HIV/AIDS in prisons in Central and Eastern Europe and the former Soviet Union

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This is one of a series of 12 info sheets on HIV/AIDS in prisons in Central and Eastern Europe and the former Soviet Union.

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HIV/AIDS and hepatitis C in prisons: the facts

This info sheet reviews what is known about HIV/AIDS and hepatitis C in prisons, with a focus on Central and Eastern Europe and the former Soviet Union.

HIV seroprevalence in prisons

In the countries of Central and Eastern Europe and the former Soviet Union, high rates of HIV infection among prisoners are a growing concern.

HIV prevalence studies have been carried out in most countries in the region. A review of injection drug users and HIV infection in prisons, undertaken for the United Nations Reference Group on HIV/AIDS Prevention and Care among Injecting Drug Users, found HIV prevalence data for all countries, with the exception of Bosnia, Croatia, Turkmenistan and Uzbekistan.

Generally, the available data tend to suggest lower HIV prevalence in prisons in Central Europe, such as in Poland, Czech Republic, Hungary and Bulgaria, and a much higher prevalence in some of the states of the former Soviet Union – in particular the Russian Federation and Ukraine, but also Lithuania, Latvia and Estonia. HIV is also a growing problem in prisons in some of the states of Central Asia. For example:

- In the **Russian Federation,** by late 2002, the registered number of people living with HIV/AIDS in the penal system exceeded 36 000, representing approximately 20 percent of known HIV cases.
- In **Ukraine,** 12 studies undertaken between 1996 and 2001 found a range in HIV prevalence from 0 to 26 percent among prisoners. In a more recent study, undertaken in January 2005, between 15 and 30 percent of prisoners in various prisons across Ukraine tested HIV- positive.
- In **Latvia,** it has been estimated that prisoners comprise a third of the country's HIV-positive population. In a 2003 study, HIV prevalence was found to be 6.2 percent.
- **Estonia** reported four studies of HIV prevalence with rates of 8.8 to 23.9 percent.
- **Belarus** reported 1131 positive cases in 2003, for a prevalence of 2.1 percent.
- In **Moldova,** a study undertaken in five penitentiaries in January 2005 found an HIV prevalence of 1.40 to 4.71 percent among male prisoners and 9.63 percent among female prisoners.
- In **Kazakhstan,** a growth in the number of HIV-positive people in the penal system has been observed since 1997. At the end of 2004, 559 people were known to be HIV-positive.
- In **Tajikistan** and in the **Kyrgyz Republic,** estimated prevalence among prisoners is eight percent.

As in countries in Central and Eastern Europe and the former Soviet Union, rates of HIV infection in prison populations **worldwide**

are much higher than in the general population. They are, in general, closely related to two factors: the proportion of prisoners who injected drugs prior to imprisonment, and the rate of HIV infection among injection drug users in the community.

Many of those who are HIV-positive in prison were already living with the virus on the outside. Indeed, the highest rates of HIV infection in prisons can be found in areas where rates of HIV infection are high among injection drug users in the community. By choosing mass imprisonment as the main response to the use of drugs, governments worldwide have created a de facto policy of incarcerating more and more individuals with HIV infection.

High HIV infection rates have been reported from countries in Southern Europe. For example, in Spain, rates reached 28 percent in 1989, but have since decreased to 12 percent, thanks to the implementation of comprehensive prevention measures inside and outside prisons. Forty-one percent of South African prisoners are reported to be HIV-positive. In Latin America, high rates of HIV infection have been found in studies in a number of countries, including Brazil (3 to 41 percent), Argentina (2 to 50 percent) and Honduras (7 percent). In contrast, relatively low rates of HIV prevalence have been reported in Australia. In the United States, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. Many U.S. prison systems continue to have rates under 1 percent, while in a few systems rates approach 10 percent among men and 15 percent among women.

Hepatitis C seroprevalence

Hepatitis C (HCV) prevalence rates in prisons are even higher than HIV prevalence rates. A 2004 review of prevalence and incidence in incarcerated populations worldwide found HCV seroprevalence rates ranging from 4.8 percent in an Indian jail to 92 percent in two prisons in northern Spain. In prisons in Ukraine, rates of up to 95 percent were found in early 2005. Most HCV-positive prisoners come to prison already infected, but the potential for further spread is high. HCV is much more easily transmitted than HIV, and transmission has been documented in prisons in several countries.

Additional reading

Dolan K et al. (2004). *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. Available via http://ndarc.med.unsw.edu.au/ndarc.nsf/website/Research.current.cp47publications.
Provides the results of a survey undertaken on behalf of the UN Reference Group on HIV/AIDS Prevention and Care among IDUs in Developing and Transitional Countries.

Macalino GE et al. (2004). Hepatitis C infection and incarcerated populations. *International Journal of Drug Policy*, 15: 103–114. A review of prevalence and incidence of HCV in prisons worldwide.

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High-risk behaviours behind bars

This info sheet presents some of the evidence of the prevalence of high-risk behaviours — in particular, injection drug use — behind bars.

Drug use

Despite the sustained efforts of prison systems to prevent drug use by prisoners — by doing what they can to prevent the entry of drugs into prisons — the reality is that drugs can and do enter. Many prisoners come to prison with established drug habits and often find a way to continue drug use on the inside. Some prisoners start using drugs inside. No country has been able to stop drug use, including injection drug use, in prisons.

Central and Eastern Europe and former Soviet Union

A number of studies have provided evidence of the extent of injection and other drug use in prisons in the region. The following are some examples:

- In a study performed in 2000 at 10 penitentiary institutions in the **Russian Federation,** 10 percent of the surveyed prisoners reported at least one injection of illegal drugs during imprisonment, with nearly 2 percent of the total prison population injecting on a regular basis. Two thirds of those who injected drugs in prison also admitted needle-sharing.
- In a study undertaken in a number of prisons in **Ukraine** in early 2005, a significant number of prisoners admitted to injecting and to sharing injection equipment in prison.
- In **Tajikistan,** one third of the prisoners who reported ever having injected also reported injecting drugs in prison.

Worldwide

Many other countries report high rates of injection drug use behind bars. Typically, injection drug use decreases in prisons among prisoners who were users on the outside. However, prisoners are more likely to inject in an unsafe manner when they do inject. Studies have therefore concluded that imprisonment increases the risk of contracting HIV infection. The following are data from some recent studies:

- A 2002 report prepared for the **European Union** found that between 0.3 and 34 percent of prisoners in the European Union and Norway injected while incarcerated; that between 0.4 and 21 percent of injection drug users started injecting in prison; and that a high proportion of injection drug users in prison share injection equipment.
- In **Canada,** 11 percent of 4285 federal prisoners participating in a survey of prisoners reported having injected since arriving in their current penal institution. In some regions, up to 23 percent of prisoners reported injection drug use.

- In **Australia,** between 31 and 74 percent of IDUs reported injecting in prison, and between 60 and 91 percent reported sharing injection equipment in prison.

- In **Mexico,** a study in two jails found rates of injection drug use of 37 percent and 24 percent respectively.

Sexual activity

In prisons, sexual activity is considered to be a less significant risk factor for HIV and hepatitis C transmission than sharing of injection equipment. Nevertheless, it occurs and puts prisoners at risk of contracting HIV infection.

Some prison systems allow conjugal visits during which prisoners may engage in sexual activity with their partners. Heterosexual activity may also occur between a prisoner and a member of the prison staff. However, there is little information about how frequent such behaviour is. Most sexual activity that takes place in penal institutions involves sex between men. Some such activity occurs as a consequence of sexual orientation. However, most men who have sex in penal institutions do not identify themselves as homosexuals.

Sexual activity between prisoners varies in frequency and kind within and across prisons and prison systems. It includes consensual sex and various kinds of non-consensual sexual activity, including so-called "quasi-consensual" sexual activity (for example, submission based on intimidation, or submission in return for protection or other favours). Sex in the prison environment, particularly in the form of rape, is thought by many experts to be more often about power and asserting control over another human being than about sexual fulfillment.

In most of the countries in the region, prisoners of the colonies are submitted to a strict internal hierarchy, which is tolerated and reluctantly acknowledged by the authorities. This hierarchy, a caste-like system, is "horizontal," and has four main groups of prisoners: the "bosses" (*Blatnye*); the "men" (*Muzhiki*) comprising the majority of inmates; the "goats" (*Kozly*) or inmates who work for, or collaborate with, the prison system; and the "untouchables" or "underdogs" (*Petukhi*). The latter are outcasts in the true sense of the word "untouchable" and live apart from the others. However, they can be (and often are) used as sexual objects by the dominating caste.

In Russia, in a survey conducted among 1100 male prisoners aged between 18 and 80 that had been in prison for 1.5 to 10 years, only 10 to 15 percent of the prisoners reported having no sexual contacts while serving their term. The 8 to 10 percent of prisoners belonging to the "underdogs" had regular sexual activity with other men as passive partners. Many reported having oral and anal sex with 30 to 50 partners, while some only "served" a "small group" (10 to 15) of prisoners.

Tattooing

In prison, tattooing is a social activity and involves sharing needles, which makes it risky. In a study conducted in the Russian Federation, tattooing in prison was reported by 26 percent of prisoners, with 62 percent sharing tattooing equipment. In Canada, 45 percent of federal prisoners reported having had a tattoo done in prison.

Additional reading

Dolan K et al. (2004). *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. Available via http://ndarc.med.unsw.edu.au/ndarc.nsf/website/Research.current.cp47publications.

Bobrik A et al. (2005). Prison health in Russia: the larger picture. *Journal of Public Health Policy*, 26: 30–59.

Frost L, Tchertkov V (2002). Prisoner risk taking in the Russian Federation. *AIDS Eduction and Prevention,* 14 (Suppl B): 7–23.

Albov AP, Issaev DD (1994). Ministry of Internal Affairs, Dep. of Reformatory Affairs, St. Petersburg, Russia. Homosexual contacts among male prison inmates in Russia. Int Conf AIDS, Aug 7–12;10(2): 53.

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HIV transmission in prison

This info sheet presents some of the evidence regarding the extent of HIV transmission in prisons. It shows that outbreaks of HIV infection have and will continue to occur in prisons unless HIV prevention is taken seriously. Transmission of hepatitis C virus (HCV) has also been documented in a number of studies. This raises important questions about the moral and legal obligations of prison systems to prevent the further spread of HIV and HCV in prisons (see info sheet 11).

High rates of injection drug use, coupled with the lack of access to sterile injection equipment, which leads to increased levels of sharing of equipment among prisoners, can result in the frighteningly quick spread of HIV in penal institutions. There were early indications that extensive HIV transmission could occur in prisons. In Bangkok, HIV infection among injection drug users rose from 2 to 27 percent in 1987 and to 43 percent by late 1988, following an amnesty and release of a large number of prisoners. Six studies on HIV infection among injection drug users in Thailand found that a history of imprisonment was associated significantly with HIV infection.

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

Outbreaks of HIV infection in prisons in Lithuania and Russia

The number of people using drugs in Lithuanian prisons has been growing every year. At the beginning of 2001, 1010 people were on a record of dispensary care, 8.8 percent of all imprisoned persons at that time. The proportion reached 12.25 percent at the beginning of 2002 and 13.3 percent at the beginning of 2003. Sharing of needles and syringes in one of the country's 14 penal establishments, Alytus correctional facility, resulted in a rapid HIV outbreak. In May 2002, the number of new HIV-positive test results among prisoners in a two-week period was equal to all the cases of HIV identified in the entire country during all of the previous years combined. A total of 284 prisoners were diagnosed HIV-positive between May and August 2002 during voluntary testing.

A similar outbreak was also documented in a correctional colony in Tatarstan, Russia, where 260 prisoners became HIV-infected in 2001.

Outbreaks in prisons in Scotland and Australia

In Scotland, a serious outbreak of HIV was investigated in one prison (Glenochil) as early as 1993. Of the 227 prisoners recruited, 76 reported a history of injection and 33 reported injecting in Glenochil. Twenty-nine of the latter were tested for HIV, with fourteen testing positive. Thirteen of them had a common strain of HIV, proving that they became infected in prison. All those infected in prison reported extensive periods of syringe sharing.

Another documented outbreak of HIV infection occurred in a penal institution in Australia. Epidemiological and genetic evidence was used to establish

that HIV infection had indeed occurred in the penal institution. Attempts to trace 31 injection drug users resulted in 25 being located. Of these, two were HIV-negative, seven were deceased, two declined to participate, and fourteen were enrolled in the study. It could be proven that eight of the fourteen injection drug users were infected with HIV while in the penal institution.

HIV and HCV transmission during medical procedures

Because of the severe underfunding of health-care services in many countries in the region, HIV and HCV transmission may also occur through the use of non-sterile equipment during medical procedures. As the World Health Organization pointed out in paragraph 25 of its *Guidelines on HIV Infection and AIDS in Prisons*, prison health services must have adequate material and resources available to ensure that transmission does not occur.

Public health implications

Due to the closed nature of prisons, the health of prisoners is an issue that rarely comes to the attention of the public at large. However, the health of prisoners is an issue of public health concern. The high degree of mobility between prison and the outside community means that communicable diseases and related illnesses transmitted or exacerbated in prison do not remain there. When people living with HIV and HCV are released from incarceration, prison health issues necessarily become community health issues. The extent to which this is the case cannot be underestimated. For example, in the Russian Federation in recent years, 300,000 prisoners annually, many of whom are living with HIV, HCV, and/or tuberculosis, have been released from prisons.

Additional reading

Caplinskiene I, Caplinskas S, Griskevicius A (2003). Narcotic abuse and HIV infections in prisons [article in Lithuanian]. *Medicina (Kaunas)*, 38(8): 797–803.

Dolan K (1997/98). Evidence about HIV transmission in prisons. *Canadian HIV/AIDS Policy & Law Newsletter*, 3(4)/4(1): 32–35. An excellent summary of the evidence as of 1997, available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/Winter9798/26DOLANE.html

Taylor A et al. (1995). Outbreak of HIV infection in a Scottish prison. *British Medical Journal*, 310: 289–292. The first documented outbreak of HIV infection in prison.

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Condoms and prevention of sexual abuse

Info sheets 1–3 in this series showed that HIV infection and hepatitis C are prevalent in prisons; that the behaviours through which these infections can be transmitted are also prevalent; and that outbreaks of infection have and will continue to occur unless efforts to prevent the spread of infections are stepped up. Info sheets 4–7 discuss what can be done to reduce the spread of HIV and other infections in prison.

Providing condoms

According to the World Health Organization, 23 of 52 prison systems surveyed allowed condom distribution as early as 1991. Significantly, no system that has adopted a policy of making condoms available in prisons has reversed the policy, and the number of systems that make condoms available has continued to grow. For example, in a number of surveys undertaken in **Europe,** the proportion of prison systems that declared having made condoms available rose from 53 percent in 1989 to 75 percent in 1992, and 81 percent in 1997. In the most recent survey, condoms were available in all but four systems.

In 1995, in **Australia,** 50 prisoners launched a legal action against the state of New South Wales (NSW) for non-provision of condoms, arguing that "[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded." Since then, at least in part because of the legal action, the NSW government has decided to make condoms available. Other Australian prison systems, prison systems in **Canada,** and even prison systems in countries like **Indonesia** and **Iran** have made condoms available.

Condoms are also available in a growing number of correctional facilities in countries in Central and Eastern Europe and in the former Soviet Union. A good example is **Moldova,** where the number of condoms distributed to prisoners increased from 26,396 in 2000–2001 to 34 036 in 2003–2004.

Evaluations of condom distribution programs

Some of the condom distribution programs have been evaluated, demonstrating positive results.

In **Canada,** an evaluation of the HIV/AIDS harm reduction measures in the Canadian federal prison system found that, in general, prisoners had easy and discreet access to both condoms and lubricant. Moreover, although some unintended usage of condoms had been experienced, providing them had not created any problems.

In **Australia,** an evaluation of the condom distribution program in NSW prisons concluded that it was feasible to distribute condoms to prisoners. There were several indicators for this:

- The majority of prisoners supported the provision of condoms;
- Most prisoners were of the opinion that the condom vending machines were in accessible locations;
- The reported level of harassment of prisoners using the machines was relatively low; and
- Most importantly, prisoners were using condoms when having anal sex.

From October 1997 to September 1998, 294 853 condoms were dispensed in NSW prisons. These figures are the equivalent of each prisoner obtaining one condom a week. Overall, there were no indicators of negative consequences as a result of the condom distribution program. Most senior correctional staff agreed with the distribution of the condoms, while views were evenly divided among correctional officers. Minor incidents of misuse, such as water balloons, water fights and littering were recorded, but these did not compromise prison safety or security. No incidents of drug concealment were recorded.

In the **United States,** a survey to measure the acceptability of a condom distribution program at the Washington, D.C. Central Detention Facility found condom access "to be unobtrusive to the jail routine, no threat to security or operations, no increase in sexual activity, and accepted by most prisoners and correctional officers."

Importance of easy access to condoms

Experience has shown that when prisoners have to ask for condoms at health-care services or are afraid to be seen when picking up a condom, few will do so. Making condoms available is therefore not enough. They must be easily and discreetly accessible, ideally in several locations.

Combating sexual abuse

However, making condoms available and accessible is not enough. As mentioned in info sheet 2, violence, including sexual abuse, is common in many prisons. It is important to prevent violent attacks on prisoners, including rape; condoms are not going to be of use in situations of non-consensual sexual activity. Combating aggressive sexual behaviour, such as rape, exploitation of vulnerable prisoners, and all forms of prisoner victimization may result in a safer environment. Adequate staffing, effective surveillance, disciplinary sanctions, and education, work and leisure programs are necessary components to reach this goal.

Recommendation

1. Condoms (and water-based lubricant) need to be made easily and discreetly accessible to prisoners in all prisons, in various locations throughout the institutions, and without prisoners having to ask for them.

2. Sustained efforts need to be undertaken to prevent rape and other non-consensual sexual activity through which HIV may be transmitted.

Additional reading

Dolan K, Lowe D, Shearer J (2004). Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine & Ethics*, 32: 124–128. This evaluation of a prison condom distribution program concluded that is was feasible to distribute condoms to prisoners.

Joint United Nations Programme on HIV/AIDS (1997). *Prisons and AIDS: UNAIDS point of view.* States that "UNAIDS believes it vital that condoms, together with lubricant, should be readily available to prisoners." Available via www.unaids.org.

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Bleach and other disinfectants

This info sheet discusses one way of reducing the spread of HIV and other infections in prisons through injection drug use: providing bleach or other disinfectants, together with instructions on correct use, to sterilize needles and syringes. Info sheets 6 and 7 will discuss two other ways: making needles and syringes available, and opioid substitution treatment.

Experience has shown that drugs, needles, and syringes will find their way through the most secure of prison walls. While continuing and often stepping up drug interdiction efforts, prison systems around the world have therefore taken steps to reduce the risk of the spread of HIV and other diseases through injection drug use. These include provision of bleach or other disinfectants to sterilize needles and syringes, making sterile needles and syringes available (see info sheet 6), and opioid substitution treatment (see info sheet 7).

Providing bleach or other disinfectants

According to the World Health Organization's network on HIV/AIDS in prison, 16 of 52 prison systems surveyed made disinfectants (mainly in the form of bleach) available to prisoners as early as 1991. Bleach was available in some prison systems in Germany, France and Australia, in prisons in Spain, Switzerland, Belgium, Luxembourg and the Netherlands, and in some African and at least one Central American prison system.

Significantly, no system that has adopted a policy of making bleach available in prisons has reversed the policy, and the number of systems that make bleach available has grown substantially. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made bleach available rose from 28 percent in 1992 to 50 percent in 1997.

Bleach is also available in many other prison systems, including in Canada, Australia, Indonesia and Iran, and in some systems in Central and Eastern Europe and the former Soviet Union.

Evaluations

The experience in the prison systems that have made bleach or other disinfectants available has shown that distribution of bleach is feasible and does not compromise security within penal institutions.

For example, the evaluation of the HIV/AIDS harm reduction measures in the Canadian federal prison system found that, in general, prisoners had easy access to bleach. Both prisoners and staff reported that bleach had become a "fact of life" in prisons. At all 18 institutions visited, staff could not recall any incident where bleach had been used as a weapon. Interviews with staff indicated that, with a few exceptions, staff concerns in terms of safety have abated.

Recommendation

Bleach or other disinfectants, together with instructions on how to sterilize needles and syringes, need to be made easily and discreetly accessible to prisoners in all institutions.

Limitations

However, while making bleach available is important, it is not enough.

Based on research, bleach disinfection should be considered as a method to reduce the risk of HIV infection from the re-use or sharing of needles and syringes only when no other safer options are available. Sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and syringes. With regard to HCV infection, a study suggests that bleach may reduce its spread. However, the authors emphasized that bleach "is not a substitute for clean needles each and every time."

Research has shown that even outside of prison many injection drug users – as many as half or more in some studies – do not know, or do not practice, the proper method of using bleach for disinfecting needles. The probability of effective decontamination is decreased further in prison. Injecting is an illegal activity. Because prisoners can be accosted at any moment by prison staff, injecting and cleaning are often hurried. Studies have shown that bleach disinfection takes more time than most prisoners can or will take.

The research team that conducted the evaluation of the HIV/AIDS harm reduction measures in the Canadian federal prison system said that it had "no confidence that the distribution of bleach alone will effectively reduce transmission of infection from Hepatitis or HIV." It concluded that:

> *[B]ecause of the clandestine and furtive nature under which injection drug users operate in prison settings; of the primitive and makeshift equipment used to inject drugs; and of the tendency of injection drug users to "cut corners" when their cravings overcome their judgment, there is no guarantee that the use of bleach alone will effectively reduce transmission of infection from HIV or hepatitis C.*

Additional reading

World Health Organization (2004). *Evidence for action technical papers: effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users.* Available at www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf. Recommends: "Disinfection and decontamination schemes are not supported by evidence of effectiveness and should only be advocated as a temporary measure where there is implacable opposition to NSPs [needle and syringe programs] in certain communities or situations (e.g. correctional facilities)."

Correctional Service Canada (2004). *Guidelines 821–2 Bleach Distribution.* Available via www.csc-scc.gc.ca/text/plcy/cdshtm/821-2-gl_e.shtml. These excellent guidelines provide details on how bleach should be made accessible to prisoners.

Dolan K et al. (1994). *Bleach availability and risk behaviours in New South Wales.* Technical Report No 22. National Drug and Alcohol Research Centre (NDARC); and Dolan K et al. (1996). *Bleach easier to obtain but inmates still at risk of infection in New South Wales prisons.* Technical Report. NDARC. The first studies to allow the independent monitoring of a prison bleach-distribution program.

Kapadia F et al. (2002). Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users? *Epidemiology*, 13(6): 738–741. The study showing that bleach disinfection may provide some protection against hepatitis C virus.

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Needle and syringe programs

This info sheet provides information about needle and syringe programs in prisons. It shows that needles and syringes can be made available in prisons safely with good results.

Outside penal institutions in many countries, needle exchange or distribution programs have become an integral part of a pragmatic public-health response to the risk of HIV transmission among injection drug users (and, ultimately, to the general public). Extensive studies on the effectiveness of these programs have been carried out. For many years, there has been scientifically sound evidence showing that they are an important preventive health measure. A worldwide survey found that, in cities with needle exchange or distribution programs, HIV seroprevalence decreased by 5.8 percent per year; in cities without such programs, it increased by 5.9 percent per year.

Particularly because of the questionable efficacy of bleach and other disinfectants in destroying HIV and other viruses (see info sheet 5), providing sterile needles and syringes to prisoners has been widely recommended, on the grounds that access to sterile drug-injection equipment would ensure that prisoners would not have to share their equipment. As early as 1993, the World Health Organization recommended that "in countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injection equipment during detention and on release."

International developments

Since the early 1990s, an increasing number of prisons, including in Central and Eastern Europe and the former Soviet Union, have established needle and syringe programs.

Moldova

The Republic of Moldova started a pilot project in one prison in 1999 (PC18). The project evolved through two stages. During Stage 1, needles were distributed hand-to-hand to prisoners through the prison medical unit. During the four or five months that this distribution system was in place, between 40 and 50 needles were exchanged.

However, the project team decided that this method of distribution was not satisfactory. Their most significant concern was that the needle exchange was being accessed by only 25 to 30 percent of the prisoners known to inject drugs. A number of barriers were identified. These included difficulty in establishing a rapport between the medical staff and the prisoners who were injecting, a lack of anonymity and of confidentiality in the service, and the fact that needle exchange was only available during office hours.

Therefore, under Stage 2 of the program, eight peer volunteers were trained to provide harm-reduction services in four different sites in the prison. Two peer volunteers were assigned to work at each site and were available on a 24-hour basis because the sites were based within the prison living units. The activities and programs were carried

out in co-operation with the prison physician. In the first nine months of 2002, 65 to 70 percent of people known to inject drugs in the prison were accessing the program through the peer volunteers.

Based on its success, the program has been expanded to six other prisons, with further expansion planned. The total number of syringes exchanged has grown from 3650 in 2000–2001 to 37 813 in 2003–2004 and 61 433 in 2004–2005.

Kyrgyz Republic

In the Kyrgyz Republic, a pilot project started in one prison in October 2002. It was decided that exchanges should take place in a location where prisoners could not be seen by guards; they therefore took place in the medical wards. The pilot also provided secondary exchange using prisoners as peer volunteers, as in Moldova. The project coordinators found that both options for syringe exchange were needed.

In early 2003, an order was issued approving the provision of sterile needles in all Kyrgyz prisons, and by April 2004 they were available in 11 prisons. In all institutions, needle exchange is done using prisoners trained as peer outreach workers who work with the medical unit. In April 2004, approximately 1000 drug users were accessing the needle exchange programs. Drug users are provided with one syringe and three extra needle tips. This allows prisoners who inject drugs to inject more — up to three times a day — without having to reuse a syringe. This also reduces the cost of the syringe exchange program, since tips cost less than complete needles.

Belarus

The Republic of Belarus started a pilot project in one prison in April 2003. There are plans to introduce them in other prisons, and the Ministry of Internal Affairs has stated that it is prepared to establish them in all prisons in the country.

Ukraine

In 2005, the State Department of Ukraine for Enforcement of Sentences decided that it would start prison needle and syringe pilot programs in two prisons in 2006 and selected two colonies — colony #48 in Lviv and colony #53 in Mykolaiv — as the sites of the pilot projects. In preparation for the start of the projects in early 2006, a conference and three training sessions on needle and syringe programs were organized in November and December 2005. Two of the training sessions took place with staff from the two colonies mentioned above.

Switzerland

In Switzerland, distribution of sterile injection equipment has been a reality in some prisons since the early 1990s. Sterile injection equipment first became available to prisoners in 1992, at Oberschöngrün prison for men. Fourteen years later, distribution is ongoing, has never resulted in any negative consequences, and is supported by prisoners, staff, and the prison administration. Initial scepticism by staff has been replaced by their full support:

> *Staff have realized that distribution of sterile injection equipment is in their own interest. They feel safer now than before the distribution started. Three years ago, they were always afraid of sticking themselves with a hidden needle during cell searches. Now, inmates are allowed to keep needles, but only in a glass in their medical cabinet over their sink. No staff has suffered needle-stick injuries since 1993.*

In June 1994, another Swiss prison, Hindelbank institution for women, started a one-year pilot HIV prevention program including needle distribution. Hindelbank's program was evaluated by external experts, with very positive results: the health status of prisoners improved; no new cases of infection with HIV or hepatitis occurred; a significant decrease in needle sharing was observed; there was no increase in drug consumption; needles were not used as weapons; and only about 20 percent of staff did not agree with the project. Following the evaluation, a decision was taken to continue the program. The prison has also experienced a drastic reduction in fatal overdoses since the program started. Other Swiss prisons have since started their own programs, and in early 2006, distribution of sterile needles was being undertaken in seven prisons in different parts of the country.

Germany

In Germany, two pilot projects started in 1996 in Lower Saxony. An evaluation undertaken after two years showed positive results, and recommended not only to continue the pilot projects but to expand them to all prisons in Lower Saxony. At the end of 2000, needle exchange schemes had been successfully introduced in seven prisons in Berlin, Hamburg and Lower Saxony, and other prisons were looking at how to implement them.

However, since then, six of the programs were closed down, not because of any problems with the programs, but as a result of political decisions by newly elected centre-right-wing state governments. It has been reported that since the programs closed, prisoners have returned to sharing needles and to hiding them, increasing the likelihood of transmission of HIV

and HCV, as well as the risk of accidental needle-stick injuries for staff. Staff have been among the most vocal critics of the governments' decision to close down the programs, and have lobbied the governments to reinstate the programs.

Spain

In Spain, the first pilot project started in August 1997. An evaluation undertaken after 22 months showed positive results and, as a result, in June 2001, the Directorate General for Prisons ordered that needle exchange programs be implemented in all prisons. As of early 2006, exchanges were operating in 38 prisons.

What can we learn?

The experience of prisons in which needles and syringes have been made available, including scientific evaluation of 11 projects, provides many lessons. Among the most important are:

1. Prison needle and syringe programs are safe.

Needles can be made available in prisons in a manner that is non-threatening to staff and that increases staff safety. Since the first prison needle and syringe program started in 1992, there have been no reported cases of a needle being used as a weapon either against prison staff or other prisoners.

2. Prison needle and syringe programs do not lead to increased drug use.

Evaluations of existing programs have consistently found that the availability of needles does not result in an increased number of drug injectors, an increase in overall drug use, or an increase in the amount of drugs in the institutions.

3. Prison needle and syringe programs do not condone illegal drug use and do not undermine abstinence-based programs.

Drugs remain prohibited in institutions where needle and syringe programs are in place. Security staff remain responsible for locating and confiscating illegal drugs. However, it is recognized that if and when drugs find their way into the prison and are used by prisoners, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, needles that are part of the official needle and syringe program are not.

Evaluations have found that needle and syringe programs in prisons actually facilitate referral of drug users to drug dependence treatment programs, and have led to an increase in the number of prisoners accessing such programs.

4. Prison needle and syringe programs have been successfully introduced in various prison environments.

Programs have been successfully implemented in prisons for men and for women, in small, medium and large institutions, as well as in prisons of all security classifications. After having been introduced in well-resourced prison systems, programs have also been established in systems with very limited resources. There are several models of distribution of sterile injection equipment, including automatic dispensing machines, distribution by medical staff or counsellors, and distribution by prisoners trained as peer outreach workers.

5. Prison needle and syringe programs reduce risk behaviour and prevent disease transmission.

Most importantly, evaluations of existing programs have shown that reports of syringe sharing declined dramatically, and that no new cases of HIV, hepatitis B, or hepatitis C transmission were reported. Other positive health outcomes have been documented in some prisons, such as a decrease in fatal and non-fatal overdoses and a decrease in abscesses and other injection-related infections.

6. Prison needle and syringe programs function best when prison administration, staff, and prisoners support them.

The support of the prison administration and staff is important, and educational workshops and consultations with prison staff should be undertaken. This is not to say, however, that staff in prisons in which such programs have been introduced have been universally supportive from the start. In several cases, they were reluctant at first, but supported the program after they experienced its benefits.

7. Prison needle and syringe programs are best introduced as pilot projects.

Experience has shown that a good way for a prison system to start a needle and syringe program, and to overcome objections, is to operate a program as a pilot project and to evaluate it after the first year of operation.

Recommendation

Needle and syringe programs should be made available in prisons where prisoners inject illegal drugs. In prison systems where distribution has not yet started, pilot projects should be undertaken immediately.

Additional reading

Lines R et al. (2004). *Prison needle exchange: a review of international evidence and experience*. Canadian HIV/AIDS Legal Network. A comprehensive and detailed report available on the international experience of prison syringe exchange. Available in English, French, and Russian via www.aidslaw.ca/Maincontent/issues/prisons.htm.

Kerr T, Jürgens R (2004). *Syringe exchange programs in prisons: reviewing the evidence.* Canadian HIV/AIDS Legal Network. A 10-page review of the evidence. Available in English, French, and Russian via www.aidslaw.ca/Maincontent/issues/prisons.htm.

Ministerio Del Interior/Ministerio De Sanidad y Consumo (2003). *Needle exchange in prison. Framework program.* Detailed plan and guidelines used for the implementation of needle exchange programs in Spanish prisons. Essential for anyone wishing to see how a successful needle exchange program can be established in a prison. Available in Spanish, English, and French.

Wolfe D (2005). *Pointing the way: harm reduction in Kyrgyz Republik*. Bishkek: Harm Reduction Association of Kyrgyzstan "Partners' network." Available in English and Russian via http://www.soros.org/initiatives/ihrd. Describes how needle and syringe programs were introduced in prisons in Kyrgyzstan.

World Health Organization (2004). *Evidence for action technical papers: effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users.* Available at www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf.

HIV/AIDS in prisons in Central and Eastern Europe and the former Soviet Union

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Opioid substitution treatment

This info sheet provides important information about opioid substitution treatment (ST) in prisons. It explains that providing ST is an HIV-prevention strategy that provides people dependent on drugs with an additional option for getting away from needle use and sharing, and points out that since it is a medically indicated form of treatment, it should be available to opiate-dependent people whether they are outside or inside prison. By far the most widely used form of ST is methadone maintenance treatment (MMT).

Why substitution treatment?

The most commonly used form of ST is methadone maintenance treatment (MMT). Methadone has been used to treat heroin and other opiate dependence for decades. The more recently-developed buprenorphine is also quite commonly used in a number of countries. Both have been proven to greatly reduce the risk of HIV infection by reducing drug injection and improving the health and quality of life of opiate-dependent people. In 2005, both were added to the World Health Organization Model List of Essential Drugs.

Community ST programs have rapidly expanded since the mid-1990s. There are ample data supporting their effectiveness in reducing high-risk injecting behaviour and in reducing the risk of contracting HIV. There is also evidence that ST is the most effective treatment available for heroin-dependent injection drug users in terms of reducing mortality, heroin consumption, and criminality. Further, ST attracts and retains more heroin injectors than any other form of treatment. Finally, there is evidence that people who are on ST and who are forced to withdraw from methadone because they are incarcerated often return to narcotic use, often within the prison system, and often via injection. It has therefore been widely recommended that prisoners who were on ST outside prison be allowed to continue it in prison.

Further, with the advent of HIV/AIDS, the arguments for offering MMT to those who were not following such a treatment outside are compelling. Prisoners who are injection drug users are likely to continue injecting in prison and are more likely to share injection equipment, creating a high risk of HIV transmission (see info sheets 2 and 3). As in the community, ST, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons. The World Health Organization *Guidelines on HIV/AIDS in Prisons* therefore recommend: "Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries where methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons."

Where is ST being offered?

Worldwide, an increasing number of prison systems are offering ST to prisoners, including prison systems in Canada and Australia, some systems in the United States, most of the systems in the 15 "old" European Union (EU) member states (with the exception of Greece, Sweden, and two jurisdictions in Germany), and systems in other countries, including Iran and Indonesia. ST programs also exist in prisons in some of the "new" EU member states (Estonia, Hungary, Malta, Slovenia and Poland), although they often remain small and benefit only a small number

of prisoners in need. Finally, an increasing number of systems in Eastern Europe and the former Soviet Union have started ST programs (such as Moldova) or are planning to do so soon (such as Kyrgyzstan), but ST remains unavailable in prisons in other countries in the region, including in Russia, Georgia, Tajikistan, Ukraine and Belarus.

Are there alternatives?

Some prison systems are still reluctant to make ST available, or to extend availability to those prisoners who were not receiving it prior to incarceration. Some consider methadone or buprenorphine as just another mood-altering drug, the provision of which delays the necessary personal growth required to move beyond a drug-centred existence. Some also object to ST on moral grounds, arguing that it merely replaces one drug of dependence with another. If there were reliably effective alternative methods of achieving enduring abstinence, substitution therapy would indeed be inadequate. However, as Dolan and Wodak have explained, there are no such alternatives:

> *[T]he majority of heroin-dependent patients relapse to heroin use after detoxification; and few are attracted into, and retained in drug-free treatment long enough to achieve abstinence. Any treatment [such as ST] which retains half of those who enrol in treatment, substantially reduces their illicit opioid use and involvement in criminal activity, and improves their health and well-being is accomplishing more than "merely" substituting one drug of dependence for another.*

In recent years, evaluations of prison ST programs in Canada, Australia and the US have provided clear evidence of their benefits. For example, results from a randomized controlled trial of the MMT program in prisons in New South Wales, Australia indicate lower rates of heroin use, injection drug use and syringe sharing among those enrolled in MMT compared to controls. In Canada, the federal prison system expanded access to MMT after evaluation demonstrated that MMT has a positive impact on release outcome and on institutional behaviour.

Another reason why ST is important

Antiretroviral therapy (ARV) for HIV is becoming available in the countries in Central and Eastern Europe and the former Soviet Union in which this treatment was, until recently, unaccessible. In most countries, the majority of people who need ARV are injection drug users. For them, access to ST is often a prerequisite for being able to take ARV. Many of them will spend time in prison, and they need to be able to access both ST and ARV without interruption (see info sheet 8 for more details).

Recommendation

ST is a medically indicated form of treatment that needs to be available to opiate-dependent people, whether they are outside or inside prison.

Additional reading

Kerr T, Jürgens R (2004). *Methadone maintenance therapy in Prisons: reviewing the evidence.* Canadian HIV/AIDS Legal Network. Available in English, French and Russian via www.aidslaw.ca/Maincontent/issues/prisons.htm.
A 10-page summary of the evidence.

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

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

Corrections Victoria (2003). *Victorian Prison Opioid Substitution Therapy Program: clinical and operational policy and procedures.* Available via www.legalonline.vic.gov.au.
An excellent document with policy and procedures providing a framework for managing substitution treatments.

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Care and treatment

Info sheets 4–7 in this series emphasize the importance of preventing the further spread of HIV and other infections in prisons. This info sheet deals with an equally important issue: providing prisoners with HIV/AIDS with care and treatment equivalent to that available to other members of the community.

The right to health and the equivalence principle

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

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

In its 1993 *WHO guidelines on HIV infection and AIDS in prisons*, the World Health Organization (WHO) highlights that, as a general principle, prisoners have the right to receive health care "equivalent to that available in the community, without discrimination."

Care and support of HIV-positive prisoners

The WHO guidelines contain the following recommendations related to care and support of HIV-positive prisoners:

> *34. At each stage of HIV-related illness, prisoners should receive appropriate medical and psychosocial treatment equivalent to that given to other members of the community. Involvement of all prisoners in peer support programmes should be encouraged. Collaboration with health care providers in the community should be promoted to facilitate the provision of medical care.*
>
> *35. Medical follow-up and counselling for asymptomatic HIV-infected prisoners should be available and accessible during detention.*
>
> *36. Prisoners should have access to information on treatment options and the same right to refuse treatment as exists in the community.*
>
> *37. Treatment for HIV infection, and the prophylaxis and treatment of related illnesses, should be provided by prison medical services, applying the same clinical and accessibility criteria as in the community.*
>
> *38. Prisoners should have the same access as people living in the community to clinical trials of treatments for all HIV/AIDS-related*

diseases. Prisoners should not be placed under pressure to participate in clinical trials, taking into account the principle that individuals deprived of their liberty may not be the subjects of medical research unless they freely consent to it and it is expected to produce direct and significant benefit to their health.

39. The decision to hospitalize a prisoner with AIDS or other HIV-related diseases must be made on medical grounds by health personnel. Access to adequately equipped specialist services, on the same level available in the community, must be assured.

40. Prison medical services should collaborate with community health services to ensure medical and psychological follow-up of HIV-infected prisoners after their release if they so consent. Prisoners should be encouraged to use these services.

Antiretroviral therapies

The right to medical care in prisons also includes the provision of antiretroviral therapy (ARV) in the context of comprehensive HIV/AIDS care.

Combination ARV, and in particular highly active antiretroviral therapy (HAART), has proven to be effective in obtaining maximal and durable suppression of HIV viral load, restoration and preservation of immunologic function, improvement of quality of life, and reduction of HIV-related morbidity and mortality. Left untreated, most people infected with HIV will eventually go on to develop HIV-related illnesses and die. If they receive ARV, however, they can live in relatively good health for many years. These results can be observed even in "difficult" HIV-infected populations, such as injection drug users, and in "difficult" contexts such as developing countries.

Providing access to ARV for those in need in the context of correctional facilities is a challenge, but it is necessary and feasible. In western countries, where ARV is relatively easily available, many HIV-positive prisoners receive ARV. As a consequence, AIDS-related deaths in prisons have decreased dramatically. For example, from 1995 to 1999, AIDS-related deaths decreased by more than 75 percent in prisons in the U.S. Similar results have been observed in other countries.

As ARV is increasingly becoming available in Central and Eastern Europe and the former Soviet Union, it will be critical to ensure that it also becomes available in the countries' prison systems. Many of the people who need access to ARV are injection drug users, and many of them move in and out of the prison system. Ensuring continuity of care from the community to the prison and back to the community, as well as continuity of care within the prison system, is therefore crucial.

The link with substitution therapy

Substitution maintenance treatment offers opportunities for improving the delivery of ARV to drug users with HIV/AIDS. Maintenance therapy enables opioid dependent drug users to stabilize their lives, and avoid or manage many of the complications of injection drug use, and is therefore seen as an essential component in strategies for retaining active injection drug users in treatment. It also provides additional entry points for scaling up ARV therapy, improves drug adherence and increases access to care. It is therefore important to ensure that substitution therapy is available both outside and inside prisons.

Recommendations

Prisons must ensure that prisoners receive care, support and treatment equivalent to that available to people living with HIV/AIDS in the community, including uninterrupted HAART.

Additional reading

Open Society Institute (2004). *Breaking down barriers. Lessons on providing HIV treatment to injection drug users.* Available via www.soros.org/initiatives/health/focus/ihrd.
This report categorically refutes negative assumptions about injection drug users' ability and desire to be treated for HIV infection. It also presents examples of innovative HIV treatment programs for drug users in a wide variety of countries, including Argentina, Brazil, France, Hong Kong, Russia, Spain and the U.S.

Pontali E (2005). Antiretroviral treatment in correctional facilities. *HIV Clinical Trials*, 6(1): 25–37.

World Health Organization (1993). *WHO guidelines on HIV infection and AIDS in prisons.* WHO/GPA/DIR/93.3. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html or via www.unaids.org.

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A comprehensive strategy

Measures directed at preventing HIV (see info sheets 4–7) and at ensuring that prisoners with HIV/AIDS receive adequate care, treatment, and support (see info sheet 8) are arguably the cornerstones of a comprehensive strategy on HIV/AIDS in prisons. However, other measures are also required.

A rare consensus

Since the late 1980s, a large number of national and international organizations including community-based groups in many countries, the World Health Organization, and the United Nations Joint Programme on HIV/AIDS (UNAIDS) have analyzed the issues raised by HIV/AIDS in prisons and have all reached the same conclusions and made the same recommendations. All recommended that a comprehensive strategy be adopted to deal with HIV/AIDS in prisons.

What are the elements of a comprehensive strategy?

Many have already been mentioned in info sheets 4–8. It is not possible to mention all of the other elements here, but some of the most important include:

A long-term, strategic approach

Prison systems need to take a proactive rather than reactive approach to the issues raised by HIV/AIDS, hepatitis, tuberculosis and drug use in prisons. In particular, they need to:

- assign adequate staff and resources to their AIDS and infectious diseases programs;
- involve prisoners, staff and external experts, including non-governmental organizations (NGOs), in the development of all initiatives taken to reduce the spread of HIV and other infectious diseases;
- ensure uniform implementation of initiatives by releasing clear guidelines and enforceable standards, monitoring implementation, and holding prison administrations responsible for timely and consistent implementation; and
- evaluate all initiatives with the help of independent external experts.

A health issue

Because prisoners come from the community and return to it, and because what is or is not done in prisons with regard to HIV/AIDS, hepatitis, tuberculosis and drug use has an impact on the health of all, health ministries need to take an active role and work in close collaboration with correctional systems. Another option, which has been widely recommended, is to transfer control over prison health to public health authorities. Some countries have already introduced such a change. Norway was one of the first. In France, where prison health was transferred to the ministry of health in 1994, a positive impact is already evident. Each prison in France is twinned with a public hospital and, according to UNAIDS, "conditions have improved noticeably since the transfer of responsibility for health." Of course, in transferring control to public health authorities, proper resources must be provided, and autonomy of the new prison health authorities guaranteed.

HIV testing

There is no public-health or security justification for compulsory or mandatory HIV testing of prisoners, or for denying prisoners with HIV/AIDS access to all activities available to the rest of the population. Rather, prisoners should be encouraged to test voluntarily for HIV, with their informed, specific consent, with pre- and post-test counselling, and with assurance of the confidentiality of test results.

Educational programs for prisoners

Education of prisoners remains one of the most important efforts to promote and protect their health. It should not be limited to written information or the showing of a video, but should include ongoing educational sessions and be delivered or supplemented by external, community-based AIDS, health or prisoner organizations. Wherever possible, prisoners should be encouraged and assisted in delivering peer education, counselling and support programs.

Educational programs for staff

Educational programs for staff are also a priority. Training about HIV/AIDS, hepatitis and other infectious diseases must be part of the core training of all prison staff, including correctional officers. In particular, staff need to learn about how to deal with prisoners with HIV/AIDS and to respect their rights and dignity, and about the need to respect medical confidentiality. NGOs and people with HIV should be delivering part of the training.

Protective measures for staff

It is crucial to make sure that the staff's workplace is safe. In this context, staff are rightly concerned about overcrowding in the institutions, and understaffing, which, rather than measures taken to prevent the spread of HIV in prisons, constitute the real threats to their safety. Prison systems have to address staff's concerns in these areas.

Drug policy

Reducing the number of drug users who are incarcerated needs to become an immediate priority. Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available.

Improving prison conditions

Taking the above measures to address the serious risk of HIV transmission in prisons is crucial and is mandated from a public-health and human-rights perspective. However, some have argued that prevention of HIV transmission in prison has more to do with improving prison conditions in general than with specifically addressing HIV. Many prison systems are severely underfunded; the lack of staff, food and other basic necessities, together with overcrowding, corruption, and gangs, are the primary causes of rape, assault and violence in prisons. The resulting environment is horrifying even without the risk of HIV infection. In addition, nobody should be surprised if many prisoners resort to drug use as a means to release tensions and to cope with being in such an environment. As one researcher, K.C. Goyer, has said:

> *Security and the provision of safe custody must be a priority. A just society would not accept that prisons are necessarily brutal environments. If the prison as an institution is proven to be intrinsically and inevitably violent, then the necessary course of action is to change the institution. Therefore, policies to address HIV transmission in prison cannot be effective without immediate and urgent prison reforms.*

Additional reading

Irish Penal Reform Trust (2004). *Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia: Prison Health is Public Health.* Available in many languages, including Russian, via www.iprt.ie.

World Health Organization (Europe) (2003). *Moscow Declaration: Prison Health as part of Public Health.* Available in English, French, Russian, and German via www.euro.who.int/prisons/publications/20050610_1. Recognizes the need for a close link between public health and the provision of health care to those in prison.

Office of the United Nations High Commissioner for Human Rights and UNAIDS (1998). *HIV/AIDS and human rights: international guidelines.* HR/PUB/98/1. Contains an important recommendation regarding HIV/AIDS in prisons — recommendation 29(e). Available in many languages, including Russian, via www.unaids.org.

World Health Organization (1993). *WHO guidelines on HIV infection and AIDS in prisons.* WHO/GPA/DIR/93.3. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html or via www.unaids.org.

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Women prisoners and HIV/AIDS

Studies have shown that the prevalence of HIV among incarcerated women is often even higher than among incarcerated men. The measures described in info sheets 4–9 will help address the issues women prisoners face in the context of HIV/AIDS, but the additional measures described in this sheet are also necessary.

The numbers

Women have always made up a relatively small proportion of the overall prisoner population worldwide. In its *Global Report on Prisons* published in 1993, Human Rights Watch estimated the proportion to be about three to seven percent of the male population. There are no reliable current global figures at the time of the writing, but the women prisoner population is increasing rapidly, particularly in those countries where substance use is a major issue.

Seroprevalence studies undertaken in prison systems in a number of countries, including in Central and Eastern Europe and the former Soviet Union, have shown that HIV infection is prevalent among women prisoners, particularly among those who have a history of injection drug use. Indeed, HIV seroprevalence among women prisoners often exceeds that of male prisoners. For example:

- In **Moldova,** a study undertaken in five penitentiaries in January 2005 found an HIV prevalence rate of 1.40 to 4.71 percent among male prisoners, but a rate of 9.63 percent among female prisoners.
- In **Canada,** in 2002, 3.71 percent of prisoners in federal women's institutions, compared to 1.96 percent of male prisoners in the federal prison system, were known to be HIV-positive.
- In the **U.S.,** incarcerated women are three times more likely to be living with HIV than are incarcerated men.

Underlying issues

Most prison systems are designed with male prisoners in mind, which explains why living conditions for women prisoners are often not tailored to their specific needs. Basic requirements such as greater access to showers when women prisoners menstruate, or making sanitary napkins available, are often not provided for. Not all women's prisons cater to prisoners who are pregnant, although some of them do provide for mothers with newborn babies or infants.

As women prisoners are fewer than males, the health services provided for women are sometimes minimal or second-rate. With the advent of HIV/AIDS, a new problem has arisen for women prisoners. Women prisoners need the same preventive measures (see info sheets 4–7), and the same level of care, treatment, and support (see info sheet 8) as male prisoners. In addition, however, there is a need for initiatives that acknowledge that the problems encountered by women in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. The task of protecting women prisoners from HIV transmission therefore presents different — and sometimes greater — challenges than that of preventing HIV infection in male prisoners.

Underlying many of the problems that women in prison encounter is the fact that many women in prisons are members of social groups marginalized not only on the basis of gender, but also on the basis of race, class, disability, substance use or occupation as sex workers. Women prisoners often have more health problems than male prisoners. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition and poor health care.

Women are at greater risk of acquiring HIV than men because cultural and societal conditions are such that women are often not in a position to control their own sexual lives. Gender inequalities, a lack of education and employment, and poverty force many women to trade sex in order to feed their families or just to survive. These women are particularly at risk of HIV infection, as their clients, sometimes with offers of extra payment, often demand unprotected sex. In the same light, even though women may be monogamous, many are at high risk of HIV because their partners have sexual intercourse with others without protection.

Many HIV-positive women do not receive the diagnostic and treatment services that could benefit them as early as do HIV-positive men. Among the reasons for this is that women are often unaware of having been exposed to HIV by their sexual or drug-using partners and as a result do not seek counselling, HIV testing, and care and treatment. Second, the needs of HIV-positive women differ from those of men, and social and community support is often less frequently available and less accessible. As a consequence, women are often less informed than men about HIV infection and AIDS and do not have the support structures they need. Third, disease manifestations attributable to HIV infection or AIDS are often different in women, which has led to under-recognition or delays in diagnosis. Thus, women who are infected have often been diagnosed as infected or having AIDS later than men.

For all these reasons, the educational needs of women prisoners regarding HIV/AIDS are different from the needs of male prisoners, and the need for HIV prevention programs in women's prisons may be even more pressing than in male prisons.

What must be done?

The World Health Organization's *WHO guidelines on HIV infection and AIDS in prisons* contain the following recommendations specific to women prisoners:

> *Special attention should be given to the needs of women prisoners. Staff dealing with detained women should be trained to deal with the psychosocial and medical problems associated with HIV infection in women.*
>
> *45. Women prisoners, including those who are HIV-infected, should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to infant, or through sexual intercourse. Since women prisoners may engage in sexual intercourse during detention or release on parole, they should be enabled to protect themselves from HIV infection, e.g., through the provision of condoms and skills in negotiating safer sex. Counselling on family planning should also be made available, if national legislation so provides. However, no pressure should be placed on women prisoners to terminate their pregnancies. Women should be able to care for their young children while in detention regardless of their HIV status.*
>
> *46. The following should be available in all prisons holding women:*
>
> - *gynaecological consultations at regular intervals, with particular attention paid to the diagnosis and treatment of STDs*
> - *family planning counselling services oriented to women's needs*
> - *care during pregnancy in appropriate accommodation*
> - *care for children, including those born to HIV-infected mothers*
> - *condoms and other contraceptives during detention and prior to parole periods or release.*

Recommendation

Prison systems need to develop and implement effective education and prevention programs targeted specifically to women prisoners.

Additional reading

World Health Organization (Europe), Prison Reform International, Medecins Sans Frontières (2001). *HIV in prison. A manual for the newly independent states.* (Russian edition, 2003). Available in English and Russian via www.afew.org/english/publications/prison.php. Contains a chapter on "women in prison and HIV."

World Health Organization (1993). *WHO guidelines on HIV infection and AIDS in prisons.* WHO/GPA/DIR/93.3. Recommendations 44–46 concern incarcerated women. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html.

HIV/AIDS in prisons in Central and Eastern Europe and the former Soviet Union

11

This is one of a series of 12 info sheets on HIV/AIDS in prisons in Central and Eastern Europe and the former Soviet Union.

1. HIV/AIDS and HCV in prisons: the facts
2. High-risk behaviours behind bars
3. HIV transmission in prison
4. Condoms and prevention of sexual abuse
5. Bleach and other disinfectants
6. Needle and syringe programs
7. Opioid substitution treatment
8. Care and treatment
9. A comprehensive strategy
10. Women prisoners and HIV/AIDS
11. A moral and legal obligation to act
12. Essential resources

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A moral and legal obligation to act

Prison systems have a moral and legal responsibility to do whatever they can to prevent the spread of infectious diseases among prisoners, and to provide care, treatment, and support equivalent to those available outside. Good prevention and care in prisons are in the interest of everyone — prisoners, prison staff, and the public.

The state's duty with respect to health

By its very nature, imprisonment involves the loss of the right to liberty. However, prisoners retain their other rights and privileges, except those necessarily removed or restricted by the fact of their incarceration. In particular, prisoners, as all other people, have a right to the highest attainable level of physical and mental health; the state's duty with respect to health does not end at the gates of prisons.

The failure to provide prisoners with access to essential HIV prevention measures and to treatment equivalent to that available outside is a violation of prisoners' right to health in international law. Moreover, it is inconsistent with international instruments that deal with rights of prisoners, prison health services and HIV/AIDS in prisons, including the United Nations' *Basic principles for the treatment of prisoners*, the World Health Organization's *WHO guidelines on HIV infection and AIDS in prisons*, and United Nations Joint Programme on HIV/AIDS (UNAIDS) documents.

Recommendations on HIV/AIDS and drug use in prisons have all stressed the importance of prevention in prisons, and have suggested that condoms, bleach, sterile needles and syringes, and opioid substitution treatment be available to prisoners. They have also stressed the importance of providing prisoners with care, treatment and support equivalent to those available outside. According to the WHO guidelines, "[a]ll prisoners have the right to receive health care, *including preventive measures*, equivalent to that available in the community without discrimination." The WHO states that prison administrations have a responsibility to put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike.

Why should we care?

Prisoners, even though they live behind bars, are part of our communities. Most prisoners leave prison at some point to return to their community, some after only a short time inside. Some prisoners enter and leave prison many times. Prisoners deserve the same level of care and protection that people outside prison get. They are sentenced to prison, not to be infected:

> *[B]y entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities (United Nations Commission on Human Rights, 1996).*

The promotion of health in prisons does not entail lessening the safety and the security of prisons. The interest of prisoners in being given access to the means necessary to protect themselves from contracting HIV is compatible with the interest of prison staff in workplace security and of prison authorities in the maintenance of safety and order in the institutions. Any measure undertaken to prevent the spread of HIV will benefit the health of prisoners, who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. But it will also protect staff: lowering the prevalence of infections in prisons means that the risk of exposure to these infections will be lowered. Finally, it will protect the public. Most inmates are in prison for short periods of time and are then released into their communities. In order to protect the general population, HIV prevention measures need to be available in prisons, as they are outside.

The promotion of health is also compatible with the goal of reducing drug use in prisons. Making sterile needles available to drug users has not led to an increase in drug use. Similarly, making substitution therapy available to users dependent on opioids does not mean giving up on the ultimate goal of getting people off drugs. Rather, it is a realistic acknowledgement that for many users this requires time, and that they need an option that will allow them to break the drug-and-crime cycle, reduce their contact with the black market, make links with needed services and reduce their risk of becoming infected with HIV.

On the other hand, refusing to make condoms, bleach, and clean needles and syringes available to prisoners, knowing that activities likely to transmit HIV are prevalent in prisons, could be seen as condoning the spread of HIV among prisoners and to the community at large.

Additional reading

Lines R et al. (2004). *Prison needle exchange: a review of international evidence and experience.* Canadian HIV/AIDS Legal Network. This report contains more detailed information about the issues addressed in this info sheet. Available in English, French, and Russian via www.aidslaw.ca/Maincontent/issues/prisons.htm. See section on "human rights and legal standards."

Irish Penal Reform Trust (2004). Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia: Prison Health is Public Health. Available in many languages, including Russian, via www.iprt.ie.

Jürgens R, Betteridge G (2005). HIV prevention for prisoners: a public health and human rights imperative. *Interights Bulletin*, 15(2): 55–59.

UNAIDS (1996). *United Nations Commission on Human Rights (Fifty-second Session, item 8 of the agenda). HIV/AIDS in prisons - statement by UNAIDS.* Argues that the treatment of prisoners in many countries constitutes a violation of the prisoners' human rights.

HIV/AIDS in prisons in Central and Eastern Europe and the former Soviet Union

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Essential resources

There is a vast amount of literature on HIV/AIDS in prisons. This info sheet provides information about a number of selected, essential resources — articles, books, reports and newsletters that provide crucial information or recommendations on HIV/AIDS in prisons.

Bobrik A et al. (2005). Prison health in Russia: the larger picture. *Journal of Public Health Policy*, 26: 30–59.

Caplinskiene I, Caplinskas S, Griskevicius A (2003). Narcotic abuse and HIV infections in prisons [article in **Lithuanian**]. *Medicina (Kaunas)*, 38(8): 797–803.

Dolan K et al. (2004). *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. Available via http://ndarc.med.unsw.edu.au/ndarc.nsf/website/Research.current.cp47publications.
Provides the results of a survey undertaken on behalf of the UN Reference Group.

Frost L, Tchertkov V (2002). Prisoner risk taking in the Russian Federation. *AIDS Eduction and Prevention*, 14 (Suppl B): 7–23.

Irish Penal Reform Trust (2004). Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia: Prison Health is Public Health. Available in many languages, including **Russian,** via www.iprt.ie.

Kerr T, Jürgens R (2004). *Syringe exchange programs in prisons: reviewing the evidence.* Canadian HIV/AIDS Legal Network. A 10-page review of the evidence. Available in English, French, and **Russian** via www.aidslaw.ca/Maincontent/issues/prisons.htm.

Kerr T, Jürgens R (2004). *Methadone maintenance therapy in prisons: reviewing the evidence.* Canadian HIV/AIDS Legal Network. Available in English, French, and Russian via www.aidslaw.ca/Maincontent/issues/prisons.htm.
A 10-page summary of the evidence.

Lines R (2002). *Pros & cons: a guide to creating successful community-based HIV/AIDS programs for prisoners.* Prisoners HIV/AIDS Support Action Network (PASAN). A comprehensive resource on developing HIV/AIDS prevention and support services for prisoners. Available at www.pasan.org.

Lines R et al. (2004). *Prison needle exchange: a review of international evidence and experience.* Canadian HIV/AIDS Legal Network. The most comprehensive and detailed report available on the international experience of prison syringe exchange. Available in English, French, and **Russian** via www.aidslaw.ca/Maincontent/issues/prisons.htm.

MacDonald M (2005). A study of the health care provision, existing drug services and strategies operating in prisons in ten countries from Central and Eastern Europe. Helsinki: HEUNI. Available in English and Russian via www.heuni.fi/12542.htm.

Ministerio Del Interior/Ministerio De Sanidad y Consumo (2003). *Needle exchange in prison. Framework program.* Detailed plan and guidelines used for the implementation of needle exchange programs in Spanish prisons. Essential for anyone wishing to see how a successful needle exchange program can be established in a prison. Available in Spanish, English, and French.

Office of the United Nations High Commissioner for Human Rights and UNAIDS (1998). *HIV/AIDS and human rights: international guidelines.* HR/PUB/98/1. Contains an important recommendation regarding HIV/AIDS in prisons — recommendation 29(e). Available in many languages, including **Russian,** via www.unaids.org.

Stover H, Hennebel L, Casselman J (2004). Substitution treatment in European prisons. A study of policies and practices of substitution treatment in prison in 18 European countries. London: Cranstoun Drug Services Publishing. Available via www.endipp.net.

UNAIDS (1996). *United Nations Commission on Human Rights (Fifty-second Session, item 8 of the agenda). HIV/AIDS in prisons — statement by the Joint United Nations Programme on HIV/AIDS (UNAIDS).* This statement by UNAIDS to the Commission on Human Rights argues that the treatment of prisoners in many countries constitutes a violation of the prisoners' human rights. UNAIDS urges all governments to use the World Health Organization's guidelines on HIV/AIDS in prisons (see infra) in formulating their prison policies and offers assistance to any government wishing to implement the guidelines. Available via www.unaids.org.

UNAIDS (1997). *Prisons and AIDS: UNAIDS point of view*; and UNAIDS (1997). *Prisons and AIDS: UNAIDS technical update.* An extremely useful pair of documents on HIV/AIDS and drug use in prisons around the world, with basic information about the issues, challenges, responses, resources, and UNAIDS' point of view. A good summary of issues related to HIV/AIDS and drug use in prisons. Available in English, French, and **Russian** via www.unaids.org.

Wolfe D (2005). *Pointing the way: harm reduction in Kyrgyz Republik.* Bishkek: Harm Reduction Association of Kyrgyzstan "Partners' network." Available in English and **Russian** via http://www.soros.org/initiatives/ihrd.
Describes how needle and syringe programs were introduced in prisons in Kyrgyzstan.

World Health Organization (Europe), Prison Reform International, Medecins Sans Frontières (2001). *HIV in prison. a manual for the newly independent states.* (Russian edition, 2003). Available via http://www.afew.org/english/publications/prison.php in English and **Russian.** A comprehensive manual with chapters on risk behaviours, prevention, and care and treatment.

World Health Organization (Europe) (2003). Moscow Declaration: Prison Health as part of Public Health. Available in English, French, **Russian**, and German via www.euro.who.int/prisons/publications/20050610_1.
Recognizes the need for a close link between public health and the provision of health care to those in prison.

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

World Health Organization (2004). *Evidence for action technical papers: effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among Injecting Drug Users.* Geneva: WHO. Available at www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf.

World Health Organization, UNAIDS and UNODC (2004). *Policy brief: reduction of HIV transmission in prisons.* Available in English and **Russian** via http://www.who.int/hiv/pub/advocacy/idupolicybriefs/en/.
A 2-page summary of the evidence on interventions to prevent the spread of HIV in prisons. Concludes that prison HIV programs should include all the measures against HIV transmission that are carried out in the community outside prisons, including HIV/AIDS education, testing and counselling performed on a voluntary basis, the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment.

World Health Organization (2005). *Evidence for action technical papers. Effectiveness of drug dependence treatment in preventing HIV among injecting drug users.* Available at http://www.who.int/hiv/pub/idu/en/drugdependencefinaldraft.pdf.
Reviews the evidence on substitution treatment and concludes that "policy-makers need

to be clear that the development of drug substitution treatment is a critical component of the HIV prevention strategy among injecting opioid users."

World Health Organization (Europe) (2005). *Status paper on prisons, drugs and harm reduction*. Available in English and **Russian** via http://www.euro.who.int/prisons/publications/20050610_1. Summarizes the evidence on harm reduction, including needle and syringe programs, in prisons.

World Health Organization (1993). *WHO guidelines on HIV infection and AIDS in prisons.* WHO/GPA/DIR/93.3. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html or via www.unaids.org.

Periodicals

Connections
The newsletter of the European Network on Drugs and Infections Prevention in Prison. Available in many languages, including **Russian,** via www.endipp.net.

HIV/AIDS Policy & Law Review
Available in English and French at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm.
Required reading for all those working on, or interested in, HIV/AIDS in prisons. Provides regular updates and feature articles on policies and programs from around the world.

Infectious Diseases in Corrections Report (formerly HEPP Report)
Available via www.idcronline.org. Provides HIV updates designed for practitioners in the correctional setting. Targets correctional administrators and HIV/AIDS care providers, with up-to-the-moment information on HIV treatment, efficient approaches to administering such treatments in the correctional environment, and U.S. and international news related to HIV in prisons. Published monthly.

International Journal of Prisoner Health
Additional information available at www.tandf.co.uk/journals/titles/17449200.asp.
An international journal aiming to act as a forum for the discussion of a wide range of health issues that affect both prisoners and prison staff.

Websites

AIDS Foundation East-West
http://www.afew.org/english/publications/prison.php
Contains a large number of resource materials on HIV/AIDS in prisons in **Russian,** particularly in a series of four "readers" with "basic articles on health promotion issues in the penal system."

Canadian HIV/AIDS Legal Network
www.aidslaw.ca
Contains many reports and articles on HIV/AIDS in prisons, including materials in **Russian**, in a special section at www.aidslaw.ca/Maincontent/issues/prisons.htm.

European Network on Drugs and Infections Prevention in Prison
www.endipp.net
Contains a number of publications and news items on issues related to drugs and infections prevention in prisons in Europe. Some of these are available in **Russian.**

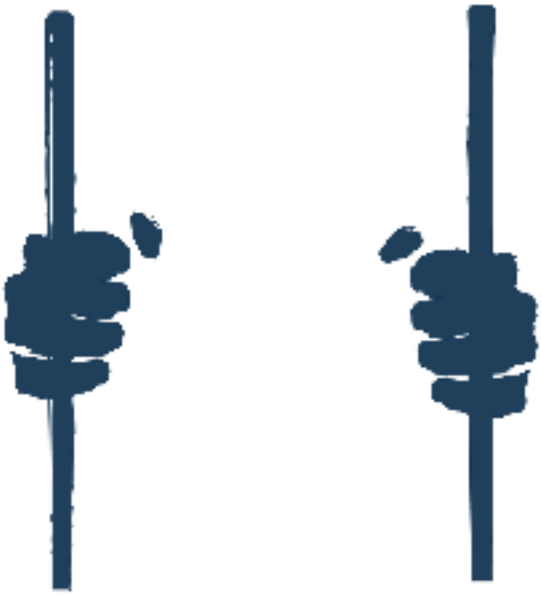
Human Rights Watch
http://hrw.org
See, in particular, the sections on "Prison conditions and the treatment of prisoners" and the "HIV/AIDS" section. Some documents available in **Russian.**

International Centre for Prison Studies
www.kcl.ac.uk/icps
This website has a section in **Russian**.

Irish Penal Reform Trust
www.iprt.ie
Contains a large number of resources on prisons and prisoners' rights, including HIV/AIDS-related issues, as well as a good list of links to websites of other organizations.

Penal Reform International
www.penalreform.org
Contains a lot of information, including in **Russian,** about prison reform activities relevant to HIV/AIDS, as well as some specific documents on HIV/AIDS, such as a report on HIV/AIDS in prisons in Malawi.

World Health Organization Regional Office for Europe
www.euro.who.int/prisons
The section of the website devoted to the "Health in Prisons Project" contains information about the project, as well as many publications, some of which are available in **Russian.**



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