prison. Bleach can therefore create a false sense of security between prisoners sharing paraphernalia. The effectiveness of disinfection procedures ... depends greatly on the method used. Effectiveness varies and disinfection is now regarded as a second-line strategy to needle- and syringe-exchange programmes.”

WHO Europe, 2005

probability that injecting equipment may be effectively decontaminated. This is because the type of syringes available in prisons are more difficult to effectively disinfect with bleach and because cleaning is a time consuming procedure and prisoners are reticent to engage in any activity that increases the risk that prison staff will be alerted to their drug use.

Therefore, bleach programmes should be available in prisons, but only as a second-line strategy to needle and syringe programmes, until opposition to such programmes can be overcome or in addition to them.

➤ **For more details and references, see WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons. Needle and Syringe Programmes and Decontamination Strategies. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_nsp_df.pdf.**

Needle and syringe programmes

Introducing needle and syringe programmes in prisons has been controversial. However, studies have demonstrated conclusively that needle and syringe programmes in the community are one of the most important, if not the most important, components of efforts to reduce the spread of HIV among people who inject drugs. More recently, good results have also been shown in prisons.

Needle and syringe programmes have been successfully introduced in a wide range of prison settings, including in men's and women's prisons, prisons of all security levels, small and large prisons, and prisons in which prisoners live in units of individual cells and in barrack-style facilities. They have been implemented in countries in which prison systems are relatively well resourced, as well as in countries in which prisons operate with significantly less funding and infrastructural support, such as in Eastern Europe and Central Asia.

There is strong evidence that providing sterile needles and syringes is readily accepted by injecting drug users in prisons and contributes to a significant reduction of syringe sharing and resulting HIV infections. At the same time, it has not had any serious, unintended negative consequences. In particular, drug use and injecting did not increase, and needles have never been used as weapons. Evaluations have found that providing needles and syringes in prisons actually facilitates referral of drug users to drug dependence treatment programmes. In order to be successful, prisoners should have easy, confidential access to needle and syringe programmes, and prisoners and staff should receive information and education about the programmes and be involved in their design and implementation.

Needle and syringe programmes should therefore be urgently introduced in prisons in countries that are experiencing or are threatened by an epidemic of HIV infections among injecting drug users. Experience has shown that, in order to overcome objections against them, such programmes may best be introduced as experimental pilot projects that are carefully evaluated. However, this should not delay the rapid expansion of the programmes to other prisons.

Detection and treatment of sexually transmitted infections

Detection and treatment of sexually transmitted infections is important because these infections increase the chances of an individual transmitting and acquiring HIV. Sexually transmitted infections that disrupt the integrity of the skin or mucous membranes can bleed easily, increasing the infectiousness and susceptibility to HIV. For this reason it is recommended that prison systems, in conjunction with health ministries and public health authorities, develop a comprehensive programme to reduce the incidence and prevalence of sexually transmitted diseases in prisons.

- For more details and references, see WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_%20ea_nsp_df.pdf

Controlling the spread of tuberculosis

Some reports estimate that tuberculosis is 100 times more common in prisons than in the community. Wherever tuberculosis is evident in prisons it is a significant health problem. Sub-standard prison living conditions, including overcrowding, poor ventilation and inadequate nutrition, make the attempts to control the spread of tuberculosis in prisons more difficult. Moreover, prisons in geographically disparate places (from Thailand to New York State to Russia) have reported high levels of drug-resistant tuberculosis. Tuberculosis poses a substantial danger to the health of all prisoners, staff, and the community outside prisons. Prisoners living with HIV are at particular risk. HIV infection is the most important risk factor for the development of tuberculosis, and tuberculosis is the main cause of death among people living with HIV.

For all these reasons, in addition to improving conditions in prisons that fuel the spread of tuberculosis (see the section below), prisons must develop and implement comprehensive tuberculosis control programmes, which should be coordinated with or integrated in national tuberculosis control programmes.

- For comprehensive information about tuberculosis control in prisons, see:

- World Health Organization & International Committee of the Red Cross (2001). *Tuberculosis Control in Prisons: A Manual for Programme Managers*. Available in English, Spanish, and Russian via <http://www.who.int/docstore/gtb/publications/prisonsNTP/>
- J. Veen. Tuberculosis control in prisons. In: World Health Organization, Regional Office for Europe (2006). *Promoting health in prisons – The essentials. A WHO guide*.
- WHO (2007). *The Status Paper on Prisons and Tuberculosis*. Available at <http://www.euro.who.int/Document/E89906.pdf>.

- For information about a programme to treat multiple drug resistant TB in prisons in Siberia, see: http://www.phri.org/programs/program_russianTB.asp

Hepatitis B vaccination

Hepatitis B is easily spread in prisons. In contrast to HIV, the risk of infection can be reduced through the administration of a vaccine. Some prison systems already offer hepatitis B vaccination to all staff and prisoners. Other prison systems should follow suit. In addition, consideration should be given to providing hepatitis A vaccination to prisoners at risk.

Box 10: Hepatitis B immunization in Canadian prisons

In 1989, the Correctional Service of Canada (CSC) instituted a programme for hepatitis B immunization of prisoners. The hepatitis B vaccine is a safe and effective means of preventing hepatitis B virus infection. Vaccination is encouraged for all incoming offenders and is available on request throughout a prisoner's sentence.

Hepatitis C prevention

In addition to contributing to reduced risk of HIV transmission in prisons, most of the measures described above also contribute to reducing the risk of hepatitis C virus (HCV) transmission. However, as explained above, in Box 3, HCV is much more easily spread than HIV, including through sharing of shavers and toothbrushes, as well as through tattooing and body piercing. It is therefore important that prison systems make information available to all prisoners and to staff about the risks of HCV transmission in prison and educate them about the ways to reduce that risk. In addition, shavers and toothbrushes should be made available to prisoners so that they do not have to share them with fellow prisoners; and prison systems should consider implementing measures to reduce the spread of HCV through tattooing and body piercing, such as making sterile tattooing equipment available to prisoners.

Providing health services in prisons equivalent to those in the community

In addition to providing comprehensive prevention programmes, governments have a responsibility to provide prisoners with care and treatment equivalent to that available to other members of the community.

Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

United Nations Basic Principles for the Treatment of Prisoners (principle 9)

The right to health and the equivalence principle

Health in prison is a right guaranteed in international law, as well as in international rules, guidelines and covenants. The right to health includes the right to medical treatment and to preventive measures and to standards of health care equivalent to those available in the community. As it was stated in April 1996 by the Joint United Nations Programme on HIV/AIDS (UNAIDS) to the United Nations Commission on Human Rights at its 52nd session:

HIV/AIDS in prisons remains a difficult and controversial subject... Often there are not enough resources to provide basic health care in prisons, much less HIV/AIDS programmes. Yet the situation is an urgent one. It involves the rights to health, security of the person, equality before the law and freedom from inhuman and degrading treatment... With regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community.

The 1993 World Health Organization *Guidelines on HIV infection and AIDS in prisons* also highlight that as a general principle prisoners have the right to receive health care “equivalent to that available in the community without discrimination.”

Effective HIV treatment in prison settings

The right to medical care in prisons includes the provision of antiretroviral therapy (ART) in the context of comprehensive HIV/AIDS care. The advent of combination ART has significantly decreased mortality due to HIV infection and AIDS in countries around the world where ART has become accessible. There has been a parallel decrease in the mortality rate among incarcerated individuals in prison systems in those countries.

Providing access to ART for those in need in prisons is a challenge, but it is necessary and feasible. Studies have documented that, when provided with care and access to medications, prisoners respond well to antiretroviral treatment. In high income countries, the right to enjoyment of the highest attainable standard of physical and mental health, in concert with the principle of equivalence, dictates that prisoners should have access to a high standard of care, including specialist consultation, diagnostic testing (CD4, viral load, viral resistance) and the full range of antiretrovirals licensed for sale within a particular country.

In September 2003, the WHO, UNAIDS, and the Global Fund to Fight AIDS, TB and Malaria launched the Treat 3 Million by 2005 (3 by 5) Initiative, partly out of the recognition that HIV/AIDS was exacerbating inequities between rich and poor countries, and the conviction that the right to health and life should not be dependent on ability to pay for medicines. Although the ambitious target of 3 by 5 was not reached, at the 2005 World Summit and the 2006 High Level Meeting on AIDS, world leaders committed to pursue all necessary efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010. In support of this, additional resources to fund an expanded response have become available, including through the Global Fund to Fight AIDS, Tuberculosis and Malaria.

As ART is increasingly becoming available in developing countries and countries in transition, and as countries are moving towards the goal of universal access to treatment by 2010, **it will be critical to ensure that treatment also becomes available to all prisoners who need it.** Ensuring continuity of care from the community to the prison and back to the community, as well as continuity of care within the prison system, is a fundamental component of successful treatment scale-up efforts.

The following actions will facilitate this:

- **prison departments must have a place within the national HIV/AIDS coordinating committees**, and prison issues need to be part of the agreed HIV/AIDS action framework and country-level monitoring and evaluation system;
- **prison departments need to be involved in all aspects of treatment scale-up**, from applications for funding (to ensure that funds are specifically earmarked for prisons), to development, implementation, and monitoring and evaluation of treatment roll-out plans;
- the **ministry responsible for health and the ministry responsible for the prison system should collaborate closely**, recognizing that prison health is public health;
- policies or guidelines should be developed specifying that people with HIV or AIDS are allowed to keep their HIV/AIDS medication upon them, or are to be provided with their medication, upon arrest and incarceration and at any time they are transferred within the system or to court hearings. Police and prison staff need to be educated about the **importance of continuity of treatment.**

➤ **For more details and references, see WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: HIV Care, Treatment and Support. Evidence for Action Technical Papers.* Available at http://www.who.int/hiv/idu/oms_ea_hiv_treatment_df.pdf**

Prison health care: the need for increased funding and a new model

HIV/AIDS, HCV, and TB have exacerbated existing problems in health-care provision in prisons. **Correctional health-care budgets must reflect the growing needs of the prison population.** Correctional health care should be recognized as an integral part of the public health sector, and evolve from its present reactive “sick call” model into a proactive system that emphasizes early disease detection and treatment, health promotion, and disease prevention. There is a need for a public health infrastructure to fulfill the core functions of public health services within prisons – i.e., to assess the health status of prisoners; have an effective surveillance system for infectious and chronic diseases; undertake health promotion efforts; have coordinated actions to prevent diseases and injuries; protect the health of prisoners; and evaluate the effectiveness, accessibility, and quality of health services. Addressing prisoners’ health needs will contribute to the prisoner’s rehabilitation and successful reintegration into the community.

Transferring control of prison health

In the longer term, transferring control of prison health to public health authorities could have a positive impact on HIV/AIDS care in prison, at least in countries with a well functioning public health service.

In the vast majority of prison systems in the world, health care is provided by the same ministry or department responsible for prison administration, not by the ministry or department responsible for health. Prisons were not designed and are generally not equipped to deal with prisoners infected with chronic, potentially fatal diseases such as HIV/AIDS, hepatitis, and tuberculosis. They do not have adequate staffing levels, adequate staff training or adequate equipment to meet the health needs of prisoners suffering from these diseases.

Experience in a range of prison systems has shown that health care in prisons can be delivered more effectively by public health authorities than by the prison system. This has the advantage of strengthening the link between health in the community and health in prisons. Some countries have already introduced such a change in prison health administration.

Moving responsibility for prison health is not a straightforward handover of responsibility and requires detailed and careful assessment of the feasibility on a case-by-case basis. However, **closer integration between community health services and prison health services** has the potential to:

- protect the independence of the clinical judgement of the prison health staff;
- improve the continuity of care between prison and the community, which is in the interests of prisoners and of society as a whole;
- provide support and training from other health professionals to their colleagues working in prisons;
- provide strong support for public health measures such as provision of condoms, bleach, and needles and syringes, even when these may be perceived to cause problems in the prison environment;
- increase the trust between prisoners and health staff, and thus facilitate the introduction of health prevention and promotion activities.

Attention to the needs of women prisoners

As prison systems develop and implement treatment and care programmes, special attention should be given to women prisoners, who require information and services specifically designed for their needs.

Women prisoners are fewer than males, and the health services provided for women are sometimes minimal or second-rate. With the advent of HIV/AIDS, a new problem has arisen for women prisoners. Women prisoners need the same preventive measures and the same level of care, treatment, and support as male prisoners. In addition, however, there is a need for initiatives that acknowledge that the problems

encountered by women in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. The task of protecting women prisoners from HIV transmission and of providing those living with HIV or AIDS with care, treatment, and support, therefore presents different – and sometimes greater – challenges than that of dealing with HIV infection in male prisoners.

Improving prison conditions – the need for prison reform

Much can be done to address the problems linked to HIV/AIDS in prisons by taking action in the areas outlined above. In the medium- and longer-term, however, it will be essential to take action to improve prison conditions. Prison conditions are integrally linked to prison health, and have the potential to affect the health of prisoners in positive or negative ways. Minimum standards for the housing and treatment of prisoners are defined by international agreement.

In the context of HIV/AIDS, **sub-standard living conditions can increase the risk of HIV transmission** among prisoners by promoting and encouraging drug use in response to boredom or stress (most often involving unsafe injecting practices) and by enabling prison violence, fighting, bullying, sexual coercion, and rape. **Sub-standard prison conditions can also have a negative impact on the health of prisoners living with HIV/AIDS** by increasing their exposure to infectious diseases such as tuberculosis and hepatitis; housing them in unhygienic and unsanitary environments; confining them in spaces that do not meet the minimum requirements for size, natural lighting, and ventilation; limiting access to open air and to educational, social or work activities, and by failing to provide them with access to proper healthcare, diet, nutrition, and/or clean drinking water, and basic hygiene.

A comprehensive programme of prison reform based on the international human rights standards would do much to improve these conditions and, ultimately, to reduce the spread of HIV. Issues that need to be addressed include:

- A **proper system of classification** needs to be in place which keeps children separately from adults, women separate from men, and pre-trial prisoners separate from sentenced prisoners – such a system will decrease the likelihood of sexual abuse and violence in prisons.
- Improved prison conditions, with **reasonable space**, decent **sanitation** and daylight and regular **access to the open air** will improve general health of prisoners, reduce the spread of tuberculosis, and likely decrease use of drugs.
- Restricted access to **adequate nutrition** has an impact on the health of all prisoners, but is particularly problematic for the health of prisoners living with HIV or AIDS. Providing a more balanced and varied diet and **clean drinking water** will reduce prevalence and incidence of infections.

- **Reducing violence**, including sexual violence, through a variety of activities, including **hiring additional staff**, will also decrease the risk of HIV infection.
- Providing prisoners with **work and other purposeful activities** has many benefits, but it will also reduce high-risk behaviours that are often the result of boredom.
- Regular **contact with family** and friends through visits, telephone and post is also important, for the same reasons.
- Several aspects of corruption are relevant to HIV/AIDS, including staff's active involvement or complicity in the smuggling of drugs. **Improving the pay and working conditions of staff**, and developing and strictly enforcing a **code of conduct for staff** are important elements of efforts to fight corruption.
 - **For more information on how to improve prison conditions and make them conform to relevant international standards, see: A Coyle. A Human Rights Approach to Prison Management. Handbook for prison staff. London: International Centre for Prison Studies, 2002. Available in many languages via <http://www.kcl.ac.uk/depsta/rel/icps/publications.html>.**

Reducing prison populations

Overcrowding or congestion is an endemic problem in most prison systems. In Africa, there is an average of 150 prisoners for every 100 berths and in some countries the problem is greater still with insufficient space in dormitories for all the prisoners to sleep. In such conditions, violence and sexual activity, consensual or coerced, can be common. Overcrowded living conditions also increase the likelihood that the health of prisoners living with HIV/AIDS will suffer through exposure to other infectious diseases and to unhygienic conditions, and create additional impediments to the ability of prison medical staff to provide adequate health services.

In the short term, overcrowding can be reduced by amnesties, reviewing the legality of detention status so that those held unlawfully can be released and removing groups inappropriately held, such as those prisoners with mental disorders.

In the medium and long term, there are two potential solutions to overcrowding: increasing the capacity of the prison system or reducing the number of prisoners. The first solution is very costly, and many countries do not have the additional financial resources required to expand their prison systems, or could put those resources to better use. **Reducing imprisonment and pre-trial detention** is a better solution. Prison should only be used as a place of last resort. In all other cases **alternatives to custody** should be used. A range of community-based pre-trial and sentencing options and programmes of supervised early release can help to ensure that prison is used as a last resort and for the shortest time. A good strategy is to **adopt official government targets for reducing prison overcrowding**.

The overuse of incarceration of people who use drugs is of particular concern. In many countries, a significant percentage of the prison population is comprised of individuals who are convicted of offences directly related to their own drug use (i.e. those incarcerated for the possession of small amounts of drugs for personal use, those convicted of petty crimes specifically to support drug habits). The incarceration of significant numbers of people who use drugs increases the likelihood of drug use inside prisons, as well as unsafe injecting practices and the risk of HIV transmission. Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available. As early as 1987, the World Health Organization, in a statement from the first Consultation on Prevention and Control of AIDS in Prisons, said that “[g]overnments may ... wish to review their penal admission policies, particularly where drug abusers are concerned, in the light of the AIDS epidemic and its impact on prisons.” Options for non-custodial sentencing include:

- a discharge (where the person is deemed not to have been convicted of the offence, despite being found guilty, and the person does not acquire a criminal record)
- a suspension (where the sentence is suspended and often replaced by a probation order, with the additional condition that the sentence will be reinstated if the probation order is broken)
- a fine
- a community service order, or
- a supervised attendance order (which might order the person to attend a place of supervision).

Various combinations and variations of these sentencing options already exist in laws governing sentencing in many countries.

One alternative sentencing option is to order a person convicted of a drug-related offence to consult with, and be assessed by, professional staff of drug dependency treatment programmes. However, legislation should not enable a court to force people, upon pain of imprisonment, to undergo drug dependency treatment. The fact that people enter treatment under the threat of incarceration, or abstain from drugs to avoid sanctions, has serious implications for the right to bodily integrity, the right to privacy and the right to equality. The extent to which people can give their free and informed consent to such treatment is doubtful. Thus, legislation should take advantage of the person’s contact with the criminal justice system to facilitate mostly voluntary access to drug dependence treatment and other health services, consistent with the notion that treatment for drug dependence should be non-coercive.

➤ For more information on alternatives to imprisonment, see

➤ UNODC (2007). *Handbook of Basic Principles and Promising Practices on Alternatives to Imprisonment. Criminal Justice Handbook Series* - http://www.unodc.org/pdf/criminal_justice/07-80478_ebook.pdf

➤ Stern V (ed). *Alternatives to Prison in Developing Countries*. London: International Centre for Prison Studies, King's College, University of London. See <http://www.kcl.ac.uk/depsta/rel/icps/publications.html> for order information. In many developing countries there are few alternatives to imprisonment. Case studies and detailed appendices in this book provide legislative and administrative guidance that will be a valuable tool for practitioners in developing countries and countries in transition.

Priorities for action

Policy makers, legislators, and parliamentarians have a crucial role to play when it comes to facilitating effective action on HIV/AIDS in prisons, as outlined in the previous section. Simply stated, many of the necessary steps will not be possible without action by policy makers, legislators, and parliamentarians, or at least their explicit or tacit consent. Priorities for action include:

- **providing leadership** by raising awareness of the issues, engaging with stakeholders, and informing and educating the public;
- **undertaking legislative and policy reform;**
- **advocating for increased funding** to address HIV/AIDS in prisons.

The prison service is a public service, meeting some fundamental needs in society, such as the need to feel safe, and to feel that crime is sufficiently punished and reparations made. As with all public services, the extent and the quality of provision is a political decision. Political support for effective action on HIV/AIDS in prisons should be based on the acceptance that

- good prison health is essential to good public health,
- good public health will make good use of the opportunities presented by prison, and
- prisons can contribute to the health of communities, by helping to improve the health of some of the most disadvantaged in any society.

Action 1: Providing political leadership

According to the *Declaration of Commitment on HIV/AIDS* adopted by all states during the 2001 United Nations General Assembly Special Session on HIV/AIDS, “strong leadership at all levels of society is essential for an effective response to the [HIV/AIDS] epidemic.” This is particularly true in the area of prisons.

In most countries, prison health standards and prison conditions suffer because of a lack of political and public interest in the wellbeing of prisoners. Taking action to address the broad concerns raised by HIV/AIDS in prisons, and enabling prison authorities to implement effective policies and strategies, requires the political commitment to publicly identify prison health, improved prison conditions, and HIV/AIDS as issues demanding government action.

Policy makers, legislators, and parliamentarians can demonstrate leadership by raising awareness about these issues among their peers.

The prevention of HIV transmission in prisons is often hampered by the denial of governments of the existence of injecting drug use and unsafe sexual practices in prisons. Therefore, official acknowledgement of the reality of high risk behaviours and HIV transmission in prisons is an essential first step in raising public awareness and implementing effective responses.

Informing and educating the public about the measures being undertaken is the next step. It is important to have a clear strategy about how to communicate to the public what is being done to address HIV/AIDS in prisons and why. Communication should emphasise that prison HIV/AIDS policies are part of the national approach to contain the HIV/AIDS epidemic, as well as part of a broader national approach to public health issues in general which includes other major illnesses affecting the community as well as prisoners (in particular tuberculosis and hepatitis B and C.).

Elements of the strategy might include:

- emphasising that action on HIV/AIDS in prisons is necessary for the benefit of prisoners, but also of staff and the general public;
- engaging the medical community and public health practitioners as spokespersons;
- working closely with media that have demonstrated that they are able to cover HIV/AIDS issues well and encouraging them to write in-depth articles, rather than issuing press releases and encouraging sensational media reporting.

Checklist 1: How you can raise awareness and engage other stakeholders: Practical steps

Awareness raising and engagement of stakeholders is usually not very difficult because the subject matter is quite straightforward. However, if your country is still in a state of denial about the existence of HIV/AIDS in prisons, it requires some courage to raise the issue. It is not recommended to go public at an early stage and involve the media, because this can create an emotional and uninformed public debate. Here are some practical suggestions on how to proceed:

- ❑ To raise awareness and engage with stakeholders, you need to have some credible information on HIV/AIDS in prisons. Such information includes the number of prisoners in your country, the extent of overcrowding, the extent of high-risk behaviour, and data on HIV, HCV, and TB. In most countries this kind of information is already available. If this is not the case, you could commission a rapid assessment in one or two prisons of your country to collect this information. A rapid assessment in the penitentiary system does not take more than two weeks. Intervention and response development – rather than the simple collection of data – is the ultimate goal of a rapid assessment. To date, rapid assessments on drug use have been conducted in 70 countries by international agencies such as the World Health Organisation.
- **For a technical guide on rapid assessments, see: G.V. Stimson, MC Donoghoe, C. Fitch and T.J. Rhodes, with A. Ball and G. Weiler (2003) *Rapid Assessment and Response Technical Guide*, World Health Organization (Department of Child and Adolescent Health and Development, and Department of HIV/AIDS) Geneva. Available at <http://www.who.int/docstore/hiv/Core/Contents.html>. For more information, contact the World Health Organization, Department of HIV/AIDS, 20, avenue Appia CH-1211 Geneva 27 Switzerland, E-mail: hiv-aids@who.int.**
- ❑ Most countries have a multi-sectoral AIDS authority, usually called the National AIDS Programme or the National AIDS Commission. In such programmes or commissions, all ministries addressing HIV/AIDS should be represented, including the ministry responsible for the penal system of your country. If your country is a recipient of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria, there will also be a so-called Country Coordination Mechanism (CCM). Participate in the next meetings of these fora and make sure that HIV/AIDS in prisons is on the agenda. Make a presentation on the HIV/AIDS situation in prisons in your country by presenting the available data. Explain the mechanisms of HIV transmission in prisons, and how prisons contribute to the spread of HIV in general society.
- ❑ If you make such a presentation, it usually triggers a lot of debate. Some of your colleagues will react very emotionally. You should provide them with as much factual information as possible. Have a two-page note on HIV/AIDS in prisons in your country ready for distribution. Schedule bilateral meetings with some of your colleagues.
- ❑ Depending on the form of government in your country, you could either use a bottom-up or a top-down approach for awareness raising and engagement of stakeholders. To be successful in policy and programme development, it is usually necessary to have the support of the highest level of the government. It might be necessary to brief the minister or the head of government.
- ❑ It has been the experience in some countries that progress in implementing HIV/AIDS strategies in prisons has been significantly helped by the work of one or a small number of individuals within the prison system who have committed themselves to advocating internally for change. Therefore, you should identify and support “champions” within the system. These individuals should be tasked with – and supported in – promoting the strategy nationally (internally within the prison system and externally with the public). These champions should be supported in developing expertise on the issue of HIV in prisons, and to act as key centres of knowledge and information for the system as a whole.

- ❑ Consult with other potential allies and explore with them how they could support you. Such allies include representatives from the United Nations system in your country. Of particular help could be the representatives of the World Health Organization and United Nations Office on Drugs and Crime, the UNAIDS Country Coordinator, the United Nations Resident Coordinator and the Chair of the United Nations Theme Group on HIV/AIDS. If the heads of these agencies come for a visit to your country, ensure that they are briefed about HIV/AIDS in the penal system in your country, and that they raise the issue in their consultations with the highest government authorities.
- ❑ Other potential allies you should consult with include associations of health professionals, health researchers, human rights and other civil society organisations, people living with HIV/AIDS, and prisoners and former prisoners.
- ❑ **Most importantly, base decisions affecting prison health on evidence, recognised best practice, and on legal and ethical obligations, rather than on public opinion or political expediency.**

Action 2: Undertaking legislative and policy reform

The next priority is to **ensure that legislation, prison policy, and prison rules promote the effective responses to HIV/AIDS in prisons** outlined above, rather than impeding progress on reducing transmission of HIV and caring for prisoners living with HIV or AIDS. The extent to which new legislation or policy is needed will vary from jurisdiction to jurisdiction. In some countries, for example, legislation to explicitly authorize HIV prevention measures in prisons will be necessary, while in others a simple guideline issued by the head of the prison system will be enough. In all countries, however, a comprehensive review of all laws, policies, and rules that impact on the ability of prison systems to deal effectively with HIV/AIDS (as well as sexually transmitted diseases, hepatitis, and tuberculosis) should be undertaken.

In particular, such a review should:

- ensure legal status of comprehensive HIV/AIDS prevention and care services in prisons, including needle and syringe programmes and substitution therapy;
- ensure there is no involuntary HIV testing or segregation of prisoners living with HIV or AIDS;
- ensure that health decisions in prisons are made by health professionals;
- ensure there is effective protection against sexual violence and prosecution of offenders
- support criminal law policies consistent with an effective HIV/AIDS response – these laws and their interpretation and enforcement should be complementary to HIV/AIDS strategies, so that they do not hinder HIV prevention and care, treatment, and support
- allow for provisions to reduce imprisonment and pre-trial detention
- allow for early release of terminally ill prisoners.

Such a review is best undertaken by a joint working group or commission including representatives of the ministry responsible for prisons, the ministry of justice, and the ministry of health, and should consult with representatives of the prison system, including staff and prisoners, civil society, medical associations, and international agencies.

Checklist 2: Review of legislation and prison rules

This list contains crucial elements of legislation and prison rules concerning HIV/AIDS in prisons. Check here whether legislation in your country conforms to international good practice.

- Does the legislation provide for access to the following HIV-related prevention and care and treatment services in prisons:
 - Information, education and communication?
 - Voluntary and confidential counselling and testing?
 - Condoms and lubricants so that prisoners can practice safer sex?
 - Bleach or other disinfectants so that prisoners can clean injecting, tattooing, and skin piercing equipment?
 - Sterile injecting equipment (needles, syringes and cotton swaps) for drug injecting prisoners?
 - Drug dependence treatment programmes, including substitution treatment?
 - Diagnosis and treatment of sexually transmitted infection?
 - Antiretroviral treatment for prisoners with HIV/AIDS?
- Does the legislation provide for clear standards for effective detection, prevention and reduction of prison rape and for effective prosecution of offenders?
- Does the legislation provide for access to post-exposure prophylaxis for staff potentially exposed to HIV during the course of their work and for prisoners who are sexually assaulted or otherwise exposed to HIV?
- Does the legislation provide for hepatitis vaccination for staff and prisoners?
- Does the legislation provide for effective tuberculosis control?
- Does the legislation provide for confidentiality of prisoners' medical and/or personal information, including HIV status?
- Does the legislation prohibit HIV discrimination in prisons, including isolating, segregating or excluding from programmes prisoners living with HIV simply on the basis of their HIV status?
- Does the legislation include provisions to reduce imprisonment and pre-trial detention?
- Does the legislation allow for early release of terminally ill prisoners and provide for an accessible and quick mechanism to apply for such a release?

How should legislation look like?

Model legislation addressing the HIV epidemic among people who use drugs has been developed. This legislation contains a section on prisons. The model legislation — a detailed framework of model legal provisions — is a resource for the reform of prison laws and regulations related to HIV/AIDS. It is “options-based” — that is, designed to be adopted or adapted to local contexts as part of an effective response to the epidemic. It is annotated in order to highlight critical issues, areas of potential conflict and possible solutions. It is “model” in the sense that it has not been developed with any particular jurisdiction in mind. Rather, it is hoped that it can be useful in a variety of countries, particularly in those regions of the world where the

HIV/AIDS epidemic is driven by injecting drug use. It is also “model” in that it is based on human rights principles and “best practice” national legislation.

- **For more information and the text of the model legislation, see <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=587>**

Box 11: Examples of legislation regarding pre-trial detention

Art. 109 of the **Russian Federation** Code of Criminal Procedure of 18 December 2001, No 174-F3, last amended 29 May 2002 sets the time limits on pre-trial detention, which may not exceed two months.

Italy's Law no. 89 of 24 March 2001, the so-called “Pinto” Act (from the name of the Senator who was its first signatory), introduced into Italian law a mechanism under which a private citizen is entitled to “fair reparation” if suffering damage due to the “unreasonable” length of proceedings.

What about prison policy?

It must be recognized from the outset that reform of legal frameworks represents only one element of a comprehensive response to HIV/AIDS in prisons. If unaccompanied by vigorous efforts to align actual practice in prisons with the law, legal reform will be nothing more than a cosmetic change. Legal reform is necessary for HIV/AIDS policies in prisons to be effective and respectful of human rights, but on its own it is insufficient to bring about meaningful change.

Therefore, the review of laws should be carried out in parallel with the formulation of an **HIV/AIDS prison policy**. In fact, policy development often informs the legal review and vice versa. Prison systems should develop or revise, implement, and make publicly accessible written policies and prison rules related to prison health, prison conditions, and prison HIV/AIDS programmes and services. Written policies and rules, and their proper implementation, are essential in the effective management of prisons, the training and support of prison staff, the ethical and humane treatment of prisoners, and the development of consistent and equitable standards within prisons and between prisons.

Box 12: National HIV/AIDS Policy in Malawi

Prisoners are particularly vulnerable to exploitative and abusive sexual relations because of the environment in which they are living. They, therefore, need to be empowered to make informed decisions in the same way as other vulnerable groups.

The government, through the National AIDS Commission undertakes to do the following:

- ◆ Ensure that prisoners are not subjected to mandatory testing, nor quarantined, segregated, or isolated on the basis of HIV/AIDS status.
- ◆ Ensure that all prisoners (and prison staff, as appropriate) have access to HIV-related prevention, information, education, voluntary counselling and testing, the means of prevention (including condoms), treatment (including antiretroviral treatment), care and support.
- ◆ Ensure that prison authorities take all necessary measures, including adequate staffing, effective surveillance, and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion by fellow prisoners and by warders. Juveniles shall be segregated from adult prisoners to protect them from abuse.

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- ◆ Ensure that prisoners who have been victims of rape, sexual violence or coercion have timely access to post-exposure prophylaxis, as well as effective complaint mechanisms and procedures and the option to request separation from other prisoners for their own protection.

Box 13: Indonesian National Strategy for HIV/AIDS Control in Prisons

In late 2002, the Ministry of Justice (MOJ) of Indonesia decided to promote HIV/AIDS prevention and care activities for prisoners to prevent spread of HIV within prisons and from there to the community as a whole. In 2005, it launched the Indonesian National Strategy for HIV/AIDS Prevention, Care and Support for Prisoners, the first national strategy of its kind in Asia. It has enabled education as well as provision of condoms, bleach, methadone and ARVs for prisoners.

For more information, see: National Strategy for Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centres, for the period 2005-2009, Ministry of Justice and Human Rights of Indonesia, Jakarta, 2005.

Box 14: Canadian Policy on Management of Infectious Diseases in Prisons

Correctional Service Canada (2004). Commissioner's Directive 821: Management of Infectious Diseases. Ottawa: CSC.

Available (in English and French) at www.csc-scc.gc.ca/text/plcy/cdshtm/821-cde_e.shtml. This document provides policy direction on the management of infectious diseases in Canadian federal prisons, but is useful as a model for other prison systems. It "reflects public health principles, and incorporates a full range of infectious disease programme elements." Its objective is to "contribute to public health and a safe and healthy environment through a comprehensive infectious diseases program." Among other things, the Directive states that:

- "a full range of infectious diseases program elements, including but not limited to screening/testing, immunization, education and training, harm reduction measures, care and treatment, surveillance activities, and partnerships, shall be implemented based on best evidence and public health expertise"
- "approved harm reduction items shall be readily and discreetly accessible to inmates in CSC operational units so that no inmate is required to make a request to a staff member for any item"
- "inmates living with infectious diseases shall be provided with humane treatment and support, in an environment free of discrimination"
- "the Institutional Head shall ensure that non-lubricated, non-spermicidal condoms, water-based lubricants, dental dams and bleach are discreetly available to inmates at a minimum of three locations, as well as in all private family visiting units"
- "CSC's Health Services shall ensure that partnerships are established nationally, regionally and locally with other federal departments, provincial and municipal governments, service agencies and stakeholder groups, in order to ensure the sharing of information, best practices, and expertise".

From policy to implementation

Implementing effective policies on HIV/AIDS prevention and care in prisons requires a further set of actions, namely the development of an implementation strategy, and the training of those who will implement the policy.

Capacity building of prison administrators and staff is key to the effective implementation of HIV/AIDS policies in prisons. Prison administrators could be sent abroad to countries where effective HIV/AIDS prison policies are being implemented

and observe how this is being done. Also, the government could bring in external experts who could advise on how to implement policies. Prison staff training must include various modules on HIV/AIDS.

➤ **For further information on important elements of prison policies, see: HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response, section 2, pages 17-19 (“Reform of prison policy and rules”). Available at www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf**

Action 3: Advocating for increased funding

Prison systems in many countries do not have the financial resources they need in order to be able to improve prison conditions and provide comprehensive HIV/AIDS prevention, care, treatment and support. That is why prisons are often overcrowded, buildings dilapidated, nutrition insufficient, and prison staff underpaid and poorly motivated. Governments do not usually accord prisons a high priority, due to other urgent needs. **In a world with HIV/AIDS, more than ever, prison systems need additional financial resources.** Conditions in under-funded prison systems not only violate human rights, but also create a danger for the health of prisoners and for public health.

Many governments have begun to allocate more resources to prison systems. **Most of the prevention measures** outlined above, such as provision of condoms, bleach, and needles and syringes, **are relatively inexpensive** and have been successfully implemented in resource-poor countries. **Other measures, like decreasing the use of prisons as a response to illegal drug use, would free up resources** by reducing the number of people in prison. Nevertheless, in order to effectively address the range of challenges that HIV/AIDS poses to the effective and ethical management of prisons, and to meet recognised international standards on prison health and prison conditions, it is imperative that both national governments and the international community provide the resources necessary to develop and implement comprehensive, evidence-based interventions.

Funding from domestic sources

As much as possible, programmes and strategies to promote prison health, improve prison conditions, and address HIV/AIDS (as well as hepatitis and tuberculosis) should be resourced from national budgets. Some actions that will facilitate this include:

- Identifying prisoners as a key vulnerable population when allocating national resources to combat HIV/AIDS.
- Expanding the parameters of existing national funding earmarked for vulnerable populations to encompass prisoners, recognising that in many countries the populations most vulnerable to HIV/AIDS are also disproportionately represented in prisons.

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- Maximising support and encouragement of peer-based HIV prevention, education, counselling, and care initiatives. Increasing the role of prisoners in developing and providing health programmes and services increases the capacity of prisons to respond to HIV/AIDS.
- Ensuring that prisoners have access to antiretroviral therapies under national treatment plans.
- Dedicating specific funding and resources for HIV/AIDS programmes and services within national prison budgets, and dedicating specific funding for prison initiatives within national HIV/AIDS, health, and drugs budgets.
- Reviewing the impact of drug control and enforcement programmes in combating the transmission of HIV/AIDS in prisons, and examining the re-allocation of funding from ineffective or counter-productive programmes into new health-based initiatives.
- Ensuring that non-governmental organisations are provided with sufficient funding to play an integrated and effective role in prison HIV/AIDS programmes and services, and that sufficient and sustainable resources and other supports are provided to outside medical, drug dependence treatment, mental health, and social services to enable them to provide post-release care for ex-prisoners.

Funding from international sources

International sources of funding to combat HIV/AIDS include the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Fund for AIDS Relief, the World Bank, various international foundations such as the Bill and Melinda Gates Foundation and the Clinton Foundation, and various bilateral donors. In order to be able to access such resources, it is essential for the ministry responsible for the prison system to be represented in national AIDS coordination mechanisms such as the National AIDS Commission and the Global Fund Country Coordination Mechanism.

Whenever the government prepares proposals for HIV/AIDS funding from international sources, the prison system should be included so that it can develop a prison component.

Box 15: The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Fund was created in 2002 to increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. As a partnership between governments, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing. The purpose of the Fund is to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals. More information about the Global Fund can be found at <http://www.theglobalfund.org>.

Many countries are implementing HIV prevention and treatment programmes in prisons with Global Fund grants.

Module 3: Issues for prison authorities and prison managers

This module is intended primarily for those who have responsibilities for the **management of prison systems and individual prisons**. We hope it will be useful to heads of national and provincial or regional prison administrations; prison directors and managers; and judges and inspectors with responsibilities for external scrutiny of prison conditions.

The module is designed to provide them with knowledge about key issues in HIV/AIDS prevention and care. The key objectives are to:

- explain how HIV is transmitted in prisons
- explain what factors contribute to making prisons high-risk environments for HIV, and how they can be addressed
- suggest what HIV prevention measures should be adopted in prisons
- suggest how prisons can best provide care, support and treatment to prisoners with HIV or AIDS.

The module concludes with answers to frequently asked questions.

Introduction and key issues for prison management

Prison authorities and prison managers have a central role in implementing effective HIV prevention as well as care, treatment and support measures.

Prisons in modern societies are complex places to manage. Overcrowding, the epidemics of serious life-threatening diseases, and the use of prisons for housing the mentally ill and people with problematic drug use have all contributed to increase the pressures on management at all levels. The majority of prisoners nowadays have multiple problems. This all produces a very challenging environment for those required to guarantee security, safety, decency, and health. We hope that this toolkit will be of value in showing how the problems related to HIV/AIDS in prisons can best be met.

Managers, leading from the top but also well supported by Ministerial or national staff, have the first challenge, namely setting the ethos, the overall 'feel' of the prison. In the context of HIV/AIDS, **three overarching issues need to guide action in prisons**.

The first is the **need for a comprehensive approach**, which aims both

- to prevent the prevalence of high risk behaviour; and
- to reduce the risk of transmission of infections when such behaviour does take place.

Many of the activities that can transmit HIV in prison are against prison rules and in some cases against the criminal law. Prisons must do all they can to prevent drug use and unsafe sexual activities in prison, and to reduce levels of violence – in particular sexual violence. However, it is important to recognise that efforts to stop these activities, such as the use of drugs in prisons, will not always be successful. Illegal drugs are available in prisons worldwide despite the sustained efforts of prison systems to prevent illegal 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 illegal drug possession and use among prisoners. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), “[w]hether the authorities admit it or not – and however much they try to repress it – drugs are introduced and consumed by inmates in many countries... Denying or ignoring these facts will not help solve the problem of the continuing spread of HIV”.

Therefore, taking measures to try to prevent the activities in the first place is not enough. Knowing that the activities cannot be completely stopped, prisons also need to implement measures to reduce the dangers to health associated with these activities, in particular unsafe injecting drugs and unsafe sexual activities. This does not mean condoning these activities. Rather, it means adopting a pragmatic approach that acknowledges that risk activities occur in prisons and reduces the potential harms to prisoners, staff, and the community.

The second key issue is that **effective HIV and AIDS programmes in prisons need to be available to staff as well as to prisoners**. Implementing programmes only for prisoners, or only for staff, would not be enough to address the issues raised by HIV/AIDS in prisons. **Both prisoners and staff have a right to health**, and the prison system has an obligation to do what it can to protect it. Without a workplace programme for officers, staff who are responsible for administering a programme for prisoners may be unwilling to do so. They may not understand why prisoners need access to certain HIV prevention measures, or may be prejudiced against prisoners or fellow staff living with HIV or AIDS. If they are not provided with information, education, and protective equipment, they may feel that more is done to protect the health of prisoners than to protect their own health.

Third, **certain groups of prisoners have particular needs** that must be addressed in prison HIV/AIDS programmes. These include those with particular vulnerability to exploitation, such as women, juveniles and children, and those with high-risk behaviour, including people who use illegal drugs, sex workers, the mentally ill, and men who have sex with men.

Finally, measures to prevent the spread of HIV and to provide care and treatment to prisoners living with HIV or AIDS must be **incorporated into a broader framework for the prevention of disease and promotion of health in prison**.

How is HIV transmitted in prisons?

Sharing of injecting equipment

In many countries, a large number of prisoners come to prison with established drug habits. In fact, many prisoners are in prison in the first place because of offences related to drugs.

People who used drugs prior to imprisonment often find a way to continue using on the inside, although prevalence and frequency rates for most – but not all – prisoners decline with imprisonment. Some people discontinue using drugs while in prison, while other prisoners start using drugs, often as a means to release tensions and to cope with being in an overcrowded and often violent environment.

Injecting drug use is also prevalent in many prisons and is of particular concern with regard to transmission of HIV (and other blood borne diseases such as hepatitis B and C). This is because those who inject drugs in prisons often share needles and syringes (and other equipment needed for injecting), which is a very efficient way of transmitting HIV.

Because it is more difficult to smuggle needles and syringes into prisons than it is to smuggle drugs into them, needles and syringes are very scarce. Often, only a handful of needles and syringes will circulate among a large population of prisoners who inject drugs. As a result, sharing of injecting equipment is frequent, and 15 to 20 people may inject using the same equipment. A needle and syringe may be owned by one prisoner and rented to others for a fee, or it may be used exclusively by one prisoner, reused again and again over a period of months. Sometimes, the equipment is home-made, and needle substitutes are fashioned out of hardened plastic and ball-point pens, often causing damage to veins, scarring, and severe infections.

A large number of studies from countries around the world report high levels of injecting drug use, including among female prisoners. Studies also show that

- the extent and pattern of injecting and needle sharing vary significantly among prisons;
- many people who inject before imprisonment reduce or stop injecting when they enter prison, but many resume injecting upon release;
- some people start injecting in prison; and
- those who inject in prison will usually inject less frequently than outside, but are much more likely to share injecting equipment than are drug injectors in the community. Furthermore, they are sharing injecting equipment with a population – fellow prisoners – that often has a high rate of HIV and HCV infections.

Box 16: Drug use in a prison in Thailand

A study conducted among prisoners in Bangkok's Klong Prem Central Prison found that 25 per cent of the surveyed prisoners were HIV-positive. Half of the prisoners surveyed were regular injecting drug users, and 70 per cent of them had injected drugs while jailed. Almost all the users (95 per cent) had shared injecting equipment at some point.

Taking drugs inside prison is obviously unlawful and in many countries strenuous efforts are made to keep prisons drug-free. These include preventive measures such as regular searching of prisoners, staff and visitors, the use of specially trained dogs and other security checks. They also include strict punishments for those who take drugs in prison and those who smuggle them in (for more details about these measures, see below the section on drug supply reduction efforts).

Despite these measures, **no prison system – even systems with large financial resources – has been able to prevent drugs from entering and being consumed in prison.**

Transmission through sexual activity

Unprotected sex in prisons poses a risk of transmission of HIV. Sex in prison may be consensual or it may be forced or coercive. Sex may also be used as a form of currency within the prison and exchanged for money, protection, property, or drugs. Violent forms of unprotected anal or vaginal intercourse, including rape, carry the highest risk for transmission of HIV, particularly for the receptive partner who is more likely to suffer damage or tears in the membranes of the anus or vagina.

The extent of consensual and non-consensual sexual activity in prisons is difficult to determine because studies must rely on self-reporting, which is distorted by embarrassment or fear of reprisal or additional punishment. Sex is prohibited in most prison systems, leading prisoners to deny their involvement in sexual activity, and in some countries, sex between men is in itself a crime, punishable by imprisonment. Sex in prison often takes place in situations of violence or intimidation, thus both perpetrators and victims are disinclined to discuss its occurrence. Nevertheless, studies in countries throughout the world have shown that sex does occur, including both non-consensual and consensual sex between prison staff and prisoners.

Box 17: Prevalence of sexual activity in prisons

Studies from many countries in different regions of the world provide evidence that sexual activity is prevalent in prisons. The following are some examples:

- In **Nigeria**, in a study of prisoners using an anonymous risk-factors identification questionnaire, 5.2% of respondents admitted having had sex in prison.
- In a study in **Zambia**, 4% of prisoners agreed in one to one interviews that they had sexual relations with other prisoners.
- In **Brazil**, in a study of 1,059 prisoners in 2 prisons, 66% of prisoners reported sex with female visitors, and 10% reported homosexual practices with other prisoners.
- In **Russia**, a study of 1,044 prisoners found that 9.7% of prisoners had ever had sex in prison.
- In **Thailand**, in a cohort of 689 male prisoners in a Bangkok central prison, more than 25% of prisoners reported ever having had sex with men, of which more than 80% continued having sex, or started having sex, with men in prison during the study period.
- In a survey carried out in six European prisons (**France, Germany, Italy, The Netherlands, Scotland and Sweden**), 1 % of 871 prisoners reported that they had ever had homosexual intercourse in prison.
- In **Canada**, 6% of federal prisoners surveyed in the mid-1990s reported sex with another prisoner.
- In **Australia**, a prisoner survey involving 530 randomly selected male New South Wales prisoners found 5% had engaged in consensual sex while in prison, with 2% reporting non-consensual sex.

A number of factors are believed to affect prevalence and type of sexual activity in prison, including

- whether the accommodation is single-cell or dormitory
- the duration of the sentence
- the extent to which conjugal visits are permitted
- the size of the prison and system (sexual activities tend to be more frequent in large systems that provide anonymity than in those where prisoners know each other's neighbourhoods and families)
- whether prison policy or practice allows children and young people to be housed with adults, thus increasing the risk of sexual abuse
- staffing levels and levels of supervision.

Tattooing

Tattooing amongst prisoners is a common practice in many countries. It can be a sign of allegiance to a particular gang or group.

Because tattooing involves breaking the skin with a needle, it is an activity that poses a risk of transmission of blood-borne diseases through the sharing and reuse of tattooing equipment such as needles and inks – both of which come into contact with large amounts of blood during the tattooing process. While tattooing is not generally recognized as a risk factor for HIV, the possibility of HIV transmission remains, and a number of cases in which HIV was apparently transmitted by tattooing in prison have been reported. The greater risk, however, is that of transmission of hepatitis C.

Tattooing and the possession of tattooing equipment are prohibited by prison authorities in many countries, and those found to be engaging in tattooing are subject to punitive sanctions. As a result, tattooing in prisons is an activity that takes place secretly, often in unhygienic environments, using homemade equipment and inks, and as quickly as possible so as to minimize the risk of detection by prison staff. All of these factors increase the risk of negative health consequences via tattooing in prisons.

Other risk behaviours

Several other behaviours represent risk factors for transmission of blood-borne infections in prisons. **Body piercing** and **ear piercing** are prevalent in some prisons. Studies have found that both are major risk factors for viral hepatitis. Sharing of **shavers** is commonly reported in developing countries and countries in transition. Sharing of toothbrushes also occurs and puts prisoners at risk of contracting blood-borne infections.

Box 18: Prevalence of other risk activities in prisons

Studies from countries in different regions of the world provide evidence that other risk activities are prevalent in prisons. The following are some examples:

- One **Australian** study indicated that about 10% of females and 5% of males engage in self harm in prison where blood is drawn.
- A study of **Canadian** female federal prisoners showed that 9% were engaging in slashing or other forms of self-injury.
- A study in **Armenia** showed that 5.2% of prisoners had taken part in blood sharing (brotherhood) rituals in prison.

What do we know about HIV transmission in prison?

The high rates of risk behaviour, particularly injecting drug use and sexual activity, if coupled with lack of access to prevention measures, can result in **frighteningly quick spread of HIV**. There were early indications that extensive HIV transmission could occur in prisons. In Thailand, the first epidemic outbreak of HIV in the country likely began among injecting drug users in the Bangkok prison system in 1988.

Box 19: The Thai example: How prisons can contribute to the spread of HIV

The first epidemic outbreak of HIV in Thailand likely began among injecting drug users (IDUs) in the Bangkok prison system in 1988. HIV infection among IDUs rose from two percent to 43 percent between 1987 and 1988. The increase closely followed, and is believed to be due to, the release of hundreds of prisoners (including many IDUs) in an amnesty on the King's birthday.

The first risk assessment among a large cohort of Bangkok IDUs found only two risk factors to be independently associated with HIV infection: having shared needles with two or more individuals in the previous 6 months and having been in prison. Bangkok IDUs with a history of prison were about twice as likely to be HIV-infected as those who had never been jailed. In terms of absolute risks, 70% of all IDUs in this study had been incarcerated at least once, and 80% of all those with HIV infection had ever been jailed.

Later studies have confirmed that Bangkok IDUs continue to be at high risk for HIV infection related to needle sharing and incarceration.

In addition, **HIV outbreaks in prison have been documented in a number of countries**, including in Scotland, Australia, Russia, and Lithuania.

Box 20: The example of Lithuania: What can happen if there is an outbreak of HIV in prison

In Lithuania, sharing of needles and syringes in one of the country's 14 penal establishments – Alytus correctional facility – resulted in a rapid HIV outbreak. Between 17 May and 20 June 2002, the Correctional Affairs Department and the Lithuanian AIDS Centre carried out a survey at the prison and identified 207 cases of HIV-positive prisoners. The survey was repeated in July 2002 and a further 77 prisoners were identified as HIV-positive. 44 of these 77 prisoners had been found to be HIV-negative during the previous survey in May 2002. In total, during the period between May and August, 299 new HIV-positive cases were identified. The cause of this HIV outbreak was established to be a result of injecting drug use in the prison.

The high degree of mobility between prison and community means that **communicable diseases transmitted in prison do not remain there**. When people living with HIV are released from incarceration, prison health issues necessarily become community health issues.

What other factors contribute to making prisons high-risk environments for HIV, and how can they be addressed?

In addition to these high-risk activities, there are a number of factors that make people in prison particularly vulnerable to HIV infection. These factors include:

- violence
- overcrowding
- gangs
- corruption
- poor medical practice involving the use or re-use of non sterile medical or dental equipment.

Violence

Prisons are often places of violence. Exposure to human blood and body fluids through **fight**s, **assaults**, and **accidents** has the potential for transmitting infections. Both prisoners and staff may be exposed to human blood or other body fluids as a result of assaults and fights, accidental needle stick injuries from hidden syringes, or when providing first aid. While the risk of HIV transmission during violence is small, there are case reports of prisoners contracting hepatitis C virus from physical assaults, with two possible cases occurring in New South Wales in Australia. There has also been one report of a prison officer acquiring hepatitis C from a blood splash resulting from two prisoners fighting.

Prisons should therefore look to find ways of reducing levels of interpersonal violence. Ways to reduce violence may include introducing or improving prisoners' access to purposeful activity such as education, work or vocational training and

proper classification of prisoners to avoid placing together those with potential conflicts as well as housing prisoners vulnerable to abuse and violence separately. Access to sport and recreational activities can also contribute to a reduction in tensions amongst prisoners.

Overcrowding

Overcrowding or congestion is an endemic problem in many prison systems. In Africa, there is an average of 150 prisoners for every 100 berths and in some countries the problem is greater still with insufficient space in dormitories for all the prisoners to sleep.

Overcrowding can impede efforts to deal with HIV/AIDS in that it exacerbates the health problems of those who are already ill, and also leads to increased high risk behaviours. Conditions of overcrowding in prisons are linked to the spread of TB. Because it is an airborne communicable disease, TB is easily spread wherever conditions combine a large number of people and low sanitary standards. Prison overcrowding has a direct bearing on many aspects of a prisoner's life in that it inevitably leads to a deterioration of hygiene, care, and supervision. In addition to the basic health and sanitation risks, the incidence of rape within a prison varies with the intensity of overcrowding.

Box 21: A few examples: How overcrowding in South African prisons impacts on HIV/AIDS in prisons

In South African prisons, overcrowding can lead to high risk behaviour in that the increasing scarcity of simple items such as blankets and shoes are then used as commodities which can be exchanged for sexual acts. One former prisoner explained that in the particularly crowded cells there are fewer beds than there are people. It is not surprising that sharing a bed with another prisoner can lead to homosexual activity, sometimes in exchange for the privilege of having a bed to sleep in. The only other option for some prisoners is to sleep in the shower or toilet as sometimes even floor space is not available.

Even if enough beds are available, the practical reality of fitting 50 beds in a space intended for 18 means that beds are not only triple or even quadruple bunked, but placed right next to each other so that they are touching other beds on almost all sides. In a typical South African prison cell, the prisoners fortunate enough to have beds are literally sleeping side by side and toe to toe. It is not hard to imagine the implications of this lack of defined or sufficient personal space on the incidence of high risk sexual behaviour.

KC Goyer (2003). HIV/AIDS in Prison. Problems, Policies and Potential. Pretoria: Institute for Security Studies (Monograph No 79). Available at <http://www.iss.co.za/Pubs/Monographs/No79/Content.html>

The overuse of incarceration of people who use drugs is of particular concern. In many countries, a significant percentage of the prison population is comprised of individuals who are convicted of offences directly related to their own drug use (i.e. those incarcerated for the possession of small amounts of drugs for personal use, those convicted of petty crimes specifically to support drug habits). The incarceration of significant numbers of people who use drugs increases the likelihood of drug use inside prisons, leading to increasing unsafe injecting practices and the risk of HIV transmission.

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Action to reduce prison populations and prison overcrowding should therefore accompany – and be seen as an integral component of – a comprehensive strategy to prevent HIV transmission in prisons, to improve prison health care, and to improve prison conditions.

The best long-term solution to overcrowding is to reduce the number of prisoners by making changes to criminal procedure and sentencing policies and establishing government targets for reducing prison overcrowding. In the short-term, overcrowding can be reduced by amnesties, reviewing the legality of detention status so that those held unlawfully can be released and removing groups inappropriately held, such as prisoners with mental disorders.

However, **prison managers can also play a role** and mitigate the effects of overcrowding by making better use of the overall space available, reviewing security levels, classifying prisoners by security risk so that lower risk prisoners can be accommodated in less secure accommodation, and introducing activities that generate income and produce food.

Gangs

Gangs present a particular problem in certain prisons. This is relevant to HIV/AIDS because gang activity can involve rape and sexual assault. Gangs can also engage in unprotected sex to initiate members.

Gangs that operate on the streets can continue their activities in prison when their members are imprisoned. Joining one of the gangs then becomes essential for a prisoner to survive and be protected from violence, and battles between gangs become a regular feature of prison life. Gangs can also play a part in the distribution of drugs within prisons.

Box 22: How gang activity impacts on HIV/AIDS in prisons

The power of the 26s and 28s gangs inside South African prisons pervades nearly every issue related to HIV/AIDS in prison. Many high risk behaviours are directly related to gang activity. Membership in both gangs frequently includes tattooing, and it is not uncommon for more than one inmate to be tattooed at a time using the same needle. Violence between prisoners which leads to bleeding is also a product of gang activity. Prisoners may be required to attack another prisoner and draw blood in order to be initiated into a gang. For members of the 26s, the practice of stabbing another person, usually a non-gang member, is referred to as phakama and allows the gang member to move up in rank depending on the severity of the attack and the situation of the person who is attacked.

While the 26s engage in stabbings, the primary activity of the 28s is sex and prostitution.

KC Goyer (2003). HIV/AIDS in Prison. Problems, Policies and Potential. Pretoria: Institute for Security Studies (Monograph No 79). Available at <http://www.iss.co.za/Pubs/Monographs/No79/Content.html>

Dealing with gang membership in prisons usually involves measures such as:

- housing gang leaders in different prisons
- using segregation for gang members and only allowing a return to the normal prison if gang membership is renounced

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- educational measures to break down the gang culture
- engaging gang leaders in the fight against HIV/AIDS and using them as peer educators
- involving civil society groups in work with gangs in prison and the community.

Corruption

Aspects of corruption particularly relevant to HIV/AIDS include staff's active involvement or complicity in the smuggling of drugs; requesting bribes to allow prisoners to see a doctor; or engaging in sexual activity with prisoners. Dealing with corruption is part of a wider process of bringing the rule of law into prisons.

Action is required on many fronts simultaneously. It includes the following measures:

- improving the pay and working conditions of staff – corruption thrives when staff pay is so low that staff expect to receive extra money from prisoners in order to survive
- developing a code of conduct for staff
- protecting those who reveal corrupt practices – setting up a corruption hotline can be effective.

Practical measures include:

- Minimising the opportunities individuals have to become involved in corrupt practices, for example by moving staff regularly to a different part of the prison so that it is more difficult to build up corrupt relationships with other staff and with prisoners. However, this system has the disadvantage that positive work and good relationships with prisoners can be disrupted.
- Searching staff when arriving and leaving work, when carried out sensitively, can be effective and help them to resist pressure from other staff and prisoners to bring in or take out illicit items.
- Introducing a cashless system in the finance department of prisons can reduce the possibilities for money to disappear.

Box 23: An example: A code of conduct for prison staff

Relationships with prisoners

Staff must exercise particular care to ensure that their dealings with prisoners, former prisoners and their friends and relations are not open to abuse, misrepresentation or exploitation on either side. Staff relationships with prisoners must be professional. In particular staff must not:

- Provoke, use unnecessary or unlawful force or assault a prisoner.
- Use offensive language to a prisoner.
- Have any sexual involvement with a prisoner.
- Give prisoners or ex-prisoners personal or other information about staff, prisoners or their friends and relatives which is held in confidence.
- Have any contact in or outside work with prisoners or ex-prisoners that is not authorised.
- Accept any approaches by prisoners for unauthorised information or favours and must report any such incidents.

Corruption

Corrupt behaviour is not acceptable. Staff must not solicit or accept any advantage, reward or preferential treatment for themselves or others by abusing or misusing their power and authority.

Excerpt from: HM Prison Service Order. Professional Standards: Preventing and Handling Staff Wrongdoing. Order number 1215 (17 February 2003). Appendix 1: Professional Standards Statement.

Medical Practices

In some countries, the use of improperly sterilised, or re-use of disposable medical and dental equipment can also be a source of transmission of HIV and other blood-borne diseases. Such practices may result from several factors such as under-funding of the prison health service, problems of supply of materials, poor training and low staff motivation. Therefore, **improving prison health services and increasing funding, training and staff motivation are important** elements of overall efforts to prevent the spread of infections in prisons.

What HIV prevention measures should be adopted in prisons?

In view of the high risk of HIV (and HCV and TB) transmission and the experience in some countries of major outbreaks of HIV in prisons, governments worldwide are recognising the need to adopt a **comprehensive approach** to prevent the spread of HIV in prisons. Although prison administrators disapprove strongly of drug use and sexual activities in their prisons, they have increasingly accepted that eradicating these activities is impossible and that a **realistic** approach is needed. This comprises the following elements:

- information, education, and communication programmes for prisoners and for staff
- providing access to voluntary HIV counselling and testing
- providing condoms and undertaking measures to prevent rape, sexual violence and coercion

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- providing substitution therapy and other forms of drug dependence treatment
- undertaking other measures to reduce the demand for drugs
- undertaking measures to reduce the supply of drugs.
- providing sterile needles and syringes or bleach or other disinfectants

Particular attention needs to be given to women and juveniles, and programmes may have to be tailored to respond to their needs.

In addition, a number of measures should be taken to reduce the risk of other infections such as sexually transmitted infections, hepatitis, and tuberculosis.

Finally, measures to reduce the risk of infection to staff also need to be taken.

Information, education, and communication programmes for prisoners and for staff

Information, education and communication programmes about HIV and how to prevent its transmission are the least controversial and most widely used ingredients of an effective HIV/AIDS prison policy.

Prisons are important settings for HIV/AIDS education efforts because of

- high prevalence among prisoners of HIV-infected persons and persons with risk factors for HIV infection;
- high potential for HIV transmission in prisons, particularly through sexual activity and sharing of drug-injecting equipment;
- eventual release of almost all adult prisoners and confined juveniles to the community;
- high rates of re-incarceration and re-confinement; and
- the feasibility of providing HIV/AIDS education programmes in prisons.

At the same time, HIV/AIDS education efforts in the prison environment present specific challenges. In particular, many prisoners are suspicious of anything 'official' or government related, which means that programmes created by the prison administration or prison staff without prisoner input can be ineffective.

Box 24: The Boma AIDS Education Collective in Suriname

An education and support programme involving activities for prisoners, staff, and non-prison personnel and organizations was developed by the Suriname National AIDS Program. Male prisoners and prison warders were selected for training as peer educators. Male prisoners formalized their status by forming the Boma AIDS Education Collective (BAEC). Female prisoners were not included in the training because most of them served short sentences and were instead involved in educational sessions which focused on sexual and mother-to-child transmission of sexually transmitted infections. BAEC produced HIV/AIDS education leaflets in three languages for new and discharged prisoners for all prisoners in Suriname. The leaflets were then pre-tested and modified based on comments from 17 prisoners. The Programme was officially introduced in April 1992 when BAEC organized an AIDS/STD week. The week's activities included HIV/AIDS educational sessions, video shows, discussions, and HIV testing. A manual was produced for peer educators, and AIDS/STD education has since been included in the prison warder training curriculum. A number of collaborative activities with non-prison organizations were organized to demonstrate that prisoners are part of a wider community concerned about HIV/AIDS.

Box 25: Radio Broadcasting in Russian prisons

A partnership project in the Urals between the BBC World Service Trust, London; the Foundation for Independent Radio, Moscow; Eurasia Media Centre, Yekaterinburg, and Helping Hand, Chelyabinsk is establishing fixed line radio networks in six selected penal colonies in the Sverdlovskaya and Chelyabinskaya oblasts. Specialists in educational programming will then produce a total of 45 radio packages aimed at raising awareness of health issues (particularly HIV/AIDS and tuberculosis) as well as legal questions and the rehabilitation process. These programmes will be broadcast in the six target colonies and further disseminated to other prisons across the region.

Information and education programmes should

- ideally be part of a broader health education and health promotion programme;
- provide the facts about HIV/AIDS and about how HIV is (and how it is not) transmitted, as well as information on other diseases that are common in prisons, in particular sexually transmitted diseases, hepatitis B and C and tuberculosis;
- contain accurate, non-judgemental, accessible and relevant information;
- raise awareness among prisoners and staff of the health issues related to risk activities such as drug injecting, tattooing, and body piercing;
- educate prisoners about how they can protect themselves from infections, including education about correct use of condoms and lubricants, how to inject safely, how to clean needles and syringes, and how to clean skin piercing equipment;
- educate staff members about the use of so-called “universal precautions” to prevent that they become HIV infected;
- counter stigma and discrimination against people living with HIV or AIDS and those vulnerable to it in prison, particularly people who use drugs and men who have sex with men;

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- explain how HIV and other diseases manifest themselves, and what treatments are available.

The education can include a variety of pedagogical approaches and use brochures or videos. Paper documents can be handed out to new prisoners, and these documents should be available in the prison for consultation at any time. These documents should be written in several languages, according to the local context. Despite this, they may be difficult to understand for prisoners from foreign countries or those who cannot read. Therefore, these documents should have as many pictures as possible to make them easy to understand.

Prisoners often react well to videos and to oral presentations. Experience shows that education sessions are much more effective if they are interactive. Peer education – education designed and delivered by prisoners for prisoners – is particularly effective.

Box 26: Peer education works! An example from Siberia

An evaluation of the effectiveness of an HIV peer training programme conducted in a prison colony for drug dependent male prisoners in **Siberia** found that the programme resulted in improved HIV knowledge. In particular, a significantly higher proportion of prisoners reported better knowledge of both how HIV can and cannot be transmitted. The evaluation concluded that the “provision of educational materials and training peer educators can be an inexpensive way to reach a population that is difficult to access outside prison”.

Peer educators play a vital role in educating other prisoners, since most of the behaviours that put prisoners at risk of HIV in prisons involve illegal or forbidden and stigmatized practices. Therefore, peers may be the only persons able to speak candidly to other prisoners about ways to reduce the risk of contracting infections. As well, peer educators' input is not likely to be viewed with the same suspicion as the information provided by the prison hierarchy. Peer educators are more likely to be able to realistically discuss the alternatives to risk behaviour that are available to prisoners, and are better able to judge which educational strategies will work within their prison and the informal power structure among prisoners.

Alongside peer approaches, experience suggests that non-governmental organisations and other professionals from outside the prison system can best provide education. Experiences with HIV/AIDS prevention initiatives show that prisoners can develop more trust with staff from non-governmental organisations and other professionals from outside the prison than with staff who are part of the prison hierarchy.

Finally, information and education activities must be tailored to the needs of particular prison contexts, particularly women's prisons or prisons for young offenders.

Box 27: The importance of involving youth in the design of education activities

A study among incarcerated male adolescents in **Brazil** found that initial efforts to develop an HIV/AIDS prevention intervention for them generated limited participation. However, when the educators worked with the adolescents to develop interventions based on their interests and needs, using modalities such as music, hip-hop arts, graffiti, and helping them to create an HIV/AIDS prevention compact disk, they responded with enthusiasm. The study concluded that interventions for incarcerated youth are better received when developed in collaboration with them and based on their beliefs, aspirations, and culture. The intervention that resulted went beyond HIV/AIDS to include issues such as violence, drugs, sexuality and human rights.

To be effective, information and education campaigns need to be embedded in a communication strategy with clear and measurable objectives and an evaluation component. It is not good enough to put some posters on a wall and distribute from time to time some leaflets. Information and education must be made available upon entry in and exit from the prisons, and periodically refreshed. Programmes should be monitored and evaluated to find out whether prisoners and staff understand the information and whether the interventions reduce risk behaviour.

➤ **For more details (and full references) on information and education programmes and the other HIV prevention measures discussed in this module, see:**

➤ WHO, UNODC, UNAIDS (2007). *Comprehensive Review of the Effectiveness of Interventions to Address HIV in Prisons. Evidence for Action Technical Papers*. Available via <http://www.who.int/hiv/pub/en/>.

Checklist 3: Information and education programmes

The following factors influence the effectiveness of informational and educational interventions in prisons. Check here whether the programme in your prison conforms to best practice:

- Is the programme comprehensive? (For example, does it include safer drug use and safer sex information and demonstrations about how a condom is properly used, or how drug paraphernalia can be safely cleaned? Does it include advice for people who use drugs on how to avoid overdose after release?)
- Is it linguistically and culturally appropriate?
- Does it respond to the needs of various populations (if present in your prison), in particular female prisoners and youth, but also cultural minorities?
- Is it appropriate to the average prisoners' reading and comprehension level?
- Has it been designed with the input of prisoners?
- Has the staff component been developed with the input of staff?
- Is peer education promoted and encouraged? (Have selection criteria for training peer educators been established? Have peer educators been trained and provided with specific tasks/responsibilities to be performed as peer educators? Are there opportunities for peer educators to continuously upgrade their knowledge on HIV/AIDS and relevant issues? Has a peer education sustainability plan been developed?)
- Are all prisoners (including detainees awaiting trial) provided with an information package on HIV and AIDS and other relevant issues upon admission? Are ongoing refresher courses and seminars offered to sustain and reinforce the HIV/AIDS-related health message?
- Are interactive educational sessions offered, in addition to distribution of pamphlets or the showing of a video?
- Are activities organised to raise awareness on calendar days relevant to HIV/AIDS, such as World AIDS Day (December 1)?
- Are modern educational methods used (such as interactive sessions)?
- Is the education programme part of a more comprehensive prevention programme that includes drug dependence treatment, the provision of condoms and bleach, a needle and syringe programme, and other measures?
- For female prisoners, does the education programme contain information on mother-to-child transmission, and is it linked to access to comprehensive reproductive health services for HIV positive female prisoners?

HIV counselling and testing

Counselling and testing are important for two reasons:

- as part of an HIV prevention programme (it gives those who may be engaging in risky behaviours information and support for behaviour change); and
- as a way to diagnose those living with HIV and offer them appropriate care, treatment and support.

Prisoners should have **easy access** to HIV testing throughout their imprisonment. It is important that efforts to improve access to HIV testing and counselling in prisons be undertaken, as they reach a clientele at high risk of HIV infection that often has not used counselling and testing services on the outside.

Therefore, prisoners should have various options for HIV testing:

- HIV testing should be **routinely offered** to **all** prisoners at the time of their medical examination upon entry.
- In addition, because entry is a stressful time and many prisoners may not want to have an HIV test at that time, HIV testing **should be available to prisoners at any time during imprisonment**. During HIV/AIDS education sessions and by health care staff, prisoners should regularly be reminded that HIV testing is available to them, and should be encouraged to be tested.

Many of the benefits of HIV testing are dependent on, or enhanced by, pre-and post-test counselling. Prisoners who receive *positive* results should receive counselling and referral to care, support, and treatment. Post-test counselling can also deliver important health and risk-reduction information to the majority of prisoners who will access testing and have a negative test result.

HIV testing and counselling should be closely linked to access to care, treatment, and support for those testing positive. HIV testing (and counselling) is not a goal in and of itself, but a means to enable people to access care, treatment, and support if they test HIV-positive, and to take measures to reduce the risk of transmitting infection to others. Linkage of HIV testing with care and treatment according to standards prevalent in the outside community is essential to encouraging prisoners to participate in HIV testing programmes.

Attention must be paid to ensuring that **confidentiality of medical information** is protected and to **avoiding stigma** and the negative consequences of testing: prisoners will not agree to participate in testing if they face discrimination or abuse if they test positive.

In addition to access to HIV testing and counselling, prisoners need access to the means to protect themselves. As shown above, many prisoners, including prisoners who are aware of their HIV status, engage in activities that carry a risk of HIV transmission. Knowledge of HIV status alone is not sufficient to prevent HIV transmission when the means that would enable a person to take steps to reduce that risk, short of being able to stop the behaviour that creates the risk, are not accessible in prison.

Checklist 4: HIV counselling and testing programmes

The following factors influence the effectiveness of HIV counselling and testing interventions in prisons. Check here whether the programmes in your prisons conform to good practice:

- Is HIV testing routinely offered to all prisoners upon entry?
- In addition, is it easily accessible to prisoners at any time during imprisonment?
- Is it free of charge?
- Are prisoners regularly reminded, through educational activities and/or by health care staff, that they can access HIV testing, and are the potential benefits explained to them?
- Is HIV testing always voluntary? (Mandatory testing, without the prisoner's informed consent, is unnecessary and ethical).
- Does everyone being tested receive pre-and post-test counselling?
- Have health care professionals been trained to deliver HIV counselling and testing services?
- Does counselling for female prisoners include discussion of mother-to-child transmission?
- Is confidentiality of test results guaranteed?
- Are test results delivered confidentially by health care personnel?
- Are prisoners testing positive protected against discrimination? In particular, are they kept in the general population and are they able to participate in the same programmes as other prisoners? (Prisoners with HIV should not be prohibited from any work, recreational or social activities because of their HIV status).
- Is HIV testing and counselling closely linked to access to care, treatment, and support? Is everyone who tests positive immediately referred to treatment and support?
- Is HIV testing and counselling part of a comprehensive prevention programme that includes access to prevention measures, so that prisoners who test positive can take steps to prevent transmission of HIV to others?

Provision of condoms and prevention of rape, sexual violence and coercion

Recognising the fact that sexual activity occurs in prisons and given the risk of disease transmission that it carries, providing condoms (and water-based lubricants) has been widely recommended. **The World Health Organization**, in its 1993 *Guidelines on HIV infection and AIDS in prisons*, **recommends that condoms be made available to prisoners “throughout their period of detention”** and “prior to any form of leave or release”.

As early as 1991, a World Health Organisation study found that 23 of 52 prison systems surveyed provided condoms to prisoners. By August 2001, 18 of the 23 prison systems in the pre-expansion European Union were making condoms available. Today, many prison systems in other parts of the world, including in Canada, Australia, some prisons in the United States, parts of Eastern Europe and Central Asia, Brazil, South Africa, Iran and Indonesia, also make condoms available to prisoners.

In some prison settings, there have been obstacles to condom distribution, including opposition to male-to-male sex from prison officers and authorities, based on a combination of factors including cultural objections, workload, institutional prohibition

of sexual activity, and security concerns. Critics of condom distribution to prisoners have argued that the provision will lead to an increase in sexual activity among prisoners, or that condoms will be used to conceal drugs.

These obstacles can be overcome, however, and the **fears have proven unfounded**. The experience of the many countries in which condoms have been made available in prisons has shown that **provision of condoms is feasible in a wide range of prison settings – including in countries in which same-sex activity is criminalised** – and that prisoners use condoms to prevent infection during sexual activity when condoms are accessible in prison.

“Unfortunately, there still exists a strong current of denial in many places about male-to-male sex (especially in prison) and a corresponding refusal to do anything which might be seen as condoning it. These attitudes will have to change if societies want to see the rate of HIV infection - inside prison and outside of it – decrease.

Prisons and AIDS. UNAIDS Point of View, April 1997

Condoms need to be **easily and discreetly available**, ideally in areas such as toilets, shower areas, waiting rooms, workshops, or day rooms where prisoners can pick up a condom without being seen by others. Distribution can be done by health staff, by dispensing machines, by trained prisoners (peers) or in a combination of these ways. Each prison should determine how to best make condoms available, to ensure easy and discreet access. Prisoners should not have to ask for condoms, since few prisoners will do so because they do not want to disclose that they engage in same-sex sexual activity. Condoms should be provided free of charge, and can be made available to all prisoners in a “health kit” given to them at entry, and containing HIV/AIDS and other health information, but also other items such as a shaver, toothbrush, soap, etc. Water-based lubricant should also be provided since it reduces the probability of condom breakage and/or rectal tearing, both of which contribute to the risk of HIV transmission.

No prison system allowing condoms has reversed its policy, and none has reported security problems or any other relevant major negative consequences. In particular, it has been found that **condom access** is unobtrusive to the prison routine, **represents no threat to security or operations**, does not lead to an increase in sexual activity, and is accepted by most prisoners and correctional officers once it is introduced. Usually support for condom provision increases once a condom programme is started.

Box 28: Evaluations of condom programmes show positive results

A survey to measure the acceptability of the condom distribution programme at the **Washington, DC** Central Detention Facility found condom access to be unobtrusive to the jail routine, no threat to security or operations, no increase in sexual activity, and accepted by most prisoners and correctional officers. The survey concluded that the model would be easily replicable in other institutions.

The evaluation of the condom distribution program in **New South Wales prisons, Australia**, found that

- 84% of the prisoners supported the provision of condoms
- the reported level of harassment of prisoners using condom distribution machines was low
- most importantly, prisoners were using condoms when having anal sex.

From October 1997 to September 1998, 294,853 condoms were dispensed in New South Wales prisons. These figures are the equivalent of each prisoner obtaining one condom a week. Overall, there were no indicators of negative consequences as a result of the condom distribution programme.

However, in Kingston, Jamaica, in 1997 a strike and prison riot by correctional officers followed a governmental announcement to provide condoms to prisoners and officers, resulting in six deaths. Offence to the implication of homosexual activity reportedly fuelled the strike and riot. This shows that in some countries where legal sanctions against sodomy exist in the community outside prison, and where there are deeply held beliefs and prejudices against homosexuality, introduction of condoms into prisons as an HIV prevention measure may have to be particularly well prepared through education and information about the purpose of the introduction of condoms, as well as initiatives to counter the stigma that people engaging in same-sex activity face.

Prevention of rape, sexual violence, and coercion

While providing condoms (together with lubricants) in prisons is important, it is not enough to address the risk of sexual transmission of HIV.

There is evidence that violence, including sexual abuse, is common in prisons. In many prison systems prisoners live in overcrowded conditions, with little supervision and protection, and are vulnerable to sexual abuse.

Therefore, **HIV prevention depends also on measures taken to prevent rape, sexual violence and coercion in prison.** Some of these measures – such as penal reform needed to reduce prison populations, so that the often few and underpaid guards are able to protect the vulnerable prisoners from violence and sexual coercion – need to be taken by policy makers and legislators, but prison authorities are also responsible for prevention of rape, sexual violence, and coerced sex. For example, the World Health Organization *Guidelines on HIV infection and AIDS in prisons* and the *International Guidelines on HIV/AIDS and Human Rights* highlight that prison authorities are responsible for combating aggressive sexual behaviour such as rape, exploitation of vulnerable prisoners and all forms of prisoner victimization by providing adequate staffing, effective surveillance, disciplinary sanctions, and education, work and leisure programmes. Structural interventions such as better lighting, better shower and sleeping arrangements are also needed. In particular,

vulnerable prisoners need to be provided with protection and juvenile prisoners kept separate from adults.

Checklist 5: Condom distribution and prevention of non-consensual sex

The following factors influence the effectiveness of condom distribution programmes and the prevention of non-consensual sex. Check here whether the interventions in your prisons conform to good practice:

- Before a condom programme is introduced: Have educational and informational activities been prepared to explain why it is important to start condom distribution? (Introduction of the programmes should be carefully prepared, particularly in prisons that could face initial opposition to the provision of condoms.)
- Are condoms easily and discreetly accessible to prisoners so that they can pick them up at various locations in the prison, without having to ask for them and without being seen by others?
- Are supplies regularly checked and, if necessary, replenished?
- Are condoms provided to prisoners at entry to prison, in a “health kit” containing other health protection information and tools, such water-based lubricant, disinfectant, shaver, toothbrush, soap, a pamphlet on HIV/AIDS, other infectious diseases, and on drug use, etc?
- Are conjugal visits allowed, and are condoms provided for such visits?
- Are condoms provided to prisoners upon release from prison?
- Are they free of charge?
- Is water-based lubricant also available?
- Are measures undertaken to increase acceptance and use of condoms among prisoners, for example by encouraging peer-to-peer discussions?
- Does the HIV/AIDS education programme instruct prisoners about the correct use of condoms and lubricants?
- Do on-going staff training programmes contain sections on HIV/AIDS and, specifically, on why it is important to make condoms available in prison?
- Do female prisoners have access to condoms as well as dental dams? (Dental dams are small, thin, square pieces of latex that are used for oral-vaginal or oral-anal sex. They get their name from their use in dental procedures. Dental dams help to reduce the transmission of sexually transmitted infections during oral sex by acting as a barrier to vaginal and anal secretions that contain bacteria and viruses.)
- Are measures being implemented to combat aggressive sexual behaviour such as rape, exploitation of vulnerable prisoners, and all forms of prisoner victimization?
- Has a plan with clear goals, objectives, and timelines been established to further decrease such behaviour?
- In particular, are juvenile prisoners always kept separate from adult prisoners? Is protection provided to vulnerable prisoners?

Opioid substitution therapy and other forms of drug dependence treatment

As shown above, many prisoners in countries around the world use drugs while in prison, including by injecting. At least in part this is due to the fact that a substantial proportion of prisoners are drug dependent.

In order to reduce transmission of HIV through the use of contaminated injecting equipment, prisoners should be encouraged

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- not to use drugs at all;
- if they continue to use, not to inject; and
- if they inject, not to share injecting equipment.

Providing both drug dependence treatment and programmes to reduce the risk of infection in prison is therefore essential.

With regard to **drug dependence treatment**, there is a growing consensus that it **can be effective in prison if it responds to the needs of prisoners, is of sufficient length and quality, and if aftercare is provided upon release.**

There are many types of drug dependence treatment, but they basically fall into two categories:

- opioid substitution treatment
- abstinence-based programmes

Opioid substitution therapy

All forms of drug dependence treatment have some impacts on risks of HIV transmission, but opioid **substitution treatment (OST) programmes have the greatest potential to reduce injecting drug use and the resulting risk of spread of infection.**

OST programmes entail prescribing a drug with a similar action to the illegal drug used, but with a lower degree of risk. They are used as an HIV-prevention strategy that provides people dependent on drugs with an additional option for getting away from needle use and sharing.

Why substitution treatment?

The most commonly used form of OST is methadone maintenance treatment (MMT). Methadone has been used to treat heroin and other opiate dependence for decades and was added to the World Health Organization list of “essential drugs” in 2005. The more recently-developed buprenorphine is also quite commonly used in a number of countries. Both have been proven to greatly reduce the risk of HIV infection by reducing drug injection and improving the health and quality of life of opiate-dependent people.

Community OST programs have rapidly expanded since the mid-1990s. Today, more than half a million people receive OST worldwide. In a common position paper, UNAIDS, WHO, and UNODC stated that

Substitution maintenance therapy is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families and society at large by reducing heroin use, associated deaths, HIV risk behaviours and criminal activity. Substitution maintenance therapy is a critical component of community-based approaches in the management of opioid dependence and the prevention of HIV infection among injecting drug users.

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There are ample data supporting the effectiveness of OST programmes in reducing high-risk injecting behaviour and in reducing the risk of contracting HIV. There is also evidence that OST is the most effective treatment available for heroin-dependent injecting drug users in terms of reducing mortality, heroin consumption, and criminality. The concerns raised about OST have been shown to be unfounded. In particular, OST has not been shown to be an obstacle to the cessation of drug use, and in fact, OST has been found to be more effective than detoxification programmes in promoting retention in drug treatment programmes and abstinence from illegal drug use. Finally, there is evidence that people who are on OST and who are forced to withdraw from methadone because they are incarcerated often return to narcotic use, often within the prison system, and often via injection. It has therefore been widely recommended that prisoners who were on OST outside prison be allowed to continue it in prison.

As in the community, OST, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons. 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."

Where is it being offered?

Worldwide, an increasing number of prison systems are offering OST to prisoners, including prison systems in Canada and Australia, some systems in the United States, most of the systems in the 15 "old" European Union (EU) member states, and systems in other countries, including Iran and Indonesia. In Spain, 18% of all prisoners, or 82% of people with a drug problem in prison, receive this treatment.

OST programs also exist in prisons in some of the "new" EU member states (Hungary, Malta, Slovenia and Poland), although they often remain small and benefit only a small number of prisoners in need. Finally, an increasing number of systems in Eastern Europe and the former Soviet Union have started OST programs (such as Moldova) or are planning to do so soon (such as Kyrgyzstan), but OST remains unavailable in prisons in other countries in the region.

Evidence of benefits

Some prison systems are still reluctant to make OST available, or to extend availability to those prisoners who were not receiving it prior to incarceration. Some consider methadone or buprenorphine as just another mood-altering drug, the provision of which delays the move beyond a drug-centred existence. Some also object to OST on moral grounds, arguing that it merely replaces one drug of dependence with another. However, in recent years, **evaluations of prison OST programs have provided clear evidence of their benefits.**

Studies have shown that, if dosage is adequate (at least 60 mg of methadone) and treatment is provided for the duration of imprisonment, such programmes **reduce drug injecting and needle sharing** and the resulting spread of HIV

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and other blood borne infections. In addition, they have additional and worthwhile benefits, both for the health of prisoners participating in the programmes, and for prison systems and the community. For example:

- substitution therapy has a **positive effect on institutional behaviour** by reducing drug-seeking behaviour and thus **improving prison safety**;
- **re-incarceration is significantly less likely** among those prisoners who receive OST;
- OST in prison significantly **facilitates entry and retention in post-release treatment** compared to prisoners enrolled in detoxification programmes;
- although prison administrations often initially raise concerns about security, violent behaviour, and diversion of methadone, these problems do not emerge once the OST programme is implemented;
- **both prisoners and prison staff report about the positive impact OST has on life in prison**;
- OST offers a daily contact between health care services and patients, often leading to a relationship that can help address other health issues and create a link with other HIV/AIDS prevention strategies.

Box 29: Canada: Evaluation of OST demonstrates benefits in prison

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 behaviour. Participants in such a treatment programme were less likely to commit crimes and return to prison. This is important because the cost of the institutional OST programme may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving such treatment.

In addition, OST may help to **reduce risk of overdose** for those released from prison. Many prisoners resume injecting once released from prisons, but do so with increased risk for fatal overdose as a result of reduced tolerance to opiates. Extensive research has noted a large number of deaths during the first weeks after discharge from prison that are attributed to drug overdose. This points to the utility and necessity of prison through care of drug treatment to counteract such risk situations and highlights the importance of OST not only as an HIV prevention strategy in prisons, but as a strategy to reduce overdose deaths upon release.

Box 30: Positive results: Methadone maintenance treatment in prisons in Iran

In order to prevent high-risk behaviour, the first methadone project was initiated in 2003 in Ghezel-Hesar prison located in Tehran province. In the following 18 months it was implemented in 12 other provinces of Iran. 1,400 prisoners underwent methadone maintenance treatment in an early stage of methadone provision in prison and this number subsequently grew rapidly. Results of the treatment include a significant reduction in injecting drug use, which plays a crucial role in HIV prevention, and a more than 90% decrease in self-injury and fighting.

Another reason why ST is important

Antiretroviral therapy (ART) for HIV is becoming available in many resource-poor countries in which this treatment was, until recently, inaccessible. In many countries, particularly in Eastern Europe and Central Asia, the majority of people who need ART are people who inject drugs. Many of them will spend time in prison, and they need to be able to access both OST and ART without interruption, since OST has proven effective in facilitating delivery of and adherence to ART among people who inject drugs.

➤ For additional information on OST, see:

➤ WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: Drug Dependence Treatments. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_ea_drug_treatment_df.pdf

World Health Organization (2004). WHO/UNODC/UNAIDS position paper – substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. Available in English and Russian at http://www.who.int/substance_abuse/publications/treatment/en/. A joint position statement on maintenance therapy for opioid dependence.

World Health Organization (2005). Evidence for action technical papers. Effectiveness of drug dependence treatment in preventing HIV among injecting drug users. Available at <http://www.who.int/hiv/pub/idu/en/drugdependencefinaldraft.pdf>. Reviews the evidence on substitution treatment and concludes that “policy-makers need to be clear that the development of drug substitution treatment is a critical component of the HIV prevention strategy among injecting opioid users.”

Corrections Victoria (2003). Victorian Prison Opioid Substitution Therapy Program: clinical and operational policy and procedures. Available via www.legalonline.vic.gov.au/CA2569020010C266/All/5DED7F4C63FC14F8CA256E530082DE2C?OpenDocument&1=Legal+System~&2=Prisons~&3=Opioid+Substitution+Therapy+Program~. An excellent document with policy and procedures providing a framework for managing substitution treatments.

Comment [DG5]: From DG: It is available “via” this site? If you can, use a much shorter URL.

Correctional Service Canada (2003). Specific guidelines for methadone maintenance treatment. Ottawa: CSC.

Available at www.csc-scc.gc.ca/text/pblct/methadone/index_e.shtml

These guidelines provide a general background on prisoners and drug use, a section detailing the goals and objectives of methadone maintenance treatment (MMT), admission criteria and quality assurance for MMT, and the role of the methadone intervention team (MIT); a section about the specific responsibilities of each MIT member; a section on dosing issues; a section on urine drug screening; a section on drug dependence treatment interventions accompanying MMT; and a number of appendices.

Other forms of drug dependence treatment

In contrast to OST, which has become increasingly available in many prison systems at least in part because of its potential to reduce injecting drug use and the resulting risk of spread of infection, **other forms of drug dependence treatment have not usually been introduced in prison with HIV prevention as one of their objectives**. It is therefore not surprising that there is little data on the effectiveness of these forms of treatment **as an HIV prevention strategy**. There is an urgent need for examining their effectiveness in the context of HIV/AIDS. More generally, with some exceptions, independent and systematic outcome evaluations of these interventions are lacking.

Nevertheless, in addition to substitution treatment, providing abstinence-based treatment programmes, in which prisoners abstain totally from taking drugs, is also important. Such programmes reinforce the aim of prison by trying to enable the prisoners to lead a life without committing criminal offences after release.

There is a great variety of abstinence-based programmes, but all of them start with an assessment phase, and all of them have a phase of detoxification. Examples for abstinence-oriented programmes include cognitive behavioural therapy, relapse prevention therapy or a therapeutic community approach.

Good quality, appropriate, and accessible treatment can improve prison security, as well as the health and social functioning of prisoners, and it can reduce reoffending, **as long as it provides ongoing treatment and support, post-release care and meets the individual needs of prisoners**. To run such a programme, it is always necessary to employ specialists who can introduce and run it. Such treatment in prison can work and help reduce the amount of drug use in prisons and upon release. Given that many prisoners have severe problems with illegal drug use, it is important to utilize the opportunity that imprisonment provides for treatment and rehabilitation.

There is also a need to ensure that investments made in prison-based treatment are not lost because of the lack of effective aftercare. **Unless treatment is maintained in the community, offenders are likely to relapse**. In addition to drug dependence treatment needs, many ex-prisoners have housing and financial difficulties and even psychiatric problems. They may be released to either poor family support or indeed deeply dysfunctional families and friends. For this reason, **aftercare should not be limited to drug treatment**. Ideally, within a few months before release from prison, correctional staff need to help prisoners with a drug dependence problem plan for continued treatment, identify other needs, and locate appropriate community-based services to address those needs. Released prisoners might, for example, require drug-free housing, literacy training, HIV/AIDS education, job placement, long-term relapse management, and social services. Efforts to help resettle offenders are often made by civil society groups. It is important for prisons to engage in partnerships with these groups.

In some countries **probation officers** provide aftercare. In some cases, part of the sentence is served under supervision in the community. Alternatively offenders may be released early on **parole** or some other form of **conditional release**. In these cases, there is an opportunity to include conditions, which can help to keep an offender away from drug taking and other high risk behaviour.

Checklist 6: Opioid substitution therapy and other forms of drug dependence treatment

The following factors influence the effectiveness of substitution treatment and other forms of drug dependence treatment in prisons. Check here whether the programmes in your prisons conform to good practice:

- Are OST guidelines in prison consistent with the OST guidelines applicable in the community?
- Are people on OST in the community prior to imprisonment able to continue such treatment without interruption upon arrest and incarceration?
- In countries in which OST is available to opiate-dependent individuals in the community, is it also available to prisoners who want to start it in prison, under the same conditions as outside?
- Does the OST programme contain a comprehensive discharge planning system for prisoners nearing release, including a system for referral to OST in the general community?
- Have staff members and prisoners been provided with factual information about OST?
- Are other, abstinence-based forms of drug dependence treatment also available to prisoners who request them?
- Are these forms of treatment evidence-based?
- Do they contain a discharge planning and aftercare component to ensure that prisoners will receive help with their dependence and reintegration upon release?

Other measures to reduce the demand for drugs

In addition to drug dependence treatment, other strategies to reducing the demand for drugs can also assist efforts to prevent HIV transmission in prisons. However, it is important to note from the outset that such efforts are unlikely to eliminate drug use in prisons. In fact, even prison systems that have devoted large financial resources to such efforts have not been able to eliminate drug use. Therefore, such efforts cannot replace the other measures described above, but rather should be undertaken to complement them.

Provision of information on drugs and drug use

On its own, the provision of information on drugs and drug use has not been found to change drug use behaviour. However, substantial and correct information is necessary to make healthy choices and all drug dependence programmes should include an education component.

Work, study, and other activities

Research shows that one of the reasons why some prisoners take drugs when they are in prison is to combat boredom and alienation, and promote relaxation. This suggests a need for more purposeful activities in prisons. Providing prisoners with opportunities to work and/or study while in prison, or activities such as sports, theatre and spiritual and cultural enhancement aimed at providing people with challenging and healthy ways to employ their time, can have a positive effect on risky behaviours, particularly when complemented by appropriate drug use prevention education (which might include both information and life skills provision).

Life-skills education

Providing life skills education is also important. Life skills are the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. These include: self-awareness, empathy, communication skills, interpersonal skills, decision-making skills, problem-solving skills, creative thinking, critical thinking, and coping with emotions and stress. Such personal and social competencies, together with appropriate information about drugs and drug use, help people make healthier choices.

Establishing so-called “drug-free units”

Another strategy to reduce the demand for drugs used by an increasing number of prison systems, mainly in resource-rich countries, is to establish so-called “drug-free” units. Typically, “drug-free” units or wings are separate living units within a prison that focus on limiting the availability of drugs and are populated with prisoners who have voluntarily signed a contract promising to remain drug free. In some instances, they focus solely on drug interdiction through increased searching, while some systems provide a multi-faceted approach combining drug interdiction measures with treatment services. “Drug-free” units could assist efforts to combat the spread of HIV in prison if they resulted in decreased drug use, particularly injecting drug use. There is some evidence from a small number of studies that so-called “drug-free” units do indeed significantly reduce levels of drug use among residents in these units. Such units appeal to a large number of prisoners, including prisoners who do not have any drug problems and want to live in a “drug-free” environment. However, the studies do not say anything about whether “drug-free” units appeal to, and are successful in retaining, the most problematic users, in particular prisoners who inject drugs. Currently, there is therefore no data on the effectiveness of drug-free units as an HIV prevention strategy.

Checklist 7: Other measures to reduce the demand for drugs

The following factors influence the effectiveness of measures to reduce the demand for drugs in prisons. Check here whether the programmes in your prisons conform to good practice:

- Are prisoners provided with opportunities to work and/or study?
- Are other activities such as sports, theatre and spiritual and cultural enhancement provided?
- Is substantial and correct information provided to prisoners about drugs and drug use?
- Is life skills education provided to prisoners?
- Do prisoners have the option of living in “drug-free” living units?
- Is additional support available to prisoners living in such units, during imprisonment and upon release?

Measures to reduce the supply of drugs

A broad range of search and seizure techniques and procedures can be used in an attempt to reduce the availability of drugs in prisons. These supply reduction measures include: random searches by security personnel; staff and visitor entry/exit screening and searches; drug detection dogs; closed-circuit monitoring; perimeter security measures (netting over exercise yards, higher internal fences to prevent projectiles, rapid response vehicles patrolling the prison perimeter); purchasing of goods from approved suppliers only; intelligence analysts at every institution; drug detection technologies (such as ion scanners, x-ray machines, etc); modifications to the design and layout of visiting areas (use of fixed and low-level furniture); and drug testing (also called urinalysis).

Many prison systems, particularly in resource-rich countries, have placed considerable emphasis on these measures to reduce the supply of drugs. While such measures are not aimed at managing HIV/AIDS in prisons, they may result in unintended consequences for HIV (and HCV) prevention efforts. Drug interdiction measures may assist HIV prevention efforts by reducing the supply of drugs and injecting in prisons. At the same time, they could make such efforts more difficult.

For example, many resource-rich prison systems regularly or randomly test prisoners' urine for illegal drug use. Prisoners who are found to have consumed illegal drugs can face penalties. From a public health perspective, concerns have been raised that these programmes may increase, rather than decrease, prisoners' risk of HIV infection. There is evidence that implementing such programmes may contribute to reducing the demand for and use of cannabis in prisons. However, such programmes seem to have little effect on the use of opiates. In fact, there is evidence that a small number of people may switch to injectable drugs to avoid detection of cannabis use through drug testing. Cannabis is traceable in urine for much longer (up to one month) than drugs administered by injecting, such as heroin and other opiates. Some prisoners choose to inject drugs rather than risk the penalties associated with smoking cannabis simply to minimise the risk of detection and punishment. Given the scarcity of sterile needles and the frequency of needle sharing in prison, the switch to injecting drugs may have serious health consequences for prisoners.

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Generally, despite the fact that many prison systems make substantial investments in drug supply reduction measures, there is little solid and consistent empirical evidence available to confirm their efficacy in reducing levels of drug use. In particular, there is no evidence that these measures may lead to reduced HIV risk.

Prison systems facing resource constraints should therefore not implement costly measures such as drug detection technologies and drug testing that may use up a substantial amount of resources that could otherwise be used for managing HIV/AIDS in prisons. Instead, they should focus on the proven and cost-effective HIV prevention measures described above and on efforts to improve prison conditions and working conditions and pay for prison staff, without whom other drug supply reduction strategies are unlikely to be successful.

Checklist 8: Measures to reduce the supply of drugs

The following questions need to be considered by prisons in resource-poor settings when they undertake measures to reduce the supply of drugs:

- Are measures to reduce the supply of drugs preceded, or at least accompanied, by measures to improve prison conditions and working conditions and pay of staff, recognising that they are unlikely to be successful without those measures?
- Are measures such as random searches by security personnel and staff and visitor entry/exit screening and searches being undertaken?
- Would other measures to reduce the supply of drugs – in particular, drug detection technologies and urinalysis – be feasible in your prisons? What pre-conditions would need to be in place for such measures to be implemented? Would they take valuable resources away from proven and cost-effective HIV prevention measures or from efforts to improve prison conditions and staff pay?

Bleach and decontamination strategies

Provision of bleach or other disinfectants to prisoners is one option to reduce the risk of HIV transmission through sharing of injecting equipment, particularly where sterile injecting equipment is not available. Many prison systems have adopted programmes that provide disinfectants, as well as instruction on how to disinfect injecting equipment before re-using it, to prisoners who inject drugs. Evaluations of such programmes have shown that distribution of bleach is feasible in prisons and does not compromise security.

However, studies in the community have raised doubts about the effectiveness of bleach in decontamination of injecting equipment. Today, **disinfection as a means of HIV prevention is regarded only as a second-line strategy to needle and syringe programmes**. Cleaning guidelines recommend that injecting equipment be soaked in fresh full strength bleach (5% sodium hypochlorite) for a minimum of 30 seconds. More time is needed for decontamination if diluted concentrations of bleach are used. Furthermore, a review of the effectiveness of bleach in the prevention of hepatitis C infection concluded that, "although partial effectiveness cannot be excluded, the published data clearly indicates that bleach disinfection has limited

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benefit in preventing HCV [hepatitis C virus] transmission among injection drug users”.

In prisons, the effectiveness of bleach as a decontaminant may be reduced even further. There are at least three reasons for this:

- The type of injecting equipment available in prisons, often consisting of whatever can be fashioned into something that pierces the skin, may be more difficult to effectively disinfect with bleach than the syringes used outside prison (on which the studies were undertaken).
- Even when bleach is made available in some locations in prison, prisoners may have problems accessing it.
- Cleaning is a time consuming procedure and prisoners are unlikely to engage in any activity that increases the risk that prison staff will be alerted to their drug use.

Therefore, bleach programmes should be available in prisons, but only as a second-line strategy to needle and syringe programmes, until opposition to such programmes can be overcome, or in addition to them.

Where bleach programmes are implemented, **full-strength household bleach should be made easily and discreetly accessible to prisoners in various locations** in the prison, **together with** information and education about how to clean injecting equipment and **information about the limited efficacy of bleach** as a disinfectant for inactivating HIV and particularly HCV.

Checklist 9: Bleach and decontamination strategies

The following factors influence the effectiveness of bleach and decontamination strategies. Check here whether the programmes in your prisons conform to good practice:

- Is full-strength, household bleach made available? (Diluted bleach is even less effective than full-strength bleach.)
- Is bleach or another disinfectant made easily and discreetly accessible to prisoners so that they can pick it up at various locations in the prison, without having to ask for it and without being seen by others?
- Is bleach or another disinfectant provided to prisoners at entry to prison, in a “health kit” containing other health protection information and tools, such condoms, water-based lubricant, shavers, a toothbrush, soap, a pamphlet on HIV/AIDS, other infectious diseases, and on drug use, etc?
- Is it free of charge?
- Are prisoners educated about how to clean injecting equipment properly?
- Are prisoners informed about the limited efficacy of bleach as a disinfectant for inactivating HIV and particularly HCV?
- Is bleach provided in addition to a needle and syringe programme, or while such a programme is being prepared?
- If a needle and syringe programme does not (yet) exist, are efforts underway to prepare for the implementation of such a programme?

Box 31: Sample guideline for bleach distribution in prisons

Guidelines 821-2 – Bleach Distribution of the Correctional Service of Canada, issued in 2004, provide details on how bleach shall be made accessible to prisoners. The guidelines are available via www.csc-scc.gc.ca/text/plcy/cdshtm/821-2-gl_e.shtml.

Among other things, they state that:

- Full-strength (between 5.25% and 7%) household bleach shall be utilized as the disinfecting agent
- bleach kits shall consist of:
 - a. one 1-ounce opaque plastic bottle of bleach, labelled with a notice reading "Bleach, Do Not Drink or Inject";
 - b. one 1-ounce empty opaque plastic bottle for water; and
 - c. instructions on the proper cleaning of syringes and needles
- every newly-admitted prisoner shall be issued one bleach kit following reception into federal custody and shall be offered a kit on each occasion of reception upon transfer to another institution
- there will be a minimum of three designated locations in each institution where prisoners can refill an empty bottle with bleach or obtain a bottle of bleach. Appropriate locations are those affording the prisoner privacy to the extent possible. In no instance shall a prisoner be required to approach a staff member in order to obtain refills
- a prisoner in possession of quantities of bleach in excess of the one-ounce bottle is considered to be in possession of contraband unless prior authorization has been obtained
- the possession of a one-ounce bottle of bleach is not in itself sufficient evidence of drug usage or other activity constituting a disciplinary offence.

Distribution of bleach should always be accompanied by a warning about the limited efficacy of bleach as a disinfectant for inactivating HIV and particularly HCV.

Needle and syringe programmes

A note about terminology

In this document we use the term needle and syringe programmes (NSPs) to refer to programmes that provide people who inject drugs with access to sterile injecting equipment (needles and syringes, but also other equipment required for injecting, such as swabs and vials of sterile water, since hepatitis C can be transmitted if such equipment has to be shared) and most often also to health education, referrals, counselling and other services. This term has grown in popularity and is increasingly replacing earlier terms like “needle exchange programmes” or “syringe exchange programmes.” It is more accurate and reflects the move of most programmes away from simple exchange of equipment to distribution of equipment with or without a return of used equipment. In prisons, in some programmes used injecting equipment is exchanged against new injecting equipment, for example through automated machines. However, in most programmes, as in the community, injecting equipment is distributed and additional services are also offered.

Particularly because of the questionable efficacy of bleach and other disinfectants in destroying HIV and other viruses, providing sterile injecting equipment to prisoners has been widely recommended. Access to sterile drug-injecting equipment would ensure that prisoners would not have to share their equipment. As early as 1993, the World Health Organization, in its *Guidelines on HIV Infection and AIDS in Prisons*, recommended that “in countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injection equipment during detention and on release”. The same

recommendation was made by the Joint United Nations Programme on HIV/AIDS and many other national and international bodies. The *International Guidelines on HIV/AIDS and Human Rights* also specifically state that prison authorities should provide prisoners with means of HIV prevention, including “clean injection equipment”.

The rationale for establishing needle and syringe programmes in prisons where injecting drug use takes place is even stronger than in communities. In prisons where injecting drug use takes place the risk of blood-borne viral infections is increased due to the often large number of prisoners who share injecting equipment. Although injecting in prison is usually less frequent than in the community, each episode of injecting is more risky due to the scarcity of injecting equipment and the higher prevalence of needle sharing. The rapid turnover of prison populations also results in far more changes in injecting partners than in community settings and there is considerable interaction between prisoner and community injecting populations.

The first prison needle and syringe programme in the world was established in Switzerland in 1992. Since then, programmes have been introduced in various prison environments in over 50 prisons in Western and Eastern Europe and in Central Asia.

In some countries, only a few prisons have needle and syringe programmes, but in Spain and in Kyrgyzstan programmes have been rapidly scaled up and operate in a large number of prisons, with the intention to make them available in all prisons.

Box 32: Needle and syringe programmes in prisons in the Kyrgyz Republic: A model of pragmatic action

In the *Kyrgyz Republic*, a pilot project started in one prison in October 2002. It was decided that injecting equipment should be made available in a location where prisoners could not be seen by guards; it therefore was made available in the medical wards. The pilot also provided another way of distributing equipment, using prisoners as peer volunteers, as in Moldova. The project coordinators found that both options were needed. In early 2003, an order was issued approving the provision of sterile injecting equipment in all Kyrgyz prisons, and by April 2004 they were available in 11 prisons. In all institutions, distribution of injecting equipment is done using prisoners trained as peer outreach workers who work with the medical unit. In April 2004, approximately 1000 people who use drugs were accessing the needle and syringe programme. People who use drugs are provided with one syringe and three extra needle tips. This allows prisoners who inject drugs to inject more – up to three times a day without having to reuse a needle tip. This also reduces the cost of the programme, since tips cost less than complete needles and syringes.

Programmes were first introduced in small Swiss prisons, but they have since been implemented in prisons for men and for women, in small, medium, and large institutions, in prisons of all security classifications, in civilian and military prison systems, in different forms of custody (remand and sentenced, open and closed), and in institutions that house prisoners in individual cells as well as in those that house prisoners in barracks.

Box 33: Needle and syringe programmes in prisons in Spain

Needle and syringe programmes were introduced in 1998-99 in 2 prisons in Spain as a pilot study. Following positive results 9 other prisons joined voluntarily. Evaluation showed that:

- ◆ Implementation in a prison setting is feasible and can be adapted to the conditions of a prison.
- ◆ Needle and syringe programmes in prison produce changes in the behaviour of prisoners that lead to less risky injection practices.
- ◆ Needle and syringe programmes in prisons help to persuade prisoners to take up drug treatment.
- ◆ Implementation of a needle and syringe programme does not lead to an increase in heroin or cocaine use.

In 2001 prison authorities issued a directive requiring all prisons to implement needle and syringe programmes as part of the prison regime. As of 2005 these programmes were working in 33 prisons in Spain.

Significantly, after having been introduced in well resourced prison systems in Western Europe, programmes have since been established in systems with very limited financial resources in Eastern Europe and in Central Asia. Programmes were typically first implemented on a pilot basis and later expanded to other prisons. Several models of distribution of sterile injecting equipment have been used, including automatic dispensing machines, hand-to-hand distribution by prison physicians, other prison health-care staff or drug counsellors, or by external community health workers, and distribution by prisoners trained as peer outreach workers.

Evidence of the effectiveness of prison-based needle and syringe programmes

The most important findings from the evaluation studies and from the experience of the other prisons in which programmes have existed include:

- **Prison-based needle and syringe programmes are effective in reducing needle sharing and resulting HIV infection.** Evaluations have shown that syringe sharing either ceased after implementation of the programme or significantly dropped.
- **Needle and syringe programmes do not undermine abstinence-based programmes.** Drugs have remained prohibited within prisons where such programmes are in place. Security staff remain responsible for locating and confiscating illegal drugs. However, it is recognized that if and when drugs find their way into the prison and are used by prisoners, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, needles that are part of the official needle and syringe programme are not. Evaluations have found that needle and syringe programmes in prisons actually facilitate referral of people who use drugs to drug dependence treatment programmes, and have led to an increase in the number of prisoners accessing such programmes.
- Other benefits include a reduction in abscesses, a reduction in stress and improved relationship between prisoners and staff, and increases in awareness about disease transmission and risk behaviours.

- Since the first programme started in 1992, there have been **no reports of syringes ever having been used as weapons** in any prison with an operating programme. In fact, there are reports of an increase in staff safety in prisons with needle and syringe programmes, due to the fact that accidental injuries to staff from hidden syringes during cell searches have been reduced. The decrease in the possibility of injury is due to the fact that prisoners are permitted to store injecting equipment in a particular area and therefore do not hide it, thus reducing the risk of needle-stick injury during searches. Staff have also reported that the introduction of needle and syringe programmes makes injecting equipment more easy to control.
- **Availability of injecting equipment does not result in an increased number of drug injectors, an increase in overall drug use**, or an increase in the amount of drugs in the institutions. In a few prisons, evaluations actually found that reported levels of drug use or injecting decreased.
- Before their implementation, prison staff regularly had to be convinced to accept or at least tolerate the needle and syringe programmes. Nevertheless, once in place, acceptance increased and was generally high among staff, as well as among prisoners who use drugs and non-drug using prisoners.
- A key determinant of the success of prison-based needle and syringe programmes is ensuring that all prisoners have easy and confidential access to the programmes and develop trust that they can access syringes when they need them and without having to fear any negative consequences from prison staff. If prisoners have limited access to the programme or lack trust in it, sharing of injecting equipment will continue, and benefits for staff will also be reduced, as needles and syringes will continue to be hidden, thus increasing the risk of needle stick injuries for staff. In many prisons, this means that distribution by prison nurses or physicians or even by non-governmental organizations or health professionals who come to the prison for this purpose will not be the best option, as access to the programme would be too limited. In such prisons, distribution through peers has led to much greater access. For example, in Moldova only a small number of prisoners accessed the programme when it was located within the health-care section of the prison. It was only when prisoners could obtain injecting equipment from fellow prisoners trained to provide harm-reduction services that the number of injecting equipment distributed increased significantly.
- Support by prisoners and staff is important, and both prisoners and staff should receive information and education about the programmes and their expected benefits, and be involved in their design and implementation.

Because of their demonstrated benefits and lack of negative consequences, needle and syringe programmes should be introduced urgently in prisons in which injecting drug use occurs.

As with other controversial measures, or those measures that apparently run counter to accepted orthodoxy within a system, it is crucial to have supportive leaders and managers to successfully create and implement prison needle and syringe programmes.

Checklist 10: Needle and syringe programmes

The following factors influence the effectiveness of needle and syringe programmes. Check here whether the programmes in your prisons conform to good practice:

- Before a programme is introduced: Have educational and informational activities been prepared to explain why it is important to start the programme? Have prisoners and staff been involved in the setting up of the programme?
- Do prisoners have trust in the needle and syringe programme? Can they access needles and syringes without suffering negative consequences?
- Do prisoners have adequate access to the programme?
- Do prisoners have access to different types of syringes and to other injecting equipment such as swabs and vials of sterile water?
- Can prisoners obtain sterile injecting equipment from fellow prisoners, without having to self-identify as drug users to prison authorities?
- Is the programme part of a more comprehensive prevention programme, including drug dependence treatment?
- Does management show support of the programme and support the staff and prisoners involved in it?
- Is the programme regularly monitored so that adjustments can be made, if necessary, to make it respond better to the needs of prisoners and of staff?

➤ **For more details and references on needle and syringe programmes, see WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_%20ea_nsp_df.pdf**

- **For a detailed plan and guidelines used for the implementation of needle and syringe programmes, see: Ministerio Del Interior/Ministerio De Sanidad y Consumo (2003). *Needle Exchange in Prison. Framework Program*. Madrid: Ministerio Del Interior/Ministerio De Sanidad y Consumo. Essential for anyone wishing to learn how a successful programme can be established in a prison. Available in Spanish, English, and French. Another, less comprehensive, document on the same issues, entitled “Elements key for the installation of programs of exchange ok (sic) syringes in prison” (Elementos clave para la implantacion de Programas de Intercambio de Jeringuillas en Prision) is available at <http://www.msc.es/ciudadanos/enfLesiones/enfTransmisibles/sida/prevencion/progInterJeringuillas/PIJPrisiones/elemClavePIJIng.htm>**

Other measures

Detection and treatment of sexually transmitted infections

Detection and treatment of sexually transmitted infections (STIs) is important because these infections increase the chances of an individual acquiring and transmitting HIV.

Checklist 11: Management of sexually transmitted infections

The following factors influence the effectiveness of efforts to manage sexually transmitted infections (STIs) in prisons. Check here whether the programmes in your prisons conform to good practice:

- Have health care workers been trained on management of STIs?
- Are prisoners screened for STIs on admission?
- Is STI treatment available and offered to all prisoners who need it?
- Are all prisoners provided with the necessary information on STIs?

Controlling the spread of tuberculosis

Some reports estimate that tuberculosis is 100 times more common in prisons than in the community. Wherever tuberculosis is evident in prisons it is a significant health problem. Sub-standard prison living conditions, including overcrowding, poor ventilation and inadequate nutrition, make the attempts to control the spread of tuberculosis in prisons more difficult. Moreover, prisons in geographically disparate places (from Thailand to New York State to Russia) have reported high levels of drug-resistant tuberculosis. Tuberculosis poses a substantial danger to the health of all prisoners, staff, and the community outside prisons. Prisoners living with HIV are at particular risk. HIV infection is the most important risk factor for the development of tuberculosis, and tuberculosis is the main cause of death among people living with HIV.

For these reasons, prison managers must implement comprehensive tuberculosis control programmes.

➤ **For comprehensive information about tuberculosis control in prisons, see: World Health Organization & International Committee of the Red Cross (2001). *Tuberculosis Control in Prisons: A Manual for Programme Managers*. Available in English, Spanish, and Russian via <http://www.who.int/docstore/gtb/publications/prisonsNTP/>**

Hepatitis B vaccination

Hepatitis B is easily spread in prisons. In contrast to HIV, the risk of infection can be reduced through the administration of a vaccine. All staff and prisoners should have easy access to free hepatitis B vaccination. In addition, consideration should be given to providing hepatitis A vaccination to prisoners at risk.

Hepatitis C prevention

In addition to contributing to reduced risk of HIV transmission in prisons, most of the measures described above also contribute to reducing the risk of hepatitis C virus (HCV) transmission. However, as explained above, in Box 3, HCV is much more easily spread than HIV, including through sharing of shavers and toothbrushes, as well as through tattooing and body piercing. It is therefore important that prisons make information available to all prisoners and to staff about the risks of HCV transmission in prison and educate them about the ways to reduce that risk. In addition, shavers and toothbrushes should be made available to prisoners so that they do not have to share them with fellow prisoners; and prisons should consider implementing measures to reduce the spread of HCV through tattooing and body piercing, such as making sterile tattooing equipment available to prisoners.

Protecting staff

Protection of staff from infectious diseases is a duty and also makes good management sense. High rates of HIV and other infectious diseases in prisons make them more stressful places in which to work. High rates of staff turnover, whether due to ill health or lack of job satisfaction have a major impact on the management of prisons.

It is essential that staff receive **initial and ongoing training** to enable them to do their duties in a healthy and safe manner, and to feel secure themselves and be able to give prisoners appropriate guidance and support. This training should enable them to anticipate and manage situations in which they may be exposed to HIV or hepatitis. Staff should also be trained in the safe provision of first aid.

When on duty, relevant staff should have access to personal **protective equipment**, such as latex gloves, masks for use in mouth-to-mouth resuscitation, protective eyewear, soap, and mirrors for use in searching.

Safe work procedures should be developed, including searching procedures. Post-exposure procedures also must be in place. The procedures should address immediate action, follow-up action, record keeping and confidentiality. Finally, staff should have access to appropriate professional counselling and follow-up services after possible and definite exposures to blood and body fluids.

Finally, ample space, adequate lighting, and optimum levels of staff are important to ensure safe work practices, and measures are required to improve the general work conditions of prison staff.

In contrast, **it is *not* important to know the HIV status of prisoners (and fellow staff)**, and all must be handled equally – as if they were positive, both for safety reasons and in order to avoid discrimination.

➤ **For more information, see: Worksafe Australia (1995). *Infectious disease control – police, prison officers, other workers in correctional facilities and emergency response workers*. This fact sheet provides examples of what**

workplaces must do to make work safe for prison staff. Available at www.worksafe.nt.gov.au/corporate/bulletins/pdf/01-05/01.01.06.pdf.

- For an example of a policy on managing exposure to blood and/or body fluids, see: Correctional Service Canada, Commissioner's Directive 821-1. Available at http://www.csc-scc.gc.ca/text/plcy/cdshtm/821-1protocol_e.shtml.

Checklist 12: Measures to protect staff

- Do staff receive initial and ongoing training to enable them to do their duties in a healthy and safe manner?
- Are staff trained in the provision of first aid?
- Do staff have access to protective equipment, such as latex gloves, masks for mouth-to-mouth resuscitation, etc?
- Have safe work procedures been developed and adopted? Do they include searching procedures?
- Has a protocol for managing exposure to blood and/or body fluids been developed and adopted?
- Do prison staff have access to post-exposure prophylactic treatment?
- Is hepatitis B vaccination accessible to all staff, free of charge?
- Is lighting in the work areas adequate? Is there enough space for staff to carry out their work safely?
- Are staffing levels adequate?

Providing care, treatment and support to prisoners living with HIV or AIDS

In addition to providing comprehensive prevention programmes, prisons have a responsibility to provide prisoners with care and treatment equivalent to that available to other members of the community.

The right to medical care in prisons includes the provision of antiretroviral therapy (ART) in the context of comprehensive HIV/AIDS care. The advent of combination ART has significantly decreased mortality due to HIV infection and AIDS in countries around the world where ART has become accessible. There has been a parallel decrease in the mortality rate among incarcerated individuals in prison systems in those countries.

Providing access to ART for those in need in prisons is a challenge, but it is necessary and feasible. Studies have documented that, when provided with care and access to medications, prisoners respond well to antiretroviral treatment. In high income countries, the right to enjoyment of the highest attainable standard of physical and mental health, in concert with the principle of equivalence, dictates that prisoners should have access to a high standard of care, including specialist consultation, diagnostic testing (CD4, viral load, viral resistance) and the full range of antiretrovirals licensed for sale within a particular country.

Module 3: Issues for prison authorities and prison managers

In September 2003, the WHO, UNAIDS, and the Global Fund to Fight AIDS, TB and Malaria launched an initiative to make effective HIV treatments available in developing countries and countries in transition (the so-called “Treat 3 Million by 2005 (3 by 5) Initiative”), partly out of the recognition that HIV/AIDS was exacerbating inequities between rich and poor countries, and the conviction that the right to health and life should not be dependent on ability to pay for medicines. Although the ambitious target of 3 by 5 was not reached, at the 2005 World Summit and the 2006 High Level Meeting on AIDS, world leaders committed to pursue all necessary efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010. In support of this, additional resources to fund an expanded response have become available, including through the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Thanks to these initiatives, ART is increasingly becoming available in developing countries and countries in transition, and countries are moving towards the goal of universal access to treatment by 2010. Therefore, **it will be critical to ensure that treatment also becomes available to all prisoners who need it.**

As prisons need to provide standard of treatment equivalent to outside, more and more **prisons over the next years will have to be ready to provide ARVs to prisoners with HIV**, including enabling treatment without interruption upon arrest and ensuring treatment can continue without interruption upon release. There are many important management issues related to this (see supra, module 2, for actions required by policy makers, legislators, and parliamentarians). In addition to ensuring that prisons are involved in all aspects of the national treatment scale-up efforts and participating in meetings of national AIDS committees responsible for these efforts, prisons should form partnerships with health clinics, hospitals and universities and NGOs (including organizations of people living with HIV or AIDS) to provide health care and other services for prisoners, and develop integrated rather than parallel care and treatment programmes.

Checklist 13: Providing treatment to prisoners with HIV or AIDS

- Do prison authorities have a place within the national HIV/AIDS coordinating committees?
- Are prison issues part of the agreed HIV/AIDS action framework and country-level monitoring and evaluation system?
- Are prison authorities involved in all aspects of treatment scale-up, from applications for funding (to ensure that funds are specifically earmarked for prisons), to development, implementation, and monitoring and evaluation of treatment roll-out plans?
- Have policies or guidelines been developed specifying that people with HIV or AIDS are allowed to keep their HIV/AIDS medication upon them, or are to be provided with their medication, upon arrest and incarceration and at any time they are transferred within the system or to court hearings?
- Have police and prison staff been educated about the importance of continuity of HIV treatment?
- At the regional and local level, have prisons formed partnerships or entered into agreements with health clinics, hospitals and universities and NGOs (including organizations of people living with HIV or AIDS) to provide health care and other services for prisoners, and developed integrated rather than parallel care and treatment programmes? (Ideally, prisoners should be able to access antiretroviral medication through public health facilities during their incarceration).
- Has health care staff received training in the comprehensive management of HIV and AIDS, including the provision of antiretroviral therapy?
- Are people who are on antiretroviral treatment before arrest and incarceration able to continue their treatment without interruption?
- Are people who are transferred within the system or to court hearings able to continue their treatment without interruption?
- Are prisoners who need to start antiretroviral treatment able to do so in prison? Are the eligibility criteria the same as in the community?
- Is information and education on access to treatment provided to all offenders who are eligible to be on antiretroviral therapy and treatment of opportunistic infections?
- Do health care workers screen offenders (including detainees awaiting trial) on admission to determine if treatment for any HIV- or AIDS-related illness or opportunistic infection, such as tuberculosis, is necessary? Do they refer them appropriately, if necessary?
- Have treatment literacy campaigns and sessions been undertaken in prisons?
- Has a "buddy system" been established to facilitate adherence to treatment?
- Does the treatment programme contain a comprehensive discharge planning system for prisoners nearing release, including a system for referral to treatment in the general community?

Compassionate or early release

Prisoners who enter the later stages of chronic or terminal illnesses – including but not limited to HIV/AIDS – require specialised end of life care. However, prisons – even in high income countries – are ill-equipped to provide such care.

End of life care is unique and demanding, and prison staff often lacks the necessary training and resources. The prison environment itself – with its security-focused architecture and routines, lack of comfort and privacy, barriers to access for family and friends, lack of adequate training and resources for staff, etc. – is also generally non-conducive to compassionate and responsive end of life care. Proper end of life care – particularly in the context of HIV/AIDS – often involves large doses of pain management medications, which may conflict with the “drug free” ethos of the prison system.

For these reasons, many prison systems have introduced compassionate release programmes to allow terminally ill prisoners to be released from prison earlier in their sentence. Such early release programmes fulfill not only a compassionate role, but in many cases can also serve a health promotion function in recognition that the life expectancy of the terminally ill prisoner may be lengthened as a result of receiving care in the community.

Compassionate release of terminally ill prisoners is recommended by the World Health Organisation *Guidelines on HIV infection and AIDS in prisons*, acknowledging that a person should be allowed to die in dignity, either in their own home or with their family, rather than forced to die isolated and alone in prison. The guidelines state:

51. If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom.

52. Prison medical services should provide full information on such prisoners' health status, treatment needs and prognosis, if requested by the prisoner, to the authorities competent to decide upon early release. The needs of those prisoners without resources in the community should be taken into account in any early release decision.

Whenever this is compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should therefore be granted compassionate early release, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom. For those prisoners who cannot be released, prisons must provide appropriate palliative care.

Checklist 14: Compassionate or early release

- Does prison policy state that where appropriate, namely where the prisoner's state of health indicates that it is necessary, prisoners with AIDS **will** be released on medical parole?
- Does the policy emphasize the obligation on the part of the prison authorities to act expeditiously and that there should be no unnecessary delays in initiating and processing these applications?
- Does health care staff seek to actively identify those prisoners whose state of health would qualify them for early release? (Due to their state of health, prisoners are not always in a position to initiate applications for early release. When prisoners become eligible for this option, they should be informed of the possibility of early release and assisted in such applications, where they unable to do so themselves).
- Has the early release policy been brought to the attention of all prisoners?
- Does the policy provide for a health care staff or social worker to contact the family and to ensure that appropriate care is available upon release? (Early identification of the relatives and other service providers for prisoners with AIDS is important to facilitate placement after release.)
- In all cases of referrals to other care providers, is the offender required to give informed consent?
- Does the decision for early release involve the input of the nurses who care for the prisoner on a day-to-day basis, confirmed by a medical practitioner? (Separate medical examinations by two medical practitioners should not be a requirement as this delays the application. Only where it is deemed necessary for a proper consideration for the application, should a specialist be required to conduct an examination.)
- Do all officials in charge of determining early release on medical grounds receive adequate education about HIV/AIDS and its treatment?
- Are urgent applications fast-tracked?
- Is palliative care available in prison for prisoners at the end stages of life who cannot be released?

Box 34: Prisoners with AIDS in Italy

Italian law prevents anyone with "overt" AIDS from being held in prison custody. The definition of "overt AIDS" is clinically established with reference to the blood cell count. To determine this, the prisoner is administered two consecutive tests, 15 days apart. Other alternatives suggest that prisoners with AIDS be released from prison but held under house arrest, admitted to a public health institution, or that the sentence be remitted indefinitely.

Moving towards implementation

The checklists above provide the key elements of a comprehensive strategy to address HIV/AIDS in prisons. By recognizing that HIV/AIDS (and HCV and TB) represent serious issues requiring urgent and pragmatic action to protect the health of prisoners, prison staff, and the community, and by acknowledging the reality that risk behaviours occur in prisons and cannot be eliminated, prison authorities and prison management can set the tone and signal that they take their responsibilities

seriously. By **developing a clear plan**, identifying activities, timelines and responsibilities, for adopting all elements of the comprehensive strategy, **prison authorities and managers can be leaders in the fight against HIV/AIDS** in countries, and demonstrate that they have a clear vision and a determination to ensure that prisons will do their part in preventing infection and providing care and treatment to people living with HIV or AIDS.

Frequently asked questions

Should prisoners be mandatorily tested for HIV and segregated from the rest of the prison population?

No. Some staff have called for mandatory HIV testing and segregation of prisoners testing HIV-positive. They have said that this is necessary to protect them from infection. In reality, it is not necessary and could even be counterproductive, for a number of reasons:

- HIV is not transmissible via casual contact (as is active TB, for example). Therefore segregation of people living with HIV or AIDS is not necessary.
- The nature of HIV antibody testing means that a prison will never be able to correctly identify and therefore isolate all prisoners infected with HIV. Because of the “window-period” inherent in the testing technology, which means that it may take up to 14 weeks – and perhaps longer – for a person infected with HIV to develop HIV antibodies in sufficient concentration to trigger a positive test result, false negative test results are unavoidable.
- Mandatory testing and forced segregation undermine HIV prevention by creating the unrealistic and dangerous assumption that all prisoners living with HIV or AIDS are segregated, and that therefore there is no HIV in the general prison population. This can lead staff to believe they need not use universal precautions.
- Ignoring universal precautions when interacting with HIV-negative prisoners may increase the risk of occupational exposure to hepatitis B and C.

In addition, mandatory testing and segregation increases and entrenches HIV-related stigma and discrimination among prisoners and prison staff.

Instead of being subjected to testing without consent, prisoners should have easy access to voluntary counselling and HIV testing and should be provided with the means necessary to act responsibly and to protect themselves and others from the risk of contracting HIV, such as access to voluntary counselling and testing, education, counselling, condoms, bleach, sterile needles and syringes, substitution treatment and other drug treatment.

Should we keep some prisoners apart?

Although prisoners with HIV or AIDS should not be segregated, effective prison management should ensure that some groups of prisoners are kept apart. Prison staff are trained to protect society from serious adult criminals. It should not be part of their task to take care of the small number of children and young people who have committed offences that require that they be deprived of their liberty. Such young people should be held in the care of welfare or social care agencies. Although this is the principle, the reality is that in several countries a number of children and young people are committed to prison custody.

When this happens the prison administration has an obligation to care for them in a manner that takes account of their age and special needs. There are two main reasons for this special treatment.

- Children and young people are more vulnerable than adults and need to be protected from violence or abuse by older prisoners or even by staff.
- Young people are generally more likely to respond to positive influences, to training and to educational opportunities.

For these reasons any children who are in the care of the prison administration should be held in separate institutions and not in prisons for adults.

Should prisoners with HIV or AIDS be allowed to do the same activities as everyone else?

Yes. Segregation, isolation, and restrictions on occupational activities, sports, and recreation are not considered useful or relevant in the case of HIV-positive people in the community. The same attitude should be adopted towards HIV-positive prisoners. They should have equal access to workshops and to work in kitchen, farms and other work areas, and to all programmes available to the general prison population. HIV cannot be transmitted through such activities.

Should staff be told who has HIV?

No. Some staff claim that they need to know which prisoners live with HIV so that they can take adequate precautions to protect themselves from contracting the infection. However, for their own sake, staff need to take universal precautions and treat **all prisoners** as if they might be HIV-positive. Knowing will not help them protect themselves, but will create a false sense of security and may increase, rather than decrease, the risk of infection, particularly with other infections such as hepatitis C.

Does making condoms and needles and syringes available to prisoners have a negative impact on security in prisons?

No. The promotion of health in prisons does not entail lessening of the safety and the security of prisons. The interest of prisoners in being given access to the means necessary to protect them from contracting HIV and/or HCV are compatible with the interest of staff in their security in the workplace and of prison authorities in the maintenance of safety and order in the institutions. The evidence from the many prisons in which condoms and/or needles and syringes have been made available shows that this can be done safely and without creating any danger for staff.

In fact, 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 prison staff. 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 prisoners 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 and HCV prevention measures need to be available in prisons, as they are outside.

Are we not condoning drug use in prison by making needles and syringes available to prisoners?

No. Many prisoners are in prison because of drug offences or because of drug-related offences. Preventing their drug use is an important part of their rehabilitation. Some have said that acknowledging that drug use is a reality in prisons, would be to acknowledge that prison staff and prison authorities have failed. Others say that making needles and syringes available to prisoners would mean condoning behaviour that is illegal in prisons.

However, making available to prisoners the means that are necessary to protect them from HIV and HCV transmission does not mean condoning drug use in prisons. Introducing needles and syringes is not incompatible with a goal to reduce drug use in prisons. Making needles and syringes available to people who use drugs has not led to an increase in drug use, but to a decrease in the number of people who inject drugs contracting HIV and other infections.

On the other hand, refusing to make needles and syringes available to prisoners, 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.

Instead of making prevention tools like condoms and needles and syringes available to prisoners, should we not rather adopt a zero tolerance approach and eliminate drugs and sexual activity from prisons?

No. It is important to undertake measures to decrease the prevalence of drug use, and it is important to fight non-consensual sexual activity in prisons. However, no prison system – even the systems with huge financial resources – has been able to keep drugs out of prisons and to eliminate sexual activity. Therefore, it is necessary to do both – take measures to reduce drug use and non-consensual sex, and provide prevention measures recognizing that drug use and sexual activity will still occur.

Module 4: Issues for prison staff

This module is intended primarily for people who work in prisons and provide security or programmes for prisoners on a day-to-day basis. We hope it will be useful to

- prison officers and guards
- teachers and instructors
- civil society, including volunteers, non-governmental organisations, and members of religious groups who visit prisons and undertake activities there.

The key objectives of the module are to:

- briefly explain **why prison staff have a key role** in combating the spread of HIV in prison (“Prison staff are key”);
- explain **how prison staff can protect themselves** from contracting HIV (“HIV/AIDS at work in prison”);
- explain the **HIV/AIDS prevention measures that need to be implemented** in prisons, and show that their introduction does not negatively affect staff safety, but contributes to their protection as well (“HIV prevention in prisons – for everyone’s benefit”);
- provide **answers to frequently asked questions.**

Prison staff are key!

Prison staff are responsible for the safeguard and care of people who are vulnerable to HIV infection and AIDS, as well as to hepatitis and tuberculosis. The rate of these infections among people in prison is usually much higher than in the general

community. In some countries (mainly where injecting drug use is a problem and HIV is widespread among injecting drug users, many of whom spend time in prison), HIV rates in prison are up to one hundred times higher than in the community. But also in other countries rates of HIV (and other infections) in prison tend to be high, partly because prisoners are drawn from the poorest and most marginalised parts of the population that are most at risk of HIV, and partly because conditions in prison can encourage the spread of infection.

A healthy prison cannot be created without the contribution of each member of its staff. Given the current health problems in prisons, staff members need to know and understand what the health problems are, how infections can spread, how they can be better controlled and how health and well-being can be promoted.

Promoting health in prisons – the essentials. A WHO guide. WHO Europe, 2006

Prisoners are at greatest risk of infection, but prison staff also run a risk of infection in prisons, particularly if they do not receive proper training or do not use adequate precautions with all prisoners. **Governments have a responsibility for ensuring health and safety of prison staff** while at work.

People who work in prisons should do all they can to protect themselves and prisoners from contracting HIV and other infections.

- They should participate in workplace training programmes about HIV, hepatitis, and tuberculosis and about how these infections are, and are not transmitted in prison. Where prison staff are not properly trained, they more likely react with fear to people with HIV or AIDS. This can lead to stigma and discrimination against people living with HIV or AIDS and those perceived to be at risk of HIV. Ignorance of HIV, as well as fear and stigma, greatly hamper efforts to stop the spread of HIV.
- They should use precautions to reduce the risk that they will contract infections.
- Finally, they should actively support prevention programmes for prisoners. **Measures to protect prisoners will ultimately also protect staff** and can be introduced in prison without compromising security.

This toolkit should help considerably to provide the knowledge that is necessary, but there should be further opportunities for staff to develop the understanding which is so important in dealing with issues relating to HIV/AIDS and other health issues, including ethical ones.

HIV/AIDS at work in prison

How can I avoid becoming infected?

Particularly if prison staff are properly trained and equipped, **the risk of being infected** with infections like HIV that are spread only through contact with blood or other body fluids (and not as a result of casual contact) **is very small**. However, other diseases that are prevalent in prisons and that are much more easily spread than HIV – particularly tuberculosis – pose a much greater threat not only to the staff directly, but also to their families and to the wider community.

It is usually safe to work with prisoners or fellow staff who are infected with HIV because HIV cannot be transmitted as a result of casual contact.

However, sometimes staff have to deal with assault (between prisoners and between prisoners and prison staff), self-mutilation by prisoners, traps set by prisoners, and objects concealed by prisoners, such as needles and syringes. In these and all other situations where there is a potential risk of exposure to blood or body fluids, all staff – just like health care workers – must adopt an attitude that all of these fluids and substances are potentially infectious and should be treated as such.

Module 4: Issues for prison staff

Preventing transmission of HIV (and hepatitis) in the workplace, therefore, means preventing:

- injuries from sharps and other instruments contaminated with blood or body fluids; and
- contact between blood or body fluids and the eye, or other mucous membranes, and broken skin or cuts.

So-called “**universal precautions**” are based on the concept that **all** blood, blood products and body fluids of **all** persons are potential sources of infection, independent of diagnosis or perceived risk.

All staff must adhere rigorously to protective measures that minimise exposure to these agents. The use of universal precautions involves placing a barrier (such as latex gloves, protective eyewear, or masks for use in mouth-to-mouth resuscitation) between staff and all blood and body fluids.

Safe work practices

It is important that all areas of the prison be kept clean to prevent transmission of disease – HIV cannot be transmitted through lack of cleanliness, but other infections can. In prisons where it may be difficult to provide all prisoners with other work or training activities, it is possible to offer some of them work as cleaners. This is a good way of keeping the prison clean as well as providing additional work.

Staff should follow safe work procedures (if such procedures do not exist, prison management should develop them, and involve prison staff in the development). At the beginning of a shift, staff should wash their hands in order to clean them and identify any cuts or breaks in the skin. If any are present, they should be covered with a waterproof dressing.

Work practices in emergency situations need to take into account the unpredictable nature of exposures to blood and body fluids that may occur. Particular care should be taken where staff are likely to come into contact with broken glass.

Violence

Violence is commonplace in prisons around the world. Staff confronted by prisoners exhibiting physical violence toward them should follow established operational guidelines for dealing with such situations (if such guidelines do not exist, prison management should develop them, and involve prison staff in the development). The risk of HIV transmission during violence (such as when prisoners splash prison staff with blood or spit at them) is very low, but there are reports of prisoners contracting hepatitis C virus from physical assaults, with two possible cases occurring in New South Wales in Australia. There has also been one report of a prison officer acquiring hepatitis C from a blood splash resulting from two prisoners fighting. Even if the risk is low, however, after any exposure post-exposure guidelines should be followed (see below).

Module 4: Issues for prison staff

Blood/ body fluid spillages

Although the risk of transmission of HIV is very low, all such spillages should be treated as though the blood or body fluid is potentially infected. Latex gloves should be worn when cleaning up spillages, and appropriate cleaning materials should be used. Clothing contaminated with blood should be removed as soon as possible.

Conducting searches/unlocking cells

Staff involved in searches should follow searching procedures to ensure their health and safety (if such procedures do not exist, prison management should develop them, and involve prison staff in their development). Some techniques that should be used in searching procedures are:

- always wear latex gloves or other suitable gloves when searching
- do not run fingers along or under tables, beds and other surfaces where sharp objects may be concealed
- use pens, rulers etc or a mirror to view areas that cannot be seen
- when searching bags etc, hands must not be placed inside – the contents should be tipped out onto a flat surface for examination
- use torches to illuminate dark areas
- safely remove any items contaminated with blood or body fluids
- promptly discard used needles, shavers and other sharp instruments using a non permeable container.

Post-exposure procedures

If a staff has a significant exposure, post-exposure procedures should be followed (if such procedures do not exist, prison management should develop them). An exposure is significant when a person has

- come in contact with body fluids capable of transmitting HIV, hepatitis B or hepatitis C, including blood, serum, plasma, and all body fluids visibly contaminated with blood; uterine/vaginal secretions or semen; or saliva; **and**
- one of the fluids comes into contact with the following:
 - tissue under the skin (needle stick type injuries, bites breaking the skin, stab wounds);
 - non-intact skin (cut, chapped, or scraped skin); or
 - mucous membranes (eyes, nose, mouth).

Fluids coming into contact with intact skin do not represent a significant exposure.

The person who has had an exposure shall **immediately**

- remove all contaminated clothing
- allow bleeding of the wound
- wash the injured area well with soap and water (although the application of antiseptics is of no proven benefit, their use is not contraindicated; it is advised, however, that the exposed skin or wound is decontaminated with soap and water before the application of antiseptics)
- if the eyes, nose or mouth are involved, flush them with large amounts of water.

Following these steps, staff who have suffered a significant exposure should immediately see the medical practitioner or the officer in charge of post-exposure procedures and arrangements for **post-exposure prophylaxis** treatment should be made.

HIV/AIDS prevention in your prison – for the benefit of all

Prison staff have a key role in helping to minimise the spread of HIV in prisons. This cannot be achieved simply by enforcing a zero tolerance approach to sexual activity and drug use in prison. Experience has shown that a comprehensive approach is needed, which aims both

- to prevent the prevalence of high risk behaviour; and
- to reduce the harm caused by such behaviour when it does take place.

Many of the activities that can transmit HIV in prison are against prison rules and in some cases against the criminal law. Prisons must do all they can to prevent drug use and unsafe sexual activities in prison, and to reduce levels of violence – in particular sexual violence. However, it is important to recognise that efforts to stop these activities, such as the use of drugs in prisons, will not always be successful. Illegal drugs are available in prisons worldwide despite the sustained efforts of prison systems and prison staff to prevent illegal 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 illegal drug possession and use among prisoners.

But taking measures to try to prevent the activities in the first place is not enough. Knowing that the activities – in particular injecting drug use and sexual activity – cannot be completely stopped, prisons also need to implement measures to reduce the dangers to health associated with these activities, for example by making condoms and needles and syringes available to prisoners. This does not mean condoning these activities. Rather, it means adopting a pragmatic approach that acknowledges that risk activities occur in prisons and reduces the potential harms to prisoners, staff, and the community.

Module 4: Issues for prison staff

Elements of the comprehensive approach to prevent the spread of HIV in prisons that have proven to be effective in reducing risks of HIV and at the same time have not created any risk for prison staff include:

- information, education, and communication programmes
- providing condoms and undertaking measures to prevent rape, sexual violence and coercion
- providing opioid substitution therapy and other forms of drug dependence treatment
- undertaking measures to reduce the demand for, and the supply of, drugs.
- providing sterile needles and syringes and bleach or other disinfectants

Staff may be required to participate in overseeing some of these measures. But even when programmes are implemented by medical staff, the programmes often cannot work if other staff do not support them or at least tolerate them and allow them to work without interference.

Education and information

Education is an essential precondition to the implementation of HIV prevention measures in prisons. At the same time, HIV/AIDS education efforts in prisons present specific challenges. In particular, many prisoners are suspicious of anything 'official' or government related, which means that **programmes created by the prison administration or prison staff without prisoner input can be ineffective.**

Experience has shown that peer education – education designed and delivered by prisoners for prisoners – is particularly effective. Peer educators play a vital role in educating other prisoners, since most of the behaviours that put prisoners at risk of HIV in prisons involve illegal or forbidden and stigmatized practices. Therefore, peers may be the only persons able to speak candidly to other prisoners about ways to reduce the risk of contracting infections. As well, peer educators' input is not likely to be viewed with the same suspicion as the information provided by the prison hierarchy. Peer educators are more likely to be able to realistically discuss the alternatives to risk behaviour that are available to prisoners, and are better able to judge which educational strategies will work within their prison and the informal power structure among prisoners.

Alongside peer approaches, experience suggests that non-governmental organisations and other professionals from outside the prison system can best provide education. Experiences with HIV/AIDS prevention initiatives show that prisoners can develop more trust with staff from non-governmental organisations and other professionals from outside the prison than with staff who are part of the prison hierarchy.

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Therefore, **prison staff should facilitate the work of peer educators**, as well as that of non-governmental organisations or other professionals from outside the prison system.

Finally, information and education are important, but not sufficient responses to HIV/AIDS in prisons. In particular, they are not of much use to prisoners if they do not have the means to act on the information provided.

➤ **For more details (and full references) on information and education programmes and the other HIV prevention measures discussed in this module, see:**

➤ **WHO, UNODC, UNAIDS (2007). *Comprehensive Review of the Effectiveness of Interventions to Address HIV in Prisons. Evidence for Action Technical Papers*. Available via <http://www.who.int/hiv/pub/en/>.**

Providing condoms and preventing sexual violence, rape, and coercion

Many prison systems in different parts of the world, including in Europe, Canada, Australia, some prisons in the United States, parts of Eastern Europe and Central Asia, Brazil, South Africa, Iran and Indonesia, make condoms available to prisoners.

In some prison settings, staff have opposed condom distribution, citing security concerns and opposition to male-to-male sex. Some have argued that condom provision will lead to an increase in sexual activity among prisoners, or that condoms would be used to conceal drugs.

However, these fears have proven unfounded. The experience of the many countries in which condoms have been made available in prisons has shown that condoms can be provided in a wide range of prison settings – including in countries in which same-sex activity is criminalised – without any security problems or any other relevant major negative consequences. In particular, it has been found that **condom access represents no threat to security or operations**, does not lead to an increase in sexual activity, and **is accepted by most prisoners and prison staff once it is introduced**. Usually support for condom provision increases once a condom programme is started.

Condoms need to be easily and discreetly available, ideally in areas such as toilets, shower areas, waiting rooms, workshops, or day rooms where prisoners can pick up a condom without being seen by others. Distribution can be done by health staff, by dispensing machines, by trained prisoners (peers) or in a combination of these ways. Each prison should determine how to best make condoms available, to ensure easy and discreet access. **Prisoners should not have to ask prison staff for condoms**, since few prisoners will do so because they do not want to disclose that they engage in same-sex sexual activity.

While providing condoms in prisons is important, it is not enough to address the risk of sexual transmission of HIV. HIV prevention also depends on measures taken to prevent rape, sexual violence and coercion in prison. **All prison staff have a role in**

combating aggressive sexual behaviour of prisoners and should bring such behaviour to the attention of prison authorities whenever they become aware of it.

Finally, it is important to recognise that sometimes staff themselves participate in risk behaviour in prison, or make it possible. Some staff enter into sexual relationships with prisoners, which is not only against prison rules, but also represents an abuse of their power and authority. In the context of HIV/AIDS, it carries a risk of HIV transmission. Other staff have reportedly procured young prisoners for the sexual gratification of older prisoners. All staff have a responsibility to prevent such activity and to inform prison managers and the police if they are aware that it occurs.

Drug dependence treatment

One of the ways of reducing transmission of HIV through the sharing of injecting equipment is to reduce the prevalence of injecting drug use. This can be achieved by providing drug dependence treatment programmes in prison. There are two main forms of treatment:

- abstinence-based treatment in which prisoners are supposed to abstain totally from taking drugs; and
- opioid substitution therapy, which involves prescribing a drug with a similar action to the illegal opiates used, but with a lower degree of risk.

Opioid Substitution Therapy

All forms of drug dependence treatment have some impacts on risks of HIV transmission, but Opioid Substitution Therapy (OST) programmes have the greatest potential to reduce injecting drug use and the resulting risk of spread of infection.

Nevertheless, some prison systems are still reluctant to make ST available. **Some prison staff consider methadone or buprenorphine as just another mood-altering drug**, the provision of which delays the move beyond a drug-centred existence. Some also object to ST on moral grounds, arguing that it merely replaces one drug of dependence with another. **However, evaluations of prison ST programs have provided clear evidence of their benefits.** Studies have shown that, if dosage is adequate (at least 60 mg of methadone) and treatment is provided for the duration of imprisonment, such programmes reduce drug injecting and needle sharing and the resulting spread of HIV and other bloodborne infections. In addition, they have additional and worthwhile **benefits, both for the health of prisoners participating in the programmes, and for prison staff and the community.** For example:

- opioid substitution therapy has a positive effect on institutional behaviour by reducing drug-seeking behaviour and thus **improving prison safety**;
- **re-incarceration is significantly less likely** among those prisoners who receive OST;

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- although prison staff often initially raise concerns about security, violent behaviour, and diversion of methadone, these problems do not emerge once the ST programme is implemented;
- both prisoners and prison staff report about the positive impact OST has on life in prison.

Other forms of drug dependence treatment

Other forms of drug dependence treatment are usually less controversial than OST in prisons, but there is little data on their effectiveness **as an HIV prevention strategy**. This is not surprising since they have not usually been introduced in prison with HIV prevention as one of their objectives – in contrast to OST, which has become increasingly available in many prison systems at least in part because of its potential to reduce injecting drug use and the resulting risk of spread of infection.

Nevertheless, in addition to substitution therapy, providing abstinence-based programmes is important. Good quality, appropriate, and accessible treatment can improve prison security, as well as the health and social functioning of prisoners, and can reduce reoffending, as long as it provides ongoing treatment and support, post-release care and meets the individual needs of prisoners.

But even in prison systems with large resources, drug dependence treatment only reaches a relatively small portion of those who need it and is not always effective. That is why HIV prevention measures such as needle and syringe programmes need to be made available as well.

In addition to drug dependence treatment, adopting other strategies to reduce the demand for, and the supply of, drugs in prisons can also assist efforts to prevent HIV transmission in prisons. However, it is important to note from the outset that such efforts are unlikely to eliminate drug use in prisons. In fact, even prison systems that have devoted large financial resources to such efforts have not been able to eliminate drug use. Therefore, such efforts cannot replace the other measures described above, but rather should be undertaken to complement them.

Drug demand and drug supply reduction strategies

In addition to drug dependence treatment, adopting other strategies to reduce the demand for, and the supply of, drugs in prisons can also assist efforts to prevent HIV transmission in prisons. However, it is important to note from the outset that such efforts are unlikely to eliminate drug use in prisons. In fact, even prison systems that have devoted large financial resources to such efforts have not been able to eliminate drug use. Therefore, such efforts cannot replace the other measures described above, but rather should be undertaken to complement them.

Drug demand reduction strategies

Research shows that one of the reasons why a relatively large number of prisoners in many prison systems take drugs when they are in prison is to combat boredom, alienation, and stress, and to promote relaxation. This suggests that, in addition to drug treatment, one of the most effective ways to reduce the demand for drugs is to improve prison conditions and to offer more purposeful activities in prisons. Providing prisoners with opportunities to work and/or study while in prison, or activities such as sports, theatre and spiritual and cultural enhancement aimed at providing people with challenging and healthy ways to employ their time, can have a positive effect on risky behaviours, particularly when complemented by appropriate drug use prevention education.

Another strategy to reduce the demand for drugs used by an increasing number of prison systems, mainly in resource-rich countries, is to establish so-called “drug-free” units. Typically, “drug-free” units or wings are separate living units within a prison that focus on limiting the availability of drugs and are populated with prisoners who have voluntarily signed a contract promising to remain drug free. In some instances, they focus solely on drug interdiction through increased searching, while some systems provide a multi-faceted approach combining drug interdiction measures with treatment services. “Drug-free” units could assist efforts to combat the spread of HIV in prison if they resulted in decreased drug use, particularly injecting drug use. There is some evidence from a small number of studies that so-called “drug-free” units do indeed significantly reduce levels of drug use among residents in these units. Such units appeal to a large number of prisoners, including prisoners who do not have any drug problems and want to live in a “drug-free” environment. However, the studies do not say anything about whether “drug-free” units appeal to, and are successful in retaining, the most problematic users, in particular prisoners who inject drugs. Currently, there is therefore no data on the effectiveness of drug-free units as an HIV prevention strategy.

Drug supply reduction strategies

A broad range of search and seizure techniques and procedures can be used in an attempt to reduce the availability of drugs in prisons. These supply reduction measures include: random searches by security personnel; staff and visitor entry/exit screening and searches; drug detection dogs; closed-circuit monitoring; perimeter security measures (netting over exercise yards, higher internal fences to prevent projectiles, rapid response vehicles patrolling the prison perimeter); purchasing of goods from approved suppliers only; intelligence analysts at every institution; drug detection technologies (such as ion scanners, x-ray machines, etc); modifications to the design and layout of visiting areas (use of fixed and low-level furniture); and drug testing (also called urinalysis).

Many prison systems, particularly in resource-rich countries, have placed considerable emphasis on these measures to reduce the supply of drugs. While such measures are not aimed at managing HIV/AIDS in prisons, they may result in unintended consequences for HIV (and HCV) prevention efforts. Drug interdiction

measures may assist HIV prevention efforts by reducing the supply of drugs and injecting in prisons. At the same time, they could make such efforts more difficult.

For example, many resource-rich prison systems regularly or randomly test prisoners' urine for illegal drug use. Prisoners who are found to have consumed illegal drugs can face penalties. From a public health perspective, concerns have been raised that these programmes may increase, rather than decrease, prisoners' risk of HIV infection. There is evidence that implementing such programmes may contribute to reducing the demand for and use of cannabis in prisons. However, such programmes seem to have little effect on the use of opiates. In fact, there is evidence that a small number of people may switch to use injectable drugs to avoid detection of cannabis use through drug testing. Cannabis is traceable in urine for much longer (up to one month) than drugs administered by injecting, such as heroin and other opiates. Some prisoners choose to inject drugs rather than risk the penalties associated with smoking cannabis simply to minimise the risk of detection and punishment. Given the scarcity of sterile needles and the frequency of needle sharing in prison, the switch to injecting drugs may have serious health consequences for prisoners.

Generally, despite the fact that many prison systems make substantial investments in drug supply reduction measures, there is little solid and consistent empirical evidence available to confirm their efficacy in reducing levels of drug use. In particular, there is no evidence that these measures may lead to reduced HIV risk.

Prison systems facing resource constraints should therefore not implement costly measures such as drug detection technologies and drug testing that may use up a substantial amount of resources that could otherwise be used for managing HIV/AIDS in prisons. Instead, they should focus on the proven and cost-effective HIV prevention measures described above and on efforts to improve prison conditions and working conditions and pay for prison staff, without whom other drug supply reduction strategies are unlikely to be successful.

Finally, it is important to recognise that sometimes drugs are smuggled into prison by staff, either because of pressure applied by prisoners or because of corruption. All staff have a responsibility to prevent such activity and to inform prison managers and the police if they are aware that it occurs.

Providing needle and syringe programmes and bleach or other disinfectants

Many prison systems have adopted programmes that provide disinfectants, as well as instruction on how to disinfect injecting equipment before re-using it, to prisoners who inject drugs. Evaluations of such programmes have shown that distribution of bleach **does not compromise security**. However, studies in the community have raised doubts about the effectiveness of bleach in decontamination of injecting equipment. In particular, bleach disinfection has limited benefit in preventing hepatitis C virus transmission among injecting drug users.

Therefore, a growing number of prisons is making needles and syringes available to prisoners who inject drugs. Prison needle and syringe programmes have been implemented in both men's and women's prisons, in institutions of varying sizes, in both civilian and military systems, in institutions that house prisoners in individual cells and those that house prisoners in barracks, in institutions with different security ratings, and in different forms of custody (remand and sentenced, open and closed).

Several models of distribution of sterile injecting equipment have been used, including automatic dispensing machines, hand-to-hand distribution by prison physicians, other prison health-care staff or drug counsellors, or by external community health workers, and distribution by prisoners trained as peer outreach workers.

Making needles and syringes available to prisoners is probably the most controversial HIV prevention measure in prison. Often prison staff have opposed it, saying that needles could be used as weapons against staff and/or fellow prisoners and that making them available would be tantamount to condoning prisoners' drug use and giving up on efforts to prevent drugs from coming into the prisons.

However, the experience of the many prisons in which programmes have been implemented has been positive not only for prisoners, but also for staff:

- Prison-based needle and syringe programmes are effective in reducing needle sharing and resulting HIV infection.
- **Needle and syringe programmes do not undermine abstinence-based programmes.** Drugs have remained prohibited within prisons where such programmes are in place. Security staff remain responsible for locating and confiscating illegal drugs. However, it is recognized that if and when drugs find their way into the prison and are used by prisoners, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, needles that are part of the official needle and syringe programme are not. Evaluations have found that needle and syringe programmes in prisons **actually facilitate referral of drug users to drug dependence treatment programmes**, and have led to an increase in the number of prisoners accessing such programmes.
- Since the first programme started in 1992, there have been **no reports of syringes ever having been used as weapons in any prison with an operating programme.** In fact, there are reports of an **increase in staff safety** in prisons with needle and syringe programmes, due to the fact that accidental injuries to staff from hidden syringes during cell searches have been reduced. The decrease in the possibility of injury is due to the fact that prisoners are permitted to store injecting equipment in a particular area and therefore do not hide it, thus reducing the risk of needle-stick injury during searches. Staff have also reported that the introduction of needle and syringe programmes makes injecting equipment more easy to control.

- **Availability of syringes does not result in an increased number of drug injectors, an increase in overall drug use**, or an increase in the amount of drugs in the institutions. In a few prisons, evaluations actually found that reported levels of drug use or injecting decreased.
- Before their implementation, prison staff regularly had to be convinced to accept or at least tolerate the needle and syringe programmes. Nevertheless, once in place, **acceptance increased and was generally high among staff**, as well as among prisoners who use drugs and non-drug using prisoners. Staff attitudes towards the programmes were least positive in those prisons in which prisoners experienced problems accessing syringes and/or did not trust that they could obtain them without suffering negative consequences, leading to continued illegal trade with syringes in the prison and generally, to reduced benefits of the programme.
- Support by prisoners and staff is important, and both **prisoners and staff should** receive information and education about the programmes and their expected benefits, and **be involved in their design and implementation**.

Box 35: Staff support needle and syringe programmes

At the end of 2000, needle and syringe programmes had been successfully introduced in seven prisons in Germany, and other prisons were looking at how to implement them. However, since then six of the programmes were closed down, not because of any problems with the programmes, but as a result of political decisions by newly elected state governments. In each of these cases, the decision to cancel the programmes was made without consultation with prison staff, and without an opportunity to prepare prisoners for the impending loss of access to the programmes. It has been reported that since the programmes closed, prisoners have gone back to sharing needles and to hiding them, increasing the likelihood of transmission of HIV and HCV, as well as the risk of accidental needle stick injuries for staff. **Staff have been among the most vocal critics of the governments' decision to close down the programmes, and have lobbied the governments to reinstate the programmes.**

Frequently asked questions

Should prisoners be mandatorily tested for HIV and segregated from the rest of the prison population?

Should prisoners with HIV or AIDS be allowed to do the same activities as everyone else?

Should staff be told who has HIV?

Does making condoms and needles and syringes available to prisoners have a negative impact on security in prisons?

Are we not condoning drug use in prison by making needles and syringes available to prisoners?

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Instead of making prevention tools like condoms and needles and syringes available to prisoners, should we not rather adopt a zero tolerance approach and eliminate drugs and sexual activity from prisons?

For detailed answers to these questions, see the section on “frequently asked questions” in module 3.

Checklist 15: Prison staff are key!

- Have you been trained to enable you to do your duties in a healthy and safe manner?
- Have you been trained in the provision of first aid?
- Do you have access to protective equipment, such as latex gloves, masks for mouth-to-mouth resuscitation, etc?
- Do you follow safe work procedures and, in particular, safe searching procedures?
- Are you familiar with the protocol for managing exposure to blood and/or body fluids?
- Have you been vaccinated against hepatitis B?
- Do you facilitate the work of peer educators and external NGOs and professionals?
- Do you actively support making condoms available to prisoners, or at least tolerate it and do not interfere with distribution?
- Do you support measures against sexual abuse in your prison, by taking active measures to protect vulnerable prisoners and denouncing abuse whenever it comes to your attention?
- Do you actively support making bleach and needles and syringes available to prisoners, or at least tolerate it and do not interfere with distribution?
- Finally, do you protect yourself against HIV and other infections outside your work hours?

Module 5: Issues for health care staff in prisons

This module is intended primarily for **medical staff who work in prisons**. We hope it will be useful to medical doctors, nursing staff, and paramedical and ancillary workers.

The module provides health workers in prisons with information on:

- international norms and standards guiding prison healthcare
- why prisoners are particularly vulnerable to HIV/AIDS
- what they can do to reduce the risk of HIV transmission in prison
- practical questions about working in prison
- constraints on providing effective health care in a prison setting.

It will not provide detailed medical information about diagnosis and treatment protocols of HIV/AIDS or the most effective ways of running health care initiatives such as opioid substitution therapy or needle and syringe programmes. However, in the relevant sections it will refer to source material that provide such additional information.

In addition to treating individual patients, health care workers in prisons have a number of important roles in dealing with HIV/AIDS.

These roles include:

- informing, educating or updating your own medical knowledge on scientific evidence and best practice on HIV-AIDS and harm reduction measures;
- contributing to prison policy and prison regulations that respect human rights, and in particular the right to health; and

The special leadership role of health staff

Physicians and nurses and other professionals working in prisons have a unique leadership role in producing the healthy prison. They should start from a sound basis of professional training in which issues such as confidentiality, patient rights and human rights have been fully covered and discussed. They should also have some knowledge of epidemiology, of how diseases spread and of how lifestyles and socioeconomic background factors can influence ill health. They should also be aware of human nutrition and of the importance of exercise and fresh air in promoting health. They should be alert to potential threats to health and able to detect early signs of mental health problems.

Promoting health in prisons – the essentials. A WHO guide. WHO Europe, 2006

Module 5: Issues for health care staff in prisons

- providing information and education to prisoners and staff with the aim of raising awareness, addressing discrimination and stigmatisation, and changing behaviour.

The roles must also include the development and promotion of specific measures to reduce the risk factors for the spread of HIV and other blood borne diseases in prison, including:

- contributing to voluntary counselling and testing (VCT) programmes
- making condoms (and lubricants) available
- initiating or continuing drug dependence treatment
- supervising bleach distribution as well as needle and syringe programmes
- assessing patients' eligibility for early release on medical grounds.

The precise role health care staff can play depends on the framework of laws, policies and practices in your country. As medical practitioners, you may be able to influence that framework and ensure that, as far as possible, the approach to HIV/AIDS prevention and treatment that is used in the wider community is also implemented in prisons.

International norms and standards guiding prison health care

Prison health is part of public health

The vast majority of people committed to prison eventually return to the wider society. Therefore any diseases contracted in prison, or any medical conditions made worse by poor conditions of confinement, become issues of public health for the wider community when people are released. This relationship between prison health and overall public health is fundamental. Reducing the transmission of HIV in prisons is an important element in reducing the spread of infection in the broader society, and should not be left to prison authorities alone to address. Improving the health status of prisoners, and reducing the incidence of disease in prisons, benefits not only the prisoners, but also benefits prison staff and is an integral part of enhancing workplace health and safety.

Therefore, HIV and AIDS, but also hepatitis and tuberculosis and all other aspects of physical and mental health in prisons, must be the concern of health professionals on both sides of the prison walls. As stated in the so-called Moscow Declaration, **"prison health is part of public health."**

The Moscow Declaration expresses the need for all health-care professionals, as well as prison administrations, policy makers and governments, to strive for closer integration between public health services and prison health services. The ethical obligations of health staff working in prisons dictate that, although they are working in

an environment where control and security are usually the first priority, **their first priority is the health of their patients**. In countries with a well functioning public health service there is a strong case for moving responsibility for prison health to the Ministry of Health. However, this is not a straightforward hand-over of responsibility and requires detailed and careful assessment of the feasibility on a case by case basis.

Closer integration between community health services and prison health services will:

- help to protect the independence of the clinical judgement of the prison health staff;
- improve the continuity of care between prison and the community, which is in the interests of prisoners and of society as a whole;
- provide support and training from other health professionals to their colleagues working in prisons;
- provide strong support for public health measures such as provision of condoms, bleach, and needles and syringes, even when these may be perceived to cause problems in the prison environment;
- increase the trust between prisoners and health staff, and thus facilitate the introduction of health prevention and promotion activities.

➤ **The full text of the Moscow Declaration is available via the website of the WHO Europe “Health in Prisons” project:**
<http://www.euro.who.int/prisons>

The principle of equivalence

As explained above, prisoners should not be seen as separated from the general community, but as part of that community. The punishment of imprisonment is the deprivation of liberty and the punishment does *not* extend to the deprivation of other fundamental human rights, such as the right to life, the right to be free from torture and other ill-treatment, and the right to freedom from discrimination. In particular, prisoners do not lose the right to health.

Health in prison is a right guaranteed in international law, as well as in international rules, guidelines, declarations, and covenants. The right to health includes the right to medical treatment and to preventive measures and to standards of health care equivalent to those available in the community. This means not only that prisoners should have access to an equivalent level of health care should they become ill while in prison, but also that those treatments or programmes that were started before entering prison should be available and should continue while in prison. This last point is particularly relevant in relation to drug dependence treatment programmes and HIV prevention measures, as will be explained in the following sections.

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The World Health Organisation *Guidelines on HIV infection and AIDS in prisons* also state that all prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality. In addition, they contain the following other recommendations related to care and support of HIV-positive prisoners:

34. At each stage of HIV-related illness, prisoners should receive appropriate medical and psychosocial treatment equivalent to that given to other members of the community. Involvement of all prisoners in peer support programmes should be encouraged. Collaboration with health care providers in the community should be promoted to facilitate the provision of medical care.
35. Medical follow-up and counselling for asymptomatic HIV-infected prisoners should be available and accessible during detention.
36. Prisoners should have access to information on treatment options and the same right to refuse treatment as exists in the community.
37. Treatment for HIV infection, and the prophylaxis and treatment of related illnesses, should be provided by prison medical services, applying the same clinical and accessibility criteria as in the community.
38. Prisoners should have the same access as people living in the community to clinical trials of treatments for all HIV/AIDS-related diseases. Prisoners should not be placed under pressure to participate in clinical trials, taking into account the principle that individuals deprived of their liberty may not be the subjects of medical research unless they freely consent to it and it is expected to produce direct and significant benefit to their health.
39. The decision to hospitalize a prisoner with AIDS or other HIV-related diseases must be made on medical grounds by health personnel. Access to adequately equipped specialist services, on the same level available in the community, must be assured.
40. Prison medical services should collaborate with community health services to ensure medical and psychological follow-up of HIV-infected prisoners after their release if they so consent. Prisoners should be encouraged to use these services.

A human rights approach to prison health

A human rights approach to prison health respects, protects, and promotes the prisoners' right to health, seeks closer integration of prison health and community health services, and upholds the principle of equivalence of health care. It is the responsibility of health staff, as well as other prison staff, to protect and promote the health of prisoners. This goes beyond the practice of simply diagnosing and treating disease as it appears in individual prisoners and includes issues of hygiene, nutrition, access to meaningful activity, recreation and sport, absence of violence, contact with family etc. Health staff who take an active role in the prevention, as well as the care, of mental and physical health problems, provide the foundation of a healthy environment, which should reduce the harm that imprisonment can cause to an individual.

Prison health staff should be aware of the various provisions of human rights instruments that are relevant to establishing and maintaining a healthy environment.

All persons deprived of their liberty have the right to be treated with respect and dignity and not to be subjected to cruel, inhumane or degrading treatment or torture. Prisoners must not be discriminated against, but must be separated according to their sex, age and whether or not they have been convicted. Accommodation in which prisoners live must be conducive to maintaining good health, provide access to bathing and sanitary facilities, and have adequate lighting, ventilation, heating and floor space. Prisoners must have a diet sufficient for health and be provided with drinking water.

In order to best protect and promote the health of prisoners, **prison health personnel should be independent of the prison administration and law enforcement agencies and must not participate in administering the prison regime and in the decision about, or infliction of, any punishment.**

Why are prisoners particularly vulnerable to HIV?

There are several reasons why prisoners are particularly vulnerable to HIV (and hepatitis):

- those most at risk of contracting HIV are over-represented in prison
- high risk activities are prevalent in prison
- prison conditions contribute to the spread of HIV
- medical practice may not be safe.

For all these reasons, serious outbreaks of HIV and HCV infection have been documented in prisons in a number of countries.

Those most at risk of contracting HIV are over-represented in prison

In general, those groups of people who are more at risk of contracting HIV (as well as hepatitis, sexually transmitted diseases, and tuberculosis) while in the community are over-represented in prison. This includes socially and educational disadvantaged groups, problem drug and alcohol users, sex workers, and others who generally have poor access to health care and health prevention measures. As a result, the prevalence of HIV in prisons is often much higher than in the community.

High risk activities are prevalent in prison

Inside prison, people may continue (or start) their involvement in behaviours such as drug use and sex, with reduced access to prevention measures (such as condoms and sterile injection equipment) and health education that are available to the general population.

Module 5: Issues for health care staff in prisons

Unsafe sexual behaviour is widespread, with prisoners having sex (forced or consensual) with each other and, at times, with prison staff. The high prevalence of sexually transmitted infections (STIs) increases the vulnerability to HIV infection.

Drug use is also widespread in prisons in most countries, including injecting drug use and the sharing of contaminated injection equipment. Even in countries with strict 'zero tolerance policies' and where authorities devote huge financial resources to efforts to reduce the supply of drugs in prisons and claim that drug use in prison does not exist, anonymous surveys show that drug use still happens. Indeed, some of the measures introduced to deter drug use have increased rather than reduced the risk of HIV infection.

The culture of drug use may be associated with gang hierarchies, and closely linked to physical and sexual violence.

Additional risk factors include the sharing or reuse of tattooing and body piercing equipment, the sharing of razors for shaving, blood sharing/'brotherhood' rituals and the improper sterilisation or reuse of medical or dental instruments.

Other factors contribute to making prisons high-risk environments

Factors related to the prison infrastructure and prison management contribute to HIV vulnerability indirectly. They include overcrowding, violence, gang activities, lack of protection for weak or young prisoners, and corruption. For example, prisoners may turn to drug use because they are constantly bullied, or prisoners may be raped or engage in sexual activities under threat as a form of 'payment' to gain 'protection'. Prison gangs may also use rape, as well as blood sharing rituals, to initiate new members. In overcrowded prisons violence tends to be even more common. Prison health staff can help reduce violence by impartially documenting and reporting (with the consent of the individual victim) cases of violence, be it psychological, physical or sexual.

Medical practices

Finally, HIV, as well as hepatitis, can be easily spread in prison through the use of contaminated medical or dental material, such as re-using material that is disposable, or through inadequate sterilisation procedures. The use of blood and blood products that have not been properly screened can also be a source of HIV, hepatitis and other blood borne viruses. **Health-care staff must ensure the implementation of sound practice for the use of medical material**, and monitor this on a regular basis. If necessary, health-care staff must **advocate for increased funding** to ensure that infections cannot occur through provision of medical services.

What can health-care staff do to reduce the risk of HIV transmission in prison?

The prevention of HIV transmission in prisons is often hampered by the denial of governments of the existence of injecting drug use and unsafe sexual practices in

prisons. Therefore, official acknowledgement of the reality of high-risk behaviours and HIV transmission in prisons is an essential first step in raising public awareness and in implementing effective responses.

As health staff, you have a pivotal role in persuading the decision makers of the absolute necessity of introducing HIV/AIDS prevention and care programmes into the prisons. The need stems from the fact that prisoners are an integral part of the community, and that prison health is a part of public health. There is strong evidence about what can be done in prisons to reduce the rate of HIV transmission, and how this can translate into reduced transmission within the broader community.

Health-care staff should be proactive and work with the prison administration, but also with the ministry responsible for prisons, the ministry of health, and other government bodies, in particular the National AIDS Commission or Programme, and non-governmental organisations (including support groups for people living with HIV or AIDS, and groups working on drug use, HIV and infectious diseases in the community), to reduce HIV transmission in prisons. High-risk behaviour will be best addressed using a comprehensive approach that is also incorporated into a broader strategy for health promotion in prisons. For example, since tuberculosis is one of the leading causes of morbidity and mortality in people living with HIV/AIDS, and HIV itself fuels tuberculosis, collaborative TB-HIV activities should be a priority for tackling both diseases.

Inform and educate yourself on best practices

As health staff, people will turn to you for advice and example on sensitive subjects such as HIV, sex in prisons, drug use etc. Health staff, as other prison staff, often harbour fears and prejudices about HIV/AIDS, drug use and sexual activity in prison which can prevent the introduction of measures to reduce the risk of transmission of disease, and of measures to improve the general conditions within prisons. Since health-care staff are responsible for health in prisons, you have a duty to inform and educate yourself on the latest medical practice for the prevention and treatment of HIV/AIDS. In particular you should familiarise yourself with the evidence and best practice for the use of HIV prevention measures in prisons. It is only through educating yourself that these barriers can be broken down.

There are many ways to keep your knowledge of specific health subjects up to date. By ensuring your own continuing education is up to date, you will be in a position to share this knowledge with other staff, design and implement information and education sessions for staff and prisoners, and thus help to raise awareness among all those working and held in prisons and help to break down the misperceptions and prejudices that surround HIV/AIDS.

As well as reading medical and nursing journals, you can obtain a wealth of information from the internet (assuming you have good access). You should also learn about the policies, practices and strategies of the national HIV/AIDS Commission of your country so that you can introduce or update the same policies

and practices in your prison. These national policies should follow international guidelines and standards. Where possible you should attend local, national, and regional seminars on the topic where you can share your experiences with other health professionals. Through establishing professional networks you may also be able to arrange study tours for health staff and prison administration of neighbouring countries prison services in which examples of best practice can be observed in action.

- **If you have access to the internet, consult the internet course for prison doctors at <http://www.lupin-nma.net/>**

For more information on Health in Prison in general and on HIV prevention, care treatment and support see

- ***WHO (2007) Health in prisons. A WHO guide to the essentials in prison health.***
http://www.euro.who.int/InformationSources/Publications/Catalogue/20070521_1
- ***WHO, UNODC, UNAIDS (2007). Comprehensive Review of the Effectiveness of Interventions to Address HIV in Prisons. Evidence for Action Technical Papers. Available via <http://www.who.int/hiv/pub/en/>.***

Contributing to prison policy and prison regulations that respect human rights, and in particular the right to health

You have a central role in encouraging the introduction of the same levels of services for HIV/AIDS prevention and care within the prison, as exist outside in the community. Any strategy for addressing HIV/AIDS must be incorporated into a broader strategy for health prevention and promotion in prisons, since health in prisons incorporates issues of conditions of detention, nutrition, hygiene, exercise, meaningful activity etc. as well as programs addressing specific diseases such as hepatitis, sexually transmitted infections, and tuberculosis. For example, you should consider how to initiate, implement, and monitor collaborative HIV-TB activities aimed at the joint prevention, care and support of both diseases.

Affecting the health strategy in your prison will necessitate **representation of prison physicians at the policy level of the national prisons organisation**, as well as **close co-operation with the ministry of health**, to ensure the inclusion of health issues in policies and regulations, and in elaborating standard operating procedures for implementation at the prison level. You should seek out a body that represents prison health staff, and enquire how they are addressing this issue at all levels of the prison system – central, regional and local - from policy to practice. If there is no body specifically representing prison physicians you can contact your National Medical Association or the World Medical Association, which represents many of the national medical associations globally (www.wma.net).

These measures are based on a human rights approach to prisons and prison health care that should be reflected in the relevant parts of prison policy, regulations and standard operating procedures. One such example is that **prison policy should not permit the segregation of HIV positive prisoners**. There is no public health

rationale for isolating HIV positive prisoners, and it would be unethical to promote or support segregation of people simply because they are HIV-positive. In some cases you may be able to promote innovative measures that have yet to be introduced into the community, and in this way be at the forefront of measures to reduce the spread of HIV.

Providing information and education to prisoners and staff

Having informed yourself about prevention of HIV you are in a strong position to disseminate information and provide education to all members of the prison community. This includes other health staff, prison guards, prison administrators and the prisoners themselves. The aim is to raise awareness, prevent stigmatisation and discrimination, and to change behaviour connected to drug use, drug-related infectious diseases and drug injecting, sexually transmitted infections, tattooing and piercing and the various forms of violence, especially sexual violence, found in prisons.

The process of informing prisoners should begin at the point of reception into the prison. As part of the general health screening on entry, prisoners should be asked about existing high-risk behaviour, and be provided with clear and simple initial information about the risks associated with HIV infection in prison.

In addition to information provided on first entering a prison, various mediums can be used to continue to spread information, and also to educate prisoners and staff on specific issues in more detail. This may be through the production of short leaflets, posters, the showing of videos, or the broadcast of radio messages (in those institutions with prison radio stations), and even through theatre plays. One of the most effective ways of providing information to prisoners may be through peer educators – fellow prisoners who have themselves received training, and who may be viewed with less suspicion than the prison staff themselves.

You will usually not have to write and produce the education materials yourself. In most countries, the National AIDS Commission or Institution and NGO's will have produced information and educational material in different formats. Some of the material may need to be adapted to the prison setting. You should also ask these same external organisations to enter the prisons and directly provide the information and training, and supervise any peer educators.

Better understanding the problem

The more familiar you are with the life and conditions inside your prison, the greater will be your understanding of the nature and level of risk that exists. You can address the issue during your confidential medical consultations, for example if a prisoner presents with an issue that may relate to drug use, or has been the victim of sexual violence. But you cannot only rely on prisoners coming to the health centre. Conducting regular tours of the prison to directly observe and interact with the daily

life of the prisoners will not only increase the trust of the prisoners, but will increase your own understanding of the nature of prison life and how this can increase or encourage high risk behaviour. For example, directly observing the nature of overcrowding will allow a better comprehension of the effects.

One additional activity that can be undertaken to better understand the existing perceptions and practices relating to high risk behaviour is conducting anonymous studies of the knowledge, attitudes and behaviour of both staff and prisoners. Such studies usually address the extent and nature of drug use (types of drugs used and how they are taken), sex within the prison (consensual and/or forced), tattooing and other piercing or blood sharing practices, understanding or misunderstanding of the modes of transmission of HIV and hepatitis, and the attitudes towards people living with HIV or AIDS. In some prisons, these types of studies have been carried out in conjunction with voluntary, anonymous testing for HIV, hepatitis B and hepatitis C.

Such studies are usually undertaken by independent organisations with expertise in this area from outside the prison, ensuring that the studies are truly independent from the prison administration and thus more confidential. Obviously, explaining to the prisoners and staff the nature of such a study, and in particular the complete anonymity of the results, is an essential part to its success.

Voluntary counselling and testing

As health professionals, you will be approached by prisoners wishing to know their HIV status. The World Health Organisation has clearly stipulated that mandatory testing of prisoners for HIV should not be conducted as it is unethical and ineffective.

The prison health service should **routinely offer** voluntary HIV counselling and testing to **all** prisoners at the time of their medical examination upon entry. In addition, because entry is a stressful time and many prisoners may not want to have an HIV test at that time, HIV testing **should be available to prisoners at any time during imprisonment**. During HIV/AIDS education sessions and during prisoner visits to health care, you should regularly remind prisoners that HIV testing is available to them, and encourage them to be tested. Special efforts should be made to offer HIV counselling and testing to TB patients.

Many of the benefits of HIV testing are dependent on, or enhanced by, pre-and post-test counselling. Prisoners who receive *positive* results should receive counselling and referral to care, support, and treatment. Post-test counselling can also deliver important health and risk-reduction information to the majority of prisoners who will access testing and have a negative test result. Information that a prisoner is HIV positive can lead to various forms of discrimination and to physical and psychological violence. Therefore, as with any personal medical information, **the results of HIV tests must remain confidential.**

HIV testing and counselling should be closely linked to access to care, treatment, and support for those testing positive, and you should make sure

that such support is available to prisoners and schedule appointments for provision of such support.

Box 36: What is counselling?

Counselling are interactive and collaborative **confidential** sessions between a person and a care provider. The objective of these sessions is to allow staff or prisoners to cope with the stress and take personal decisions about HIV/AIDS. The counselling process will address issues such as the personal risk of HIV transmission, facilitation of preventive behaviours and the evaluation of coping mechanism should one be confronted with a positive result. **Counselling takes place before and after the HIV test and is done regardless of the result. Continued counselling and support should also be available to staff and prisoners.**

Providing condoms and preventing rape, sexual violence, and coercion

Many prison systems in different parts of the world, including in Europe, Canada, Australia, some prisons in the United States, parts of Eastern Europe and Central Asia, Brazil, South Africa, Iran and Indonesia, make condoms available to prisoners (together with lubricants which reduce the risk of the condom splitting, especially in anal intercourse).

The provision of condoms in prisons confronts many of the taboos surrounding men having sex with men, and directly challenges the common view of the control associated with prison life. In some prison settings, staff have opposed condom distribution, citing security concerns and opposition to male-to-male sex. Some have argued that condom provision will lead to an increase in sexual activity among prisoners, or that condoms would be used to conceal drugs.

However, these fears have proven unfounded. The experience of the many countries in which condoms have been made available in prisons has shown that condoms can be provided in a wide range of prison settings – including in countries in which same-sex activity is criminalised – without any security problems or any other relevant major negative consequences. In particular, it has been found that condom access represents no threat to security or operations, does not lead to an increase in sexual activity, and is accepted by most prisoners and prison staff once it is introduced. Usually support for condom provision increases once a condom programme is started.

Health-care staff will usually be responsible for managing the condom programme and as such need to make sure that condoms (and lubricant) are always available. Condoms need to be easily and discreetly available, ideally in areas such as toilets, shower areas, waiting rooms, workshops, or day rooms where prisoners can pick up a condom without being seen by others. Distribution can be done by health services (either directly from health staff, or freely available in the health clinic), by dispensing machines, by trained prisoners (peers), by NGOs who have access to the prison, or in a combination of these ways. Each prison should determine how to best make condoms available, to ensure easy and discreet access. **Prisoners should not have to ask prison staff for condoms**, since few prisoners will do so because they do not want to disclose that they engage in same-sex sexual activity.

While providing condoms in prisons is important, it is not enough to address the risk of sexual transmission of HIV. HIV prevention also depends on measures taken to prevent rape, sexual violence and coercion in prison. **All prison staff have a role in combating aggressive sexual behaviour. You should bring such behaviour to the attention of prison authorities whenever it comes to your attention.**

Drug dependence treatment

One of the ways of reducing transmission of HIV through the sharing of injecting equipment is to reduce the prevalence of injecting drug use. This can be achieved by providing drug dependence treatment programmes in prison. There are two main forms of treatment:

- abstinence-based treatment in which prisoners are supposed to abstain totally from taking drugs; and
- opioid substitution therapy, which involves prescribing a drug with a similar action to the illegal opiates used, but with a lower degree of risk (since the dose is strictly controlled and the drug is not administered intravenously).

Opioid Substitution Therapy

All forms of drug dependence treatment have some impacts on risks of HIV transmission, but opioid substitution therapy (OST) programmes have the greatest potential to reduce injecting drug use and the resulting risk of spread of infection.

Nevertheless, some prison systems are still reluctant to make OST available. Some prison staff consider methadone (a synthetic opiate that is taken orally) or buprenorphine (a more recently developed OST that is taken sub-lingually) as just another mood-altering drug, the provision of which delays the necessary personal growth required to move beyond a drug-centred existence. Some also object to OST on moral grounds, arguing that it merely replaces one drug of dependence with another. However, evaluations of prison OST programs have provided clear evidence of their benefits. Studies have shown that, if dosage is adequate (at least 60 mg of methadone) and treatment is provided for the duration of imprisonment, such programmes reduce drug injecting and needle sharing and the resulting spread of HIV and other bloodborne infections. In addition, they have additional and worthwhile **benefits, both for the health of prisoners participating in the programmes, and for prison staff and the community.** For example:

- substitution therapy has a positive effect on institutional behaviour by reducing drug-seeking behaviour and thus **improving prison safety**;
- **re-incarceration is significantly less likely** among those prisoners who receive OST;

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- although prison staff often initially raise concerns about security, violent behaviour, and diversion of methadone, these problems do not emerge once the OST programme is implemented;
- both prisoners and prison staff report about the positive impact OST has on life in prison ;
- health care staff report that regular provision of OST provides a further opportunity for them to address other health problems of the prisoners and to pass additional health information to them.

As a health-care intervention, opioid substitution therapy is usually administered by health-care staff at health-care services. Procedures ranging from eligibility for such treatment to storage and administration of the treatment to disciplinary sanctions in case of infringements of the rules have to be established.

- **Corrections Victoria (2003). Victorian Prison Opioid Substitution Therapy Program: clinical and operational policy and procedures.** Available via www.legalonline.vic.gov.au/CA2569020010C266/All/5DED7F4C63FC14F8CA256E530082DE2C?OpenDocument&1=Legal+System~&2=Prisons~&3=Opioid+Substitution+Therapy+Program~. An excellent document with policy and procedures providing a framework for managing substitution treatments.
- **Correctional Service Canada (2003). Specific guidelines for methadone maintenance treatment.** Ottawa: CSC. Available at www.csc-scc.gc.ca/text/pblct/methadone/index_e.shtml. These guidelines provide a
- **general background on prisoners and drug use, a section detailing the goals and objectives of methadone maintenance treatment (MMT), admission criteria and quality assurance for MMT, and the role of the methadone intervention team (MIT); a section about the specific responsibilities of each MIT member; a section on dosing issues; a section on urine drug screening; a section on drug dependence treatment interventions accompanying MMT; and a number of appendices.**
- **A Kastelic. Substitution treatment in prisons.** In: *Promoting health in prisons – The essentials. A WHO guide.* World Health Organization, Regional Office for Europe, 2006.

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- **WHO, UNODC, UNAIDS (2007). Interventions to Address HIV in Prisons: Drug Dependence Treatments. Evidence for Action Technical Papers.** Available via http://www.who.int/hiv/idu/oms_ea_drug_treatment_df.pdf.

Other forms of drug dependence treatment

Other forms of drug dependence treatment are usually less controversial than ST in prisons, but there is little data on their effectiveness **as an HIV prevention strategy**. This is not surprising since they have not usually been introduced in prison with HIV prevention as one of their objectives – in contrast to ST, which has become increasingly available in many prison systems at least in part because of its potential to reduce injecting drug use and the resulting risk of spread of infection.

Nevertheless, in addition to substitution treatment, providing abstinence-based programmes is important. Good quality, appropriate, and accessible treatment can improve prison security, as well as the health and social functioning of prisoners, and can reduce reoffending, as long as it provides ongoing treatment and support, post-release care and meets the individual needs of prisoners.

But even in prison systems with large resources, drug dependence treatment only reaches a relatively small portion of those who need it and is not always effective. That is why HIV prevention measures including needle and syringe programmes need to be made available as well.

Providing bleach or other disinfectants and needle and syringe programmes

Many prison systems have adopted programmes that provide disinfectants, as well as instruction on how to disinfect injecting equipment before re-using it, to prisoners who inject drugs. Evaluations of such programmes have shown that distribution of bleach **does not compromise security**. However, studies in the community have raised doubts about the effectiveness of bleach in decontamination of injecting equipment. In particular, bleach disinfection has limited benefit in preventing hepatitis C virus transmission among injecting drug users. In prisons, the effectiveness of bleach as a decontaminant may be reduced even further. Therefore, bleach programmes should be available in prisons, but only as a second-line strategy to needle and syringe programmes. Where bleach programmes are implemented, **full-strength household bleach should be made easily and discreetly accessible to prisoners in various locations** in the prison, **together with** information and education about how to clean injecting equipment and **information about the limited efficacy of bleach** as a disinfectant for inactivating HIV and particularly HCV.

Because of the limited effectiveness of bleach, a growing number of prisons is making needles and syringes available to prisoners who inject drugs. Needle and syringe programmes for people who use drugs in the community have been available in many parts of the world for years as part of the backbone of HIV prevention, and have been shown to reduce the spread of HIV. The principle of equivalence of health care in prisons dictates that the same level of protection available in the community should be available to those in prison. A person who injects drugs should not lose access to this potentially life-saving prevention measure upon entering prison.

Prison needle and syringe programmes have been implemented in both men's and women's prisons, in institutions of varying sizes, in both civilian and military systems, in institutions that house prisoners in individual cells and those that house prisoners in barracks, in institutions with different security ratings, and in different forms of custody (remand and sentenced, open and closed).

Several models of distribution of sterile injecting equipment have been used, including automatic dispensing machines, hand-to-hand distribution by prison physicians, other prison health-care staff or drug counsellors, or by external

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community health workers, and distribution by prisoners trained as peer outreach workers.

Making needles and syringes available to prisoners is probably the most controversial HIV prevention measure in prison. Often prison staff have opposed it, saying that needles could be used as weapons against staff and/or fellow prisoners and that making them available would be tantamount to condoning prisoners' drug use and giving up on efforts to prevent drugs from coming into the prisons.

However, the experience of the many prisons in which programmes have been implemented has been positive not only for prisoners, but also for staff:

- Prison-based needle and syringe programmes are effective in reducing needle sharing and resulting HIV infection.
- The programmes have had other benefits, such as a decrease in injection-related abscesses, phlebitis, endocarditis, etc. In one prison, a decrease in overdose incidents and deaths was observed. One of the reasons cited for this is that **the implementation of needle exchange and the adoption of a harm-reduction philosophy within the prison fundamentally changed the way that prison health and social work staff were able to engage in counselling with prisoners**. Honest discussions about risk behaviour and overdose risk were able to take place in an atmosphere where prisoners did not have to fear sanctions for admitting their drug use.
- **Needle and syringe programmes do not undermine abstinence-based programmes**. Drugs have remained prohibited within prisons where such programmes are in place. Security staff remain responsible for locating and confiscating illegal drugs. However, it is recognized that if and when drugs find their way into the prison and are used by prisoners, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, needles that are part of the official needle and syringe programme are not. Evaluations have found that needle and syringe programmes in prisons **actually facilitate referral of drug users to drug dependence treatment programmes**, and have led to an increase in the number of prisoners accessing such programmes.
- Needle and syringe programmes have brought people who use drugs in contact with health care staff and peer educators, and allowed for provision of education and information on other aspects of HIV, HCV, and other infections.
- Since the first programme started in 1992, there have been **no reports of syringes ever having been used as weapons in any prison with an operating programme**. In fact, there are reports of an **increase in staff safety** in prisons with needle and syringe programmes, due to the fact that accidental injuries to staff from hidden syringes during cell searches have been reduced. The decrease in the possibility of injury is due to the fact that prisoners are permitted to store injecting equipment in a particular area and therefore do not hide it, thus reducing the risk of needle-stick injury during searches. Staff have also reported that the

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introduction of needle and syringe programmes makes injecting equipment more easy to control.

- **Availability of syringes does not result in an increased number of drug injectors, an increase in overall drug use**, or an increase in the amount of drugs in the institutions. In a few prisons, evaluations actually found that reported levels of drug use or injecting decreased.
- Before their implementation, prison staff regularly had to be convinced to accept or at least tolerate the needle and syringe programmes. Nevertheless, once in place, **acceptance increased and was generally high among staff**, as well as among drug users and non-drug using prisoners. Staff attitudes towards the programmes were least positive in those prisons in which prisoners experienced problems accessing syringes and/or did not trust that they could obtain them without suffering negative consequences, leading to continued illegal trade with syringes in the prison and generally, to reduced benefits of the programme.
- Support by prisoners and staff is important, and both **prisoners and staff should** receive information and education about the programmes and their expected benefits, and **be involved in their design and implementation**.

Often, medical staff have been instrumental in starting and running needle and syringe programmes in prisons.

Box 37: Switzerland: Health care staff start first needle and syringe programme

The first prison needle and syringe programme started as an act of “medical disobedience.” In Switzerland, sterile injecting equipment first became available to prisoners in 1992, at Oberschöngrün prison for men. Dr Probst, a part-time medical officer working at Oberschöngrün, was faced with the ethical dilemma of as many as 15 of 70 prisoners regularly injecting drugs, with no adequate preventive measures. Probst began distributing sterile injecting equipment without informing the warden. When the warden discovered this, instead of firing Probst he listened to Probst’s arguments and sought approval to sanction the distribution of needles and syringes.

Box 38: Moldova: Health care staff supervise peer-led needle and syringe programme

In Moldova, the prison needle and syringe programme evolved through two stages. During Stage 1 needles and syringes were distributed hand-to-hand to prisoners through the prison medical unit. During the four or five months that this distribution system was in place, between 40 and 50 needles and syringes were exchanged. However, the project team decided that this method of distribution was not satisfactory. Their most significant concern was that the programme was being accessed by only 25 to 30 percent of the prisoners known to inject drugs. A number of barriers were identified. These included difficulty in establishing a rapport between the medical staff and the prisoners who were injecting, a lack of anonymity and of confidentiality in the service, and the fact that needle exchange was only available during office hours. Therefore, under Stage 2 of the programme, eight peer volunteers were trained to provide harm-reduction services in four different sites in the prison. Two peer volunteers were assigned to work at each site and were available on a 24-hour basis because the sites were based within the prison living units. The activities and programmes were carried out in cooperation with the prison physician. In the first nine months of 2002, 65 percent to 70 percent of people known to inject drugs in the prison were accessing the programme through the peer volunteers. Health-care staff remain involved in the programme, but only as supervisors.

- For a detailed plan and guidelines used for the implementation of needle and syringe programmes, see: Ministerio Del Interior/Ministerio De Sanidad y Consumo (2003). *Needle Exchange in Prison. Framework Program*. Madrid: Ministerio Del Interior/Ministerio De Sanidad y Consumo. Essential for anyone wishing to see how a successful programme can be established in a prison. Available in Spanish, English, and French. Another, less comprehensive, document on the same issues, entitled “Elements key for the installation of programs of exchange ok (sic) syringes in prison” (Elementos clave para la implantacion de Programas de Intercambio de Jeringuillas en Prision) is available at <http://www.msc.es/ciudadanos/enfLesiones/enfTransmisibles/sida/prevencion/progInterJeringuillas/PIJPrisiones/elemClavePIJIng.htm>

➤ WHO, UNODC, UNAIDS (2007). *Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies. Evidence for Action Technical Papers*. Available at http://www.who.int/hiv/idu/oms_%20ea_nsp_df.pdf.

Collaborative HIV-TB activities

TB is one of the major causes of morbidity and mortality in HIV patients. The detection and treatment of tuberculosis cases is one important measure for addressing the HIV epidemic. Since HIV prevalence rates are often several fold higher in prison than in the surrounding community, the risk of TB in prisons is also multiplied. Increased case detection of TB among prisoners will serve to bring treatment to one of the most common infection in HIV positive people, and if necessary, to provide preventive treatment to HIV positive patients. Ensuring that the National TB Control Program (NTP) is integrated into the prison will help to reduce the spread of TB, both in the prisons and in the surrounding community. While the segregation of HIV positive prisoners has no public health rationale, and should *not* be considered, it is important to isolate active cases of tuberculosis who may transmit the infection to anyone within the prison, including staff, until they become non-infectious after the initial treatment phase.

For details of implementing collaborative HIV-TB activities you should refer to WHO policies and guidelines, and consult with the relevant sections of the Ministry of Health.

- For comprehensive information about tuberculosis control in prisons, see:

- World Health Organization & International Committee of the Red Cross (2001). *Tuberculosis Control in Prisons: A Manual for Programme Managers*. Available in English, Spanish, and Russian via <http://www.who.int/docstore/gtb/publications/prisonsNTP/>
- J. Veen. Tuberculosis control in prisons. In: World Health Organization, Regional Office for Europe (2006). *Guide to Prison Health*.

- WHO (2007) Status Paper on Prisons and Tuberculosis
<http://www.euro.who.int/Document/E89906.pdf>
- For information about a programme to treat multiple drug resistant TB in prisons in Siberia, see:
http://www.phri.org/programs/program_russiantb.asp
- WHO (to be published in 2008) Providing Comprehensive TB and HIV Prevention, Treatment and Care Services for Injecting Drug Users – A collaborative Approach

Hepatitis B vaccination

Hepatitis B is easily spread in prisons. In contrast to HIV, the risk of infection can be reduced through the administration of a vaccine. Some prison systems already make hepatitis B vaccination available to all staff and prisoners. If it is available in your prison, you should encourage all prisoners and your fellow staff to be vaccinated. If it is not, you should inform the prison management of the benefits of making the vaccination available. In addition, consideration should be given to offer hepatitis A vaccination to prisoners at risk.

Hepatitis C prevention

In addition to contributing to reduced risk of HIV transmission in prisons, most of the measures described above also contribute to reducing the risk of hepatitis C virus (HCV) transmission. However, as explained above, in Box 3, HCV is much more easily spread than HIV, including through sharing of shavers and toothbrushes, as well as through tattooing and body piercing. It is therefore important that all prisoners and staff receive information about the risks of HCV transmission in prison and are educated about the ways to reduce that risk. In addition, shavers and toothbrushes should be made available to prisoners so that they do not have to share them with fellow prisoners; and prisons should consider implementing measures to reduce the spread of HCV through tattooing and body piercing, such as making sterile tattooing equipment available to prisoners.

Detection and treatment of sexually transmitted infections

Detection and treatment of sexually transmitted infections (STIs) is important because these infections increase the chances of an individual transmitting and acquiring HIV. STIs that disrupt the integrity of the skin or mucous membranes can bleed easily, increasing the infectiousness and susceptibility to HIV. For this reason, health care staff should screen individuals for STIs and offer treatment, and educate prisoners about the importance of prevention and treatment of STIs.

Practical questions for health service staff in prisons

General health management

As described in the earlier sections, the prevention of HIV infection, and the treatment and support of people living with HIV/AIDS in prisons, while requiring specific actions such as HIV prevention measures, must be integrated into a **comprehensive health strategy** for prisons. A health strategy in prisons is not only about the diagnosis and management of disease, but encompasses both **health prevention** and **health promotion**.

Initial medical screening

Health prevention and promotion should begin at the point of entry into a prison where an initial medical screening should take place as soon as possible, but usually within 24 to 48 hours. The screening may be done by a doctor, but also by a suitably trained nurse who reports to the prison doctor. As well as identifying common diseases and ensuring continuation of any treatments, the screening should provide health prevention and promotion messages on the risks of HIV, hepatitis, sexually transmitted infections and other diseases such as TB, to all new prisoners. It is particularly important to identify prisoners who may undergo drug or alcohol withdrawal upon entering prison. It is also important to identify prisoners with mental disorders since they may require diversion to mental health services for treatment, rather than imprisonment. Also, you should pay attention to those groups of prisoners who may be at risk of self-harm or suicide, such as first time offenders, young women etc.

Accessing health services

Prisoners should be provided with information about how to access the prison health services, and the confidential nature of any appointments and records must be stressed so as to increase the trust of the prisoner. If peer education programs are in place in your prison, the prisoner should be provided with basic information on how to access such programs.

In general, prisoners are entitled to **free health care services** in prison since, while imprisoned, they have no income and are dependent upon the prison service for their daily existence. The health services should be of an **equivalent level** to those available in the community and should include medical, psychiatric/psychological and dental care. This is not to say that the prison must have all of these services permanently on site, but through establishing formal links prisoners must have access to the relevant medical staff, including specialists, and in-patient care, in the community hospitals or clinics. Links with the community health services will also ensure that there is support for prison health staff and the availability of continuing medical education to ensure the maintenance of professional standards and new treatments. It is crucial that the legitimate security concerns of the prison administration do not impede the access of prisoners to outside health facilities, and prior arrangements for secure transport and treatment must be made between the prison and the health facilities.

Health care versus security

The ethical medical treatment of prisoners dictates that the care of the prisoner should be the doctors' primary concern. The prison doctor has the same duties and responsibilities as a doctor practicing in the community. However, by nature of working in, and in many cases being employed by, the prison service, there can be contradictions between the health needs of a prisoner and the security concerns of the administration. These are sometimes referred to as "dual loyalties", where a doctor owes simultaneous obligations to the patient and to a third party, such as the state or to a prison, police or military service. The doctor must not subordinate their medical judgement to security concerns, but must retain independent clinical judgement. For example, the handcuffing of patients during consultations can clearly interfere with treatment and with the trust of the prisoner. Attention should be paid to securing the facility or room, rather than handcuffing the patient.

Providing antiretroviral therapy and other treatment for prisoners with HIV or AIDS

The advent of widely available and increasingly affordable antiretroviral (ARV) therapy for people with HIV/AIDS has meant that, for those who receive the medication, HIV has become a manageable disease. The World Health Organization and other organizations have been driving an initiative to make ARVs available to as many patients as possible, especially in those countries where HIV prevalence is high and resources low. At the 2005 World Summit and at the 2006 High Level Meeting on AIDS, world leaders committed to pursue all necessary efforts towards the goal of **universal access to comprehensive prevention programmes, treatment, care and support by 2010**. In support of this, additional resources to fund an expanded response have become available, including through the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Thanks to these initiatives, ART is increasingly becoming available in developing countries and countries in transition, and countries are moving towards the goal of universal access to treatment by 2010. Therefore, **it will be critical to ensure that treatment also becomes available to all prisoners who need it.**

As prisons need to provide standard of treatment equivalent to outside, prisons have to be ready to provide ARVs to prisoners with HIV wherever treatment becomes available in the community, including enabling treatment without interruption upon arrest and ensuring treatment can continue without interruption upon release. As has been detailed in the preceding sections, since the risk of spread of HIV is much greater in prisons, the control of the infection in prisons, which can include ARV therapy, is an integral part of control in the community. This is especially true for those prisoners who have already commenced ARVs in the community, and for whom the treatment would be interrupted by entry into prison, or may be interrupted upon release. Continuation of treatment with ARVs is a crucial point, as even a short interruption of the treatment may lead to HIV resistance to the drugs.

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Administering ARVs in prison settings is a challenge, but experience in a growing number of countries shows that it can be done, with good results, provided it is well planned, undertaken as part of a country's general treatment scale-up effort, integrated with the provision of treatment outside prisons, and adequately supported by resources and staff. The following issues need to be considered:

- You will have to receive training in the comprehensive management of HIV and AIDS, including the provision of antiretroviral therapy.
- Forming partnerships or entering into agreements with local or regional outside health clinics, hospitals and universities and NGOs (including organizations of people living with HIV or AIDS) to provide antiretroviral therapy and other services for prisoners, and developing integrated rather than parallel care and treatment programmes can be useful. Ideally, prisoners should be able to access antiretroviral medication through public health facilities during their imprisonment. Links with community health services are also important for obtaining specialist advice on the treatment regimes and on managing side-effects, and also for continuing care and support upon release of the individual.
- Information and education on access to treatment should be provided to all offenders who are eligible to be on antiretroviral therapy and treatment of opportunistic infections.
- You should screen offenders (including detainees awaiting trial) on admission to determine if treatment for any HIV- or AIDS-related illness or opportunistic infection, such as tuberculosis, is required. If necessary, you should refer them appropriately.
- Treatment literacy campaigns and sessions should be undertaken in prisons to increase people's understanding of the benefits (and limits) of treatment.
- Measures need to be established to facilitate adherence to treatment.
- The treatment programme needs to contain a comprehensive discharge planning system for prisoners nearing release, including a system for referral to treatment in the general community.
- The guidelines for administration of ARVs in prison should be the same as the national guidelines outside prison.
- The prison health staff must give careful consideration to the practicalities of the daily administering of drugs and the monitoring for side-effects, since this can easily identify prisoners as being HIV positive.

Until ARV therapy is available in your prison, the recommended treatment for HIV positive individuals is "symptomatic management" of the disease. This usually requires treating and preventing the more common opportunistic infections associated with HIV. In the case of HIV positive patients with latent infection with *Mycobacterium tuberculosis* the WHO recommends that Isoniazid be used to prevent progression to active tuberculosis. In the case of active tuberculosis, the initiating of the WHO DOTS strategy (Directly Observed Treatment – short course) for treating TB is as effective in HIV positive patients. In the case of other opportunistic bacterial and parasitic infections, consideration should be given to the WHO and UNAIDS

recommendation of providing Cotrimoxazole preventive therapy (CPT) to eligible patients.

For more information on HIV and Tuberculosis treatments including post-exposure prophylaxis see:

- *WHO (2006) Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach. –2006 rev.
<http://www.who.int/hiv/pub/guidelines/artadultguidelines.pdf>*
- *WHO (2007) Tuberculosis care with TB-HIV co-management : Integrated Management of Adolescent and Adult Illness (IMA)
http://www.who.int/entity/hiv/TB_HIVModuleCover23.05.07.pdf*
- *WHO (2006) HIV/AIDS Treatment and Care for Injecting Drug Users Clinical Protocol for the WHO European Region
http://www.euro.who.int/document/SHA/WHO_Chapter_5_web.pdf*
- *WHO (2006) Post exposure prophylaxis for HIV infection
http://www.euro.who.int/document/SHA/chap_13_prophylaxis.pdf*

Confidentiality

Prisoners are entitled to the same respect of medical confidentiality as any other patient. Thus, the privacy of the medical consultation should be ensured so as to respect confidentiality. It is clear that in relation to issues of HIV status, drug use, sexually transmitted infections, and in particular allegations of physical or sexual violence, prisoners must be afforded absolute confidentiality to allow them to discuss freely with the health staff. If, exceptionally, guards must be present, they should remain in eyesight, but out of range of hearing.

HIV/AIDS-related stigma and discrimination is common in most countries, both inside and outside of prison. People living with HIV/AIDS routinely face social isolation, discrimination, and even violence as a result of their HIV status, and in prison the risk of facing negative consequences can be much greater. The stigma attached to HIV, as well as to drug use and same-sex activity, results not only in stress and fear for people living with HIV or AIDS, but can discourage people from seeking testing and/or accessing advice/information or treatment.

The medical records of individual prisoners should remain under the control of the medical officer and should not be disclosed without the prior written authorisation of the prisoner. They are not part of the general prison records. There should be no system of marking medical records, prison records or cells to indicate HIV status, since this can become easily known to guards and even to prisoners. Attention must also be given to institutional practices for delivering health care, medical appointments, HIV voluntary counselling and testing, and medications. If they are

noticeably different for those seeking information on HIV and for HIV-positive prisoners, this will quickly become obvious to staff and prisoners, and will discourage participation in prevention, testing and treatment programmes, as well as potentially increasing discrimination, victimisation or violence.

Prison officers may believe they have the right to know who is HIV-positive and that such information will protect them from workplace exposure to HIV infection. **It is the role of the prison health staff to challenge such false beliefs**, and to address them through information and education aimed specifically at prison staff. The prison administration itself, together with the health staff, should ensure that policies and practices are put in place that protect confidentiality and form part of a comprehensive HIV/AIDS strategy in prisons.

Confidentiality may also be deliberately put at risk by other prisoners who, like prison officers, mistakenly believe that identifying people living with HIV/AIDS will protect them from HIV infection. Misinformation about HIV/AIDS can create false fears about the risk of HIV transmission via shared living spaces, shared bathing areas, shared food utensils, etc. If such attitudes are not challenged, they can undermine the effectiveness of HIV prevention initiatives among prisoners by creating an atmosphere where identifying HIV-positive prisoners – rather than reducing high risk behaviours – is seen as the most effective manner to protect oneself against HIV infection. Such attitudes can also sustain an atmosphere of discrimination and potential violence against people living with HIV or AIDS. This not only has an impact on the lives of HIV-positive prisoners, it can also deter others from seeking voluntary HIV counselling and testing.

Early or compassionate release

In the case of terminally ill prisoners, prison policy should allow for release on compassionate grounds, so that they are able to die with dignity at home in the company of family or friends. Similarly, it may be that some prisoners are unable to receive the appropriate long-term or intensive level of medical care while in prison. In these cases, consideration should be given to the release of the prisoner so that they can obtain the appropriate care in the community, or while at home.

In both these scenarios, the prison health staff should be in a position to provide independent clinical judgements that are given the appropriate consideration by the prison administration.

Continuity of care

Prison health staff should ensure that there is a continuity of medical care for released prisoners. In the case of drug dependence treatments, such as methadone maintenance therapy, or in the case of antiretroviral or tuberculosis therapy, the individuals, together with their confidential medical records, should be referred to the appropriate community health services. To ensure that contact with the health

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services is made, and maintained by the patient, the staff should enlist the help of community support groups or social services since simply advising a prisoner to go to a particular clinic may meet with little success.

Continuity of care also applies to those arriving in prison. Links with the community health services, community organisations and social services will facilitate a smooth continuation for those who are already receiving some form of treatment in the community.

Checklist 16: The role of prison health care staff

As health care workers you should provide equivalent services inside prison as you would outside. In the particular case of HIV/AIDS, in addition to providing medical care and treatment for infected patients you should:

- Advocate for prison policies, regulations and procedures that respect the rights of prisoners, particularly to an equivalent level of healthcare, freedom from discrimination and stigmatisation, and protection of patient confidentiality;
- Ensure the promotion of both good physical and mental health, through the provision of a healthy prison environment;
- Ensure that the prevention of the spread of HIV and other blood borne viruses forms part of a comprehensive health strategy in prisons.
- Ensure proper diagnosis and treatment of sexually transmitted infections
- Ensure proper diagnosis and treatment of TB, often linked to HIV infection
- Advocate for comprehensive HIV prevention programmes
- Provide information and educational material to prisoners and staff
- Promote and support peer education projects/programs
- Promote voluntary counselling and testing for HIV
- Promote and initiate drug dependence treatment programmes
- Promote and initiate or supervise needle and syringe programmes
- Promote and initiate the distribution and correct use of bleach for disinfecting injecting and tattooing equipment, while pointing out its limitations
- Make condoms, dental dams and lubricant available
- Assess patients eligibility for early release
- Ensure continuity of care, including ARV treatment, for prisoners arriving in, and leaving prison