

# **THE CASE FOR PRISON SYRINGE EXCHANGE:** *10 reasons why sterile syringes should be provided to prisoners*

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This brief is excerpted from the report, *Prison Needle Exchange: A Review of International Evidence and Experience* (R Lines, R Jürgens, H Stöver, D Laticevschi, J Nelles) to be published in 2004 by the Canadian HIV/AIDS Legal Network ([www.aidslaw.ca](http://www.aidslaw.ca)). The full report is based upon a comprehensive review of the existing international literature on HIV, injection drug use, and syringe exchange in prisons. It is also based upon site visits conducted in prisons providing needle exchange in Switzerland, Germany, Spain, and Moldova, where meetings were held with prison staff, health officials, and prisoners to discuss the programs and their impact.

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## **A (Very) Short History of Prison Syringe Exchange**

The first prison syringe exchange program began in the Oberschöngrün prison for men in the Swiss canton of Solothurn in 1992/93. A part-time physician at the prison, Dr. Probst, knew that more than 20% of the prisoners in the institution were injection drug users. He also knew that these men had no access to sterile injecting equipment, and as a result were sharing syringes by necessity. As described by Dr. Joachim Nelles,

*Unlike most of his fellow prison doctors, all of whom fe[lt] obliged to compromise their ethical and public health principles daily, Probst began distributing sterile injection material without informing the prison director. When this courageous but*

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*apparently foolhardy gesture was discovered, the director, instead of firing Probst on the spot, listened to his arguments about prevention of HIV and hepatitis, as well as injection-site abscesses, and sought approval from the Cantonal authorities to sanction the distribution of needles and syringes. Thus, the world's first distribution of injection material inside prison began as an act of medical disobedience.<sup>1</sup>*

More than ten years later, this “act of medical disobedience” can be seen as one of the most innovative and effective prison health care initiatives of recent times – one that continues to challenge the failure of most prison systems worldwide to effectively address HIV and hepatitis C transmission via injection drug use occurring within their walls.

In June 1994, a second Swiss program was established in the women’s prison of Hindelbank. This program was scientifically evaluated after one year, during which time over 5,000 syringes had been distributed. The program was found to be a great success in all indicators of health and safety, and shortly thereafter syringe exchange programs began to expand in number, first in Switzerland and later internationally.

At the time of this writing, sterile syringes are available to prisoners in over 50 prisons in the countries of Switzerland, Germany, Spain, Moldova, Kyrgyzstan and Belarus. In some countries, such as Spain and Kyrgyzstan, these programs are available in all prisons. In the others, syringes are available in only a small number of institutions. Although each of these countries faced different social, political, correctional, and health care challenges, each arrived at the conclusion that providing sterile syringes to prisoners – while controversial – was necessary to prevent the transmission of HIV and hepatitis C.

High rates of HIV, hepatitis C, and injection drug use among prisoners are not unique to these six countries. Many other countries across the globe are faced with rates of HIV and hepatitis C seroprevalence within prisons that are many times higher than those in the general society – infection rates that are often driven by unsafe injection drug use both in the community and inside the prison itself. Addressing the HIV and hepatitis C crisis within prisons is therefore a matter of international concern. Over the past decade, syringe exchange programs have proven to be an essential tool in this effort.

A number of objections have consistently been made against syringe exchange programs in prisons. In many countries, these objections form the basis for the continued rejection of these programs by politicians, correctional officials, and trade unions representing prison staff. Fears about security and safety and of increased drug use or injecting have created particular barriers to a reasoned consideration of the evidence of prison syringe exchange programs.

This brief will address these concerns, and others.

## **10 Reasons why Sterile Syringes should be provided to Prisoners**

### **1. Prison syringe exchange programs reduce risk behaviour and prevent disease transmission.**

The most important lesson emerging from the international evidence on prison needle exchange is that these programs are effective in reducing injecting-related risk behaviours and therefore in preventing the transmission of HIV and HCV.

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<sup>1</sup> Nelles, J., Harding, T. (1995). “Preventing HIV Transmission in Prison: A Tale of Medical Disobedience and Swiss Pragmatism”. *The Lancet* 1995; 346: 1507.

In a recent review of evaluated prison needle exchange programs in Switzerland, Germany, and Spain, Stöver and Nelles found that syringe sharing was “strongly reduced” in seven of nine prisons collecting data on this risk behaviour. One prison experienced no change, while one experienced syringe sharing in “single cases only” In the five prisons whose evaluations included blood testing, there were no new cases of HIV/HCV infection, while two institutions experienced a strong reduction in seroprevalence rates.<sup>2</sup>

## 2. Prison syringe exchange programs are safe.

One of the most important lessons to emerge from international experience is that implementing prison needle exchange programs does not necessitate a trade-off between health and security. In fact, as explained by Stöver and Nelles in a 2003 review of the evaluations conducted of prison needle exchanges,

Scientific evaluations of the pilot phase have been carried out in 11 projects (Nelles/Stöver, 2002; Rutter et al. 2001). **Generally it can be said that in no case needles had been used as weapons either against the personnel or other inmates.** This was and is of course one of the controversial issues in the whole debate. For reasons of safety in the working place, it is interesting to note, that exchange rates within needle exchange projects are nearly 1:1, so that the danger of needle stick injuries by needles not disposed properly is in fact very low.<sup>3</sup> [*emphasis added*]

The safety of these programs has been noted by officials from the Correctional Service of Canada (CSC). In January/February 1999, a delegation from the CSC’s *Study Group on Needle Exchange Programs* travelled to Switzerland to observe the syringe exchange initiatives in three different prisons. Among the findings of the delegation’s report was a note on the safety of these programs.

Inmates involved in the needle exchange program are required to keep their kit in a pre-determined location in their cells. This assists the staff when they enter the cell to conduct cell searches. Because syringes and needles are an approved program, there is no need for the offender to conceal them in their cells. To date, no injury has been inflicted on staff by a needle.<sup>4</sup>

The safety of prison needle exchange has also been affirmed in Moldova, Spain, Kyrgyzstan, and Belarus, none of which have reported syringes being used as weapons against either prisoners or staff.

It can also be argued that providing prisoners with access to the means necessary to protect them from contracting HIV and HCV is in fact compatible with the interests of workplace safety and of the maintenance of safety and order in the institutions.

All the international evidence indicates that there are already syringes present within the prisons of many countries. Therefore, any suggestion that the implementation of prison needle exchange will introduce syringes into a “syringe-free” environment is demonstrably false. Therefore the question becomes “Which situation is preferable?” The status quo – where there are syringes in prisons, the number and location of which are unknown, but these syringes are most likely contaminated with disease – or the situation presented in institutions with well-managed needle exchange programs, in which the number of syringes in circulation is known, they are kept in secure and visible locations, and the needles are sterile, or at least used by only one person. Clearly any objective measure would conclude that the second scenario is preferable to the first.

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<sup>2</sup> Stöver, H., Nelles, J. (2003) *10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies*. Draft copy on file. p.15.

<sup>3</sup> Stöver, Nelles. P.14.

<sup>4</sup> Headrick, W. (April 9, 1999). *Report on the Needle Exchange Program in Switzerland Prisons*. Copy on file.

This issue is nicely summarised by the Spanish Ministry of the Interior and Ministry of Health and Consumer Affairs in their 2002 guidelines the implementation of prison needle exchange programs. On the issue of safety, it is noted that

The start-up of a NEP should not increase the risk, but rather, as previously stated, result in greater safety. First of all, illicit syringes, which are usually hidden and unprotected, are replaced by program syringes equipped with a rigid protective case. Secondly, in the event of an accident, it is less likely that the syringe has been used because the inmate can and should exchange it for a new one at the first opportunity after use. Thirdly, in the event that the syringe has been used, it is less likely that it has been shared by various inmates, thus reducing the probability of it being infected and enabling the user to be identified with greater certainty, which allows preventive actions to be taken if necessary. Finally, in the long term, reduction of parentally transmitted diseases will make prisons a healthier and less risky environment.<sup>5</sup>

### **3. Prisoners have a right to access health care equivalent to that available in the outside community.**

Numerous international instruments address the rights of prisoners, access to health by prisoners, and HIV/AIDS in prisons. Some of these are laws, while others are international rules, standards, and guidelines.

Principle 5 of the UN *Basic Principles for the Treatment of Prisoners* states

Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the *Universal Declaration of Human Rights*, and ... the *International Covenant on Economic, Social and Cultural Rights*, and the *International Covenant on Civil and Political Rights* ... as well as such other rights as are set out in other United Nations covenants.<sup>6</sup>

In particular, there is general consensus that prisoners have a right to health, and that the standard of health care provided must be comparable to that available in the general community. Principle 9 of the *Basic Principles for the Treatment of Prisoners* states that “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”<sup>7</sup> In the context of HIV/AIDS, “health services” would include providing prisoners the means to protect themselves from exposure to HIV and HCV.

Similar statements are found in documents emanating from the European Union and the Council of Europe. Article 35 of the *Charter of Fundamental Rights of the European Union* states “Everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.”<sup>8</sup> Recommendation 10 of Council of Europe’s *Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison* states that “Health policy in custody should be integrated into, and compatible with, national health policy. A prison health care service should be able to... implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public.”<sup>9</sup>

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<sup>5</sup> Ministerio Del Interior/Ministerio De Sanidad y Consumo (October 2002). *Needle Exchange in Prison: Framework Program*. Ministerio Del Interior/Ministerio De Sanidad y Consumo: Madrid. p.16.

<sup>6</sup> Adopted by General Assembly Resolution 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990).

<sup>7</sup> Ibid.

<sup>8</sup> Charter of Fundamental Rights of the European Union, Article 35.

<sup>9</sup> Council Of Europe Committee Of Ministers. *Recommendation No. R (98) 7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison*. Adopted by the Committee of Ministers on April 8, 1998 at the 627th Meeting of the Ministers' Deputies.

This principle of equivalence of care is specifically applied to the issue of HIV/AIDS by the World Health Organization (WHO). In 1991, the WHO Regional Office for Europe recommended the provision of sterile syringes in prisons as part of a comprehensive HIV prevention strategy.<sup>10</sup> Two years later, the WHO published its *Guidelines on HIV Infection and AIDS in Prisons*. Principle 1 of the *Guidelines* emphasizes “All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination...with respect to their legal status”.<sup>11</sup> Principle 2 further states “general principles adopted by national AIDS programmes should apply equally to prisons and to the general community.”<sup>12</sup> The WHO *Guidelines* are clear 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 injecting equipment during detention and on release.”<sup>13</sup>

The right of people in prison to access adequate standards of HIV/AIDS prevention and care is also supported by UNAIDS, which has stated that “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.”<sup>14</sup> This would again support the position that where sterile syringes are provided to people who inject drugs in the community, these same programs must be implemented in prisons.

International codes of practice governing physicians and other health professionals working in prisons also support the position that comprehensive HIV and HCV prevention measures, including syringe exchange, must be made available to incarcerated populations. The *Oath of Athens for Prison Health Professionals*, adopted in 1979 by the International Council of Prison Medical Services, “recognize[s] the right of the incarcerated individuals to receive the best possible health care” and undertakes that “medical judgements be based on the needs of our patients and take priority over any non-medical matters.”<sup>15</sup>

International opinion supporting the right of prisoners to health care is not limited to the documents above. Reports from the European Committee for the Prevention of Torture, the Eight United Nations Congress have expressed similar positions, as have legal scholars and medical experts within national contexts such as the United States and Australia.<sup>16</sup> As has been explored in detail by Jürgens (1996), recommendations on HIV/AIDS in prisons developed by the international community consistently support “equivalence of treatment of prisoners,” and stress the importance of prevention of transmission of HIV in prisons, and suggest that prevention measures – including sterile syringes – be provided to prisoners.<sup>17</sup>

#### **4. Syringe exchange programs have other positive outcomes on prison health.**

In addition to the reductions in HIV and HCV transmission detailed in Point 1 (above), international evidence has shown that the provision of sterile syringes has other positive outcomes on the health of prisoners.

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<sup>10</sup> Stöver, H.(2002) *Drugs and HIV/AIDS Services in European Prisons*. Universitat Oldenburg, Germany. pp.127—128.

<sup>11</sup> World Health Organization. *WHO Guidelines on HIV Infection and AIDS in Prisons*. World Health Organization, Geneva. 1993. p.4.

<sup>12</sup> *Ibid*.

<sup>13</sup> *Ibid*, p.6.

<sup>14</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS). Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996.

<sup>15</sup> International Council of Prison Medical Services (1979). *Oath of Athens for Prison Health Professionals*. Adopted September 10, 1979, Athens.

<sup>16</sup> Jürgens, R. (1996) *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society. pp.81-88.

<sup>17</sup> *Ibid*.

Perhaps the most significant is a dramatic decrease in fatal and non-fatal heroin overdoses among incarcerated injection drug users. For example, the Swiss prison of Hindelbank averaged between one and three fatal heroin overdoses annually during the years before the needle exchange program was implemented. Since the program has been in place, Hindelbank has experienced only one fatal OD in the past nine years.<sup>18</sup> This experience was also reported in the Swiss prison of Oberschöngrün (which has a heroin maintenance program in addition to a syringe exchange). Prior to the implementation of syringe exchange, staff at the prison estimated there was approximately one non-fatal overdose a week, and approximately two fatal ODs annually. Overdoses of any kind are now extremely rare, and the prison has experienced only one OD death since 1995.<sup>19</sup> Prison needle exchanges therefore save lives in ways other than the prevention of disease transmission.

The prison staff interviewed as part of this report offered two reasons why the provision of needle exchange has resulted in such significant decreases in overdoses. The first is that by providing each injection drug user with his or her own personal needle, it allows the individual to consume a smaller amount of drugs with each injection. In the past, when a syringe was shared among many prisoners, people injecting drugs would only have limited access to injecting equipment and would be more likely to inject large doses on those rare occasions when he or she was in possession of the syringe.

The second reason cited was that the provision of needle exchange, and the adoption of a harm reduction philosophy within the institution, fundamentally changed the way that prison health and social work staff were able to engage in counselling with prisoners. As injection drug use was an accepted reality inside the prisons, the counsellors/health workers and prisoners were able to be much more open and frank in discussions about drug use and harm reduction. The need for prisoners to pretend to be “drug-free” was therefore removed, and honest discussions about risk behaviour and overdose were able to take place in an atmosphere where they did not fear punitive sanctions for admitting to drug use.

The other significant health benefit experienced was a decrease in abscesses and other injection-related infections. Both Hindelbank and Oberschöngrün reported a near disappearance in abscesses, which had been a major problem before the needle exchange programs were implemented. Staff at Hindelbank noted that this has resulted in significant cost savings to the prison, as treating abscesses had previously been a significant part of the work of the prison medical staff.

## **5. Prison syringe exchange programs do not increase drug use or injecting among non-injectors.**

The belief that programs such as needle exchange promote injection drug use has historically been a barrier to the implementation of harm reduction measures in both the community and in prisons. However, within prisons this argument is complicated by the fact that many prisoners are incarcerated as a result of drugs or of drug-related offences. Consequently, providing sterile needles to prisoners is seen as condoning or promoting behaviour that the prison should be seeking to eradicate as part of the individual’s “rehabilitation”. Acknowledging the reality of drug use in prisons is also difficult for prison systems, as it is perceived as an admission of their failure to maintain institutional control and security.

In the case of prison syringe exchange, scientific evaluations have consistently found that the availability of sterile 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 recent review of eleven evaluated prison needle exchange programs in Switzerland, Germany, and Spain, Stöver and Nelles found that in no case examined did the introduction of a needle exchange program result in increased

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<sup>18</sup> DeSantis, D., Hindelbank Institution (June 2, 2003). Interview with Rick Lines.

<sup>19</sup> Stutz, H., Weibel, U., Oberschöngrün Institution (June 4, 2003). Interview with Rick Lines.

drug use or injecting within the institution. In two prisons in Switzerland, drug use actually decreased.<sup>20</sup>

These findings demonstrate conclusively that the provision of sterile syringes to prisoners does not result in either increased drug consumption or an increase in drug injection.

That said, there is already clear evidence in a number of countries that many prisoners inject drugs for the first time while in prison.<sup>21</sup> The argument that a needle exchange program would lead to prisoners begin using injection drugs is therefore undermined by the fact that this behaviour is already the norm in many countries *without* prison needle exchange programs. In these jurisdictions – where sterile syringes are not provided – these individuals are forced to share or reuse needles, creating a high risk of HIV and HCV transmission.

## **6. Prison syringe exchange programs do not condone illegal drug use, nor undermine abstinence-based programs.**

It is difficult to argue that the provision of sterile syringes results in the condoning of the use of illegal drugs in the institution. The provision of needle exchange in the countries examined in this report has not resulted in prison officials permitting the possession or sale of drugs. In all cases, drugs remain prohibited within institutions where syringe exchange is in place, and security staff are instructed to locate and confiscate all such contraband. In this sense, the policy and practice is no different than in jurisdictions that do not have needle exchange. What is different, however, is the recognition 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, syringes that are part of the official needle exchange programs are not.

In many instances, particularly in the Western European examples, syringe exchange programs are only one component of a comprehensive drug service within prisons, that includes abstinence-based programs, drug treatment, drug-free units, and harm reduction measures. The availability of sterile syringes therefore does not undermine or impede the provision of other drug services, but rather offers drug users more options for improving their health status.

In the case of the original German pilot programs, the evaluator found that the syringe exchange program actually *increased* the number of people accessing drug treatment services, demonstrating that needle exchange programs can serve as valuable points of contact and referral for a difficult to reach drug using population. This was also the experience in Spain, where the Ministry of the Interior and Ministry of Health and Consumer Affairs concluded not only that “[i]t is feasible for a NEP and other drug addiction prevention or intervention programs to coexist”, but also that the “[i]mplementation of a NEP does not generally cause an increase in drug use” and that “NEPs in prison facilitate referral of users to drug addiction treatment programs”.<sup>22</sup>

This is not to say that prison officials and staff do not have to struggle with challenging philosophical and practical issues when implementing needle exchange programs. Prison staff trained within an ethos of zero tolerance have had to come to terms with confiscating drugs but not injection equipment. This is a reality to which police forces in countries with community needle exchange programs have adapted. As the Head of the Merseyside Police Drug Squad has stated,

As police officers, part of our oath is to protect life. In the drugs field that policy must include saving life as well as enforcing the law. Clearly, we must reach injectors and

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<sup>20</sup> Stöver, Nelles. p.15.

<sup>21</sup> For example, see European Monitoring Centre on Drugs and Drug Addiction. (2002). 2002 Annual Report on the State of the Drugs Problem in the European Union and Norway. Luxembourg: Office for Official Publications of the European Community. p. 46—47.

<sup>22</sup> Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.5.

get them the help they require, but in the meantime we must try and keep them healthy, for we are their police as well ... People can be cured of drug addiction, but at the moment they cannot be cured of AIDS.<sup>23</sup>

This sentiment was echoed by Martin Lachat, the Interim Director of Hindelbank institution in Switzerland in 1994,

The transmission of HIV or any other serious disease cannot be tolerated. Given that all we can do is restrict, not suppress, the entry of drugs, we feel it is our responsibility to at least provide sterile syringes to inmates. The ambiguity of our mandate leads to a contradiction that we have to live with.<sup>24</sup>

Ultimately, the provision of sterile syringes is not incompatible with the goal of reducing drug use in prisons. While making sterile needles available to incarcerated drug users has not led to an increase in drug use, it has led to a decrease in the number of prisoners contracting HIV, HCV, and other infections. Therefore, it can be argued that the refusal to make sterile needles available to prisoners with the knowledge that the sharing of injecting equipment is prevalent is to condone the spread of HIV and HCV among prisoners and to the community at large.

## **7. Syringe exchange programs are adaptable to differing prison environments.**

One of the rationales often used by prison systems to dismiss the evidence of the effectiveness of prison needle exchange programs is to characterize these programs as “boutique” projects that are in place only in unusual prison environments (i.e. small institutions, women’s prisons, low security prisons with docile prisoner populations, etc.). Therefore, this argument goes, the success of these programs cannot be replicated in other, larger, or more “difficult” prisons.

While it is true that the initial Swiss pilot projects were conducted in prisons that are “small” by most standards (Oberschöngrün has a population of 75 while Hindelbank has a population of 110), subsequent programs have been successfully implemented in a wide variety of settings in both civilian and military systems. In Germany, for example, needle exchange programs have been introduced in prisons as small as 50 people (the women’s prison in Hannöversand) and as large as 500 (Am Hasenberge men’s prison in Hamburg). In Moldova, syringe exchange programs operate in medium/maximum security men’s prisons with populations of 1,000 or more. Soto de Real prison in Madrid, which was visited in preparation of this report, has a population approaching 1,600.

Indeed, Spain provides the most compelling refutation of this argument, as the framework for needle exchanges is in place in all 69 prisons (*all sizes, all security levels*). This clearly dispels the notion that prison needle exchange is limited only to unusual prison environments.

Needle exchanges have also been established in radically different prison environments. In the case of Western European programs, the prisons’ physical structures are based on ranges of individual cells, each housing one or two prisoners each. In the case of Moldova, prisoners live in barracks-style facilities that have 70 or more men living and sleeping in a single large room. In both cases, prison needle exchange programs have been successfully and safely implemented.

The cases examined also demonstrate that needle exchange projects can be implemented in those jurisdictions that are relatively well resourced and financed (Western Europe), and those that operate with significantly less funding and infrastructural supports (Eastern Europe and Central Asia).

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<sup>23</sup> Cited in D Riley. Drug Use in Prisons. In: Correctional Service of Canada. HIV/AIDS in Prisons: Background Materials. Ottawa, 1994, at 156.

<sup>24</sup> Lachat, M. (1994) Account of a pilot project for HIV prevention in the Hindelbank Penitentiaries for Women - Press conference, 16 May 1994. Berne: Information and Public Relations Bureau of the Canton.



Therefore, access to funding and resources alone is not an indicator of the ability of a jurisdiction to provide needle exchange to prisoners.

That said, several jurisdictions have placed some limitations on individual prisoners allowed to participate in syringe exchange programs. In some German prisons, for example, prisoners receiving methadone maintenance or involved in abstinence-based programs were not eligible to access syringe exchange programs. However, this is not a universal approach, and other countries do not enforce such restrictions. Prisoners with histories of psychosis or serious violence are also disqualified in some jurisdictions, although others assess each on a case-by-case basis, seeking to identify safe ways to provide sterile syringes, on the assumption that otherwise the individual in question will share a syringe with someone else.

Rather than institutional size, security level, or structure, prison needle exchange programs have been implemented based upon need of the prisoner population. In the cases examined for this report, syringe exchange projects have been initiated in response to high rates of HIV seroprevalence and/or high levels of injection drug use within prisons. When this need has been established, each of the jurisdictions examined has shown flexibility and creativity in adopting a model of syringe exchange that meets the needs of the prison population.

## **8. Prison syringe exchange programs can be successfully implemented using a variety of distribution methods.**

Different jurisdictions have adopted different methods to distribute or exchange syringes in prisons. These include,

- distribution by a prison nurses or physicians based in a medical unit or other part(s) of the prison
- distribution by one-for-one automated syringe dispensing machines
- distribution by prisoners trained as peer outreach workers
- distribution by external NGOs or other health professionals whom come into the prison for this purpose

Each distribution method has its own unique opportunities and challenges. Some of the features of each distribution method are summarized below.<sup>25</sup>

### **Hand-to-hand exchange by nurses and/or the prison physician**

- Provides personal contact with prisoners, and an opportunity for counselling
- Can facilitate outreach to and contact with hard-to-reach drug users
- Prison maintains high degree of control over access to syringes
- One-for-one exchange, or multiple syringe distribution, possible (as necessary, and as reflects individual prison policy)
- Lower degree of anonymity and confidentiality, which may reduce the participation rate (although high acceptance by prisoners is possible if confidentiality maintained)
- Access more limited, as syringes are available only during the established hours of the health service (this is particularly true if the prison follows a strict one-for-one exchange policy)
- Creates possibility of proxy exchanges by prisoners obtaining syringes on behalf of those who do not want to participate in-person due to lack of trust with staff

### **Distribution through automated dispensing machines**

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<sup>25</sup> This analysis is adapted and expanded from that found in Stöver, Nelles, J. p.14.

- High degree of accessibility (often multiple machines are in various places in the institution, which can be accessed outside of the established hours of the medical service)
- High degree of anonymity, as there is no involvement with staff
- High acceptance by prisoners
- Strict one-for-one exchange
- Machines are vulnerable to vandalism and damage by prisoners and staff who are not in favour of this program.
- Technical problems with functioning of the dispensing machines can mean syringes are unavailable for periods of time, which can decrease prisoner confidence in the program
- Some prisons are not architecturally suited for the use of dispensing machines (i.e. lack of discreet areas freely accessible to prisoners in which machines may be placed)

#### **Hand-to-hand exchange by peer outreach workers**

- High acceptance by prisoners
- High degree of anonymity and trust
- High degree of accessibility (peer outreach workers live in the prison units, and are available at all hours)
- No staff control over distribution, which can lead to increased fears among staff
- One-for-one exchange more difficult to ensure

#### **Hand-to-hand provision by external NGO or health professionals**

- Provides personal contact with prisoners, and an opportunity for counselling
- Facilitates outreach to and contact with hard-to-reach drug users
- Prison maintains high degree of control over access to syringes
- One-for-one exchange, or multiple syringe distribution, possible (as necessary, and as reflects individual prison policy)
- Provides a higher degree of anonymity and confidentiality, as there is no interaction with prison staff
- Access more limited, as syringes are available only during set hours or set times of the week (this is particularly true if the program follows a strict one-for-one exchange policy)
- Anonymity and confidentiality may be compromised if the external agency is required to provide information on prisoner participation to the prison
- Potential for mistrust by prison staff of the external workers providing syringes
- External workers may experience more barriers in dealing with the prison bureaucracy than internal prison health staff
- Turn-over in NGO staff may result in lack of program continuity, and lack of a consistent “face” for the program for prisoners and prison staff

It is worth noting that different jurisdictions have adopted different approaches to the question on one-for-one syringe exchange (i.e. a person is only given one syringe, and only when he or she produces a used one for exchange). While some of the jurisdictions examined for this report adhere to a strict one-for-one policy, others do not. Hindelbank, for example, while using dispensing machines that operate on a one-for-one basis, will provide up to five additional “points” or needle tips to program participants who have trouble finding veins to inject into. Spain has also shown flexibility in its approach. While Spanish guidelines acknowledge that “the rule should be exchange, i.e., the previous syringe must be returned before a new kit is handed out”, they direct that “a flexible attitude should be maintained towards [the one-for-one rule’s] application keeping in mind that the primary objective of the program is to prevent shared use of syringes.”<sup>26</sup> The guidelines advise that “[t]he number of kits to be supplied depends on the frequency of exchange and the user’s consumption habits: it should be

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<sup>26</sup> Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.11.

sufficient to cover the inmate's needs so that he does not have to reuse the syringe before the next day of exchange."<sup>27</sup>

## **9. The provision of bleach alone is not a sufficient response to the risk of HIV/HCV transmission via syringe sharing among prisoners.**

While very few prison systems have implemented syringe exchange programs, many have opted to provide bleach or other disinfectants to enable prisoners to clean syringes that are then to be reused. According to UNAIDS, the provision of full-strength bleach to prisoners as a harm reduction measure has been adopted in prisons in Europe, Australia, Africa, and Central America.<sup>28</sup> In August 2001, it was reported that bleach was provided in 11 of 23 EU prison systems.<sup>29</sup> In Canada, bleach is available as a harm reduction measure in the federal, British Columbia, and Québec systems.<sup>30</sup> However, while bleach is an important harm reduction option for injection drug using prisoners who must share injecting equipment, it is not an adequate substitute for the provision of needle exchange for injection drug users.

There are a number of reasons why this is true, the foremost being doubts about the efficacy of bleach in sterilizing syringes. While clearly a useful measure in *reducing* the risk of transmission of blood-borne diseases, numerous scientific studies have cast doubt on the effectiveness of bleach in *eliminating* HIV<sup>31</sup> and HCV<sup>32</sup> in syringes. Many studies promoting the value of bleach as a harm reduction measure still conclude that access to sterile syringes is preferable to disinfecting previously used needles.<sup>33</sup> There is also evidence that many injection drug users – as many as half or more in some studies – do not know or do not practice the proper method of using bleach for disinfecting needles.<sup>34</sup> This further undermines the effectiveness of an already less-than-optimal HIV/HCV prevention measure. It has even been suggested that the reuse of an HIV contaminated syringe cleaned with bleach may actually *increase* the risk of HIV transmission.<sup>35</sup> Therefore, the provision of

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<sup>27</sup> Ibid, p.14.

<sup>28</sup> Joint United Nations Programme on HIV/AIDS (April 1997). *Prisons and AIDS: UNAIDS Point of View*. UNAIDS Information Centre, Geneva. p.6.

<sup>29</sup> Stöver, H, von Ossietzky, C. (August 2001). *An overview study: Assistance to drug users in European Union prisons*. European Monitoring Centre from Drugs and Drug Addiction, Lisbon. p.24.

<sup>30</sup> Lines, R. (2002). *Action on HIV/AIDS in Prisons: Too Little, Too Late—A Report Card*. Canadian HIV/AIDS Legal Network, Montreal. p.18.

<sup>31</sup> Titus, S., Marmor, M., Des Jarlais, D., Kim, M., Wolfe, H., Beatrice, S. (July 1994). Bleach use and HIV seroconversion among New York City injection drug users. *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):700-4.

<sup>32</sup> Kapadia, F., Vlahov, D., Des Jarlais, D.C., Strathdee, S.A., Ouellet, L., Kerndt, P., Morse, E., Williams, I., Garfein, R.S. (2002) Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users? *Epidemiology*. 2002 Nov;13(6):738-41.

<sup>33</sup> Kapadia, *et al.* (2002). See also Flynn, N., Jain, S., Keddie, E.M., Carlson, J.R., Jennings, M.B., Haverkos, H.W., Nassar, N., Anderson, R., Cohen, S., Goldberg, D. (July 1994). In vitro activity of readily available household materials against HIV-1: is bleach enough? *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):747-53.

<sup>34</sup> See Carlson, R.G., Wang, J., Siegal, H.A., Falck, R.S. (December 1998). A preliminary evaluation of a modified needle-cleaning intervention using bleach among injection drug users. *AIDS Education and Prevention*. 1998 Dec;10(6):523-32. See also McCoy, C.B., Rivers, J.E., McCoy, H.V., Shapshak, P., Weatherby, N.L., Chitwood, D.D., Page, J.B., Inciardi, J.A., McBride, D.C. (July 1994). Compliance to bleach disinfection protocols among injecting drug users in Miami. *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):773-6. and Gleghorn, A.A., Doherty, M.C., Vlahov, D., Celentano, D.D., Jones, T.S. (July 1994). Inadequate bleach contact times during syringe cleaning among injection drug users. *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):767-72.

<sup>35</sup> In a syringe cleaned with bleach, traces of bleach are likely to remain present even after flushing with water. Bleach contains free chlorine, a known oxidant, and in vitro laboratory studies have shown that low concentrations of oxidants can lead to both tissue inflammation and HIV-1 replication. Therefore, although not statistically proven, “[h]ypothetically, oxidant effects of the residual bleach in the bleach-cleaned syringes could enhance the possibility of infection by remaining HIV-1 contained in a contaminated syringe.” Contoreggi, C.,

sterile syringes is clearly a more effective HIV/HCV prevention strategy than is providing only bleach.

As discussed in Point 6, prisons providing syringe exchange have also realized other health improvements in addition to a reduction in HIV and HCV transmission. These include a significant reduction in abscesses and other vein problems that results from reusing dull or damaged needles, as well as a decrease in fatal and non-fatal overdoses in some institutions. The provision of bleach alone does not offer these same health benefits.

Also, as explored in Point 1, the provision of needle exchange can significantly improve staff safety by reducing or eliminating the risk of accidental needle stick injury from hidden syringes during cell and personal searches. The provision of bleach alone does not offer this benefit for staff, as syringes are still considered contraband within the institutions and are therefore hidden rather than stored safely in visible areas.

In conclusion, bleach should be made available to prisoners as one option to enable injection drug users to reduce their risk of contracting HIV and HCV infection. Making bleach available is, however, not enough, and there are many additional benefits from establishing needle exchange programs in prisons.

#### **10. The provision of methadone alone not a sufficient response to the risk of HIV/HCV transmission via syringe sharing among prisoners.**

Methadone is a medically indicated treatment used internationally as an effective replacement therapy for opiates, and is an important harm reduction option for injection heroin and morphine users. Administered orally, methadone allows injection opiate users a valuable option for ending their reliance on illegal drugs, and ceasing injecting practices.

Methadone is a crucial element of a comprehensive harm reduction strategy, both in prisons and in the community, as it provides an important option for injection drug using prisoners who wish to stop using illegal drugs. However, despite its value, there are several reasons why methadone provision *in isolation* is not a sufficient response to the risk of HIV and HCV transmission in prisons via injection drug use.

The primary reason is that methadone – as a form of drug treatment – is of no benefit to those drug users who do not want to stop using illegal drugs. Injection drug users not wishing to access a methadone program will therefore continue to inject, and to share syringes when sterile needles are not available.

Methadone treatment is also only appropriate for drug users who are physically dependent upon opiates. Therefore, it is not an alternative for those who are occasional or recreational injection opiate users, who again will continue to inject and to share syringes where needle exchange is not provided. Even among those drug users who access methadone treatment, there will be a number who will continue to inject either sporadically or habitually, and will therefore share syringes where sterile ones are not available. This has been recognized by the Spanish government, and is cited as one of the reasons for allowing prisoners on methadone programs to also access needle exchange.<sup>36</sup>

Within prisons, barriers often exist to the optimal provision of methadone. As a medical therapy, a methadone program requires the involvement of a prison physician who is both trained in methadone provision and philosophically supportive of the use of substitution treatment. This is not always the

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Jones, S., Simpson, P., Lange, W.R., Meyer, W.A. (2000). Effects of varying concentrations of bleach on in vitro HIV-1 replication and the relevance to injection drug use. *Intervirology*. 2000;43(1):1-5.

<sup>36</sup> *Recomendaciones sobre los Programas de Intercambio de Jeringuillas (PIJ)*. Obtained from the Prisión Soto de Real: Madrid. Copy on file.

case in many prisons. Additionally, because of the cost associated with the provision of this medical service, the number of methadone spaces is often limited, thereby creating a situation where some drug users will be excluded from accessing the program. Many of these users will therefore continue to inject, and to share needles where sterile ones are not available.

Finally, methadone is only a useful treatment for opiate dependency. It is not a harm reduction option for those who inject non-opiates, such as cocaine. Therefore, the availability of methadone does nothing to address the unsafe injecting practices of these drug users.

Therefore it is clear that the provision of methadone – while an essential element of a harm reduction strategy – is not in itself a sufficient response to the risk of disease transmission via injection drug use in prisons. Furthermore, as examined in Point 9, the implementation of needle exchange in prisons has achieved other important benefits in the areas of prisoner health and staff safety that will be denied where syringe distribution programs are not available.

## **Conclusion**

Although the number of countries that have implemented prison syringe exchange is relatively small, the experience of these projects is very diverse.

Prison needle exchange programs can be found in countries of Western Europe, Eastern Europe, and Central Asia. They are operating in well-funded prison systems and severely under-funded prison systems. They are operating in civilian prison systems and military prison systems, and in institutions with drastically different physical arrangements for the housing of prisoners. They are operating in men's and women's institutions, and in prisons of all security classifications and all sizes. They are operating as individual pilot projects, and as integrated components of overall prison policy. They utilize various methods for distributing syringes.

While these prison syringe exchange programs have been implemented in diverse environments and under differing circumstances, the results of the programs have been remarkably consistent. Hopes for improved prisoner health and reduction of syringe sharing have been achieved. Fears of violence, increased drug intake, or other negative consequences from providing syringes to prisoners have not materialized. By any objective measure, prison syringe exchange programs are a major success.

However, when it comes to the issue of syringe exchange in prison, objective measures have often proved secondary to political considerations and public apathy towards prison conditions. Many countries which exhibit significant rates of HIV/HCV and injection drug use in prison populations refuse to consider syringe exchange programs despite the evidence of their effectiveness and safety. This has even been the case in countries that have acted to implement other harm reduction initiatives to address the severity of their prison health crises. Yet, as has been explored in this brief, a harm reduction strategy that excludes syringe exchange is not only sub-optimal, it is in contravention of international guidelines on prison health, and fails to meet best practice.

Based upon the findings of this report, two clear lessons emerge.

The first is that prison syringe exchange is a health response that has been proven to be effective and safe. Needle exchange has been available in some prisons for as long as ten years, and it is an approach that has been rigorously evaluated everywhere it has been enacted. Prison systems and governments can no longer avoid their responsibilities to provide for the health of prisoners by dismissing prison needle exchange as something new or untested. It is neither.

The second is that – no matter how effective in practice – prison harm reduction initiatives remain controversial and are still subject to political interests other than health care.



UNITED NATIONS  
*Office on Drugs and Crime*

12 May 2004

The United Nations Office on Drugs and Crime welcomes your participation in roundtable discussion on:

**HIV/AIDS and Prisons**  
**Monday, 17 May 2004, 1300 to 1430 hrs**  
**Room CO II, 7<sup>th</sup> Floor**

Chair: **Jan van Dijk**, Officer-in-Charge, Human Security Branch,  
Division for Operations, UNODC

Panellist: **Lars Moller**, Project Coordinator, Health in Prisons  
Project, WHO  
**Heino Stoever**, Lecturer, University Bremen, Germany  
**Rick Lines**, Executive Director, Irish Penal Reform Trust  
**Leonora Lowe**, Programme Coordinator, Penal Reform  
International  
**Michael Platzer**, Officer-in-Charge, Rule of Law Section,  
Human Security Branch, UNODC  
**Monica Beg**, Advisor, HIV/AIDS Unit

UNIS/CP/489  
17 May 2004

## Round-table on “HIV-AIDS and Prisons” during the Commission on Crime Prevention and Criminal Justice

VIENNA, 17 May (UN Information Service) -- The rapid spread of HIV/AIDS in prisons, and practical measures to curb the spread of the disease in this section of society was the subject of a round table organized today by the United Nations *Office on Drugs and Crime* (UNODC) and attended by high-level international experts.

The round table took place as a side event during the 13th session of the Commission on Crime Prevention and Criminal Justice, currently underway in Vienna. Today, the Commission discussed the use and application of United Nations standards and norms in crime prevention and criminal justice. The Special Envoy of the Secretary-General on HIV/AIDS in Russia and Central Asia, Lars Kallings, addressed the Commission this morning.

Existing evidence indicates that the rates of HIV-infection among prison inmates in some countries are significantly higher than in the general population. Some prisoners had been infected outside the institution and then been incarcerated, but a large number have been infected inside the prisons. The infection rates have reached levels as high as 20 per cent in Europe or even over 50 per cent in parts of the developing world. Overcrowding, hierarchical homosexual relations, gangs within prisons, lack of protection for the youngest and weakest and poor prison management create an environment, which increases vulnerability to HIV transmission among the inmates (e.g. through unsafe sexual practices, sharing of injecting equipment or other crude substitutes, tattooing, violence including rape and blood exposure in general).

Elaborating an effective policy to prevent HIV/AIDS inside correctional settings is often hampered by the denial of prison authorities of the existence of these contextual factors. However, these factors are almost always present in such settings. While some institutions have been dealing with these issues in a pragmatic way (e.g. through the provision of condoms, needle dispensers, bleaching liquid, drug substitution therapy), only a few provide for antiretroviral treatment to HIV infected inmates. Perhaps even more important, measures are needed to address overcrowding and to curb violence and gang pressure within the prisons.

The experts discussed possible strategies to improve the understanding of the nature of the HIV/AIDS problem in prisons and to improve the capacity of national prison systems to reduce the HIV vulnerability of prisoners and thus the transmission of HIV among prisoners, guards, inmates' families and the entire community.

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