CANADIAN HIV/AIDS LEGAL NETWORK

PRISON NEEDLE AND SYRINGE PROGRAMS: POLICY BRIEF

"I know 13 women and men who caught hepatitis C or HIV while they were [in prison]. They got it from sharing needles. Prison is not going to stop anybody from doing drugs. But the Correctional Service of Canada can stop people from sharing needles if they gave [them] out. The rates of hepatitis C and HIV would go down if they did that. Right now, in prison we are given courses on infectious diseases, but what is the sense of that if they don't also give out clean needles?"

LENITA SPARKS, HALIFAX, NOVA SCOTIA,
FORMERLY INCARCERATED IN KINGSTON PENITENTIARY FOR WOMEN

HIV AND HEPATITIS C IN PRISON

In Canada and elsewhere, prisons have become breeding grounds for HIV and the hepatitis C virus (HCV). A Vancouver study estimated that incarceration more than doubled the risk of HIV infection for people who use illegal drugs, and estimated that 21 percent of all HIV infections among people who inject drugs in Vancouver may have been acquired in prison.[1] A 2010 survey by the Correctional Service of Canada (CSC) reported rates of HIV and HCV in federal prisons to be 15 and 39 times, respectively, the estimated prevalence in the Canadian population.[2]

The sharing of used needles to inject drugs is a principal factor contributing to the high rates of infection in prisons.[3] Because of the scarcity of needles and syringes in prison, people who inject drugs there are more likely to share injecting equipment than people in the outside community, thereby compounding their risk.

Needle and syringe programs (NSPs) are an important way to reduce the risk of infection from sharing used injecting equipment. In 2001, over 200 NSPs were serving Canadian communities, with more planned, and these programs have been supported by all levels of government.[4] Many evaluations of NSPs have demonstrated that they reduce the risk of HIV and HCV, are cost-effective, and facilitate access to care, treatment and support services.[5]

Prison-based needle and syringe programs (PNSPs) offer similar benefits, but for a population even more at risk. As of 2011, and in response to this known risk, PNSPs have been introduced in more than 60 prisons of varying sizes and security levels in Switzerland, Germany, Spain, Luxembourg, Moldova, Belarus, Kyrgyzstan, Armenia, Romania and Iran.[6]

No matter the context studied, evaluations of PNSPs — including in 2006 by the Public Health Agency of Canada (PHAC) at CSC's request — have consistently demonstrated that they:

- reduce needle-sharing;
- do not lead to increased drug use or injecting;
- reduce drug overdoses;
- facilitate referrals of users to drug treatment programmes;
- have not resulted in needles or syringes being used as weapons against staff or other people in prison;
- have been effective in a wide range of institutions; and
- have effectively employed different methods of needle distribution, such as peer distribution by people in prison, hand-to-hand distribution by prison health-care staff or outside agencies, and automatic dispensing machines.[7]

Yet in spite of the overwhelming evidence of these benefits, Canadian prisoners continue to be denied access to sterile injecting equipment. This harms the health of people in prison, given the increasing prevalence of HIV and HCV behind bars, as well as correctional staff who run the risk of being exposed to non-sterile needles. Denying prisoners access to PNSPs also poses broader public health risks, since the vast majority of people who spend time in prison return to their families and communities — with whatever health problems they may have acquired while serving time.

Between 2000 and 2002, the number of federal prisoners living with HIV and/or HCV being released into the community increased 60 percent and 13 percent respectively.[8] With skyrocketing rates of HIV and HCV in prison, society also bears the cost of treatment for those who are infected; according to CSC, treating a person in prison with HCV costs an estimated $22,000 and treating a person in prison with HIV costs $29,000 *per year.*[9] It is far more cost-effective to provide prisoners with sterile injecting equipment than to treat their HIV or HCV infection.

Specific factors contribute to the HIV and HCV epidemic behind bars:

- **Conflict with the law and incarceration are often a result of offences arising from the criminalization of certain drugs, related to supporting drug use**, or to behaviours brought about by drug use.[10] In 2002, more than half a million criminal charges filed in Canada were attributed to illicit drugs.[11] In Canadian federal prisons, 30 percent of women and 14 percent of men have been incarcerated on drug-related charges.[12]
- Many people assume that in a highly restricted, secured environment such as a prison, drug use would be rare. But despite their illegality, the penalties for their use, and the considerable resources spent by prison systems to control their availability, **illegal drugs do get into prisons and people use them** — a reality recognized by prison systems themselves.[13] Drug-use patterns between persons who inject drugs in prison and those who are not in prison are strikingly similar.[14]
- In a 2010 survey by CSC, 34 percent of men and 25 percent of women in federal prisons admitted using drugs in the past six months in prison, and 17 percent of men and 14 percent of women admitted injecting drugs.[15] **Numerous international studies have also confirmed the prevalence of injection drug use in prisons worldwide.**[16]
- According to the Public Health Agency of Canada (PHAC), **two thirds of people incarcerated in federal prisons have substance-use problems, of which 20 percent require treatment.**[17] In particular, women and Aboriginal people suffering addiction are disproportionately represented in prison.[18]
- **Many people suffering from addiction also suffer from mental health issues.** In 2007, CSC reported that 12 percent of men and 26 percent of women in federal prisons had been identified with "very serious mental health problems,"[19] 15 percent of men and 29 percent of women in federal prisons had previously been hospitalized for "psychiatric reasons,"[20] and the percentage of federal prisoners prescribed medication for "psychiatric concerns" at admission had more than doubled from 10 percent in 1997–1998 to 21 percent in 2006–2007.[21]
- Although people who inject drugs may inject less frequently in prison, the scarcity of sterile injecting equipment and the punishments meted out for drug use **mean more people in prison resort to sharing used needles.**[22] Among the prisoners who reported having injected drugs in prison in the 2010 CSC study, 55 percent of men and 41 percent of women used someone else's used needle, and 38 percent of men and 29 percent of women shared a needle with someone who has HIV, HCV, or an unknown infection status.[23]
- A number of prison systems in Canada have responded to the problem of HIV and HCV transmission in prison by making bleach available.[24] Bleaching used injecting equipment is an important second-line strategy in the absence of access to sterile needles and syringes, but numerous studies have demonstrated that using **bleach to clean injecting equipment is not fully effective in reducing HCV transmission and that disinfection with bleach appeared to offer no, or at best little, protection against HIV infection, for reasons such as incorrect or ineffective application.**[25] The likelihood that people will effectively clean their needles or syringes using bleach is further decreased in prison because cleaning is a time-consuming procedure and some people are reticent to engage in any activity that increases the risk of alerting prison staff to their drug use, given the possibility of punishment.[26]

RIGHTS AND REASON: THE WAY FORWARD

In spite of compelling evidence of the public health benefits of PNSPs and growing community support for such programs, the Canadian government has chosen to focus primarily — and ineffectively — on drug prohibition. Not only does this harm the health of people in prison and public health more broadly, but it is also a violation of prisoners' human rights. The pressing need for safe access to sterile injecting equipment within Canadian prisons must be met to ensure that the rights enshrined in Canadian and international law are not abstract values, but tangible rights to be enjoyed by all — and for the protection of all.

Everyone is entitled to human rights, and people do not surrender those rights when they enter prison. Rather, people in prison are supposed to retain all human rights that are not necessarily removed as a consequence of their imprisonment.[27]

This includes:

- the right to the "highest attainable standard of health"[28]
- the right to life[29]
- the right to liberty and security of the person[30]
- the right to equality[31]
- the right not to be subjected to cruel and unusual treatment or punishment[32]
- access to a standard of health care that is equivalent to that available in the community[33]

Prisoners who inject drugs experience violations of those rights, particularly in cases where individuals suffer from addiction, are compelled to go to dangerous lengths to inject, or have been infected with HIV and/or HCV in prison because they were denied access to sterile injection equipment that would have been available to them from a needle and syringe program on the outside. Governments in Canada have a legal obligation to act to protect and promote health, including that of people in prison — and this includes taking measures to prevent the spread of contagious diseases in prison.[34]

RECOMMENDATIONS

- Initiate a study in the Standing Committee on Health on PNSPs, and seek the perspective and expert opinion of prisoners, correctional staff, prison authorities, harm reduction organizations and community health authorities in Canada and worldwide, especially in jurisdictions where PNSPs already exist.
- Based on the findings of the Standing Committee on Health, and in meaningful consultation with prisoners, correctional staff, prison authorities, harm reduction organizations and community health authorities, develop a plan of action to introduce PNSPs in federal prisons across Canada.
- Monitor, evaluate and publicize the plan of action, and include prisoners in the monitoring and evaluation process to identify barriers to accessing PNSPs and ensure the programs are being effectively implemented.

FACTS AND FIGURES

- **Federal prisoners** — many of whom inject drugs and/or suffer from addiction — **have higher rates of HIV and HCV than the general public.** Rates of HIV and HCV are, respectively, 15 and 39 times greater than in the Canadian adult population as a whole.
- **PNSPs work.** There is international evidence that PNSPs reduce the risks of HIV and HCV infection that result from injection drug use in prison and have not resulted in increased institutional violence.
- People in our communities currently have access to needle and syringe programs. Therefore, people in prison should have the same access to sterile injecting equipment. It **violates the human rights of people in prison to deny them the same tools available to people in our communities**, who use these programs to protect themselves from disease.
- Investing in the prevention of blood-borne diseases in prisons **saves taxpayer dollars**. CSC has estimated the annual cost of providing HIV treatment for a prisoner at $29,000, and for HCV treatment at $26,000.[35]
- In Canada, PNSPs have been called for by bodies ranging from CSC's own Expert Committee on AIDS and Prisons[36] and the Correctional Investigator of Canada,[37] to the Canadian Medical Association,[38] the Ontario Medical Association[39] and the Canadian Human Rights Commission.[40] PHAC has also affirmed many of the positive findings regarding PNSPs in a 2006 study.[41] Worldwide, numerous international organizations including the World Health Organization, UNAIDS and the UN High Commissioner on Human Rights have called for governments to provide sterile injecting equipment to people in prison as a matter of sound public-health policy and human rights.[42]

CASE STUDY: Prison-based needle and syringe programs in Moldova

Over a decade ago, Moldova's prison authorities acknowledged that it was impossible to prevent illegal drugs from entering prisons, and that pretending that drug use wasn't occurring would only increase the spread of HIV and hepatitis C virus.

Since 1999, local non-governmental organizations have provided prisoners with HIV/AIDS education and a wide range of harm reduction services, including sterile injecting equipment. The experience has been overwhelmingly positive: drug use has not increased in prisons, available data suggests a reduction in HIV and hepatitis C incidence, and needles have never been used as weapons against prison staff or fellow prisoners.

Importantly, sterile injecting equipment is distributed by prisoners who have been trained as outreach volunteers to provide services to fellow prisoners. This ensures users' confidentiality and that materials are accessible 24 hours a day, seven days a week. And health and human rights are being safeguarded in the process.

Source: J. Hooever and R. Jürgens, *Harm Reduction in Prison: The Moldova Model*, Open Society Institute, 2009.

ENDNOTES

1 H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17(6) (2003): 911–913 at 912.
2 CSC, *Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey* by Dianne Zakaria et al. (Ottawa: CSC, March 2010).
3 R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience, Second edition*, Canadian HIV/AIDS Legal Network, 2006.
4 See, e.g., footnotes 49-52 in S. Chu & R. Elliott, *Clean Switch: The Case for Prison Needle and Syringe Programs in Canada* (Canadian HIV/AIDS Legal Network, 2009).
5 See, for example, studies cited in footnotes 53–56 of S. Chu and R. Elliott, *Clean Switch* (supra).
6 R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, WHO, UNODC and UNAIDS, p. 25 and C. Cook, *The Global State of Harm Reduction 2010*, International Harm Reduction Association, 2010.
7 See, for example, studies cited in footnote 60 of S. Chu and R. Elliott, *Clean Switch* (supra).
8 J. Smith, "Hepatitis C Surveillance," *Focus on Infectious Disease* 3(1), 2005.
9 CSC, *Evaluation Report: Correctional Service Canada's Safer Tattooing Practices Pilot Initiative*, January 2009, p. 37.
10 R. Lines et al., *Prison Needle Exchange* (supra), p. 9.
11 PHAC, *Prison needle exchange: Review of the evidence, report prepared for Correctional Service of Canada*, April 2006, p. 10.
12 K. DeBeck et al., "Incarceration and drug use patterns among a cohort of injection drug users," Addiction 104(1) (2009): 69-76, citing Public Safety and Emergency Preparedness Portfolio Corrections Statistics Committee, *Corrections and Conditional Release Statistical Overview*, 2004.
13 Public Safety and Emergency Preparedness Canada, *Corrections Fast Facts No. 2: Drugs in Prisons*, undated.
14 K. DeBeck et al., "Incarceration and drug use patterns among a cohort of injection drug users" (supra).
15 CSC, 2007 *National Inmate Infectious Diseases and Risk-Behaviours Survey* (supra).
16 See, for example the studies cited in R. Lines et al., *Prison Needle Exchange* (supra), pp. 10–11.
17 PHAC, *HIV/AIDS: Populations at Risk*, 2006.
18 See, for example, M.B. Pongrac, "The Social Determinants of Health and Women Offenders' Vulnerability to Infection," *Focus on Infectious Diseases* 6(1), 2008; Statistics Canada, *Incarceration of Aboriginal people in adult correctional facilities*, July 2009; K.J.P. Craib et al., "Gender differences and HIV and hepatitis C related vulnerabilities among Aboriginal young people who use street drugs in two Canadian cities," *Women and Health* 48(3) 2008: 235-260 at 237-238; K.J.P. Craib et al., "Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver," *Canadian Medical Association Journal* 168(1) (2003): 19–24 at 20-21; C. Benoit, D. Carroll and M. Chaundry, "In search of a healing place: Aboriginal women in Vancouver's Downtown Eastside," *Social Science and Medicine* 56 (2003): 821-833 at 824 and 826.
19 CSC, *Changing Offender Population: Quick Facts*, April 2007.
20 Public Safety Canada Portfolio Corrections Statistics Committee, *Corrections and Conditional Release Statistical Overview 2007*, December 2007, p. 55.
21 Ibid.
22 See, for example, studies cited in footnote 22 of S. Chu and R. Elliott, *Clean Switch* (supra).
23 CSC, 2007 *National Inmate Infectious Diseases and Risk-Behaviours Survey* (supra).
24 In Canada, all federal and most provincial prisons have a policy of making bleach available to prisoners. See, for example CSC, *Commissioner's Directive, 821–2 Bleach Distribution*, 4 November 2004 and B.C. Corrections Branch, Adult Custody Division, *Health Care Service Manual, Chapter 14 Blood and Body Fluid Borne Pathogens*, August 2002.
25 See, for example, studies cited in footnotes 38–44 of S. Chu and R. Elliott, *Clean Switch* (supra)..
26 See WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, 2005, p. 12.
27 See s. 4(e) of the *Corrections and Conditional Release Act*, S.C. 1993, c. 20 (CCRA) and *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, U.N. Doc. A/45/49 (1990), Principle 5.
28 See Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights*, 16 Dec 1966, 993 U.N.T.S. 3 (entered into force 3 January 1976). Section 86 of the CCRA also mandates CSC to provide every person in prison with "essential health care" that will contribute to his or her rehabilitation and reintegration into the community.
29 See Article 6 of the *International Covenant on Civil and Political Rights*, 16 Dec. 1966, 999 U.N.T.S. 171 (entered into force 23 March, 1976) (ICCPR) and s. 7 of the *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 (Charter).
30 See Article 9 of the ICCPR and s. 7 of the Charter.
31 See Article 26 of the ICCPR and s. 15 of the Charter.
32 See Article 7 of the ICCPR and s. 12 of the Charter.
33 See *Basic Principles for the Treatment of Prisoners* (supra), Principle 9; WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993; UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006, p. 10; UNAIDS, "Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View* (Geneva: UNAIDS, 1997), p. 3. Under Canadian law, the CCRA stipulates that medical care for prisoners "shall conform to professionally accepted standards," thereby implying a right to comparable health care as offered in the community at large. See CCRA, s. 86(2).
34 Prison health standards and declarations from the WHO, the World Medical Association and the U.N., for example, are clear that people in prison must be provided with measures to prevent the transmission of disease. See WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons* (supra); World Medical Association, *Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases*, 2000; and *Rules for the Protection of Juveniles Deprived of their Liberty*, UNGAOR 45th Sess., Supp. No. 49A, U.N. Doc.A/45/49 (1990) at para. 49.
35 CSC, *Correctional Service Canada's Safer Tattooing Practices Pilot Initiative* (supra) at p. 37.
36 CSC, *HIV/AIDS in prisons: final report of the Expert Committee on AIDS and Prisons*, Minister of Supply and Services Canada, 1994.
37 See Annual Reports of the Correctional Investigator 2003–2004, 2005–2006, 2006–2007 and 2009–2010.
38 Canadian Medical Association, Resolution 26 of 17 August 2005.
39 Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004.
40 Canadian Human Rights Commission, *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*, 2004.
41 PHAC, *Prison needle exchange* (supra).
42 See, for example, organizations discussed on p. 10 of S. Chu and R. Elliott, *Clean Switch* (supra).

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