

Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS

Prisons



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This model law resource consists of eight modules, addressing the following issues:

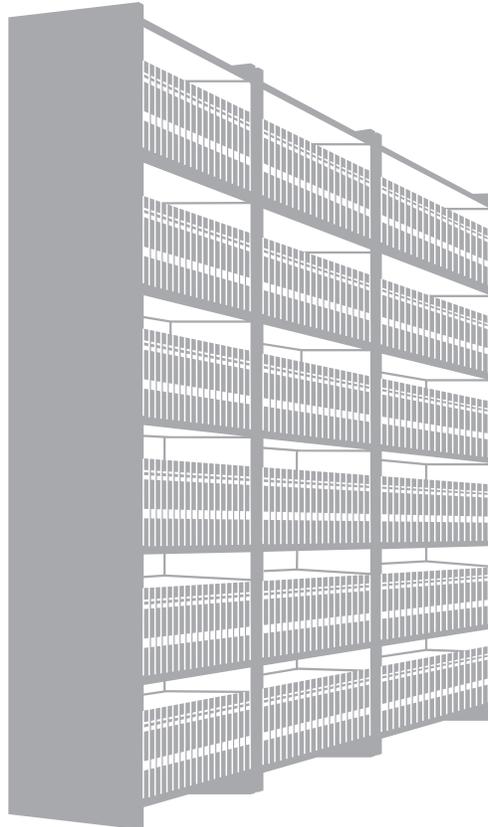
1. Criminal law issues
2. Treatment for drug dependence
3. Sterile syringe programs
4. Supervised drug consumption facilities
5. Prisons
6. Outreach and information
7. Stigma and discrimination
8. Heroin prescription programs

This module, and the other modules, are available in multiple languages on the website of the Canadian HIV/AIDS Legal Network at www.aidslaw.ca/drugpolicy.



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Legislating on Health and Human Rights: Model Law on Drug Use and HIV/AIDS Module 5: Prisons

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About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

Introduction

UNAIDS (the Joint United Nations Programme on HIV/AIDS) suggests that approximately 30 percent of new HIV infections outside sub-Saharan Africa are due to contaminated injection equipment.¹ In eastern Europe and Central Asia, the use of contaminated injection equipment accounts for more than 80 percent of all HIV cases.² Yet, globally, less than five percent of people who inject drugs are estimated to have access to HIV prevention services,³ and even in regions where they account for the majority of HIV infections, people who use drugs are routinely excluded from HIV/AIDS care and treatment.

Many countries with injection-driven HIV/AIDS epidemics continue to emphasize criminal enforcement of drug laws over public health approaches, thereby missing or even hindering effective responses to HIV/AIDS. There is considerable evidence that numerous interventions to prevent HIV transmission and reduce other harms associated with injection drug use are feasible, effective as public health measures and cost-effective.⁴ Despite such evidence, millions of people around the world who use drugs do not have access to such services because of legal and social barriers.

International human rights law establishes an obligation on states to respect, protect and fulfill the right to the highest attainable standard of health of all persons, including those who use drugs. Other human rights are equally relevant in the context of the HIV/AIDS epidemic. When human rights are not promoted and protected, it is harder to prevent HIV transmission, and the impact of the epidemic on individuals and communities is worse. Consequently, UN member states have committed to

enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups⁵

¹ UNAIDS, *2006 Report on the Global AIDS Epidemic*, May 2006, p. 114. At www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

² UNAIDS, *2006 Report on the Global AIDS Epidemic*, p. 114.

³ United States Agency for International Development et al, *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*, June 2004. At www.futuresgroup.com/Documents/CoverageSurveyReport.pdf.

⁴ See, for example, N. Hunt, *A review of the evidence-base for harm reduction approaches to drug use*, Forward Thinking on Drugs, 2003. At www.forward-thinking-on-drugs.org/review2-print.html.

⁵ *Declaration of Commitment on HIV/AIDS*, UN General Assembly, Res/S-26/2, 27 June 2001, para. 58. At www.un.org/ga/aids/docs/aress262.pdf.

UN member states have also committed to ensuring that a wide range of HIV prevention programs is available, including the provision of sterile injecting equipment and harm reduction efforts related to drug use.⁶

The widespread legal, social and political ramifications of the HIV/AIDS epidemic make it necessary to review and reform a broad range of laws. Some countries have adopted national HIV/AIDS laws, but these laws often ignore crucial policy issues, as well as human rights abuses that perpetuate the HIV epidemic. This is particularly true with respect to illegal drug use. HIV prevention, care and treatment services operate best within a clear legal framework that specifically protects the human rights of people who use drugs and enables harm reduction measures to mitigate the impact of HIV. A legislative framework can provide clarity and sustainability for such services. This is particularly important, given the often dominant approach of criminalizing illegal drug use and people who use drugs, which creates additional barriers to delivering health services. Law reform is not a complete solution to effectively addressing the HIV epidemic among people who use illegal drugs, but it is a necessary and often neglected step.

The model law project

In early 2005, the Legal Network established a project advisory committee and, in consultation with the committee, developed a plan to produce model law that would assist states in more effectively addressing the HIV epidemic (and other harms) among people who use drugs, based on evidence of proven health protection and promotion measures, and in accordance with states' human rights obligations.

Comprehensive consultations were conducted during the drafting of the model law. A draft version of the model law was reviewed by a group of legal experts, harm reduction advocates and government representatives from central and eastern Europe, and countries of the former Soviet Union, during a meeting in Vilnius, Lithuania (7–8 November 2005). The document was modified in line with this feedback and recommendations. In early 2006, the model law was circulated in electronic form to a large number of people and organizations, providing a further opportunity to modify and strengthen the resource. This final document has, therefore, benefited from the thinking of a wide range of experts in the fields of HIV/AIDS, human rights and drug policy.

About this resource

This model law resource is a detailed framework of legal provisions and accompanying commentary. It makes reference to examples of law from those jurisdictions that have attempted to establish a clear legal framework for addressing HIV/AIDS issues among people who use drugs.⁷ This resource also incorporates human rights principles and

⁶ *Declaration of Commitment on HIV/AIDS*, para. 52.

⁷ References to national legal instruments are included in order to demonstrate the feasibility of establishing progressive legal frameworks so that law reform in other jurisdictions can be informed by such examples.

obligations of states throughout the document. It is annotated in order to highlight critical issues and evidence that supports the measures proposed.

This model law resource is designed to inform and assist policy-makers and advocates as they approach the task of reforming or making laws to meet the legal challenges posed by the HIV epidemic among people who use drugs. The model law resource is not intended for any one country or set of countries. Rather, it is designed to be adaptable to the needs of any of a wide number of jurisdictions. In some instances, the model law presents different legislative options for implementing states' human rights obligations. It is hoped that this resource can be most useful for those countries where injection drug use is a significant factor driving the HIV epidemic, and particularly for developing countries and countries in transition where legislative drafting resources may be scarce.

The model law resource consists of eight modules, addressing the following issues:

- (1) Criminal law issues
- (2) Treatment for drug dependence
- (3) Sterile syringe programs
- (4) Supervised drug consumption facilities
- (5) Prisons
- (6) Outreach and information
- (7) Stigma and discrimination
- (8) Heroin prescription programs

Each of the eight modules in this series is a stand-alone document. Each module begins with the introduction that you are reading now; the text of the introduction is identical in all of the modules.

Following the introduction, each model provides a prefatory note, model statutory provisions and a list of selected resources. (Taken together, the model statutory provisions in all eight modules would form a model law addressing HIV/AIDS and drug use.)

The prefatory note presents a rationale for reforming laws and policies in the area covered by the module. This is followed by a discussion of the relevant UN conventions on drug control, and of states' human rights obligations in this area.

The section on model statutory provisions contains provisions that could be included in a model law on HIV/AIDS and drug use. The provisions are divided into chapters, articles, sections and subsections. The first chapter ("General Provisions") describes the purpose of that Part of the model law, and provides definitions for many of the terms included in the provisions.

These references do not imply that the actual practice in the jurisdictions cited represents "best practice." There is often a long way to go in ensuring that actual practice conforms to these legal undertakings.

Some of the provisions are accompanied by a commentary. The commentary provides additional information on, or rationale for, the provision in question. For some model statutory provisions, two options are presented; a note inserted into the text indicates either (a) that one or the other option should be selected, but not both; or (b) that one or the other option, or both options, can be selected. As well, some of the provisions have been labelled as “optional.” This means that these provisions may or may not be applicable, depending on the situation in the country.

The section on selected resources contains a short list of resources which the Legal Network considers to be particularly useful. There are two subsections: one on articles, reports and policy documents, and one on legal documents.

The model law resource is heavily footnoted. The notes provide additional information on the issues being addressed, as well as full references. If the same source is cited more than once in a module, the second and subsequent references to that source are somewhat abbreviated (usually just the name of the author, or organization, and the title of the article or report).

Module 5: Prisons

Module 5 contains a prefatory note which discusses the rationale for reforming laws and policies in prisons in order to implement a comprehensive harm reduction approach. The prefatory note describes relevant international laws and policies, including human rights obligations. This is followed by a section on model statutory provisions designed to assist with implementing policy that is sound from the perspective of both public health and human rights. Module 5 concludes with a list of recommended resources.

Prefatory Note

Rationale for reform

In virtually all countries for which data has been collected, the prevalence of HIV, as well as hepatitis C (HCV) and other blood-borne diseases, is higher among prisoners than in the non-prison population. Prisoners may be exposed to high risk activities such as sharing drug injection equipment and consensual or non-consensual unprotected sex. Since the great majority of prisoners return to their communities after serving their sentences, and since many prisoners move repeatedly between prisons and the general community, large segments of the population are affected by the presence and spread of HIV in prisons, as are personnel working in prisons.⁸

In many countries, the prevalence and transmission of HIV in prisons are linked to the incarceration of people who use drugs and unsafe drug use in prisons. In a growing number of countries, there is evidence that significant new HIV transmission occurs in prison.⁹ But efforts to reduce such harms are impeded in some countries by the official policy of denying the existence of drug use. Research and experience show that no

⁸ For useful summaries of research literature on this subject, see: R. Jürgens, *HIV/AIDS and HCV in prisons: A select annotated bibliography*, Health Canada, 2005. At www.hc-sc.gc.ca/ahc-asc/alt_formats/hpb-dgps/pdf/intactiv/hiv-vih-aids-sida-prison-carceral_e.pdf. See, also, WHO/UNODC/UNAIDS, *Policy Brief: Reduction of HIV transmission in prisons*, 2004.

⁹ C.P. Krebs and M. Simmons, "Intraprison HIV transmission: an assessment of whether it occurs, how it occurs, and who is at risk," *AIDS Education and Prevention*, 14 (Suppl B) (2002): 53–64; K. Dolan et al, *Review of injection drug users and HIV infection in prisons in developing and transitional countries*, UN Reference Group on HIV/AIDS Prevention and Care among IDUs in Developing and Transitional Countries, 2004; A. Taylor et al, "Outbreak of HIV infection in a Scottish prison," *British Medical Journal*, 310(6975) (1995): 289–292; S. Caplinskas and G. Likatavicius, "Recent sharp rise in registered HIV infections in Lithuania," *Eurosurveillance Weekly*, 6(2) (2002); K. Dolan and A. Wodak, "HIV transmission in a prison system in an Australian State," *Medical Journal of Australia*, 171(1) (1999): 14–17.

country has succeeded in completely eradicating illegal drug use in prisons.¹⁰ Many prisoners have a history of drug use or use drugs during their imprisonment. In many countries, policies of actively pursuing and imprisoning those who produce, traffic, possess or consume illegal drugs have significantly increased prison populations and have led to prison overcrowding. In addition to those who enter prison with a history of drug use, some prisoners begin using drugs while in prison as a means to cope with living in an overcrowded, hostile and often violent environment. Similarly, despite its prohibition in many jurisdictions, sexual activity also occurs within prisons and often, because of prison policy, without adequate access to condoms to reduce the risk of transmitting HIV.

Despite the presence of behaviours and activities in prison systems that carry a high risk of HIV and HCV transmission, very few countries provide comprehensive harm reduction services in prisons commensurate with services available outside prisons. In all but a very few countries, services to reduce the harms of drug use are highly inadequate in absolute terms and relative to the scale of the problem. In the U.S., for example, opioid substitution treatment is rarely available to prisoners.¹¹ Many countries have yet to ensure that prisoners have access to sterile syringes, even though sterile syringe programs have been repeatedly shown to be one of the most important measures to protect against the spread of blood-borne diseases such as HIV.¹² In many countries, even inexpensive bleach for partial sterilization of injecting equipment is not readily accessible to people in prison.¹³

Prisoners living with HIV/AIDS are particularly vulnerable to harm in prison environments. Many prisons are overcrowded, have unsanitary conditions and are unequipped to provide the proper counselling, education and medical treatment required to respect the rights and preserve the health of HIV-positive prisoners.

Because prison is such a high-risk environment with respect to HIV and other blood-borne diseases, one of the most important ways to reduce drug-related harms associated

¹⁰ R. Jürgens, *HIV/AIDS and HCV in prisons: A select annotated bibliography*, Health Canada, 2005. See, also, WHO/UNODC/UNAIDS, *Policy Brief: Reduction of HIV transmission in prisons*, 2004; WHO, *Effectiveness of interventions to manage HIV/AIDS in prison settings — needle and syringe programmes and bleach*, Evidence for action technical paper, 2006.

¹¹ R. Heimer et al., “Methadone maintenance in a men’s prison in Puerto Rico: a pilot program,” *Journal of Correctional Health Care* 11(3) (2005): 295–305.

¹² Sterile syringes are only available to prisoners in a small number of countries worldwide. See R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2nd Ed., Canadian HIV/AIDS Legal Network, 2006.

¹³ For Canada, for example, see R. Lines, *Action on HIV/AIDS in Prisons: Too little, Too late — A report card*, Canadian HIV/AIDS Legal Network, 2002. Bleach has proven effective for reducing the risk of HIV transmission by sterilizing shared injection equipment. However, bleach is not effective at destroying all types of virus, and the risk of transmission of HCV remains; see F. Kapadia et al., “Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users?,” *Epidemiology* 13(6) (2002): 738–741.

with incarceration is to institute measures that reduce or eliminate periods spent in prison. One option is to provide alternatives to incarceration for those convicted of drug use and possession of drugs for personal use.¹⁴ In some countries, large numbers of people are incarcerated while they await trial. A further option is to establish statutory limitations on the time period of pre-trial detention. This can be helpful in addressing prison overcrowding and generally improving the likelihood that effective programs can be instituted for those who remain in prison.

A harm reduction approach to addressing HIV and other blood-borne diseases within prisons also involves implementing a number of programs and services designed:

- to minimize the transmission of HIV and other blood-borne diseases among groups involved in high-risk activities such as sharing drug injection equipment;
- to facilitate counselling and education regarding HIV and other blood-borne diseases, and the risks involved in certain activities;
- to facilitate prisoners' access to voluntary HIV and HCV testing; and
- to respect the human rights of those prisoners living with HIV/AIDS, HCV or drug dependence.

Some countries have moved forward with certain harm reduction measures in prison, including opioid substitution treatment and other drug dependence treatment, sterile syringe programs, provision of bleach for disinfecting syringes and provision of condoms. An extensive body of research on these programs has shown that they are effective in reducing transmission of both HIV and HCV in prison and that they are generally cost-effective, particularly when compared to the high cost of treating these illnesses.¹⁵ It should also be noted that reducing the prevalence of HIV and HCV in prisons is of benefit to prison personnel as well, making their workplaces safer.

¹⁴ The European Council has called on member states to “further develop alternatives to imprisonment for drug abusers and drug services for people in prisons, with due regard to national legislation.” See European Council, *EU Drugs Action Plan (2005-2008)*, 2005/C168/01, Objective 13. Available via www.emcdda.europa.eu.

¹⁵ Numerous studies have demonstrated the efficacy of various harm reduction programs in prisons. Studies of sterile syringe programs have shown that syringe-sharing among prisoners, an activity which puts prisoners at high risk for HIV infection, dramatically decreases when sterile syringes are made available. See, for instance, J. Nelles and A. Fuhrer, *Drug and HIV Prevention at the Hindelbank Penitentiary: Abridged Report of the Evaluation Results*, Swiss Federal Office of Public Health, 1995; and R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2nd Ed. Opioid substitution treatment has also been widely recognized as an effective means of stabilizing opioid dependence while reducing incidence of needle use; see K. Dolan et al, “Methadone Maintenance Reduces Injecting in Prison,” *British Medical Journal* 312 (1996): 1162. For a general review of harm reduction programs in prisons, see R. Jürgens, *HIV/AIDS in prisons: A selective annotated bibliography*.

International law and policy

In enacting and implementing domestic legislation and policy in the context of prisons and prisoners, governments must consider their obligations under international law to respect, protect and fulfill human rights. Under the *Charter of the United Nations*, all member states have a binding treaty obligation “to take joint and separate action” to achieve the purpose of the UN, which includes promoting “solutions of international ... health problems” and “universal respect for, and observance of, human rights and fundamental freedoms for all.”¹⁶ The *Universal Declaration of Human Rights*, which further elaborates on UN member states’ human rights obligations under the UN Charter, states that “everyone has the right to a standard of living adequate for health and well-being, including medical care and necessary social services.”¹⁷ The UN Charter (Article 103) also specifies that in the event of a conflict between a state’s obligations under the Charter and those under any other treaty, the Charter obligations prevail.

States that are parties to the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) have recognized the right of every person to enjoy “the highest attainable standard of physical and mental health” (Article 12). They also have a binding legal obligation to take steps to realize fully this right, including those steps “necessary for ... prevention, treatment and control of epidemic, endemic ... and other diseases” and “the creation of conditions which would assure to all medical services and medical attention in the event of sickness.”¹⁸ In addition, the *International Covenant on Civil and Political Rights* (ICCPR) states that every person has the inherent right to life (Article 6).¹⁹ The Human Rights Committee, the expert body charged with addressing states’ compliance with their obligations under the ICCPR, has explained that this right “should not be interpreted narrowly” and that governments must adopt positive, pro-active measures to protect human life, including measures that can help reduce the spread of epidemics.²⁰ The *UN Convention Against Torture, and Other Cruel, Inhuman, or Degrading Treatment or Punishment* explicitly obliges states to undertake to prevent torture and treatment or punishment that is cruel, inhuman or degrading.²¹

¹⁶ *Charter of the United Nations*, UN, TS 993 (entered into force 24 October 1945), art. 55 and 56.

¹⁷ *Universal Declaration of Human Rights*, UN General Assembly, Resolution 217 A(III), UN GAOR, 3rd Session, 183rd plenary meeting, 71, UN Doc. A/910 (1948), art. 25.

¹⁸ *International Covenant on Economic, Social and Cultural Rights* (ICESCR), UN General Assembly, 993 UNTS 3, art. 12(2).

¹⁹ *International Covenant on Civil and Political Rights* (ICCPR), 999 UNTS 171.

²⁰ UN Human Rights Committee, *The Right to Life* (Art. 6), General comment 6, UN Doc. HRI/GEN/1/Rev.1, 6 (1982). Available via www.ohchr.org/english/bodies/hrc/comments.htm.

²¹ *Convention Against Torture, and Other Cruel, Inhuman, or Degrading Treatment or Punishment* 1465 UNTS 85, 10 December 1984.

A number of international legal instruments address specifically the issue of the human rights of prisoners. The UN *Standard Minimum Rules for the Treatment of Prisoners* contain provisions directed at respecting the fundamental rights of prisoners and provides a set of guidelines designed to ensure respect for prisoners' rights, including adequate health care, treatment and living conditions.²² The UN *Basic Principles for the Treatment of Prisoners* states that prisoners shall not be subject to discrimination on a variety of grounds, including health status, and that prisoners shall not have any human rights limited other than those necessarily limited by the fact of incarceration.²³ The *Basic Principles* also provide that prisoners shall have access to the medical and health services available in their country of incarceration without discrimination based on their legal status.²⁴ One consequence of this principle is the requirement of equivalence of health care, whereby prisoners have the right to receive health care, including preventative measures, equivalent to that available in the general community.²⁵ This approach to health care and human rights is supported in the World Health Organization's (WHO) *Guidelines on HIV Infection and AIDS in Prisons*, which outline principles relating to (a) prisoners' right to access to health care and (b) implementing HIV prevention strategies in prisons.²⁶

In order to respect these international obligations, legislation and regulations relating to prisoners and imprisonment should embody a number of principles directed at preserving prisoners' human rights, including respecting prisoners' rights to health care, confidentiality and treatment with informed consent; ensuring the prohibition on cruel, inhuman or degrading treatment or punishment; and ensuring that prisoners living with HIV/AIDS, HCV or drug dependence are treated without discrimination.

²² UN, *Standard Minimum Rules for the Treatment of Prisoners*, Adopted by the First United Nations Congress on The Prevention of Crime and the Treatment of Offenders, Geneva, 1955. Articles 22 through 26 set out basic minimum access to health care and treatment for prisoners, including the availability of medical officers and access to hospitals.

²³ UN *Basic Principles for the Treatment of Prisoners*, UN General Assembly. Resolution 45/111 of 14 December 1990, art. 2 and 5.

²⁴ UN *Basic Principles for the Treatment of Prisoners*, art. 9.

²⁵ This position has widespread acceptance by United Nations organizations and member states. See, for example, WHO, *WHO guidelines on HIV infection and AIDS in prisons*, 1993, principle 1; Council of Europe, Committee of Ministers, Recommendation No. R (98) 7 Concerning the ethical and organizational aspects of health care in prison, principle 10; UN *Basic Principles for the Treatment of Prisoners*, principle 9; UN General Assembly, *Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees from Cruel, Inhuman or Degrading Punishment or Treatment*, Resolution 37/194 of 18 December 1982, Principle 1.

²⁶ WHO *Guidelines on HIV Infection and AIDS in Prisons*, WHO/GPA/DIR/93.3, 1993.

Model Statutory Provisions

Chapter I. General Provisions

Article 1. Purpose of this Part

The purpose of this Part is to contribute to a safe and healthy environment for prisoners and prison staff by:

- (a) providing prisoners with humane treatment and support for HIV/AIDS and other blood borne diseases, and for drug dependence, in an environment free of discrimination;
- (b) enabling a wide range of services for prisoners to minimize the harms related to unsafe drug use, including the risk of infection by HIV and other blood-borne diseases;
- (c) developing a safer work environment for prison staff; and
- (d) providing for the development of national data and research on the prevalence of sexual violence (including rape) in prison and the issuance of national standards to eradicate sexual violence in prison.

Article 2. Definitions

For the purposes of this Part, the following definitions are used:

“Cruel, inhuman or degrading treatment or punishment” means any harsh or neglectful treatment that could damage a person’s physical or mental health, or any punishment intended to cause physical or mental pain or suffering, or to humiliate or degrade the person concerned.

“Dispensing machine” means any machine or mechanical device used for selling or supplying sterile syringes without the personal attention of the seller or supplier at the time of the sale or supply.

“Drug dependence treatment” means a program with specific medical or psycho-social techniques aimed at managing or reducing a patient’s dependence on one or more controlled substances, thereby improving the general health of the patient. Such programs include opioid substitution treatment, residential or out-patient services, administration of medicines to reduce cravings or diminish an adverse impact of using controlled substances, psychiatric and psychosocial support services and supervised support groups.

“Health care” refers to services provided by health professionals in the formal health system for prevention or treatment of mental or physical diseases or conditions.

“Health practitioner” means a person entitled under the [relevant health law] to provide health services. Health practitioners include accredited physicians, registered nurses and other trained medical staff.

“Opioid substitution treatment” means the administration of an opioid substitute to a person with dependence on a pharmacologically related opioid, for achieving defined treatment aims,²⁷ including maintenance treatment.

“Parole” means the authority granted to a prisoner by the [relevant authority] to be in the general community during the prisoner's sentence, and may include day parole.

“Prison” includes

- (a) a facility of any description that is operated, permanently or temporarily, by the [relevant prison authority] for the care and custody of prisoners; and
- (b) a private prison facility constructed or operated under an agreement with the relevant prison authority for the confinement of prisoners.

“Prisoner” includes

- (a) a person who is in a prison pursuant to a sentence for an offence; or who has been convicted of an offence and is awaiting imposition of a sentence; or who is in prison because of a condition imposed by the [relevant authority] in connection with parole or statutory release;
- (b) a person who, having been sentenced, committed or transferred to prison, is temporarily outside prison by reason of a temporary absence or work release authorized under [relevant legislation]; or is temporarily outside prison for reasons other than a temporary absence, work release, parole or statutory release, but is under the direction or supervision of a staff member or of a person authorized by the [relevant authority]; and
- (c) a person who is in prison awaiting trial.

“Staff”, in the context of a sterile syringe program, includes the following persons:

- (a) the operator or manager of the program;
- (b) a person engaged by the operator or manager of the program to provide services at the facility, whether under a contract of employment or otherwise; and
- (c) a person engaged by the operator or manager of the program to provide voluntary assistance at the facility.

“Sexual violence” means an act of sexual violence, including rape, committed against a prisoner who is in the actual or constructive control of prison officials.

²⁷ This wording has been derived from WHO/UNODC/UNAIDS, *Substitution maintenance therapy*, 2004, p. 12.

“Sterile syringe program” means a program that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or referrals to substance abuse treatment services. It includes needle exchange programs, needle distribution programs and other forms of sterile syringe distribution.

“Torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from the person or a third person information or a confession; punishing the person for an act he or she or a third person has committed or is suspected of having committed; or intimidating or coercing the person or a third person; or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions.²⁸

²⁸ This definition is derived from Article 1 of the UN *Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment and Punishment*, 1984. Similar definitions have been incorporated into domestic legislation in various countries.

Chapter II. Human Rights of Prisoners

Article 3. Human rights governing the procedure and conditions of imprisonment

- (1) The state shall respect and protect the human rights and fundamental freedoms of prisoners and shall provide the conditions necessary for their social, legal and medical protection and care.
- (2) Except for those limitations that are demonstrably necessitated by the fact of imprisonment, all prisoners shall retain the human rights and fundamental freedoms set out in international human rights law.²⁹

Commentary: Article 3

It is a well established legal principle that prisoners retain their basic human rights while imprisoned. The *International Covenant on Civil and Political Rights* guarantees, for instance, that prisoners will be treated with humanity and respect for their dignity.³⁰ Other instruments contain the principle that prisoners should have their rights diminished only so far as is necessary for imprisonment and for being subject to the discipline of prison institutions, and national legislatures and courts have demonstrated a willingness to uphold this principle.³¹

Human rights implicated in the context of prisons often include the right to be free from discrimination; the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment; the right to privacy; and the right to enjoy the highest attainable standard of physical and mental health.³² Recognition of the basic rights and fundamental freedoms of prisoners is central to preventing the transmission of HIV, by facilitating the sharing of information on transmission and prevention and by reducing the impact of the virus on individuals and the communities they belong to.

²⁹ This wording is derived from the UN *Basic Principles for the Treatment of Prisoners*, Principle 5.

³⁰ ICCPR, art. 10(1).

³¹ See, also, UN, *Basic Principles for the Treatment of Prisoners*, Principle 5. The UNAIDS *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999, states at p. 61 that “services for prisoners as a captive population should be equivalent to the education, treatment, care and support received by the general population. This means providing access to HIV-related prevention information, education, ... voluntary (including anonymous) testing and counseling, and the actual means to implement them (condoms, dental dams, water-based lubricants and bleach).” An example of national legislation enshrining the principle that prisoners should only have those rights removed which are necessitated by the fact of incarceration may be found in Canada’s *Corrections and Conditional Release Act* 1992, c.20, s.4(e). The [U.K.] House of Lords has applied the principle of limited restriction of prisoners’ rights, stating that prisoners, while incarcerated, “retain all civil rights which are not taken away expressly or by necessary implication;” see *Raymond v Honey* [1983] 1 AC 1.

³² Regarding the right to health, see ICESCR, art. 12.

Chapter III. Pre-Trial Prisoners and Others Under Detention Without Sentence

Article 4. Rights upon arrest or detention

- (1) Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time and without undue delay or to release.³³
- (2) Pre-trial detention shall be used as a means of last resort in criminal proceedings, with due regard for the investigation of the alleged offence and for the protection of society and the victim.³⁴
- (3) Pre-trial prisoners and others under detention without sentence are entitled to the same rights as sentenced prisoners, including those rights related to health care.

Commentary: Article 4

Consistent with the presumption of innocence, defendants should normally be granted release prior to trial.³⁵ This basic human rights principle takes on even greater importance in the light of the health risks associated with detention. Pre-trial prisoners and persons under detention without sentence risk infection with HIV and other blood-borne viruses through similar means to that of the prison population, including unsafe injection drug use and unsafe sex, whether consensual or non-consensual. These risks may be exacerbated by features typical of pre-trial detention facilities, such as overcrowding and a transient population.³⁶ Furthermore, health care and harm reduction programs available to the general prisoner population are often not made available to

³³ This wording is derived from Article 9(3) of the ICCPR. The principle is also found in Council of Europe's *Convention for the Protection of Human Rights and Fundamental Freedoms*, ETS 5 (1950), art. 5(1)(c)(3) and 6(1). In national law, this provision is often governed by case law or criminal procedure legislation. Determining how long is a "reasonable time" depends on the circumstances of the case; there is no absolute time limit. When the European Court of Human Rights decides whether this requirement has been fulfilled, it generally has regard to (1) the complexity of the case, (2) the conduct of the applicant and (3) the conduct of the authorities. Italy's *Law No. 89* of 24 March 2001, the so-called "Pinto Act" (from the name of the Senator who was its first signatory), introduced into Italian law a mechanism under which a private citizen is entitled to "fair reparation" if he or she suffers damage due to the "unreasonable" length of proceedings.

³⁴ The wording of this Article is derived from the UN *Standard Minimum Rules for Non-custodial Measures* (The Tokyo Rules). Adopted by the UN General Assembly resolution 45/110 of 14 December 1990, Principle 6.

³⁵ See Article 9(3) of the ICCPR. Pre-trial release may be made subject to conditions, including guarantees to appear at trial and, if relevant, for execution of the judgment.

³⁶ See Human Rights Watch, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation*, 2004. At <http://hrw.org/reports/2004/russia0404/>.

persons in pre-trial detention.³⁷ Persons in pre-trial detention who require medical treatment may not receive it, and those in ongoing treatment programs may be subject to interruption of treatment. Because persons in pre-trial detention, who are presumed innocent until proven guilty, are at high risk of violation of their rights to health and security of the person, legal reform in this area is intended to provide a legally enforceable guarantee within national legislation to trial or release within a reasonable time.

³⁷ Studies have indicated that the standard of medical facilities and the accessibility of treatment may be lower in pre-trial detention facilities than in long-term prisons. In particular, harm reduction programs may be less available to those in pre-trial detention; see Morag MacDonald, *A study of health care provision, existing drug services and strategies operating in prisons in ten countries from Central and Eastern Europe*, 2005, pp. 99–138. Available via www.heuni.fi.

Chapter IV. Health Care in Prisons

Article 5. Right to equal and adequate health care for prisoners

- (1) A prisoner who has tested positive for infection with HIV is entitled to adequate health care, counselling and referrals to support services while in prison.³⁸
- (2) Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.³⁹

Commentary: Article 5

The UN's *Basic Principles for the Treatment of Prisoners* state that the attainment of the highest possible standard of health is a human right, and should not be restricted because of the fact of imprisonment.⁴⁰ Providing care and treatment to prisoners ensures that their right to health is protected. In particular, it ensures that individuals in traditionally marginalized groups, such as those living with HIV/AIDS, receive the care needed to maintain their well-being and dignity. National courts have upheld this view, recognizing that a certain standard of care for prisoners living with HIV/AIDS, modeled on the services available to the public in general, should be accessible in prisons.⁴¹

³⁸ For example, this right to health care is contained in the Criminal Executive, Penitentiary or Correction Codes of a number of former Soviet Union countries. See Articles 8.1 and 116 of the *Criminal Executive Code of Ukraine*, of 1 January 2004.

³⁹ UN, *Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment*, G.A. Res. 37/194 of 18 December 1982, U.N.GAOR, 111th mtg., Annex, U.N. Doc. A/RES/37/194, Principle 1.

⁴⁰ UN *Basic Principles for the Treatment of Prisoners*, art. 9.

⁴¹ A 1997 South African decision stated that prisoners have the constitutional right to an adequate standard of medical treatment, including provision of drugs at the state's expense; see *Van Biljon and Others v. Minister of Correctional Services and Others* (1997), 50 BMLR 206, High Court (Cape of Good Hope Division). The plaintiffs were four HIV-positive prisoners seeking a declaration that they were entitled to receive antiretroviral (ARV) medication at the state's expense. The Court found that denial of ARV treatment to symptomatic HIV-positive prisoners with a CD4 count below 500 was a violation of this guarantee, and ordered the provision of treatment to the claimants meeting these criteria. In *EN and Others v. the Government of the Republic of South Africa and Others* (2006), the Durban High Court ordered the South African government and prison authorities to provide access to ARV medication for fifteen HIV-positive prisoners. See *EN and Others v. the Government of the Republic of South Africa and Others* (2006) Case 4576/2006, Judgment 22 June 2006 (High Court of South Africa — Durban and Coast Local Division). Information on the case is available via www.alp.org.za/index.php. See also *Leatherwood et al. v. Campbell*, United States District Court for the Northern District of Alabama, Case No. CV-02-BE-2812-W (2004). In this case, the complainants alleged that the prison provided inadequate health care and substandard housing, resulting in an excessive number of preventable prisoner deaths and exposing other prisoners to an excessive risk of harm. The Court approved a settlement between the class of HIV-positive prisoners and corrections officials. The settlement agreement included providing prisoners access to a number of HIV/AIDS health care specialists and services and improvement of living conditions for HIV-positive prisoners. These cases, and others on HIV issues in prison, are included in UNAIDS and Canadian

WHO recommends that all prisoners have the right to receive health care, including preventative measures, equivalent to that available in the general community without discrimination based on legal status.⁴² Prisoners living with HIV/AIDS are especially vulnerable to having their rights violated, as they may face barriers to health treatment including minimal care resources and unresponsive institutions, and may avoid seeking treatment for fear of stigmatization or discrimination. Access to health care, including preventative treatment, is necessary to reduce the effects of HIV on prison communities by maintaining the rights of HIV-positive prisoners and controlling and preventing primary and secondary infections associated with HIV.

Article 6. Voluntary counselling and testing

- (1) A prisoner is entitled to free confidential testing for infection with HIV and other blood-borne viruses, and to counselling in connection with such testing.⁴³
- (2) No test for HIV or other blood-borne disease shall be undertaken except with the informed voluntary consent in writing of the prisoner.
- (3) All prisoners presenting themselves for testing shall be offered pre-test and post-test counselling by a health practitioner, in accordance with professional standards.⁴⁴

Commentary: Article 6

Compulsory HIV testing, and segregation of prisoners testing HIV-positive, have been proposed as a means of identifying and isolating HIV within prison populations.⁴⁵ Compulsory HIV testing infringes the right to security of the person, the right to privacy and the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment.⁴⁶ Compulsory HIV testing is also discriminatory. Studies suggest that compulsory testing is less productive and less effective in educating prisoners and

HIV/AIDS Legal Network, *Courting Rights: Case Studies in Litigating the Human Rights of People living with HIV*, UNAIDS Best Practice Collection, March 2006. At www.aidslaw.ca/Maincontent/issues/discrimination/Courtingrights-ENG.pdf.

⁴² WHO *Guidelines on HIV Infection and AIDS in Prisons*, art. 1.

⁴³ This wording is derived from Illinois [USA] *Public Act 094-0629*, § d-5.

⁴⁴ This wording is derived from Correctional Services Canada, *Commissioner's Directive 821: Management of Infectious Diseases*, 4 November 2004, art. 24.

⁴⁵ See A. Spaulding et al., "Human immunodeficiency virus in correctional facilities: a review," *Clinical Infectious Diseases* 35 (2002): 305-312.

⁴⁶ L. Sanders Branham, "Opening the bloodgates: the blood testing of prisoners for the AIDS virus," *Connecticut Law Review*, 20 (1988):763-834. Article 9 of the ICCPR guarantees security of the person, Article 17 prohibits arbitrary or unlawful violation by the state of the right to privacy and Article 7 prohibits cruel, degrading, or inhuman punishment. Similar provisions may be found in the *European Convention on Human Rights and Fundamental Freedoms*.

changing their behaviour than voluntary testing and broad education programs.⁴⁷ It may also lead to a false sense of security on the part of prisoners who test HIV-negative and who think that their contacts (such as sexual activity or sharing drug injection equipment) are only with other prisoners who are also HIV-negative, something that cannot be guaranteed given the “window period” between HIV infection and testing positive for that infection using current HIV-antibody tests.

It is important to make voluntary, confidential HIV testing with well-informed counselling accessible to prisoners throughout their period of imprisonment. This should include anonymous HIV testing in jurisdictions where such testing is available outside of prisons.⁴⁸ To protect prisoners from violations of their right to security of the person, HIV testing should only be carried out with the informed consent of the prisoner.⁴⁹ Voluntary, confidential testing for HIV infection should be available in prisons together with adequate pre- and post-test counseling.⁵⁰ Well-informed pre- and post- test counselling should be a mandatory component of all HIV testing protocols and practices in prisons.⁵¹

Article 7. Informed consent

- (1) Informed voluntary consent of a prisoner is a necessary preliminary condition for medical treatment or a preventative or diagnostic intervention.
- (2) The following are the elements required for consent to treatment:
 - (a) the consent must relate specifically to the treatment administered;
 - (b) the consent must be fully informed;
 - (c) the consent must be given voluntarily;
 - (d) the consent must be provided in writing; and
 - (e) the consent must not be obtained through misrepresentation or fraud.
- (3) For the purpose of paragraph (2)(b), a prisoner's consent to a health care intervention or procedure is informed consent only if the prisoner has been advised of, and has the capacity to understand:

⁴⁷ See, for example, J.K. Andrus et al., “HIV testing in prisoners: is mandatory testing mandatory?,” *American Journal of Public Health* 79(7) (1989):840–2.

⁴⁸ UNODC, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings. A Framework for an Effective National Response*, 2006.

⁴⁹ *WHO Guidelines on HIV Infection and AIDS in Prisons*, Recommendation 11.

⁵⁰ *UN Basic Principles for the Treatment of Prisoners*, Principle 9; *WHO Guidelines on HIV Infection and AIDS in Prisons*, Recommendation 11.

⁵¹ UNODC, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings. A Framework for an Effective National Response*, 2006.

- (a) the likelihood and degree of improvement, remission, control or cure as a result of the intervention;
 - (b) any significant health or other risk, and the degree thereof, associated with the intervention;
 - (c) any reasonable alternatives to the intervention;
 - (d) the likely effects of refusing the intervention; and
 - (e) the prisoner's right to refuse the intervention or withdraw from the intervention at any time.⁵²
- (4) The prisoner has the right to refuse health care interventions or withdraw from health care interventions at any time. If the prisoner refuses to consent to a specific intervention or procedure, no punitive action shall be taken and medically appropriate alternative interventions or procedures shall, if possible, be made available.⁵³

Commentary: Article 7

Health care interventions (including HIV testing, treatment with antiretroviral or other medications, and drug dependence treatment) should only be undertaken with the consent of the prisoner involved. Health care provided without consent, or with consent obtained under pressure or duress, infringes the right to security of the person, the right to privacy, and the right not to be subjected to cruel, inhuman or degrading treatment or punishment. The presence of coercive testing or treatment schemes may also discourage prisoners from seeking necessary care for fear of loss of privacy or of the treatment itself. As a result, prisoners at risk for poor health may not receive the care needed to improve their conditions and maintain the safety of others. The provision of health care only with informed consent encourages those in need of testing and treatment to seek it as appropriate.

Article 8. Confidentiality

- (1) All information on the health status and health care of a prisoner is confidential, and all health care procedures shall be designed so as to preserve the confidentiality of prisoners.
- (2) Information referred to in Section (1) shall be recorded in files available only to health practitioners and not to non-health care prison staff. No mark, label, stamp or other visible sign shall be placed on prisoner's files, cells or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.⁵⁴

⁵² This wording is derived from *Corrections and Conditional Release Act* (Canada), art. 88.

⁵³ This wording is derived from Correctional Services Canada, *Commissioner's Directive 803: Consent to Health Services Assessment, treatment and release of information*, 3 September 2003, art. 8–9.

⁵⁴ This wording is derived from *WHO Guidelines on HIV Infection and AIDS in Prisons*, Recommendations 31 and 33.

(3) Information referred to in Section (1) may only be disclosed:

- (a) with the prisoner's consent; or
- (b) where warranted to ensure the safety of other prisoners or staff;

with the same principles as generally applied in the community applying to the disclosure.⁵⁵

Commentary: Article 8

Information regarding a prisoner's health status should be made available to that prisoner and, beyond him or her, only to those for whom knowledge of the prisoner's status is absolutely necessary (such as a health practitioner, and only if that information is relevant to the particular treatment to be provided by that practitioner).⁵⁶ There will be few instances in which HIV, HCV and drug dependence are justifiably disclosed out of concern for safety of others. The right to confidentiality should be respected regardless of the fact of imprisonment.⁵⁷ Moreover, information about one's health status can result in discrimination and other human rights violations purely on the basis of health status, especially in communities where information regarding the nature of certain health conditions, such as HIV, may be scarce or where HIV-related stigma is prevalent. Ensuring confidentiality may therefore protect a prisoner against discrimination and stigmatization on the basis of his or her health status. A lack of confidentiality and the possibility of discrimination may also discourage prisoners from undergoing voluntary testing or seeking the appropriate treatment for fear that information about their health status may be released. Confidentiality affords prisoners an environment in which they can undergo testing and treatment for health conditions without fear of social or institutional violations of their human rights.

Article 9. Prohibition of torture and other cruel, inhuman or degrading treatment or punishment

Every health practitioner, or every person acting at the instigation of or with the consent or acquiescence of an health practitioner, who inflicts torture or cruel, inhuman or

⁵⁵ This wording is derived from *WHO Guidelines on HIV Infection and AIDS in Prisons*, Recommendations 31 and 32. See, also, Correctional Services Canada, *Commissioner's Directive 821: Management of Infectious Diseases*, art. 14.

⁵⁶ Section 31 of the *WHO Guidelines on HIV Infections and AIDS in Prisons* recommends that "[i]nformation on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel." Exceptions to this rule, such as providing information on health status to prison managers or judicial authorities, should only occur if the prisoner's consent is obtained.

⁵⁷ See, for instance, Article 8(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* and Article 17(1) of the ICCPR.

degrading treatment or punishment on any other person is guilty of an offence under [relevant criminal law] and liable to imprisonment for a term not exceeding [x].⁵⁸

Commentary: Article 9

Prohibitions against torture and other cruel, inhuman or degrading treatment or punishment are found in binding international treaties and conventions, international norms and many domestic constitutions.⁵⁹ The prohibition of torture and certain forms of treatment and punishment is fundamental to the preservation of prisoners' right to life and security of the person, and helps fulfill the obligation that prisoners be treated with respect for their humanity and dignity as human beings.⁶⁰ The European Court of Human Rights has interpreted "torture" to indicate deliberate inhuman treatment causing very serious and cruel suffering,⁶¹ while "degrading" and "inhuman" have been interpreted by the same court to indicate treatment or punishment which causes intense mental or physical suffering and humiliation beyond that which is associated with punishment in general.⁶² The inclusion of "treatment" in addition to "punishment" in prohibitions of this kind has been interpreted to indicate that they apply not only to the punishment imposed by the courts in sentencing, but also to treatment by the state more broadly, including a conditions associated with servicing a penal sentence. For instance, the European Court of Human Rights has accepted that the failure to provide adequate medical attention to prisoners constitutes "treatment" for the purposes of Article 3 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*.⁶³ The *European Convention* contains a provision similar to the one proposed here. In the context of HIV in prisons, the prohibition on cruel, inhuman or degrading treatment or punishment is relevant in two senses. First, substandard or unsanitary conditions associated with cruel, inhuman or degrading treatment may increase the

⁵⁸ This definition is derived from the Canadian *Criminal Code*, s. 269.1. See UN General Assembly, *Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Principle 2.

⁵⁹ International treaties and conventions include the ICCPR, art. 7; the *European Convention for the Protection of Human Rights and Fundamental Freedoms*, art. 3; and the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. International norms may be found in widely accepted legal documents such as the UN *Standard Minimum Rules for the Treatment of Prisoners*, s. 31, and the UN *Universal Declaration on Human Rights*, art 5. Domestic constitutions and legislation also contain prohibitions on cruel, inhuman or degrading treatment or punishment.

⁶⁰ See ICCPR, art. 10(1).

⁶¹ *Aydin v. Turkey* (1997), 23178/94 [1997] ECHR 75.

⁶² *Soering v. The United Kingdom* (1998), 14038/88 [1989] ECHR 14.

⁶³ *McGlinchey and Others v. The United Kingdom* (2003), [2003] ECHR 211. In this case, the deceased was found not to have received adequate medical attention for heroin withdrawal while imprisoned. U.S. courts have reached similar conclusions, deciding that certain restrictions on prisoners' access to medical care constitute cruel and unusual punishment. For example, in *Domenech v. Goord*, 2005 N.Y. App. Div., 20 A.D. 3d 416, denial of a prisoner's access to treatment for HCV until he completed a drug treatment program was found to constitute cruel and unusual punishment.

exposure of prisoners living with HIV to secondary infections leading to further health problems, as well as an increased risk of transmission of infections among the general prison community. Tuberculosis, more easily transmitted in conditions of poor sanitation, nutrition and overcrowding in prisons, is a prime example. Second, prisoners who are HIV positive, especially those living with AIDS, may have medical needs which render them more susceptible to harm from certain kinds of treatment or punishment. The European Court of Human Rights has ruled that the state of health of a prisoner is relevant in determining whether treatment or punishment is cruel, inhuman or degrading.⁶⁴

Article 10. No discrimination against prisoners on the basis of HIV or HCV status

- (1) In all prison facilities, it shall be illegal to discriminate against a prisoner on the basis of his or her infection with HIV or diagnosis of AIDS, or his or her infection with hepatitis C.
- (2) Prisoners living with HIV/AIDS or HCV shall:
 - (a) be housed with the general prisoner population, unless they require a level of health care which cannot be provided in such a setting or unless separate housing is necessary for their protection from other prisoners;⁶⁵
 - (b) be offered the same opportunities as other prisoners to participate in educational, job, vocational or other programs, except where limitations to a specific assignment are clinically indicated; and
 - (c) have access to the full range of available institutional counselling and support services and, to the greatest extent possible, to local community counselling and support services.⁶⁶

Commentary: Article 10

Isolating, segregating or excluding prisoners living with HIV or HCV from programs on the basis of their HIV or HCV status is contrary to the right to equality and non-discrimination.⁶⁷ Fear of loss of confidentiality, stigmatization, and discrimination may discourage prisoners from undergoing voluntary testing and may reinforce misconceptions concerning the transmission and physical effects of the virus. Segregation also undermines HIV prevention messages by encouraging the false assumption that there is “no HIV in the prison” because “everyone who is HIV-positive is

⁶⁴ *Soering v. The United Kingdom* (1989) ECHR 14, para. 100.

⁶⁵ This wording is derived from Correctional Services Canada, *Commissioner's Directive 821: Management of Infectious Diseases*, art. 29.

⁶⁶ This wording is derived from Correctional Services Canada, *Commissioner's Directive 821: Management of Infectious Diseases*, art. 31.

⁶⁷ See, for instance, the UN *Basic Principles for the Treatment of Prisoners*, s. 2.

segregated.” HIV-positive prisoners should not be restricted any further than is medically necessary, and should have equal access to all opportunities and amenities available to the general prison population, including work and educational programs.⁶⁸ According to WHO Guidelines, decisions concerning the isolation of prisoners living with HIV based on health considerations should only be taken by medical staff, applying the same criteria as is applied to those living outside prison, and in accordance with public health standards and regulations.⁶⁹

Article 11. Compassionate Release

Conditional or unconditional release may be granted by [relevant authority] at any time to a prisoner:

- (a) who is terminally ill;
- (b) whose physical or mental health is likely to suffer serious adverse effects if the prisoner continues to be held in confinement; or
- (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the prisoner was sentenced.⁷⁰

Commentary: Article 11

The continued incarceration of prisoners who are terminally ill, and prisoners for whom ongoing incarceration will bring serious adverse physical or mental effects or will constitute an excessive hardship, offends the underlying values of human rights law. It may also violate the prohibition against cruel, inhuman or degrading treatment or punishment, as well as the right to the highest attainable standard of physical and mental health. A South African court has recognized that, in certain instances, the continuing incarceration of prisoners may violate the prohibition against cruel, inhuman or degrading treatment or punishment, and also that the (domestic) constitutional right to human dignity also encompasses the right to die with dignity.⁷¹ In the case of terminally ill prisoners, compassionate release may be necessary for prison institutions to fulfill these obligations. In particular, prisoners living with HIV/AIDS may be highly susceptible to fatal secondary infections acquired in prison environments, and may not have access to treatment for HIV/AIDS or secondary infections while in prison (though the provision of such treatment should be a matter of high priority in all jurisdictions).

⁶⁸ See, for example, *X & Y v. State of Western Australia* (1996) HREOCA 32 (Australia).

⁶⁹ *WHO Guidelines on HIV Infection and AIDS in Prisons*, Recommendations 27–30.

⁷⁰ This wording is derived from *Corrections and Conditional Release Act* (Canada), s. 121.

⁷¹ *Stanfield v. Minister of Correctional Services & Others* (2003), 12 BCLR 1384 (High Court — Cape of Good Hope Provincial Division). The plaintiff was a terminally ill prisoner who had served about one-third of a six-year sentence. The court granted conditional release on compassionate grounds, noting the right of the prisoner to die with dignity, as well as the possibility that in the case of a terminally ill prisoner, the potential health care deprivation and exposure to further infection which may occur in prisons might violate the prohibition against cruel, inhuman and degrading treatment.

Article 12. Review of prison policies and practices regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment

- (1) The [relevant public health authority] is hereby authorized and directed to review any policy or practice instituted in facilities operated by the [relevant prison authority] regarding HIV/AIDS, other blood-borne diseases and drug dependence, including the prevention of the transmission of HIV and other blood-borne diseases and the treatment of prisoners living with HIV/AIDS, other blood-borne diseases or drug dependence.
- (2) Such review shall be performed annually and shall focus on whether such policy or practice is consistent with current, generally accepted medical standards and procedures used in the general population to prevent the transmission of HIV and other blood-borne diseases and to treat persons living with HIV/AIDS, other blood-borne diseases or drug dependence.
- (3) Upon the completion of such review, the [relevant public health authority] shall, in writing, report to the [relevant prison authority] on such policy or practice as instituted in facilities operated by the [relevant prison authority]. The report may direct the [relevant prison authority] to prepare and implement a corrective plan to address deficiencies in areas where such policy or practice fails to conform to current, generally accepted medical standards and procedures. The [relevant public health authority] shall monitor the implementation of such corrective plans and shall conduct such further reviews as the [relevant public health authority] deems necessary to ensure that identified deficiencies in policies and practices regarding HIV/AIDS, other blood-borne diseases and drug dependence are corrected.
- (4) All written reports pertaining to such reviews provided for in this section shall be maintained as public information available for public inspection.

Chapter V. Enabling Harm Reduction Services in Prisons

A. Condoms and other safer sex materials

Article 13. Distribution and possession of condoms and other safer sex materials in prisons

- (1) The [relevant public health authority] shall ensure that condoms and other safer sex materials, such as water-based lubricants and dental dams, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.⁷²
- (2) The [relevant public health authority] shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.
- (3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this Part shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

Commentary: Article 13

Given that sexual activity (both consensual and non-consensual) is common in prisons, the availability of safer sex materials helps prevent the spread of sexually transmitted infections and preserves the right to health of prisoners. The *International Guidelines on HIV/AIDS and Human Rights* recommend the availability of condoms as an important component in the prevention of HIV and the preservation of the rights of people living with HIV.⁷³ Consistent with the principle that prisoners should have the same access to health care and treatment as people outside prisons, WHO has recommended that condoms should be made available to prisoners throughout the span of their detention.⁷⁴

⁷² This wording is based on a model law developed by the American Medical Association, *An Act to Provide for the Availability of Condoms in Correctional Institutions*, 1991. Section 2 of this model Act guarantees the availability of condoms in correctional institutions.

⁷³ Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 1998, HR/PUB/98/1. Available via www.ohchr.org/english/issues/hiv/guidelines.htm.

⁷⁴ WHO *Guidelines on HIV infection and AIDS in prisons*, p. 5. Support for legislative action promoting the accessibility of condoms in prisons may be found in UNAIDS, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999, p. 63.

As the use of condoms may reveal aspects of prisoners' personal lives, respecting prisoners' right to privacy is important when safer sex materials are provided.⁷⁵ The provision of condoms and safer sex materials in prisons should be done in a manner that protects the anonymity of the prisoners using them, ensuring that the right to privacy and the confidentiality of the prisoners are respected. In addition to the importance of the rights to health and privacy in the distribution of condoms and other safer sex materials, a 1995 Australian High Court decision recognized that the Australian government's decision not to supply or permit condoms within prisons may form the basis of a negligence action, prompting prison officials to alter policy and allow condom distribution and possession.⁷⁶

B. Sterile syringe programs

Article 14. Authorization of sterile syringe programs

- (1) Sterile syringe programs shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.
- (2) The [responsible public health authority] may authorize a specified person or organization to supply:
 - (a) sterile syringes and other related material to prisoners; and,
 - (b) information concerning hygienic practices in the use of syringes and other related material;

in order to prevent the spread of blood-borne diseases and minimize the health risks associated with injection drug use by prisoners.

Commentary: Article 14

Despite prohibitions on illegal drugs in prisons, large numbers of prisoners report having injected drugs while incarcerated.⁷⁷ Scarcity of syringes (or other injection equipment, including home-made equipment) often leads prisoners to share equipment when

⁷⁵ *The European Convention on Human Rights and Fundamental Freedoms*, art. 8, guarantees the right have one's private life respected. The ICCPR provides that nobody shall have their private lives interfered with arbitrarily or unlawfully (art. 17).

⁷⁶ *Prisoners A–XX Inclusive v. State of New South Wales*, [1995] 38 NSWLR 622. The Australian High Court held that if the government was shown to owe a duty of care to individual prisoners with respect to maintaining their health, and the failure to provide or permit condoms was a breach of that duty, an action against the government may succeed. Though the plaintiffs did not pursue litigation on the negligence issue, the New South Wales Department of Correctional Services changed its policy of making condoms available to prisoners as a result of the litigation.

⁷⁷ See, for example, European Monitoring Centre for Drugs and Drug Addiction, *Annual report on the state of the drugs problem in the European Union and Norway*, Office for the Official Publications of the European Communities, 2002, p. 46.

injecting, increasing the risk of transmission of certain infections, including HIV and HCV. Studies have demonstrated that HIV outbreaks can occur in prison populations as a result of syringe sharing.⁷⁸ Prison sterile syringe programs implemented in a number of countries have been effective in decreasing syringe sharing among prisoners using injection drugs, thereby reducing the risk of disease transmission among prisoners and prison staff.⁷⁹ Combined with other interventions, these programs are credited with reducing the risk of HIV transmission in prisons in Spain, Moldova, Germany, Switzerland, Belarus and Kyrgyzstan.⁸⁰ Sterile syringe programs have not been associated with increased attacks on prison staff, nor with increased new drug consumption or injection. Indeed, experience has shown that prison guards in some countries recognize that the availability of sterile syringes protects their safety too; when prisoners are not forced to conceal injection equipment and each prisoner is permitted to possess his or her own syringe for personal use, rather than sharing equipment likely used by numerous other prisoners, guards conducting searches of prisoners or cells are less likely to be pricked with a contaminated needle.⁸¹

Given the association of HIV and HCV transmission with sharing injection equipment, the availability of sterile injecting equipment helps protect the right of prisoners and prison staff to the highest attainable standard of health. Furthermore, in jurisdictions where sterile syringe programs are available outside of prisons, prisoners are entitled to access similar programs by virtue of their right to have the same access to health care services as enjoyed by people outside prison.

National courts have shown support for sterile syringe programs. For example, in 1996, a Spanish provincial criminal court ordered officials at Pamplona Prison to provide sterile needles to prisoners.⁸² In 1997, the ombudsman's office recommended the implementation of a sterile syringe program in that prison.⁸³ Following this decision, sterile syringe programs were implemented in Spanish prisons.⁸⁴

⁷⁸ See, for example, A. Taylor, "Outbreak of HIV infection in a Scottish prison"; S. Caplinskas and G. Likatavicius, "Recent sharp rise in registered HIV infections in Lithuania."

⁷⁹ See R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2nd Ed. This publication reviews evidence from prison needle exchange programs implemented in Belarus, Germany, Kyrgyzstan, Moldova, Spain and Switzerland. WHO, *Effectiveness of interventions to manage HIV/AIDS in prison settings – needle and syringe programmes and bleach*, Evidence for action technical paper, 2006.

⁸⁰ See, for example, R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2nd Ed.

⁸¹ H. Stöver and J. Nelles, "Ten years of experience with needle and syringe exchange programmes in European prisons," *International Journal of Drug Policy* 14(5) (2003): 442.

⁸² Decision 247 of the Provincial Court of Navarre [Spain], 14 October 1996. The court cited WHO recommendations that prisoners be given the same access to health care as the population outside prison and that prison authorities have a responsibility to minimize HIV infections in prisons.

⁸³ H. Stöver and J. Nelles, "Ten years of experience with needle and syringe exchange programmes in European prisons," p. 6.

Article 15. Supply of sterile syringes and other related materials

Staff of a sterile syringe program may provide the following material:

- (a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
- (b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm; and
- (c) condoms and other safer sex materials such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections.

Commentary: Article 15

The availability of sterile materials in addition to syringes forms part of the general harm reduction strategy for people who use injection drugs. Materials such as clean ampoules, pipes, swabs, and solutions can further reduce the spread of blood-borne infections, and prevent the transmission of infections other than HIV and HCV.⁸⁵

Article 16. Information

Staff of sterile syringe programs may provide information including, but not limited to, the following:

- (a) drug dependence treatment services and other health services;
- (b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
- (c) the risks associated with the use of controlled substances;
- (d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
- (e) legal aid services;
- (f) employment and vocational training services and centres; and
- (g) available support services for people with drug dependence and their families.⁸⁶

⁸⁴ Directorate General for Prisons, Ministry of the Interior (Spain), *Needle exchange in prison: Framework Program*, 2002.

⁸⁵ Studies have identified crack smoking as a possible risk factor for HIV, HCV and tuberculosis; infectious disease may be transmitted via the sharing of implements through which contaminated blood particles are transmitted. See A.E. Weber et al, "Risk Factors associated with HIV infection among young gay and bisexual men in Canada," *Journal of Acquired Immune Deficiency* 28 (2001): S1-S8; J. McMahon and S. Tortu, "A potential hidden source of hepatitis C infection among noninjecting drug users," *Journal of Psychoactive Drugs* 35 (2003): 523-534; S. Tortu et al, "Sharing of noninjection drug-use implements as a risk factor for hepatitis C," *Substance Use & Misuse* 39 (2004): 211-224.

⁸⁶ This wording is derived from Portugal's *Decree-law no. 183/2001*, art. 31(1).

Article 17. Distribution and possession of sterile syringes and related material

- (1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:
 - (a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
 - (b) prisoners trained as peer outreach workers;
 - (c) non-governmental organizations or health professionals who enter the prison for this purpose;
 - (d) one-for-one automated sterile syringe-dispensing machines.
- (2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.
- (3) The [relevant prison authority] shall establish rules for the safe storage of syringes possessed by prisoners in accordance with the provisions of this Part.
- (4) The sterile syringe program shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.
- (5) Sterile syringes and related material distributed pursuant to this Part shall be used only in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.
- (6) The distribution and possession of syringes and related material in prison in accordance with this Part shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Optional: C. Bleach

Article 18. Availability of bleach as a disinfectant

- (1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.
- (2) Any such Regulations or policies established pursuant to Section (1) will:
 - (a) encourage participation of prisoners and their assistance in bleach distribution;
 - (b) ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity; and

- (c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.
- (3) Bleach distributed pursuant to this Part shall be used only in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.
- (4) The distribution and possession of bleach in prison in accordance with this Part shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Commentary: Article 18

Bleach is able to degrade both HIV and HCV when used properly as a cleanser, and may therefore be used as a harm-reduction technique to reduce the risk of transmitting those viruses through sharing drug injection equipment. However, while bleach has been shown to be effective at eliminating HIV viral particles, it has also been shown that bleach is not fully effective at destroying HCV.⁸⁷ Thus, shared syringes and other paraphernalia cleaned with bleach may still pose an HCV transmission risk.⁸⁸ The use of bleach should be accompanied by instruction on its proper use as a disinfectant in order to maximize its protective effect. To facilitate its use, bleach possession should not carry any penalty. Studies have found no risk to institutional safety when bleach has been made available, and thus the risk posed to staff and other prisoners by the provision of bleach is negligible.⁸⁹

D. Opioid substitution treatment in prison

Article 19. Opioid substitution treatment programs in prison

- (1) The [relevant public health authority] shall establish opioid substitution treatment programs in all prisons.
- (2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.⁹⁰

⁸⁷ See F. Kapadia et al, “Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users?,” *Epidemiology* 13(6) (2002): 738–741.

⁸⁸ W. Small et al, “Incarceration, addiction and harm reduction: inmates experience injecting drugs in prison,” *Substance Use and Misuse* 40(6) (2005): 831–843.

⁸⁹ Correctional Service Canada, *HIV/AIDS in Prisons: Final report of the Expert Committee on AIDS and Prisons*, 1994, p. 76.

⁹⁰ This wording is derived from Correctional Services Canada, *Commissioner’s Directive 800: Health Services*, 30 September 2004, para.33. For methadone treatment guidelines, see Correctional Services

- (3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.⁹¹
- (4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.
- (5) Participation in the opioid substitution treatment programs shall be offered on a voluntary basis to all prisoners with opioid dependence.
- (6) Opioid substitution treatment programs may include a variety of approaches, including maintenance treatment.
- (7) The program shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.
- (8) The program shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programs in the general community.

Commentary: Article 19

Substitution of heroin and other illegal opium-based drugs with legal synthetic opioids such as methadone and buprenorphine is one of the most widely used and proven methods of treatment for opioid dependence.⁹² Opioid substitution treatment (OST) is well established in western Europe, North America, and, increasingly, in a number of eastern and central European countries and some parts of Asia and Latin America. It is clear, however, that even where OST is available, there often remain many barriers to sustained access to this treatment.⁹³

In 2005, WHO added methadone and buprenorphine to its *Model List of Essential Medicines*, a strong endorsement of the importance of these medicines for persons with opioid dependence.⁹⁴ WHO is categorical in its recommendation on OST in prison:

Canada, *Commissioner's Directive 800-1: Specific Guidelines for Methadone Maintenance Treatment*, November 2003.

⁹¹ The right to free dependence treatment for prisoners, including free substitution treatment, is found in Article 3 of *Law 109/99*, 20 July 1999 [Portugal].

⁹² WHO/UNODC/UNAIDS, *Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, 2004.

⁹³ See, for example, European Monitoring Centre for Drugs and Drug Addiction, *Annual report 2005: the state of the drugs problem in Europe*, Chapter 6: Heroin and injecting drug use, treatment demand data. At <http://ar2005.emcdda.eu.int/en/page061-en.html>.

⁹⁴ WHO, *WHO Model List of Essential Medicines*, Revised March 2005. Available at <http://mednet3.who.int/EMLib/index.aspx>. The entry states that “[b]oth buprenorphine and methadone are effective for the treatment of heroin dependence. However, methadone maintenance therapy at appropriate

“Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opioid-dependent individuals in the community, this treatment should also be available in prisons.”⁹⁵ The WHO Regional Office for Europe adds further strong rationale for OST in prisons, including that OST in prison can help to avoid

problems in managing regimens and difficulties for staff that arise during withdrawal, including drug smuggling and acts of violence toward staff and other prisoners; the growing problem of suicide and self-harm during the period of withdrawal among prisoners who used drugs and who have drug dependence; the importance of equity in provision between prisons and communities; the drive to provide clinical services at a standard equivalent to internationally agreed best practice; the risk of a fatal overdose in the first few days following release from prison, especially for short-term prisoners
....⁹⁶

Finally, access to OST within prisons is required by states’ obligation to take steps to respect, protect and fulfil prisoners’ right to the highest attainable standard of health. This duty is heightened in the case of persons entirely dependent for health services on the state that has incarcerated them. When OST is available outside prisons, the right to non-discrimination requires that prisoners have equal access to this treatment.

E. Information and education

Article 20. Information and education programs regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons

- (1) The [relevant public health authority] shall develop and implement information and education programs in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.
- (2) In developing such programs, the [relevant public health authority] shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within

doses is the most effective in retaining patients in treatment and suppressing heroin use.” Methadone and buprenorphine are included in the model list on the “complementary list”: this listing does not signify a partial or limited endorsement of methadone or buprenorphine, but indicates that specialized diagnostic or monitoring facilities, or specialist medical care or specialist training are needed.

⁹⁵ WHO, *Guidelines on HIV infection and AIDS in prisons*, at para. 23.

⁹⁶ WHO Europe, *Status paper on prisons, drugs, and harm reduction*, 2005, at p. 10. See, also, K. Dolan, W. Hall, and A. Wodak, “Methadone maintenance reduces injecting in prison,” *British Medical Journal* 312 (1996): 1162; K. Dolan et al., “A randomized controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system,” *Drug and Alcohol Dependence* 72 (2003): 59–65; K. Dolan et al., “Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection,” *Addiction* 100 (2005): 820–828.

prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

- (3) Such programs required by Section (1) may include peer education and use of non-[relevant prison authority] personnel, including delivery of these programs by community-based organizations.
- (4) Materials shall, as much as possible, be available in the languages of the relevant populations, shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

Article 21. Responsibility of the [relevant public health authority] for providing training and education

The [relevant public health authority] is responsible for ensuring:

- (a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis;
- (b) that training and education provided to prisoners also include available services and treatments; and peer education and counselling programs that include the meaningful participation of prisoners as counsellors; and
- (c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.⁹⁷

⁹⁷ This wording is derived from Correctional Services Canada, *Commissioner's Directive 821: Management of Infectious Diseases*, 4 November 2004, art.18. Universal precautions are simple standards of infection control practices to be used in the care of all patients, at all times, to reduce the risk of transmission of blood borne infections. They include: careful handling and disposal of "sharps"; hand washing with soap and water before and after all procedures; use of protective barriers such as gloves, gowns, aprons, masks and goggles for direct contact with blood and other body fluids; safe disposal of waste contaminated with blood or body fluids; proper disinfection of instruments and other contaminated equipment; and proper handling of soiled linen.

Chapter VI. Sexual Violence in Prisons

Article 22. Statistics on sexual violence (including rape) in prisons

- (1) The [relevant public health authority] shall carry out, at regular intervals, a comprehensive statistical review and analysis of the incidence of sexual violence in prisons, which shall include, but not be limited to, the identification of the common characteristics of:
 - (a) both victims and perpetrators of sexual violence; and
 - (b) prisons and prison systems with a high incidence of said violence.
- (2) In carrying out Section (1), the [relevant public health authority] shall consider:
 - (a) how incidents of sexual violence will be defined for the purposes of the statistical review and analysis; and
 - (b) how the [relevant public health authority] should collect information about sexual violence against prisoners committed by other prisoners and by staff, beyond prisoner self-reports of such violence.
- (3) The [relevant public health authority] shall solicit views from representatives of the following: state prison departments, county and municipal prisons, juvenile prison facilities, former prisoners, health service providers, victim advocates, researchers, and other experts in the area of sexual violence (including within prisons).⁹⁸

Article 23. Development of national standards against sexual violence in prisons

- (1) The [Attorney General or Minister of Justice], the [relevant public health authority] and [relevant prison authority] shall develop national standards for enhancing the detection, prevention, and reduction of sexual violence (including rape) in prisons and for prosecution of offenders.
- (2) The information provided under paragraph (1) shall include national standards relating to:
 - (a) the classification and assignment of prisoners, using standardized instruments and protocols, in a manner that limits the occurrence of sexual violence in prison;
 - (b) the investigation and resolution of prisoners' complaints of sexual violence by responsible prison authorities, local and state police, and national and state prosecution authorities;

⁹⁸ This wording is derived from *Prison Rape Elimination Act* (U.S.), S1435, 2003, s. 4.

- (c) the preservation of physical and testimonial evidence for use in an investigation of the circumstances relating to sexual violence;
- (d) acute trauma care for victims of sexual violence, including standards relating to the manner and extent of physical examination and treatment to be provided; and the manner and extent of any psychological or psychiatric examination and care, medication or counselling to be provided;
- (e) referrals for long-term continuity of care for those who have experienced sexual violence;
- (f) educational and medical testing measures for reducing the risk of HIV transmission as a result of sexual violence in prison;
- (g) post-exposure prophylactic measures, including a short course of antiretroviral drugs, for reducing the incidence of transmission of HIV;
- (h) the training of prison staff sufficient to ensure that they appreciate the significance of sexual violence in prison and the need to prevent it;
- (i) the timely and comprehensive investigation of staff sexual misconduct involving rape or other sexual violence on prisoners;
- (j) creating a system for reporting incidents of sexual violence in prison that will ensure the confidentiality of complainants, protect prisoners who make complaints from retaliation, and assure the impartial resolution of complaints;
- (k) data collection and reporting of sexual violence (including rape) in prison, sexual misconduct toward prisoners on the part of prison staff, and the resolution of prisoners' sexual violence complaints by prison officials and national, state, and local investigation and prosecution authorities; and
- (l) such other matters as may reasonably be related to the detection, prevention, reduction and punishment of sexual violence in prison.⁹⁹

Commentary: Articles 22 and 23

Rape and other forms of sexual violence committed by prisoners and by prison staff is endemic in many prisons.¹⁰⁰ Rape and other forms of sexual violence within prisons pose a serious threat to the health of prisoners, psychologically and physically, including the risk of HIV and other sexually transmitted infections. Incidents of rape and other forms of sexual violence are chronically under-reported in prisons, largely as a result of fear and shame on the part of victims, rendering the collection of data difficult.¹⁰¹ Moreover, distinguishing consensual from non-consensual sexual activity may be difficult in a prison setting, since fear of retribution may compel victims to “consent” rather than face the consequences. Development of a comprehensive data collection scheme on the nature and frequency of sexual violence in prison and the parties involved is necessary in order to design protocols to prevent such violence. Incorporating views from a variety of sources — including prison officials, current and former prisoners, health service providers, and NGOs working in prisons or providing support services to current or

⁹⁹ This wording is derived from *Prison Rape Elimination Act* (U.S.), s. 7(e).

¹⁰⁰ See, for example, Human Rights Watch, *No Escape: Male Rape in U.S. Prisons*, 2001.

¹⁰¹ See Human Rights Watch, *No Escape: Male Rape in U.S. Prisons*, part VII.

former prisoners — will help develop effective approaches to preventing sexual violence in prison that take into account the institutions’ means and the prisoners’ needs and human rights. Data should be collected anonymously to remedy (in part) the problem of under-reporting.

Prison environments that are conducive to or that permit sexual violence against prisoners violate prisoners’ rights to security of the person, and the prohibition against cruel, inhuman or degrading treatment or punishment, and offend the underlying principles of human rights law. The failure of prison institutions to provide adequate security and supervision often facilitates rape and other sexual assault.¹⁰² Therefore, the prison system is obliged to develop protocols for preventing rape, to provide education and testing for prisoners, and to provide both medical and psychological treatment and support to those who suffer sexual violence in prison.

¹⁰² See Human Rights Watch, *No Escape: Male Rape in U.S. Prisons*, part I.

Selected Resources

This section provides a list of resources that the Legal Network considers to be particularly relevant.

Articles, reports and policy documents

Canadian HIV/AIDS Legal Network, *Courting Rights: Case Studies in Litigating the Human Rights of People living with HIV*, UNAIDS Best Practice Collection, March 2006. At www.aidslaw.ca/Maincontent/issues/discrimination/Courtingrights-ENG.pdf.

Council of Europe, Committee of Ministers. *Recommendation No. R (98) 7 Concerning the Ethical and Organisational Aspects of Health Care in Prison*, 1998.

Council of the European Union. *Recommendation on the prevention and reduction of health-related harm associated with drug dependence* of 18 June 2003. 2003/488/EC.

Department of State legislation, American Medical Association, *An Act to Provide for the Availability of Condoms in Correctional Institutions*, 1991.

Dolan, K. et al. “A randomized controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system.” *Drug and Alcohol Dependence* 72(1) (2003):59–65.

Dolan, K. et al. “Prison-based syringe exchange programmes: a review of international research and development.” *Addiction* 98(2) (2003): 153–158.

European Parliament. *Recommendation to the Council and the European Council on the EU drugs strategy (2005-2012)*. A6-0067/2004, 15 December 2004.

Jürgens, R. *HIV/AIDS and HCV in prisons: A select annotated bibliography*. Health Canada, 2005. At www.hc-sc.gc.ca/ahc-asc/alt_formats/hpb-dgps/pdf/intactiv/hiv-vih-aids-sida-prison-carceral_e.pdf.

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UNAIDS. *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999.

UN Congress on the prevention of crime and treatment of offenders. *Standard Minimum Rules for the Treatment of Prisoners*. UN Doc A/CONF/611, 1955.

UN General Assembly. *Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment*. Resolution 37/194 of 18 December 1982.

UN General Assembly. *Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment*. Resolution 43/173, UN Doc A/43/49, 1988.

UN General Assembly. *Basic Principles for the Treatment of Prisoners*. Resolution 45/111, UN Doc. A/45/49, 1990.

UNODC. *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings. A Framework for an Effective National Response*, 2006.

WHO Europe. *Prisons, Drugs and Society: A Consensus Statement on Principles, Policies and Practices*. Health in Prisons Project and the Pompidou Group of the Council of Europe, 2001.

WHO Europe. *Status Paper on Prisons, Drugs and Harm Reduction*, 2005.

WHO/UNODC/UNAIDS. *Policy Brief: Reduction of HIV Transmission in Prisons*, 2004.

WHO. *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993.

WHO, *WHO Model List of Essential Medicines*, Revised March 2005. Available at <http://mednet3.who.int/EMLib/index.aspx>.

Legal documents

Correctional Services Canada, *Commissioner's Directive 803: Consent to Health Services Assessment, treatment and release of information*, 3 September 2003.

Correctional Services Canada, *Commissioner's Directive 800-1: Specific Guidelines for Methadone Maintenance Treatment*, November 2003.

Correctional Services Canada, *Commissioner's Directive 821: Management of Infectious Diseases*, 4 November 2004.

Decision 247 of the Provincial Court of Navarre, 14 October 1996 [Spain].

Directorate General for Prisons, Ministry of the Interior. *Needle exchange in prison: Framework Program*, 2002 [Spain].

EN and Others v. the Government of the Republic of South Africa and Others (2006). Case 4576/2006. Judgment 22 June 2006 (High Court of South Africa — Durban and Coast Local Division).

Leatherwood et al. v. Campbell (2004). Case No. CV-02-BE-2812-W (United States District Court for the Northern District of Alabama.)

Prison Rape Elimination Act. S1435, 2003[United States].

Prisoners A-XX Inclusive v. State of New South Wales (1995). 38 NSWLR 622 [new South Wales, Australia].

Stanfield v. Minister of Correctional Services & Others (2003). 12 BCLR 1384 (High Court of South Africa — Cape of Good Hope Provincial Division).

Van Biljon and Others v. Minister of Correctional Services and Others (1997). 50 BMLR 206 (High Court of South Africa — Cape of Good Hope Provincial Division).

McGlinchey and Others v. United Kingdom (2003). Application no 50390/99. Judgment 29 April 2003 (European Court of Human Rights).

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