

Improving Our Health:

Why is Canada Lagging Behind
in Establishing Needle
Exchange Programs in Prisons?



A Position Paper by the
Ontario Medical Association

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ONTARIO MEDICAL ASSOCIATION

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OMA Position Paper

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EXECUTIVE SUMMARY

The Ontario Medical Association (OMA) has prepared this paper as an extension of its work on issues surrounding the care of HIV-infected patients and those at risk of becoming infected.

Work by other groups has resulted in recommendations that needle exchange programs (NEPs) be established in both federal and provincial prisons. However, to date, no Canadian prison system has started or piloted NEPs. The OMA believes that this is an issue of concern to all Canadians, not only because the health of prisoners is at stake but also because prisoners return to the community and, when they do, if they are infected with HIV or hepatitis C (HCV) they can and do infect others. The OMA believes that not only is this happening now but that it will continue to happen. This situation constitutes a clear and present health crisis.

This paper proposes possible solutions that – if carried out by government and correctional institutions – would contribute significantly to the prevention of the transmission of HIV and other bloodborne pathogens in the prison system as well as to the community at large.

Current Situation in Canadian Prisons

Rates of HIV and HCV in prison populations in Canada are much higher than those found in the general population. The high rates of HIV and HCV in Canadian prisons are closely related to two factors – the high proportion of prisoners who injected illegal drugs prior to their incarceration, and the high rates of HIV and HCV among injection drug users in the wider community.

Despite their illegality, the penalties for their use, and the significant amounts of money and effort spent by correctional services to stop their entry, illegal drugs do get into prisons and prisoners do use them. Outbreaks of HIV and HCV in prison have been documented in other countries, and there is evidence that it is also occurring in Canadian prisons.

All prison systems in Canada have implemented some harm reduction measures to varying degrees, including the provision of bleach for disinfecting needles, and methadone maintenance. While bleach and methadone programs are important components of a harm reduction approach in prisons, they are not an adequate substitute for the provision of needle exchange for injection drug users.

International Experience

Over 50 NEPs have been established in prisons of varying sizes and security levels in six countries in Europe and Central Asia. Evaluations of these NEPs have shown that NEPs reduce risk behaviour and prevent disease transmission; that NEPs result in other positive outcomes for prison health; NEPs do not result in an increase in illegal drug consumption; NEPs facilitate referrals to drug treatment programs; there were no instances of syringes being used as weapons; and there was a high level of acceptance of NEPs among prison staff.

The international evidence also demonstrates that the availability of NEPs in prisons does not imply that illegal drug use is being condoned; and that NEPs do not undermine abstinence-based programs.

OMA Position

The OMA believes that a full range of harm reduction measures – including NEPs – is required to reduce the spread of HIV and HCV through injection drug use in Canada’s prisons. The OMA therefore advances the following recommendations:

Recommendation I – Correctional Service of Canada should make a commitment to develop and implement needle exchange programs in the prisons under its jurisdiction.

Recommendation II – The Ontario Ministry of Community Safety and Correctional Services should make a commitment to develop and implement needle exchanges in the prisons under its jurisdiction.

Recommendation III – The Correctional Service of Canada should implement in as timely a manner as possible at least one pilot needle exchange program in the Ontario Region, and at least one pilot needle exchange program in each of the other regions of the country.

Recommendation IV – The Ontario Ministry of Community Safety and Correctional Services should implement in as timely a manner as possible at least one pilot needle exchange program in Ontario.

Recommendation V – The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should consult with relevant stakeholders on the design and implementation of needle exchange programs in prisons.

Recommendation VI – The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should consult with prisoners on the design and implementation of needle exchange programs in prisons.

Recommendation VII – The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should embark on an educational campaign among prison staff and their union representatives to promote the merits of needle exchange programs in prisons and to address any concerns that staff may have.

Recommendation VIII – The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should involve prison staff in the design and implementation of needle exchange programs in prisons.

Recommendation IX – The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should ensure that a comprehensive evaluation is carried out of the pilot needle exchange programs. Relevant stakeholders –

including physicians, Non-Government Organizations (NGOs), prisoners, prison staff and outside researchers - should be involved in the design and implementation of the evaluations.

Recommendation X – The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should ensure that the permanent needle exchange programs are monitored and evaluated on an ongoing basis.

Recommendation XI – The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should fund a public education campaign to explain how needle exchange programs in prisons can save lives both within prisons and in the community.

INTRODUCTION

The states' duty towards health care does not end at the gates of the prison.

– T.W. Harding¹

The elevated rates of infectious diseases in the inmate population in combination with risky behaviours present several challenges to [correctional services] and the broader Canadian community. The frequent movement of individuals between prisons and the community means that any transmission of disease within prisons will increase the burden and risk of disease transmission in the community.

– Correctional Service of Canada²

The Ontario Medical Association (OMA) is the professional association of the province's 25,000 physicians and represents its members in a variety of clinical, policy and economic areas. The mission of the association is "to serve the medical profession and the people of Ontario in the pursuit of good health and excellence in health care."

The OMA has explored many of the issues surrounding the care of HIV-infected patients and those at risk of becoming infected, and has determined that there is a need to examine the delivery of care to these patients. This includes the issue of HIV infection in prisons. Work by other groups in this area has resulted in recommendations that needle exchange programs (NEPs) be established in both federal and provincial prisons. However, to date no Canadian prison system has started or piloted NEPs. The OMA, representing Ontario's medical community, believes that this is an important issue.

Issues concerning prisoners do not seem to be of high concern to the public. People should be concerned, not only because the health of prisoners is at stake but also, because prisoners do return to the community. There is a high rate of turnover in prisons, especially provincial prisons. Prisoners returning to the community, if infected with HIV or hepatitis C (HCV), can and do infect others. The OMA believes that not only is this happening now but that it will continue to happen. This situation constitutes a clear and present health crisis.

Injection drug users have access to sterile injection equipment in most Canadian cities but not in prisons, despite the extremely high numbers of drug users in prisons and the high rates of HIV and HCV.

The OMA believes that the many radical changes that have occurred since the beginning of the HIV/AIDS epidemic, including the fact that what was once an untreatable terminal disease can now be treated thus prolonging life, have resulted in the need to change how people now living with HIV/AIDS in prisons receive care, and how people in prisons access prevention measures.

In 1987, the then OMA Task Force on AIDS was established with a mandate “to increase the awareness of the physician population about AIDS.” The Task Force looked at many issues including the role of the general and family practice physician in managing this disease. Today, the OMA Committee on HIV Infection continues this work, making recommendations to the OMA Board of Directors on legislation related to HIV infection and the role of physicians, program and practice guidelines for HIV-infected patients, and issues related to access to care.

Many physicians in Ontario who are involved in the provision of medical care within the prison system have expressed concerns that the quality of care available in prisons is often far below that which is available to the general population. The absence of NEPs in Canadian prisons is a prime example of this gap.

This discussion paper, therefore, explores issues of concern to both the prisoners and the general public, and proposes possible solutions that – if carried out by government and correctional institutions – would contribute significantly to the prevention of the transmission of HIV and other bloodborne pathogens in the prison system as well as to the community at large.

Although the OMA is a provincial association, there are both provincially and federally run prisons in Ontario. Consequently, this paper directs recommendations to both the Ontario and federal governments. All Canadians have a vested interest in ensuring that the pool of individuals with infectious diseases is not amplified through the country’s prison systems.³

Note Concerning the Text

The term “needle exchange” is used in this paper to denote the one-to-one exchange of a used syringe (which includes a needle) for a new syringe. Although “syringe exchange” is the more accurate term, “needle exchange” is better known. “Needle exchange” can also refer to the distribution of needles where there is no strict requirement for a one-for-one exchange.

This paper uses the term “prisons” to denote all forms of correctional institutions, including jails, detention centres and remand centres.

CURRENT SITUATION IN CANADIAN PRISONS

Prevalence Rates of HIV and HCV

Rates of HIV and HCV in prison populations in Canada are much higher than those found in the general population.

Human Immunodeficiency Virus (HIV)

Health Canada estimates that at the end of 2002 there were 56,000 people living with HIV/AIDS in Canada,⁴ which constitutes an HIV prevalence rate of 0.18 percent, or just less than one-fifth of one percent.⁵

Correctional Service of Canada (CSC) indicates that at the end of 2001, the last year for which solid data are available, there were 223 reported cases of HIV in federal prisons, out of a total prisoner population of 12,755.⁶ In terms of reported cases, therefore, the HIV prevalence rate in the federal prison system at the end of 2001 was 1.8 percent,⁷ a rate that is ten times higher than that found in the general population. (In certain prisons, the prevalence rate based on reported cases is even higher than 1.8 percent.)

However, the actual number of people living with HIV/AIDS in federal prisons at the end of 2001 would have been higher than 223, since it is reasonable to assume that many HIV positive prisoners have not disclosed their status to the CSC or are unaware of their status.

Rates of HIV infection among female prisoners are much higher than among male prisoners. At the end of 2001, 4.7 percent of women prisoners in federal prisons were known to be living with HIV/AIDS.⁸

With respect to provincial prisons, a study of 1,617 prisoners in institutions in Québec, released in 2004, found an HIV seroprevalence rate of 2.3 percent among men and 8.8 percent among women.⁹ Preliminary results from a study conducted in 2003 in 13 prisons in Ontario revealed that 1.2 percent of the prisoners self-reported being HIV positive. Among injection drug users, the rate was 4.1 percent.¹⁰

Hepatitis C Virus (HCV)

Health Canada estimates that at the beginning of 2004 there were 240,000 people living with HCV in Canada,¹¹ which constitutes an HCV prevalence rate of about 0.8 percent, or just over three-quarters of one percent.¹²

The CSC indicates that at the end of 2001, the last year for which solid data are available, there were 2,993 reported cases of HCV in federal prisons, which represents 23.5 percent of the total prisoner population.¹³ In terms of reported cases, therefore, the HCV prevalence rate in the federal prison system at the end of 2001 was more than 29 times higher than that found in the general population. (In certain prisons, the prevalence rate based on reported cases is even higher than 23.5 percent.)

As with HIV/AIDS, the actual number of people living with HCV in federal prisons at the end of 2001 would have been higher than the number of reported cases.

Rates of HCV infection among female prisoners are much higher than among male prisoners. At the end of 2001, 41.2 percent of women prisoners in federal prisons were known to be living with HCV.¹⁴

With respect to provincial prisons, the 2004 Québec study revealed HCV seroprevalence rates of 16.6 percent among men and 29.2 percent among women.¹⁵ Preliminary results from the 2003 Ontario study found that 14.3 percent of prisoners self-reported being HCV positive. Among injection drug users, the rate was 43.5 percent.¹⁶

Link to Illegal Drug Use

The high rates of HIV and HCV in Canadian prisons are closely related to two factors – the high proportion of prisoners who injected illegal drugs prior to their incarceration, and the high rates of HIV and HCV among injection drug users in the wider community.

A 1995 prisoner survey conducted by the CSC found that 34 percent of prisoners reported having injected illegal drugs prior to incarceration.¹⁷ A survey of prisoners in six provincial correctional centres in Ontario, conducted in 1996 and 1997, found that 32 percent of the prisoners had injected illegal drugs at some point prior to incarceration, and that 17 percent had injected illegal drugs in the year preceding their current sentence.¹⁸

Various studies undertaken in recent years in Canadian cities have revealed HIV prevalence rates among injection drug users of 12.6 percent in Winnipeg (in 1998), 21 percent in Victoria (in 1999), 19.7 percent in Ottawa-Hull (in 2001), 14.5 percent in Montréal (in 2001), 14.5 percent in Québec City (in 2001),¹⁹ and 28 percent in Vancouver (in 2000).²⁰

HCV prevalence rates among injection drug users are considerably higher. Recent studies have revealed prevalence rates of 86 percent in Vancouver (in 2000),²¹ 70 percent in Montréal (in 1997),²² and 47 percent in semi-rural areas of Nova Scotia (in 1997).²³

Illegal Drug Use in Prison

Prisoners are thirty times more likely than other Canadians to have injected illegal drugs.²⁴

Despite their illegality, the penalties for their use, and the significant amounts of money and effort spent by correctional services to stop their entry, illegal drugs do get into prisons and prisoners do use them. Many prisoners arrive in prison with histories of past or current illegal drug use. Other prisoners start using illegal drugs once in prison.²⁵ The CSC's 1995 inmate survey found that 38 percent of prisoners reported having used illegal drugs since arriving at their current institution.²⁶

With respect to injection drug use specifically, several Canadian studies have revealed high rates of use within prisons. In federal prisons, for example, three studies showed rates ranging from 11 to 67 percent. (See Appendix A for more details.)

The sharing of needles is a significant risk factor for HIV and HCV transmission. Needles and syringes are usually scarce in prisons because it is more difficult to smuggle them in than it is to smuggle in illegal drugs. As a result, injection drug users in prison are more likely to share and re-use syringes. This situation creates a high risk environment where HIV and HCV can spread very quickly.²⁷

TRANSMISSION OF HIV AND HCV IN PRISONS

Although there have been no studies in Canadian prisons that focused specifically on outbreaks of HIV or HCV infection within the institutions, a 1998 study on HIV and HCV prevalence and risk behaviours in a medium-security federal prison identified a small group of men who reported having ever injected illegal drugs only inside prison. Over half of this group was HCV positive.²⁸

As well, a prisoner in a Canadian prison has started legal action against the prison system for allegedly contracting HIV through injection drug use, after being refused methadone maintenance treatment.²⁹

Outbreaks of HIV and HCV in prisons have been documented in other countries. Outbreaks of HIV have been recorded in prisons in Thailand, Scotland, Australia and Lithuania. Outbreaks of HCV have been recorded in prisons in Germany, Australia and Scotland. For both HIV and HCV, a relationship has been shown between the outbreaks and the sharing of injection drug use equipment. (See Appendix B for more details.)

PRISONERS' RIGHT TO HEALTH

One of the goals of the OMA is “to influence the development of health care policy and programs in Ontario.” The OMA believes that people in prisons should be able to protect themselves against HIV and HCV transmission.

Numerous international declarations and covenants provide that “[e]very person has a right to the highest attainable level of physical and mental health.”³⁰ The International Covenant on Civil and Political Rights, to which Canada is a signatory, sets forth the right of “persons deprived of their liberty” to be treated with “dignity” and with “respect for the inherent dignity of the human person.”³¹ Adopted by the UN General Assembly in 1966 (it came into force in 1976), the Covenant requires that all of the rights and freedoms it sets out be respected for “everyone,” including persons deprived of their liberty by process of law.

The declarations and covenants mentioned above have the force of law. International guidelines and standards provide states with guidance on how to fulfill their legal obligations to prisoners. While not binding on states, these guidelines and standards are important because they provide a

moral and philosophical norm that should guide national administrators and courts.³² (See Appendix C for more information on these international guidelines and standards.)

In Canada, the federal prison system is governed by the Corrections and Conditional Release Act (CCRA) and the accompanying CCRA Regulations. Under the CCRA, the CSC is mandated to provide every prisoner with essential health care, and reasonable access to non-essential mental health care that will contribute to his or her rehabilitation and reintegration into the community. The CCRA states that this medical care “shall conform to professionally accepted standards.”³³

Syringe exchange is the accepted standard in the community for preventing the transmission of HIV and HCV via injection drug use. In Ontario, for example, all boards of health are required to provide (or ensure the provision of) NEPs in accordance with guidelines issued under provincial legislation.³⁴ The Ontario Ministry of Health and Long Term Care publishes an annual review of these NEPs.³⁵

Since NEPs are the standard of care in the community, under the terms of the CCRA these programs must be made available to prisoners in the federal system.³⁶

THE RESPONSE OF CANADIAN PRISON SYSTEMS

Traditionally, in Canada, concerns about disease transmission through injection drug use have been met with calls for a “zero tolerance” approach, involving increased penalties for illegal drug use, tightened security measures to reduce the supply of illegal drugs, and heightened surveillance of individual illegal drug users. However, the health risks posed by HIV and HCV infection through the sharing of injection equipment have underscored the limitations of a strictly zero tolerance approach. This has led to the development and implementation of community health programs that enable injection drug users to reduce their risk of contracting HIV and HCV while continuing to use illegal drugs. Harm reduction initiatives – such as methadone maintenance and NEPs – have been enacted as pragmatic responses to injection drug use, and the attendant risks that HIV and HCV infection pose to the individual and to society as a whole.³⁷

Already in 2001, there were over 200 needle exchange sites in communities across Canada.³⁸ These programs are a normal part of public health practice.³⁹

All prison systems in Canada have implemented some harm reduction measures.⁴⁰

- In the federal prison system, the policy calls for bleach (for disinfecting needles) to be available in all institutions (though in practice access is sometimes limited). There is also a policy that methadone be available in all institutions, both for prisoners who were on methadone when they entered prison and for prisoners who want to start on methadone while in prison (though in practice access is sometimes limited). Drug treatment programs (designed to reduce or eliminate drug dependence) are available. In March 2004, Correctional Service of Canada announced that it was implementing a pilot project involving the establishment of on-site prison tattoo parlours.
- In the Ontario prison system, bleach is not available. Methadone is available in most institutions for prisoners who were on methadone when they entered prison. Initiation of

methadone while in prison is only considered in the case of pregnant women. Drug treatment programs are available.

- In the prison systems of the other provinces and territories, bleach is available only in British Columbia and Québec. Methadone is available in most jurisdictions where it is available in the community; however, for the most part, methadone is available only for those prisoners who were on methadone when they entered prison.

No prison system in Canada however has implemented NEPs, despite numerous calls from both governmental and non-governmental bodies in Canada for the provision of sterile injecting equipment to prisoners. (See Appendix D for more information on these calls.) In opposing the introduction of NEPs, prison authorities have traditionally cited two main concerns: (a) that NEPs would condone and encourage illegal drug use, an illegal activity; and (b) that syringes would be used as weapons and would therefore create a safety problem for prison staff and other prisoners.⁴¹ In fact, NEPs established in several other countries have shown that these concerns are *not* valid (see below).

ARE BLEACH AND METHADONE MAINTENANCE PROGRAMS ALONE A SUFFICIENT RESPONSE?⁴²

While bleach and methadone programs are important components of a harm reduction approach in prisons, they are not an adequate substitute for the provision of needle exchange for injection drug users.

Programs that provide bleach have several limitations:

- While bleach is useful in reducing the risk of transmission of blood-borne diseases, numerous scientific studies have cast doubt on the effectiveness of bleach in eliminating HIV⁴³ and HCV⁴⁴ in syringes.
- There is evidence that many injection drug users do not know or do not practice the proper method of using bleach for disinfecting needles.⁴⁵
- It has even been suggested that the re-use of an HIV-contaminated syringe cleaned with bleach may actually *increase* the risk of HIV transmission.⁴⁶
- Since the possession of needles is an offence in prisons, people who use needles are anxious to complete the operation as quickly as possible in order to avoid detection. This is particularly true when the needles are hidden in common areas, which they often are because prisoners want to avoid being charged should a search be made of their cells. In these circumstances, therefore, the time required to sterilize the needle with bleach becomes a barrier to the use of bleach.
- The provision of bleach alone does not provide some of the health benefits associated with the provision of needle exchange – such as reduction in abscesses and in overdoses (see next section).
- The provision of bleach alone is not as effective as needle exchange in reducing or eliminating the risk of accidental needle stick injury because syringes are still considered contraband within the institutions and, therefore, are hidden rather than being stored safely in visible areas.

Methadone programs also have a number of limitations:

- As a form of treatment, methadone is of no benefit to those drug users who do not want to stop using illegal drugs.
- Methadone is not a harm reduction option for prisoners who inject non-opiates, such as cocaine.
- Methadone is only appropriate for illegal drug users who are physically dependent upon opiates, and is therefore not an alternative for those who are occasional or recreational injection opiate users.
- Even among users who access methadone treatment, some will continue to inject either sporadically or habitually.
- 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. Many prisons are not able to offer this.
- Because of the high cost associated with the provision of this medical service, the number of methadone spaces is often limited, thereby creating a situation where some illegal drug users will be excluded from accessing the program.

REVIEW OF THE INTERNATIONAL EXPERIENCE WITH NEEDLE EXCHANGE PROGRAMS IN PRISONS

In many countries, NEPs in the community have become an integral part of a pragmatic public health response to the risk of HIV transmission among injection drug users and, ultimately, to the general public. Extensive studies on the effectiveness of these programs have provided scientific evidence that syringe exchange is an appropriate and important preventive health measure.⁴⁷ The success of these interventions in the community led to calls in these countries to establish NEPs in prisons.

So far, over 50 NEPS have been established in prisons of varying sizes and security levels in six countries in Europe and Central Asia – Switzerland, Germany, Spain, Moldova, Kyrgyzstan and Belarus. Eleven formal evaluations of prison NEPs have been carried out.⁴⁸ The following is a brief summary of the situation in each of the six countries.

Switzerland

In 1992, the first prison NEP in the world was started in Oberschöngrün Prison. Since then, NEPs have been implemented in six additional prisons in Switzerland – Hindelbank Institution for Women, Champ-Dollon Prison, Realta Prison, Witzwil Prison, Thorberg Prison and Saxerriet Prison. The methods used to distribute the syringes varied. In some institutions, the distribution was done by medical staff. In others, automatic dispensing machines were used.

The Hindelbank NEP was formally evaluated at the end of its first year. The evaluation revealed that; syringe sharing virtually disappeared; there was no evidence of an increase in illegal drug consumption; there were no new cases of HIV, HCV or HBV infection in the prison population; there were no reports of syringes being used as weapons against staff or other prisoners and,

there was a high level of acceptance of the program among prison staff.⁴⁹ In addition, according to a prison official, the prison experienced a significant decrease in overdoses and abscesses.⁵⁰

The Realta NEP was also formally evaluated. The evaluation found that; syringe sharing fell drastically (sharing was found only in a few cases); there was no evidence of new HIV, HCV or HBV infections; there were no instances of syringes being used improperly; there was one report of a prisoner receiving a needle stick injury from a discarded syringe and; there was a high level of acceptance of the program among prison staff.⁵¹

The original program at Oberschöngrün has not been evaluated scientifically. However, the physician in charge made the following observations at the end of the third year of the NEP: syringe sharing and abscesses disappeared; there were no increases in deaths or overdoses among injection drug users and; there were no instances of syringes being used as weapons.⁵² While prison staff at Oberschöngrün were initially sceptical of the program, over time, they came to support it. In 1996, Warden Peter Fäh said:

Staff have realized that distribution of sterile injection equipment is in their own interest. They feel safer now than before the distribution started. Three years ago, they were always afraid of sticking themselves with a hidden needle during cell searches. Now, prisoners are allowed to keep needles, but only in a glass in their medical cabinet over their sink. No staff has suffered needle-stick injuries since 1993.⁵³

(See Appendix E for more information on the history of NEPs in Switzerland, and for a discussion of the current situation.)

Germany

In 1995, pilot NEPs were established in two prisons in the state of Lower Saxony: at Vechta and Lingen 1 Dept. Groß-Hespe. Since then, NEPs were established at Vierlande Prison, Hannöversand Prison and Am Hasenberge Prison in Hamburg; and in Lichtenberg Prison and Lehrter Str. Prison in Berlin. Distribution of the syringes was done either by staff or through machines.

The Vechta and Lingen pilot programs were formally evaluated after two years.⁵⁴ The evaluation showed that there was no increase in illegal drug use; the amount of illegal drugs seized within the institutions did not change; the number of illegal drug users entering treatment programs went up; there were no instances of syringes being used as weapons against staff or other prisoners; that observance of the program rules by participants was high; there were no new cases of HIV among the participants who were permanent members of the NEP and; there was a significant decrease in abscesses.

The evaluation also revealed that both staff and prisoners found the existence of the NEP to be non-threatening. Staff adapted quickly to the new programs, which came to be seen as a normal part of the institutional routine. There were differences found in the level of acceptance of the programs by prisoners in the two different institutions. The women in Vechta had much more confidence and trust in the program than did the men in Lingen. This difference was attributed to the differing methods of syringe distribution in the two prisons (anonymous dispensing machines

in Vechta vs. hand-to-hand distribution by prison health staff in Lingen). The evaluation found that many prisoners in Lingen were hesitant to participate in the program for fear of being identified as injection drug users.

(See Appendix E for more information on the history of NEPs in Germany, and for a discussion of the current situation.)

Spain

In 1997, a pilot NEP was established in the Centro Penitenciario de Basauri in Bilbao. This was quickly followed by the introduction of NEPs in Pamplona Prison and in prisons in Tenerife, San Sebastian and Orense. By the end of 2001, there were NEPs operating in 11 Spanish prisons.

Based on the experience of these NEPs, the Spanish government made a commitment to expand their availability. In March 2001, the parliament approved a green paper recommending the implementation of NEPs in all prisons. In March 2002, the Ministry of the Interior and the Ministry of Health and Consumer Affairs jointly published a document entitled “Needle Exchange in Prison: Framework Program,” which provided the prisons with guidelines, policies and procedures, and training and evaluation materials for implementing NEPs.⁵⁵ By early 2004, NEPs had been established in over 30 Spanish prisons.

In all of the NEPs, distribution is done by hand, either by health care staff or through collaborative initiatives between the prison and external non-governmental organizations (NGOs). Harm reduction kits are provided rather than single syringes. The policy requires that the kits include a syringe in a hard plastic transparent case, distilled water and an alcohol swab. Some institutions also provide a cooker and filters in their kits.

The original Basauri pilot project was formally evaluated.⁵⁶

The evaluation revealed that illegal drug consumption among prisoners did not increase; there was a reduction in high-risk behaviours and; there were no instances of syringes being used as a weapon. Prisoners interviewed during the evaluation said that the personalized approach used for distribution of the syringes was preferable to using dispensing machines. The prisoners were supportive of the program being run by an NGO; correctional officers expressed a preference for the program to be run by prison staff.

Evaluations of the other NEPs were also positive, as evidenced by the following conclusions contained in a 2002 government report: Implementation of an NEP is feasible and adaptable to the conditions of execution of the prison sentence; the NEPs produced behavioural changes that

Common Themes in the Evaluations

From the formal evaluations of NEPs in Switzerland, Germany and Spain, the following common themes emerge:

- NEPs reduce risk behaviour.
- NEPs result in other positive outcomes for prison health.
- NEPs do not result in an increase in illegal drug consumption.
- NEPs facilitate referrals to drug treatment programs.
- There were no instances of syringes being used as weapons.
- There was a high level of acceptance of NEPs among prison staff.

led to a reduction in the risks associated with injecting drug use; the NEPs facilitated referral of users to drug addiction treatment programs; and it is feasible for an NEP and other drug addiction prevention or intervention programs to co-exist. It is important to note that the evaluations found that implementation of an NEP does not generally cause an increase in illegal drug use in the institution.⁵⁷

Prison service officials have also stated that there have been no instances of syringes provided by the NEPs being misused or used as weapons.⁵⁸

(See Appendix E for more information on the history of NEPs in Spain, and for a discussion of the current situation.)

Moldova

In 1999, a pilot NEP was established in Prison Colony 18 in Branesti. Since then, NEPs have been established in Prison Colony 4 in Cricova and the women's prison in Rusca. For the most part, distribution of the syringes was done by prisoner peer volunteers. There have been no formal evaluations of the Moldova NEPs. Writing about the first NEP pilot, Dr. Nicolae Bodrug, the physician in Prison Colony 18, said that there were no instances of syringes being used as weapons. He added:

It took two years to break the ice of mistrust. We had to learn a lot, say strange things, and act oddly in front of a [sceptical] majority. But harm reduction became normal. And with the head of the prison administration in favor of harm reduction, as well as the minister of justice now, we can look forward confidently to expansion.⁵⁹

Kyrgyzstan

In 2002, a pilot NEP was established in Prison IK-47 in Bishkek. Initially, two methods of distribution were used: (a) exchanges conducted by medical staff and (b) exchanges conducted by peer volunteers. Eventually, only the second method was retained. In early 2003, an order was issued approving the provision of sterile injecting equipment in all prisons. NEPs are now operating in all 11 prisons in Kyrgyzstan. Distribution is being done through peer volunteers. There has been no formal evaluation of the Kyrgyzstan NEPs.

Belarus

In 2003, a pilot NEP was launched in Reformatory School 15/1 in Minsk. Distribution is done through peer volunteers. The program has yet to be evaluated. The project manager reports that there have been no instances of syringes being used as weapons.⁶⁰ The program is being extended into two additional prisons, and the Ministry of Internal Affairs has indicated that it is prepared to expand it to all prisons in Belarus.

SHOULD NEEDLE EXCHANGE PROGRAMS BE IMPLEMENTED IN CANADIAN PRISONS?

A full range of harm reduction measures – including NEPs – is required to reduce the spread of HIV and HCV through injection drug use in Canada's prisons.

The health of people in prison should be a matter of concern to every Canadian. Everyone in the prison environment – prisoners, prison staff and family members of both – benefits from enhancing the health of prisoners and reducing the incidence of disease. At the same time, the high degree of mobility between prison and community means that any illnesses or health conditions developed or exacerbated in prison do not stay there. When individuals are released from jail, prison health issues necessarily become community health issues.⁶¹ This is particularly true given the rapid rate of turnover in prisons, especially provincial prisons, and the frequent use of temporary absence and gradual release programs.

It is clear from the evidence that; there are high rates of HIV and HCV among prison populations; many prisoners engage in injection drug use behaviour while in prison; this behaviour carries a high risk of HIV and HCV transmission because prisoners are forced to share needles and; transmission of HIV and HCV is occurring within prisons.

There are national and international laws and guidelines that outline the legal and ethical responsibility of Canadian governments to act to prevent the spread of HIV and HCV in prisons.

It is clear that programs that provide bleach and methadone are not sufficient in themselves to address the risk of HIV and HCV transmission in prisons.

It is clear from the international evidence that the prison NEPS reduce risk behaviour and prevent disease transmission, and that the NEPs have other positive outcomes on prison health. Furthermore, debunking some common myths, the international evidence demonstrates that the NEPs are safe and can even contribute to greater security in prisons; and that the NEPs do not result in an increased number of drug injectors, an increase in illegal drug use, or an increase in the amount of illegal drugs in prisons.

The international evidence also demonstrates (a) that the availability of NEPs in prisons does not imply that illegal drug use is being condoned; and (b) that NEPs do not undermine abstinence-based programs. The provision of needle exchange in the six countries of Europe and Central Asia has not resulted in prison officials permitting the possession or sale of illegal drugs. In all cases, illegal drugs remain prohibited within institutions where needle exchange is in place, and security staff are instructed to locate and confiscate all such contraband. In many instances, 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 another option for improving the health status of prisoners.⁶²

In the case of the German pilot programs, the evaluator found that the syringe exchange program actually *increased* the number of people accessing drug treatment services, demonstrating that NEPs can serve as valuable points of contact and referral for a difficult to reach illegal drug using population.⁶³ This was also the experience in Spain, where the government concluded that “NEPs in prison facilitate referral of users to drug addiction treatment programs.”⁶⁴

There is nothing in the international evidence that demonstrates that syringe exchange programs are incompatible with Canadian prison environments. Furthermore, in recent years many Canadian jurisdictions have successfully introduced other harm reduction measures, such as condoms and bleach, in prisons. The implementation of these programs has proved trouble free, despite initial concerns in some quarters that they would “send the wrong message,” or lead to increases in violence and vandalism. This history should be instructive to people who now make the same claims to argue against the implementation of NEPs.⁶⁵

It is also clear from the international evidence that funding need not be a barrier to prison syringe exchange. NEPs are operating in both well-resourced Western European prisons and poorly resourced prisons in Eastern Europe and Central Asia. Indeed, it can be argued that NEPs would quickly pay for themselves by preventing HIV and HCV transmission, thereby reducing the significant expense of providing medications and services to an increasing number of prisoners infected with HIV and HCV.⁶⁶ A recent Australian report concluded that money invested in syringe exchange programs in that country had produced a greater than fifteen-fold return in savings as a result of the infections prevented over a 10-year period. The Australian National Council on Drugs said that an investment of about AUD\$150 million resulted in estimated savings of between AUD\$2.4 billion and AUD\$7.7 billion.⁶⁷

Based on the evidence, therefore, the OMA advances the following recommendations:

Recommendation I

Correctional Service of Canada should make a commitment to develop and implement needle exchange programs in the prisons under its jurisdiction.

Recommendation II

The Ontario Ministry of Community Safety and Correctional Services should make a commitment to develop and implement needle exchanges in the prisons under its jurisdiction.

NEPs need to be tailored to the particular needs of each institution, its prisoner population and its staff. A particular distribution method for syringes may work better in one type of institution than another, as may other elements of the design of the NEP. Therefore, it makes sense for prison authorities to implement pilot NEPs in order to determine what works best in the Canadian context, in the different regions of the country and in the different types of institutions.

Recommendation III

The Correctional Service of Canada should implement in as timely a manner as possible at least one pilot needle exchange program in the Ontario Region, and at least one pilot needle exchange program in each of the other regions of the country.

Recommendation IV

The Ontario Ministry of Community Safety and Correctional Services should implement in as timely a manner as possible at least one pilot needle exchange program in Ontario.

Ideally, the pilot NEPs would test different program designs.

There are a number of stakeholders who have relevant expertise that can be shared with prison authorities who are designing NEPs. These stakeholders include (but are not limited to) physicians who provide medical services in prisons; Non Government Organizations (NGOs) that provide educational and other services in prisons related to HIV and HCV; NGOs that work on prison issues; physicians involved with NEPs in the community; NGOs that are involved in NEPs in the community; and the NEPs themselves.

Recommendation V

The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should consult with relevant stakeholders on the design and implementation of needle exchange programs in prisons.

The prisoners themselves are best placed to define their needs and can also contribute valuable expertise.

Recommendation VI

The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should consult with prisoners on the design and implementation of needle exchange programs in prisons.

The support of prison administrations and staff is an integral part of successful NEPs. It is important that the introduction of NEPs in Canadian prisons not follow simply a “top-down” approach.

Recommendation VII

The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should embark on an educational campaign among prison staff and their union representatives to promote the merits of needle exchange programs in prisons and to address any concerns that staff may have.

Recommendation VIII

The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should involve prison staff in the design and implementation of needle exchange programs in prisons.

It is important that the pilot NEPs be well evaluated, so that the outcomes of the evaluation can guide the expansion of NEPs into additional prisons. The permanent NEPs established following the completion of the pilot programs should also be monitored and evaluated on an ongoing basis.

Recommendation IX

The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should ensure that a comprehensive evaluation is carried out of the pilot needle exchange programs. Relevant stakeholders – including physicians, NGOs, prisoners, prison staff and outside researchers – should be involved in the design and implementation of the evaluations.

Recommendation X

The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should ensure that the permanent needle exchange programs are monitored and evaluated on an ongoing basis.

Public understanding and support for the establishment of NEPs in prisons is critical.

Recommendation XI

The Correctional Service of Canada and the Ontario Ministry of Community Safety and Correctional Services should fund a public education campaign to explain how needle exchange programs in prisons can save lives both within prisons and in the community.

CONCLUSION

The recent SARS-related Naylor,⁶⁸ Campbell⁶⁹ and Walker⁷⁰ reports have all raised public awareness about the weaknesses of Ontario's public health system. Public awareness regarding prison-related public health concerns also needs to be raised, especially since prisoners, when released, do return to society. Those prisoners who are infected with HIV or other blood-borne pathogens can and do infect others.

Health issues and concerns cross many boundaries – municipal, provincial and federal. The OMA strongly urges the Ontario government to work with the federal and other provincial

correctional services to address this important public health issue through the implementation of pilot NEPs in prisons.

The OMA believes that if small countries such as Moldova, Kyrgyzstan and Belarus can implement NEPs in their prisons, then surely the time has come for Canada to do the same and for Ontario to lead the way.

The situation calls for an urgent response. Where political will is combined with a solid implementation plan, NEPs in prisons can quickly become a reality.⁷¹

APPENDIX A – INJECTION DRUG USE IN PRISON

This appendix provides a brief summary of the findings of studies on the rates of injection drug use in Canadian prisons.

- A 2003 study of federally incarcerated women found that 19 percent reported engaging in injection drug use while in prison.⁷²
- A 1998 study at Joyceville Penitentiary in Kingston, Ontario found that 24.3 percent of prisoners reported having injected illegal drugs in prison, up from the 12 percent found in a similar study at the same prison in 1995.⁷³
- A 1996 survey of prisoners in a federal prison in British Columbia found that 67 percent reported injection drug use either in prison or outside.⁷⁴
- The CSC's 1995 National Inmate Survey found that 11 percent of 4,285 federal prisoners reported having injected illegal drugs since arriving in their current institution. Of the prisoners who reported having injected, 41 percent said that either the equipment they used was not clean or they did not know if the equipment was clean. Injection drug use was particularly high in the Pacific Region (23 percent of the prisoner population).⁷⁵ The figure for the Ontario Region was the same as the national average (11 percent).
- A 1995 study among provincial prisoners in Montréal who used illegal drugs while in prison found that 6.2 percent of men and 1.5 percent of women reported injecting illegal drugs.⁷⁶
- A 1995 study of provincial prisoners in Québec City found that 12 of 499 prisoners (2.4 percent) admitted injecting illegal drugs during imprisonment, and that 11 of the 12 had shared needles. Three were HIV-positive.⁷⁷

APPENDIX B – TRANSMISSION OF HIV AND HCV IN PRISONS

This appendix provides a brief description of outbreaks of HIV and HCV in prison settings that have been recorded in countries outside Canada.

With respect to HIV, the following outbreaks have been documented:⁷⁸

- Between 1987 and 1989, Bangkok, Thailand experienced a major rise in HIV infection among injection drug users in the general population, with seroprevalence rates going from two percent to 27 percent during 1987, and then to 43 percent by the end of 1988. This significant increase in HIV infection rates among injection drug users in the community paralleled the amnesty and release of a large number of Thai prisoners. Six studies of HIV infection among injection drug users in Thailand found that a history of imprisonment was associated significantly with HIV infection.
- A study investigating an outbreak of HIV infection in Glenochil Prison in Scotland in 1993 revealed that of the 227 prisoners involved in the study, 76 reported a history of injection, and 33 reported injecting in Glenochil. Twenty-nine of the latter were tested for HIV, with 14 testing positive. Thirteen had a common strain of HIV, proving that they became infected in the prison. All of the prisoners infected in Glenochil reported extensive periods of syringe sharing.
- Another outbreak of HIV infection was documented in 1993 in an Australian prison, using epidemiological and genetic evidence. Attempts to trace 31 injection drug users resulted in 25 being located. Of these, 14 were found to be HIV positive and were enrolled in the study. It was shown that eight of the 14 were infected with HIV while in the prison.
- In Lithuania, according to the Associated Press, random checks undertaken in 2002 by the state-run AIDS Center revealed that 263 prisoners at Alytus prison had tested positive for HIV. Tests at Lithuania's other 14 prisons found only 18 cases. Before the tests at Alytus prison, Lithuanian officials had listed just 300 cases of HIV in the whole country, a number that represents less than 0.01 percent of the population, the lowest rate in Europe. Prisoners interview by Associated Press said that the outbreak at Alytus was due to sharing of drug injection equipment.

With respect to HCV, the following outbreaks have been documented:

- A study conducted in 1996 in the women's prison in Vechta, Lower Saxony, Germany found that 78 percent of illegal-drug-using women were infected with hepatitis B and 74.8 percent were infected with HCV. The authors found that nearly half of these women (20 out of 41) had been infected with hepatitis during incarceration.⁷⁹
- A study conducted in two prisons in Australia in 2000-2001 showed that four of the 29 prisoners who were HCV negative at the start of the study became HCV positive while still in prison. The authors concluded that three of the four seroconversions were most likely related to needle sharing.⁸⁰
- A study conducted in Australian prisons in the mid-1990s documented four cases of HCV transmission. The prisoners tested HCV negative on entry to prison and subsequently

tested HCV positive. All four were in continuous full-time custody during the period between the two tests. The authors concluded that at least two of the four seroconversions were associated with injection drug use.⁸¹

- A study in a long-stay Scottish prison in 1999-2000 documented four cases of HCV seroconversion.⁸²

APPENDIX C – LEGAL OBLIGATIONS TO PRISONERS

This appendix provides a brief summary of the legal obligations to prisoners as set out in international standards and guidelines.

In 1990, the United Nations General Assembly adopted the Basic Principles for the Treatment of Prisoners.⁸³ Principle 5 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.

Principle 9 states that “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”

In 1993, the World Health Organization (WHO) published Guidelines on HIV/AIDS in Prisons.⁸⁴ Principle 1 of the Guidelines states that “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.” Principle 2 further states that “general principles adopted by national AIDS programmes should apply equally to prisons and to the general community.”

The WHO Guidelines go on to state that “[i]n 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.”⁸⁵

Recommendations on HIV/AIDS in prisons developed by the international community consistently support “equivalence of treatment of prisoners,” stress the importance of prevention of transmission of HIV in prisons, and suggest that prevention measures – including sterile syringes – be provided to prisoners.⁸⁶

International codes of practice governing physicians and other health professionals working in prisons also support the argument that comprehensive HIV and HCV prevention measures, including needle 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.”⁸⁷

APPENDIX D – CALLS FOR IMPLEMENTING NEEDLE EXCHANGE PROGRAMS IN CANADIAN PRISONS

This appendix contains a list of the reports⁸⁸ issued in the last decade that have called for NEPs to be implemented in Canadian prisons.

- 1992 – HIV/AIDS in Prison Systems: A Comprehensive Strategy, Prisoners with AIDS Support Action Network
- 1994 – Final Report of the Expert Committee on AIDS and Prisons, Expert Committee on AIDS and Prisons, Correctional Service of Canada
- 1996 – HIV/AIDS and Prisons: Final Report, Canadian HIV/AIDS Legal Network and Canadian AIDS Society
- 1997 – HIV, AIDS, and Injection Drug Use: A National Action Plan, Task Force on HIV/AIDS and Injection Drug Use
- 1998 – HIV/AIDS in the Male-to Female Transsexual/Transgendered Prison Population: A Comprehensive Strategy, Prisoners' HIV/AIDS Support Action Network
- 1999 – Final Report of the Study Group on Needle Exchange Programs, Study Group on Needle Exchange Programs, Correctional Service of Canada
- 2001 – Reducing the Harm Associated with Injection Drug Use in Canada, F/P/T Advisory Committee on Population Health (and other F/P/T Committees)
- 2002 – Action on HIV/AIDS and Prisons: Too Little, Too Late – A Report Card, Canadian HIV/AIDS Legal Network
- 2003 – Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C, Prisoners' HIV/AIDS Support Action Network
- 2003 – Strengthening the Canadian Strategy on HIV/AIDS, House of Commons Standing Committee on Health
- 2003 – Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women, Canadian Human Rights Commission.

APPENDIX E – NEEDLE EXCHANGE PROGRAMS IN PRISONS IN SWITZERLAND, GERMANY AND SPAIN

This appendix provides a summary of the history of NEPs in prisons in Switzerland, Germany and Spain, and describes the current situation in the three countries. All prisons listed in this appendix are men's prisons unless otherwise indicated.

Switzerland

History

- In 1992, the first prison NEP in the world was started on an informal basis in Oberschöngrün Prison (prisoner population: 75), in the canton of Solothurn, by a physician who was ignoring prison regulations. When the warden learned about it, rather than stop it, he sought and received approval from authorities to continue the program.⁸⁹ Distribution of the syringes was done by medical staff.
- In 1994, a pilot NEP was implemented in Hindelbank Institution for Women (population: 110) in the canton of Bern. Distribution was done through automatic dispensing units placed in six discreet locations around the institution.
- In 1996, an NEP was established in Champ-Dollon Prison (population not available) in the canton of Geneva. Distribution was done by medical staff.
- In 1997, an NEP was established in Realta Prison (population: 100) in the canton of Graubünden. Distribution was done using a single dispensing machine.
- In 1998, NEPS were established in Witzwil Prison (population: 195) and Thorberg Prison (population: 165), both in the canton of Bern. Distribution was done by medical staff.
- In 2000, an NEP was established in Saxerriet (population not available) in the canton of Salez. Distribution was done primarily through dispensing machines, but also by staff.

Current Situation⁹⁰

NEPs continue to operate without incident in the seven prisons identified above. Some of the prisons have adapted their programs based upon experience gained over several years. Hindelbank, for example, now provides prisoners participating in the program with up to five additional “points” (needles) to attach to the main body of the syringe. This is to accommodate injection drug users who may have trouble injecting due to difficulty finding veins. This practice has not resulted in any security problems.

The canton of Bern recently mandated that all prisons under its administrative control must provide sterile syringes to prisoners. Unfortunately, in some prisons the programs have been implemented in a manner that makes it very difficult for prisoners to access the syringes. Thus, these prisons are able to fulfil the legal requirement of “providing” NEPs, while creating a

situation where prisoners will not use the program. This resistance may be indicative of the challenges posed by a “top-down” implementation of needle exchange in prisons.

Germany

History⁹¹

- In 1995, two-year pilot NEPs were established in two prisons in the state of Lower Saxony: the women’s prison (population: 200) in Vechta, and the prison (population: 230) in Lingen 1 Dept. Groß-Hespe. In the Vechta prison, the distribution was done through five automatic dispensing machines placed in various parts of the institution. In addition to providing sterile syringes, the machines also dispensed other harm reduction materials necessary to practice safe injecting, including alcohol swabs, ascorbic acid, filters, plaster and sodium chloride. In the Lingen prison, distribution was done by medical staff. In both prisons, consultations and educational programs were provided for staff to make them aware of the rationale for, and the objectives of, the programs, and to receive their input and suggestions.
- In 1996, an NEP was established in the Vierlande Prison (population: 300+ men, 20 women) in Hamburg. Both staff and dispensing machines were used to distribute the syringes.
- In 1998, NEPs were established in two prisons in Berlin: the prison for women (population: 75) in Lichtenberg and in the Lehrter Str. prison (population: 100). Distribution was done through dispensing machines. In the Lichtenberg prison, every prisoner entering the institution was provided a harm reduction kit as part of the contents of her cell.
- In 2000, NEPs were established at the prison for women (population not available) in Hannöversand and in the Am Hasenberge Prison (population: 450) in Hamburg. Distribution was done by staff.

Current Situation⁹²

In recent years, the prison NEPs in Germany have come under political attack.

In 2002, all three NEPs operating in the prisons in Hamburg (Hannöversand, Am Hasenberge and Vierlande) were cancelled. This was not caused by any problems with the programs per se, but rather was the result of a political decision by the centre-right wing coalition government that was elected in September 2001. The government decided to abolish harm reduction measures and declared illegal drug free prisons as their main target.⁹³

In 2003, the needle exchanges in Vechta and in Lingen 1 Dept. Groß-Hespe were also withdrawn in similar circumstances by a new centre-liberal government in Lower Saxony. The state’s Justice Minister cited lack of staff support for the NEPs as one reason for the decision to terminate the programs.

In Berlin, the social-democratic and socialist coalition indicated in 2003 that it would close the NEP in the Lichtenberg prison in Berlin. The government alleged that there was a lack of

acceptance of the program among prison staff. The government also claimed that the prison did not exhibit a lower HIV infection rate than another prison without an NEP. However, there is no epidemiological research to support this claim. By early 2004, the Lichtenberg NEP was still operating, but the NEP at the Lehrter Str. Prison, also in Berlin, had been closed.

In each of these cases, the decision to cancel the NEPs was made without consultation with prison staff. In fact, the staff are among the most vocal critics of the governments' decisions. In Vechta Prison, for example, prison staff launched a petition to lobby the government to reinstate the program. The official staff representative for the prison wrote to the government to refute allegations that the withdrawal of the program came as the result of a lack of staff support. In Lichtenberg Prison in Berlin, prison staff (85 percent of whom opposed the initial introduction of the NEP) are now the main actors lobbying the government to keep the program operating.

The situation in Germany illustrates the continuing controversial nature of prison NEPs, even within jurisdictions where they have a history of successful implementation.

Spain

History

- In 1997, a pilot NEP was established in the Centro Penitenciario de Basauri (population: 250) in Bilbao. Exchanges were made by NGO workers five hours each day in two discreet areas of the prison. In addition to a sterile syringe, the prisoners also received a harm reduction kit that contained an alcohol swab, distilled water, a hard container for carrying the needle, and a condom. The program emphasized the safe storage of syringes in plastic cases so as to minimize risk of accidental needle stick injuries.⁹⁴
- In 1998, an NEP was established in Pamplona Prison (population not available).
- In 1999, NEPs were established in prisons in Tenerife, San Sebastian and Orense (populations not available).
- Additional NEPs were established in the following two years, such that by the end of 2001, there were NEPs operating in 11 Spanish prisons.
- By early 2004, NEPs had been established in over 30 Spanish prisons, and a pilot NEP had been introduced in one prison in the autonomous region of Cataluña.

Current Situation

The infrastructure for needle exchange exists in all 69 prisons under the jurisdiction of Spain's Ministry of the Interior, with the exception of psychiatric prisons and one extremely high security prison. It should be noted that even in the psychiatric prisons and the extremely high security prison, needle exchange is considered on a case by case basis. Evaluations and assessments of the programs will be conducted annually.

ENDNOTES

¹ Harding TW. Communicable Diseases in Prisons with Special Reference to AIDS. 8th Conference of Directors of Prison Administration (CPAP), Strasbourg, 2-5 June 1987. Strasbourg: Council of Europe, 1988.

² Correctional Service of Canada. A health care needs assessment of federal inmates in Canada. *Canadian Journal of Public Health*, 2004; 95(Sup. 1). p. 34.

³ Correctional Service of Canada (2004), *ibid*.

⁴ Health Canada. Looking Forward: Focussing the Response – Canada's Report on HIV/AIDS 2003. Minister of Public Works and Government Services Canada; 2003. p. 2. The report is available at www.hc-sc.gc.ca/hppb/hiv_aids/report03/pdf/wad_2003.pdf.

⁵ The prevalence rate is based on the fact that Canada's population at the end of 2002 was 31,361,600. This information was taken from the website of Statistics Canada at www.statcan.ca/english/Pgdb/demo02.htm. Accessed 11 August 2004.

⁶ Correctional Service of Canada. Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries 2000-01. Report of the CSC Infectious Diseases Surveillance System. 2003. pp. 5 and 7. The report is available on the CSC website at www.csc-scc.gc.ca/text/pblct/infectiousdiseases/index_e.shtml. The number of reported cases has gone from 24 at the end of 1989, to 170 at the end of 1996, to 223 at the end of 2001. In the five years between 1996 and 2001, the number of reported cases has increased by 31 percent. Note: Preliminary data from the CSC for the end of 2002 indicate that the number of people in federal prisons known to be infected with HIV had risen to 251.

⁷ Correctional Service of Canada (2003), *ibid*, p. 7. The rate ranged from one percent in the Ontario Region to 2.7 percent in the Québec Region.

⁸ Correctional Service of Canada (2003), *ibid*, p. 9. The rate ranged from 0.0 percent in the Ontario Region to 8.2 percent in the Prairie Region. The 8.2 percent rate was in the Edmonton Institution for Women. (There is only one women's prison in each region.)

⁹ Landry S *et al*. Étude de prévalence du VIH et du VHC chez les personnes incarcérées au Québec et pistes pour l'intervention. *Canadian Journal of Infectious Diseases* 2004 ; 15 (Supl. A) : 50A (abstract 36).

¹⁰ Ramuscak N *et al*. Prevalence and correlates of hepatitis C (HCV) among Ontario inmates: preliminary results from the Ontario Remand Study. Presented at the annual conference of the Canadian Association for HIV Research, 13-16 May 2004, Montréal.

¹¹ Health Canada website at www.hc-sc.gc.ca/hppb/hepatitis_c/. Accessed 11 August 2004.

¹² The prevalence rate is based on the fact that Canada's population at the end of 2003 was 31,629,700. This information was taken from the website of Statistics Canada at www.statcan.ca/english/Pgdb/demo02.htm. Accessed 11 August 2004.

¹³ Correctional Service of Canada (2003), *ibid*, p. 15. The number of new HCV positive test reports increased at a rate of over 500 a year between 1998 and 2001. The rate of infection ranged from 15.5 percent in the Québec Region to 34.8 percent in the Pacific Region. The rate was 23.2 percent in the Ontario Region. Note: Preliminary data from the CSC for the end of 2002 indicate that the number of people in federal prisons known to be infected with HCV had risen to 3,173.

¹⁴ Correctional Service of Canada (2003), *ibid*, p. 19. The rate ranged from 19.0 percent in the Québec Region to 57.1 percent in the Prairie Region. The rate was 43.7 percent in the Ontario Region.

¹⁵ Landry S (2004), *ibid.*

¹⁶ Ramuscak N (2004). *ibid.*

¹⁷ Correctional Research and Development. 1995 National Inmate Survey: Final Report. Ottawa; Correctional Service of Canada., 1996. No. SR-02. As reported in McVie F. Drugs in federal corrections – The issues and challenges. Correctional Operations and Programs, Correctional Service of Canada. Available at www.csc-scc.gc.ca/text/pblct/forum/v13n3/v13n3a3e.pdf. Some of the survey results are available on the CSC website at www.csc-scc.gc.ca/text/rsrch/briefs/b14/b14e04_e.shtml.

¹⁸ Calzavara L, and Burchell A. Developing Effective HIV Prevention Programs for Inmates: Results from an Ontario-Wide Survey. *Canadian HIV/AIDS Policy & Law Newsletter*, 1999; 5(1). pp. 32-34.

¹⁹ Health Canada. HIV/AIDS Epi Update. Centre for Infectious Diseases Prevention and Control, April 2003. Available at www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aepi/index.html#HIV.

²⁰ British Columbia Centre for Excellence in HIV/AIDS. The Vanguard Project Five Year Report: Summary of Research Findings, 1995 to 2000. Vancouver, 2000. The prevalence rate cited comes from the section of the report that describes the Vancouver Injection Drug User Study (VIDUS), a cohort study with 1,400 participants. The VIDUS section is available at <http://cfeweb.hivnet.ubc.ca/Vanguard/5YR/5YR034.html>.

²¹ British Columbia Centre for Excellence (2000), *ibid.*

²² Lamothe F, Vincelette J, Bruneau J *et al.* Prevalence, seroconversion rates and risk factors for hepatitis B core, hepatitis C and HIV antibodies among intravenous drug users (IDU) of the Saint-Luc Cohort (abstract 221). 6th annual Canadian Conference on HIV/AIDS Research, May 1997. In *Canadian Journal of Infectious Diseases* 1997; 8(suppl. A). p. 28A.

²³ Stratton *et al.* As cited on the Health Canada Hepatitis Resource Library webpage at www.hc-sc.gc.ca/hppb/hepatitis_c/pdf/careDiscCanada/hcv.html.

²⁴ Correctional Service of Canada (2004), *ibid.* pp. 31 and 49, with reference.

²⁵ Lines R, Jürgens R, Stöver H, Laticevschi D, Nelles J. Prison Needle Exchange: A Review of International Evidence and Experience. *Canadian HIV/AIDS Legal Network*, Montreal; 2004 (forthcoming), with reference.

²⁶ Correctional Research and Development (1995), *ibid.*

²⁷ Lines R (2004), *ibid.*

²⁸ Ford PM, Pearson M, Sankar-Mistry P, Stevenson T, Bell D, Austin J. HIV, hepatitis C and risk behaviour in a Canadian medium-security federal penitentiary. *Quarterly Journal of Medicine*, 2000: 93. pp. 113-119.

²⁹ Kloetze D. Inmate sues the Correctional Service of Canada. In: Jürgens R. HIV/AIDS in prisons: new developments. *Canadian HIV/AIDS Policy & Law Review*, 2002; 6(3). pp. 13-19.

³⁰ See, for example, Article 25 of the Universal Declaration of Human Rights; and Article 12 of the International Covenant on Social, Economic and Cultural Rights.

³¹ International Covenant on Civil and Political Rights. Article 10(1).

³² Lines R (2004), *ibid.*

³³ Corrections and Conditional Release Act, 1992. c.20. Sections 85-88.

³⁴ Mandatory Program and Service Guidelines. Published by the Public Health Branch, Ontario Ministry of Health and Long-Term Care pursuant to Section 7 of the Health Protection and Promotion Act. December 1997.

³⁵ See Communicable Disease Control: Needle and Syringe Exchange Programs in Ontario, 2002. Public Health Branch, Ontario Ministry of Health and Long-Term Care. December 2003.

³⁶ Lines R (2004), *ibid*. In Ontario, the prison system is governed by the Ministry of Correctional Services Act. The Act does not contain any references to the obligation of the state to provide health care.

³⁷ Lines R (2004), *ibid*.

³⁸ Single E. Harm reduction as the basis for Hepatitis C policy and programming. Presentation to the First Canadian Conference on Hepatitis C. Montreal, 4 May 2001. Available at www.ccsa.ca/pdf/ccsa-008853-2001.pdf.

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⁴⁰ The information in this paper on which harm reduction programs are available in the various prisons systems is taken from Lines R Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card. Canadian HIV/AIDS Legal Network, Montréal; 2002. Available at www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm.

⁴¹ Correctional Service of Canada. HIV/AIDS in Prisons: Final Report of the Expert Committee on Aids and Prisons. Minister of Supply and Services, Ottawa, 1994.

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