HIV/AIDS in Prisons: Final Report

by Ralf Jürgens
Project on Legal and Ethical Issues Raised by HIV/AIDS

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It is our hope that this Report will be a useful resource and advocacy tool for people and organizations working on or interested in issues raised by HIV/AIDS and by drug use in prisons, in the United States and internationally.

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The views expressed in this document are those of its author and do not necessarily reflect the views or the policies of the Department of Health or the Correctional Service of Canada.

(Ce document est également disponible en français)

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SUMMARY

A prisoner retains all civil rights which are not taken away expressly or by necessary implication.(1)

A sentence of imprisonment should not carry with it a sentence of AIDS.(2)

Background

Issues raised by HIV/AIDS in prisons have been extensively studied in Canada, in particular by the Expert Committee on AIDS and Prisons (ECAP) and the Prisoners with HIV/AIDS Support Action Network (PASAN). Nevertheless, individuals and organizations consulted during Phase I of the Project on Legal and Ethical Issues Raised by HIV/AIDS, undertaken jointly by the Canadian HIV/AIDS Legal Network (Network) and the Canadian AIDS Society (CAS), indicated that issues raised by HIV/AIDS in prisons remain a priority in Canada. In particular, they expressed concern about the reluctance of the Correctional Service of Canada (CSC) to implement some of ECAP's major recommendations, such as the recommendation to undertake a pilot study of needle distribution in at least one prison.

They suggested that the Joint Network/CAS Project examine whether governments and the prison systems have a legal obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV; and address the issue of the potential liability for not providing condoms, bleach, and sterile needles and the resulting transmission of HIV in prisons.

Activities Undertaken

Work started in August 1995. Since then, the Project Coordinator has, among other things:

- undertaken extensive research on legal and ethical issues raised by HIV/AIDS in prisons;
- participated in national and international meetings on HIV/AIDS in prisons; and
- visited one of the prisons in Switzerland in which sterile needles and syringes are made available to prisoners.

As part of his work, he prepared HIV/AIDS in Prisons: A Discussion Paper. More than 500 copies of the

Paper have been distributed in Canada and internationally, and over 70 responses have been received from prisoners, staff, physicians, lawyers, ministries of health and of corrections, and national and international organizations. The vast majority of respondents supported the conclusions and recommendations in the Discussion Paper and agreed that more needs to be done in prisons to prevent the spread of HIV among inmates and to staff and the public, and to care for HIV-positive inmates.

The Final Report

The Final Report and its appendices

- review the history of the response to HIV/AIDS in prisons, nationally and internationally;
- present relevant new developments in the area;
- examine whether there is a legal and/or ethical obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV;
- address the issue of the potential liability for not providing condoms, bleach, and sterile needles and the resulting transmission of HIV in prisons; and
- make recommendations for action.

The Goal of the Project

The goal of the Project is to assist CSC and provincial prison systems in their efforts to reduce HIV transmission in prisons and to staff and the public: the Discussion Paper and Final Report will help them to respond to some of the challenges that arise out of new developments that have occurred since the release of ECAP's recommendations. Prison systems will be asked to respond to the Report.

New Developments

The Discussion Paper reviewed the following new developments that had arisen since the release of ECAP's Final Report:

- a 40 percent increase in the number of known cases of HIV/AIDS in federal correctional institutions over a period of only 16 months (from April 1994 to August 1995);
- an increase in the number of prisoners living with symptomatic HIV infection or AIDS in prisons, requiring more extensive and costly medical care;
- increasing evidence of high-risk behaviours in prisons;
- increasing evidence that, as a result of such behaviours, HIV is being transmitted in prisons;
- very high hepatitis C seroprevalence rates in prisons, as evidenced by three Canadian studies that revealed rates of between 28 and 40 percent;

- legal action undertaken by prisoners in two Australian states against their prison systems for failing to provide measures to prevent the spread of HIV;
- reports on HIV/AIDS in prisons issued in other countries, reinforcing the consensus that more needs to be done to prevent the spread of HIV in prisons and to care for prisoners living with HIV/AIDS;
- a pilot project providing for needle distribution in a prison in Switzerland, demonstrating that sterile needles can be distributed in prisons safely and with the support of inmates, staff, prison administrations, politicians, and the public.

The Final Report provides an update on these developments and discusses the following developments that have occurred since the release of the Discussion Paper:

- a further, although slight, increase in the number of known cases of HIV/AIDS in federal correctional institutions;
- progress and delays in the implementation of some of the harm-reduction measures promised by CSC;
- the release of the report of the Commission of Inquiry into Certain Events at the Prison for Women in Kingston, highlighting systemic shortcomings within CSC, the absence of a culture respectful of individual rights, and an unwillingness to be responsive to outside criticism and to engage in honest self-criticism - issues and problems that also affect CSC's response (or lack of response) to HIV;
- the release of the results of a CSC survey of 4,285 inmates, confirming that a high proportion of inmates engage in high-risk behaviours;
- legal action undertaken by a prisoner in British Columbia against the provincial prison system for failing to provide her with methadone; and
- an increase in the number of prisons and prison systems in which sterile needles and syringes are made available to prisoners, and the release of a study demonstrating the positive effects of making them available.

Recommendations for Action

CSC and, often to a lesser extent, provincial prison systems are responding to the issues raised by HIV/AIDS and other infectious diseases in prisons, but they are responding slowly.
In the federal system, some positive initiatives are being undertaken or planned - such as bleach distribution, introduction of non-nominal and anonymous HIV testing, and a pilot inmate peer education

project in one prison in New Brunswick - but not enough is being done to prevent the spread of HIV and other infectious diseases, in particular hepatitis C. Instead of implementing a longer-term strategy to deal with the many issues raised by HIV/AIDS and drug use, a piecemeal approach is being taken, demonstrating a clear lack of coordination, commitment, inspiration, and vision. As a result, CSC is falling further and further behind in the fulfillment of commitments made in its official response to ECAP's Final Report, and is sometimes clearly breaching those commitments.

With few exceptions, most notably British Columbia, provincial systems are also reluctant to face the reality of HIV and of drug use in prisons, and sometimes do not provide even the most basic preventive means that would allow prisoners to protect themselves from contracting HIV.
In order to prevent the further spread of HIV in prisons and to provide better care, support and treatment for HIV-positive inmates, the Final Report urges Canadian federal and provincial prison systems to:

- adopt a long-term, coordinated, strategic approach to HIV/AIDS and drug use in prisons;
- coordinate their efforts and collaborate more closely in the fight against HIV/AIDS in prisons;
- involve prisoners and staff in the development of all initiatives taken to reduce the spread of HIV;
- adopt a more pragmatic approach to drug use, acknowledging that the idea of a drug-free prison is no more realistic than the idea of a drug-free society and that, because of HIV/AIDS, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy: reduction of drug use is an important goal, but reduction of the spread of HIV and other infections is more important;
- acknowledge that making bleach, sterile needles, and methadone programs available to inmates does not mean condoning drug use, but is a necessary and pragmatic public health measure;
- educate the Canadian public and decision-makers about the importance of implementing harm-reduction measures in prisons; and, most importantly,
- act without further delay to protect prisoners, staff, and the public: the recommendations made in the Discussion Paper, by ECAP, the Prisoners with HIV/AIDS Support Action Network, the World Health Organization, and many other national and international organizations need to be implemented to prevent the further spread of HIV among prisoners and to staff and the public.

The Moral and Legal Responsibility of Prison Systems

Clearly, prison systems have a moral, but also a legal, responsibility to act without further delay to prevent the spread of infectious diseases among inmates and to staff and the public, and to care for inmates living with HIV and other infections. Canadian prison systems are failing to meet this responsibility, because they are clearly not doing all they could: measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment and methadone maintenance available to injection drug users, are not being undertaken in Canadian prisons, although other prison systems have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrations, politicians, and the public.

In 1989, a Canadian court held that detention centres in Toronto were failing to come to grips with the detention of people with HIV/AIDS by not providing adequate treatment and by not educating staff

about HIV/AIDS. Since then, conditions in Canadian prisons have improved markedly with respect to the treatment of prisoners with HIV/AIDS. Nevertheless, the case is important: it shows that Canadian courts are willing to closely scrutinize the action or inaction of prison authorities in the area of HIV/AIDS. If courts are willing to hold that not providing those already infected with adequate care constitutes a violation of their constitutional rights, they may be willing to hold that denying incarcerated people the opportunity to prevent infection in the first place is also unconstitutional.

Already, in one Australian state prisoners have initiated legal action in order to force prison authorities to provide them with condoms, arguing that the refusal to provide condoms constitutes negligence on the part of the authorities. The latter, publicly embarrassed by the publicity the case was getting, have since started making condoms available: legal action has provided the catalyst necessary to the institution of long-recommended change. In another Australian state, a prisoner started a legal action in negligence after having contracted HIV while in prison. And in Canada, legal action was undertaken by a prisoner against the British Columbia provincial prison system for failing to provide her with methadone.

Conclusion

It is to be hoped that governments and the prison systems in Canada will act without courts having to set a legal precedent holding them morally and legally responsible for the harm resulting from their refusal to provide adequate preventative means. Prisoners, even though they live behind the walls of a prison, are still part of our communities and deserve the same level of care and protection that people outside prison get: they are sentenced to prison, not to be infected.
We owe it to the prisoners, and we owe it to the community, to protect prisoners from infection in prison. Unless we do so, courts or a commission of enquiry may one day have to explore why not enough was done to prevent HIV infection in prisons, although everyone was aware of the risks and knew the measures that could be taken to reduce them.

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FOOTNOTES

1 Lord Wilberforce in Raymond v Honey [1982] 1 All ER 756 at 759.

2 Note. Sentenced to Prison, Sentenced to AIDS: The Eighth Amendment Right to be Protected from Prison's Second Death Row. Dickinson Law Review 1988; 92: 863-892.

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INTRODUCTION

As part of the Joint Project on Legal and Ethical Issues Raised by HIV/AIDS (see Appendix 4), the Canadian HIV/AIDS Legal Network (Network) and the Canadian AIDS Society (CAS) have undertaken a project on HIV/AIDS in prisons. The project was co-funded by the Correctional Service of Canada, the AIDS Care, Treatment and Support Unit, Health Canada, and the HIV/AIDS Prevention and Community Action Programs, Health Canada, under the National AIDS Strategy, Phase II.

Activities Undertaken

The Project started in August 1995 and has undertaken the following activities:

- organized a plenary and a small group session at the First National Workshop on HIV/AIDS in Prisons held in Kingston on 20 August 1995. At the plenary, two experts presented the results of their research on legal and ethical issues raised by HIV/AIDS in prisons. In particular, they analyzed whether the law can and should be used to force prison systems to provide prisoners with the means that would allow them to protect themselves against contracting HIV (for a summary of these presentations, see appendices 1 and 2). The small group session was dedicated to the discussion of the issues raised by the presenters;
- produced the proceedings and summarized the main results of the Workshop in a special issue of the Canadian HIV/AIDS Policy & Law Newsletter (1995; 2(1));
- undertaken extensive research on legal and ethical issues raised by HIV/AIDS in prisons;
- published numerous articles on HIV/AIDS and prison issues in the Canadian HIV/AIDS Policy & Law Newsletter;
- contributed to the training program on "Hepatitis B and C, Tuberculosis and AIDS: Risks and

Challenges in Prisons" for health services staff working in detention centres under Québec jurisdiction, on 23 November 1995;
- participated in an interdisciplinary symposium on harm-reduction strategies in prisons in Berne, Switzerland, from 28 February to 3 March 1996; and
- visited one of the prisons in Switzerland in which sterile needles and syringes are made available to prisoners.

The Discussion Paper

As part of the Project, the Project Coordinator prepared HIV/AIDS in Prisons: A Discussion Paper.(1) More than 500 copies of the Paper have been distributed in Canada and internationally to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and drug use in prisons an opportunity to provide input into the Final Report.

Responses to the Discussion Paper

Since November 1995, over 70 responses to the Discussion Paper have been received from prisoners, staff, physicians, lawyers, ministries of health and of corrections, and national and international organizations. The vast majority of respondents supported the conclusions and recommendations in the Discussion Paper. As stated by Mr Demers, Assistant Deputy Minister, Ministry of Attorney General of British Columbia, respondents generally agreed that more is needed to be done in both federal and provincial correctional systems to minimize the very real public and individual health consequences resulting from disease transmission during high risk behaviours.

"There is no time to waste. It would be unethical not to immediately implement a fully integrated response to HIV/AIDS in Canadian prisons," wrote Anne Malo in her former capacity as National Coordinator of CSC's AIDS Programs.(2) Dr Christiane Richard, a member of the Expert Committee on AIDS and Prisons and of the Health Care Advisory Committee of CSC, said: "I can't but agree with the conclusions, namely to implement in prisons, as soon as possible, a needle and syringe exchange program, as well as methadone maintenance."(3)

The Inmate Committee of William Head Institution in British Columbia emphasized that "the problems of disease transmission inside of our prisons, is an issue which should concern society in general because it will ultimately affect the community as a whole, and not enough is being done to prevent exposure to HIV and other infections." The Committee continued by saying:

> [B]y the look of some of the homemade syringes around here lately, we're in for a tough year. It certainly does seem ridiculous for Corrections Canada to supply condoms and not syringes. It is our opinion that many more people are in danger of contracting HIV/AIDS through intravenous drug use than through sexual practices.... We view the present policy concerning hypodermic syringes as a blatant disregard for human life, and responsibility should fall squarely on their shoulders.(4)

Not all respondents, however, were supportive of making sterile injection equipment available to inmates. According to Lynn Ray, National President of the Union of Solicitor General Employees,

> [p]eace officers cannot condone, or be seen to condone, what amounts to an illegal activity.... Does the CSC expect Correctional Officers to hand over a clean needle to an inmate knowing that an hour later they may have to extract him from his cell by force due to an overdose?

Ms Ray continued by emphasizing the importance of "a coherent, practical and manageable approach to controlling the influx of drugs into institutions.... The flow of drugs into institutions can, and must, be curtailed. I am perfectly aware that it will be expensive, but the safety and health of staff are at stake."(5)

The Final Report

With only a few exceptions, responses to the Discussion Paper did not warrant a significant departure from the format and content of the Discussion Paper and, in particular, its recommendations. In the Final Report, much of the text of the Discussion Paper has therefore been retained. However, the information has been updated and new material has been incorporated. In particular, the sections on needle exchange and on availability of methadone maintenance treatment in prisons have grown, responding to an often-expressed wish by respondents to the Discussion Paper.

The Report and its appendices:

- review the history of the response to HIV/AIDS in prisons, nationally and internationally;
- review relevant new developments;
- examine whether there is a legal and/or ethical obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV even if they "voluntarily" engage in illegal or forbidden behaviours (drug use and sexual activity);
- address the issue of the potential liability for not providing condoms, bleach, and sterile needles and the resulting transmission of HIV in prisons; and
- make recommendations for action.

Goal of the Project

The goal of the Project is to assist CSC and provincial prison systems in their efforts to reduce HIV transmission in prisons and to staff and the public: the Discussion Paper and Final Report will help them to respond to some of the challenges that arise out of new developments that have occurred since the release of ECAP's recommendations, by proposing solutions that will enable them to increase their prevention efforts and fulfil their legal and ethical obligations toward inmates, staff, and the public. The

Final Report will be widely distributed and the federal and provincial prison systems will be asked to respond to it.(6) Their responses will be published in future issues of the Canadian HIV/AIDS Policy & Law Newsletter, and further activities are planned to ensure that the Report's recommendations will be implemented.

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FOOTNOTES

1 R Jürgens. HIV/AIDS in Prisons: A Discussion Paper. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1995.

2 Response to the Discussion Paper, dated 23 February 1996.

3 Response to the Discussion Paper, dated 20 February 1996.

4 Response to the Discussion Paper by Salisbury and M Smith, dated 10 January 1996.

5 Response to the Discussion Paper, dated 18 January 1996.

6 The process used is similar to that of the Expert Committee on AIDS and Prisons (ECAP). The Project Coordinator of the Joint CAS/Network Project was also Project Coordinator of ECAP and prepared both the Working Paper and the Final Report for the Committee.

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RESPONDING TO HIV/AIDS IN PRISONS: HISTORY

The Expert Committee on AIDS and Prisons

In Canada, the National Advisory Committee on AIDS(7) the Royal Society of Canada,(8) the Parliamentary Ad Hoc Committee on AIDS,(9) the Federal/Provincial/Territorial Advisory Committee on AIDS,(10) the Ontario Regional HIV/AIDS Advisory Committee,(11) and the Prisoners with HIV/AIDS Support Action Network (PASAN),(12) have each issued a variety of recommendations aimed at reducing the risk of HIV transmission in Canadian prisons, and at ensuring that care, treatment and support be available for prisoners living with HIV/AIDS. Internationally, similar recommendations have been made, most notably by the World Health Organization.(13)

Perhaps the most comprehensive analysis of the issues raised by HIV/AIDS in prisons has been undertaken by the [Canadian] Expert Committee on AIDS and Prisons (ECAP). The Committee was created on 15 June 1992 to assist the federal government in promoting and protecting the health of inmates and of staff, and preventing the transmission of HIV and other infectious agents in federal correctional institutions.

During its 18 months of existence, ECAP visited federal correctional institutions in British Columbia, Ontario, and Québec; interviewed prison authorities, staff and inmates about issues raised by HIV/AIDS and drug use in the prison environment; reviewed Canadian and international policies and reports relating to HIV/AIDS and drug use in prisons; received submissions from Canadian and international bodies, groups and individuals; sent questionnaires to prison staff and to prisoners to obtain information regarding their concerns about HIV/AIDS and drug use in prisons; and released a Working Paper containing the Committee's preliminary conclusions in July 1993.(14) More than 1000 copies of this Working Paper were distributed in Canada and internationally to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and drug use in prisons an opportunity to review the Committee's work and proposals. In March of 1994, the Committee's Final Report was released.(15)

The Committee's Final Report and Recommendations

In its Final Report, the Committee examines the full range of medical, educational, institutional, legal, and social concerns raised by HIV/AIDS and by drug use in federal correctional facilities in Canada. The Report further provides a review of the federal and provincial prison policies relating to HIV/AIDS of Canada and 14 selected countries, and of the policies issued by international organizations.

The Report takes a strong public health approach to the problem of HIV infection in prison, and a harm-reduction approach to the problem of drug use. It contains 88 recommendations designed to protect the health of inmates and staff, and relating to:

- the incidence of, and testing for, HIV infection;
- confidentiality of offender medical information;
- housing and activities of HIV-positive prisoners;
- educational programs for inmates and for staff;
- consensual and non-consensual sexual activities;

- drug use, tattooing, and piercing;
- protective measures for staff;
- health care;
- tuberculosis;
- compassionate release;
- aftercare;
- female offenders; and
- aboriginal offenders.

The Committee's recommendations are consistent with the recommendations issued by the other national and international organizations and, in particular, with the World Health Organization's 1993 Guidelines on HIV Infection and AIDS in Prisons. (16) Among the recommendations are that:

- anonymous testing for HIV be made accessible to inmates;
- in general, an inmate's personal medical information remain confidential between medical personnel and the inmate;
- existing educational programs for inmates and for staff be improved by including more input from external, community-based organizations or experts, and from peers;
- condoms, dental dams and water-based lubricant be easily and discreetly accessible to inmates;
- protective measures for staff be improved;
- the care of inmates with HIV infection or AIDS be comparable to that
- available in the community;
- inmates with progressive life-threatening diseases, including AIDS, regularly be released earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety;
- full-strength household bleach be made available to inmates;
- injection drug users have access to methadone.

The Committee further concluded that making sterile injection equipment available in prisons "will be inevitable," particularly because of serious doubts that have arisen in relation to the efficacy of bleach in destroying HIV.(17) ECAP was concerned that, in prisons, the scarcity of drug-injection equipment almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment, and pointed out that only access to sterile equipment would ensure that inmates would not have to share their equipment. However, the Committee was also aware that making needles and syringes available in prisons raises many contentious and potentially divisive issues:
First, because needles and syringes have not been made available in any prison system, data on the efficacy, benefits, risks, harms and cost-effectiveness of making them available are lacking. For example, it is not clear whether the model developed for needle exchange outside prisons could be adapted to prisons. Whereas the impact of needle distribution or exchange on levels of injection drug use outside prisons appears to be negligible, its impact in prisons is unknown. Second, there is concern for the safety and security of fellow prisoners and staff. It is feared that needles could be used as weapons, although there is no inherent reason to believe that the needles that would be made available would be more dangerous than those already present in penitentiaries. Third, providing sterile needles in prisons is often rejected because it would appear that, in an environment designed to uphold the law, to encourage or condone illegal drug use would be a contradiction in terms.(18)

ECAP concluded that, while making it available would be inevitable, sterile injection equipment could not be made available immediately. Therefore, ECAP recommended that research be undertaken "to identify ways and develop measures, including access to clean injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use." It further recommended that this research include one or more scientifically valid pilot projects, and that it be accompanied by planning, communication and education "that will expedite making sterile injection equipment available in the institutions."(19)

CSC's Response to ECAP's Report

Promises Made

The CSC accepted many of the recommendations made by ECAP, acknowledging that AIDS represents "a serious public health problem for all of society and that there are particular concerns about inmates in federal penitentiaries." The Commissioner of the Correctional Service added that, "[g]iven that over 80 per cent of inmates are serving fixed sentences and will eventually be returned to the community, the Correctional Service is particularly sensitive to its responsibility to protect the public, including staff and inmates, from the consequences of HIV/AIDS transmission." He concluded by saying that CSC has "a responsibility to do all we can to prevent the spread of this fatal disease."(20)

In its official response to the Report,(21) the Service announced, among other things, that it

- accepted ECAP's recommendation to reaffirm and strengthen its policy of maintaining the confidentiality of inmates who have HIV infection or AIDS;
- agreed to build on and improve educational programs on HIV/AIDS and drug use for staff and inmates, and design special programs for female and aboriginal inmates;
- agreed that condoms, dental dams and water-based lubricant be more easily and discreetly available to inmates through a variety of distribution channels throughout institutions;
- agreed to permit inmates to engage professional tattooing services at their own expense;
- agreed with ECAP's recommendations relating to health care, and would
- provide inmates with health care and treatment comparable to that in the community, including (1) maintaining strong links with external health-care services; (2) facilitating inmates' access to specialized or experimental treatments, including possible transfer where security permits; and (3) assessing health-care services for HIV/AIDS in each institution; and
- agreed with ECAP's recommendation of regularly recommending to the National Parole Board the release of inmates with progressive, life-threatening diseases, including AIDS, earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety.

At the time, ECAP's recommendations that (1) bleach be made available to inmates, and (2) access to testing for HIV in prisons be increased by introducing non-nominal and anonymous testing were rejected. CSC agreed only to pilot-test anonymous HIV testing and a bleach-distribution program in one institution. However, in the spring of 1995 this decision was reversed and the Commissioner of the Correctional Service, with approval from the Solicitor General, instructed CSC to initiate the implementation of anonymous HIV testing and bleach distribution in all institutions.

The following is a description of the main initiatives that have been undertaken or are being prepared in response to ECAP's Report:

- distribution of bleach;
- increased access to HIV testing;
- an inmate peer health-promotion project; and
- revisions to Commissioner's Directive 821: Infectious Diseases.

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Promises Kept?

Distribution of Bleach

Background

In its Report, ECAP recommended that:

- Full-strength household bleach be made available to inmates in federal
- correctional institutions as a general disinfectant. ECAP suggested that small quantities of bleach and instructions on how to clean needles most effectively be included in a "health kit" given to every inmate on entry into the institution and offered to every inmate on exit from the institution, and that bleach be made available to inmates in a manner similar to that for condoms, dental dams and lubricant; that is, small quantities of bleach should be easily and discreetly accessible.
- In making bleach available in correctional institutions, CSC's policies be revised as follows: until bleach is made available, and thereafter, possession of small quantities of bleach should not be classified as an institutional offence, nor should it be considered to be presumptive evidence of illicit drug use.
- The impact of making bleach available in federal correctional institutions be carefully evaluated, with participation of experts independent of CSC.
- In order to re-emphasize CSC's strong commitment to reducing drug use in federal correctional institutions, making bleach available be accompanied by a clear warning to inmates that possession or use of illicit drugs will not be tolerated in correctional institutions.(22)

ECAP reported that bleach is made available to inmates in many prison systems: 16 of 52 systems surveyed around the world late in 1991 made bleach available to prisoners, often accompanied by instructions on how to clean needles.(23) For example, in Spain a bottle of bleach is included in the sanitary kit that inmates receive at entry into the prison system and monthly thereafter, "and more is provided whenever needed." In Switzerland, "first-aid kits" containing small bottles of bleach have been given to inmates since June 1991. Bleach is also available in some prison systems in Germany, France and Australia, in prisons in Belgium, Luxembourg and the Netherlands, and in some African and at least one Central American prison system. (24) In some prisons systems, bleach has always been available as a general cleaning agent and prison authorities have tolerated that it also be used for the purpose of cleaning injection equipment. In others, it has been made available specifically for the purpose of cleaning injection equipment, and various ways have been devised to make it available.

There are no reported incidents of any negative consequences of making bleach available. This is consistent with the Canadian experience. Bleach had been available in Canadian institutions for a long time without any suggestion of it being a threat to institutional security, until it became associated with the sterilization of injection equipment. Further, in some institutions it is still informally available, and there is no evidence that this has created any problems.

ECAP felt that making bleach available in prisons is "mandated by the fact that, because prisoners have reduced possibilities of protecting their health, and because this results from state action, the state has special responsibility for their health." It further emphasized that "[m]aking bleach available in no way condones drug use, but rather emphasizes that in correctional facilities as elsewhere, the overriding concern in any effort to deal with drug use needs to be the health of the persons involved and of the community as a whole."(25)

The Pilot Project

A pilot project for distribution of bleach started in December 1994 at Matsqui Institution. Its purpose, as stated in the 1994-1995 Annual Report of CSC's National AIDS Program, was to:
- provide CSC with a model of how best to distribute bleach (strength, amount, filtering and packaging);
- track participation and the use bleach is put to;
- measure the impact on needle-cleaning behaviour; and
- document security problems.

Activities Undertaken

A working group including Trudi Nichol, the Project Coordinator,

- developed a communication strategy for all institutional staff that included a one-day information fair in the institution to ensure their support for the pilot;
- devised a way to distribute bleach to inmates easily and discreetly;

- prepared, with support from the British Columbia Centre for Excellence in HIV/AIDS, a questionnaire to track inmate participation, use, and impact on needle-cleaning behaviour;
- distributed the questionnaire twice, at the beginning and end of the project;
- prepared a video for inmates, explaining the project and how to properly clean needles;
- started bleach distribution on 5 June 1995; and
- evaluated the project and made recommendations about how to best continue bleach distribution.

Inmate Questionnaire Data: Project Beginning

Although the survey results cannot be generalized to all inmates at Matsqui Institution because only 182 of 423 inmates (43 percent) responded to the questionnaire distributed at the beginning of the project, the data were nevertheless significant in many ways: they provided evidence of both the necessity of easy access to bleach for prisoners, as well as the support for such a program from prisoners, particularly those most at risk of contracting HIV:

- 54 percent of respondents admitted having received tattoos in prison.
- 21 percent had had piercing done while in prison.
- 71 percent reported having used IV drugs. Of these:
- 12 percent reported drug use only in prison;
- 20 percent only on the street; and
- 68 percent reported having used drugs both inside and outside prison.
- 89 percent admitted having shared a needle at least once:
- 19 percent reporting having shared on the street;
- 23 percent in prison; and
- 47 percent both in prison and outside.

Most respondents reported having cleaned their equipment before sharing it, whether they shared it inside or outside prison. Support for the bleach distribution program among inmates was overwhelming: 99 percent of respondents felt that having bleach available to inmates is "very
important," with only one inmate saying it is "not important at all." Equally significant is that the vast majority of respondents said that they would use bleach if it was given to them in prison. Of injection drug users responding to the survey, only one responded that he would not use the bleach.(26)

Inmate Questionnaire Data: Project End

Results of the first questionnaire were confirmed by a second questionnaire distributed to 350 inmates in January 1996 (however, as with the first survey, results cannot be generalized to all inmates because only 126 inmates (35 percent) responded):(27)

- 67 percent reported ever having used IV drugs:
- 17 percent reported drug use only in prison;
- 2.5 percent only on the street;
- 44.5 percent both inside and outside prison;
- 3 percent reported having quit using.
- 63 percent had received a tattoo or piercing while in prison.
- 71 percent of respondents reported having participated in the bleach pilot project by obtaining their own bleach kits:
- 37 percent used bleach mostly to clean syringes;
- 18 percent to clean syringes and tattoo/piercing equipment;
- 14 percent for laundry and other cleaning and disinfecting purposes only;
- 14 percent had never obtained any bleach at all; and
- the remaining had used bleach for other purposes or never used it, but given it to someone else.

Other important results of the survey include:

- 94 percent of all respondents (and 99 percent of those reporting IV drug use) expressed the view that all federal prisons should have a needle exchange;
- a majority of those who had not been tested for antibodies to HIV said that they would have a test if it was completely anonymous;
- only 6 percent said that they thought that enough is being done to stop the spread of HIV in federal prisons;
- 70 percent said that they thought that more education needed to be done for inmates, and 65 percent said that more needed to be done for staff; and
- only 2 percent thought that the bleach pilot project had not been a success.

To the question: "In your opinion, how many inmates in this institution use IV drugs on a regular basis?",

- 2 percent responded 90 percent or more;
- 8 percent responded 80 to 90 percent;
- 20 percent responded 70 to 80 percent;
- 17 percent responded 50 to 70 percent;
- 16 percent responded 30 to 50 percent;
- 2 percent responded less than 30 percent;
- 30 percent responded don't know; and
- 5 percent gave no response.

Of those reporting IV drug use,

- 84 percent reported always using bleach before and after using syringes or tattoo equipment;
- 93 percent felt they know how to clean their syringe properly;
- 19 percent own their equipment and do not share with others;
- 41 percent own their own equipment and share with others;
- 35 percent do not own equipment and always use other people's equipment;
- 6 percent reported using approximately every day while in prison;
- 21 percent 2 to 3 times a week;
- 27 percent once a week;
- 31 percent 1 to 3 times a month; and
- the remaining reported using less frequently;
- 90 percent had been tested for antibodies to HIV (56 percent had been tested in the last six months); of these, 3 percent reported having tested positive;
- 46 percent had been tested for hepatitis C, and 20 percent tested positive;
- 18 percent responded that they had ever shared a needle with someone who has tested positive for HIV; and
- 33 percent responded that they had ever shared a needle with someone who has tested positive for hepatitis C.

Staff Questionnaire

A questionnaire was also handed out to staff, although only before the project started. Of 220 questionnaires, 49 were returned.

Because of the low response rate, the results cannot be generalized to all staff:

- 86 percent of responding staff expressed concern about the spread of HIV in the institution, and 92 percent were concerned about its spread in the community;
- 63 percent felt that making bleach available to inmates as a preventative measure is important; and
- 51 percent did not have any concerns about one-ounce bottles of bleach
- being distributed in the institution.

Some staff opposed distribution of bleach because, in their view, this would mean condoning drug use, or because they were concerned that bleach could be used as a weapon. Surprisingly, many staff thought that it was a waste of time to study how bleach could best be handed out to inmates and that, instead, a needle-exchange program should be made available to inmates. (28) Some staff said that they "felt less threatened by a needle exchange than by giving inmates bleach and others were just the opposite."(29) Generally, the difference in the staff's attitude between the beginning of the project and its end was "very noticeable."

Conclusion

The Project Coordinator concluded her report by saying that she believed the project had been an overwhelming success, that staff and management at the institution had been very supportive, and that she was hoping that other institutions would be as successful as they were.(30)

National Implementation of Bleach Kit Distribution

As a result of the decision to initiate the implementation of bleach distribution and anonymous HIV testing in all institutions, a National Bleach Distribution and Anonymous HIV Testing Working Group was established even before the results of the bleach pilot project became available. Its mandate is to establish successful bleach distribution and anonymous HIV testing programs, and to develop national guidelines that will ensure equal implementation of both programs across Canada.

On 21 June 1995, the former Commissioner of CSC, Mr John Edwards, attended the Group's meeting to express his "full support" for the work of the Group. He pointed out that the reported cases of HIV/AIDS in Canadian federal prisons have been rising steadily, and emphasized that offenders are human beings and deserve to be protected. "We do believe in respecting offenders' needs," he stated, and added that there "is no doubt in my mind that we have a duty to protect offenders, staff and the public." The former Commissioner pointed out that CSC has a public health responsibility to the communities to which offenders return: "Whatever concerns we have [about making bleach available to inmates] are superseded by public health concerns." He continued by emphasizing that making bleach available is not in conflict with CSC's Drug Strategy. "We need to do both well," he concluded, "protect the health of inmates, staff, and the public, as well as continue CSC's efforts to reduce drug use in prisons."

At the time of writing, although bleach kit distribution had not started in other institutions, the design of a national bleach kit distribution program had been completed and actual implementation of bleach kit distribution was expected to start soon. A completion date of end of September 1996 has been set by the Commissioner of CSC for national implementation at all sites. Reports on the progress of implementation by region will be provided to the Commissioner on a monthly basis.(31)

As stated by CSC, developing an implementation framework for bleach kit distribution "has proven to be a complex and challenging task as we had to devise a mechanism to work closely with regional staff, guarantee uniformity in our approach as well as accountability for the implementation of the initiative in each institution."(32) In Phase I, a safe, practical and effective method of distributing bleach kits to inmates in all institutions according to national guidelines was devised.

Members of the National Working Group have addressed:

- the health aspects of the program (the choice of instructions on how to use bleach, first aid for staff and inmates, the composition of the kit, and the promotion of a harm-reduction philosophy); and
- the logistical aspects (securing all the necessary equipment and supplies, finding the best way to filter and decant the bleach and the best way of distributing it to inmates and of handling refills; devising a communications strategy for staff and inmates and developing a bleach kit distribution education package).

In Phase II, after consultation with the unions, the education package served as the basis for a regionally delivered training course, by members of the National Working Group, to a coordinator chosen from each institution. Once trained, the coordinators are responsible for implementing the program in their respective institutions in conformity with national guidelines.

Increasing Access to HIV Testing and Protecting Confidentiality

Background
In its Report, ECAP recommended that:

- testing be readily accessible to all inmates in federal correctional institutions at their own request; that it always be voluntary and accompanied by counselling and education before and following testing;
- that all inmates have access to HIV testing from CSC health-care personnel as well as from primary-care or community clinic personnel who are independent of CSC; and, finally,
- that all inmates have access to anonymous HIV testing.(33)

ECAP felt that making non-nominal and anonymous testing available to inmates would be important because many inmates do not seek testing in prison for fear that their test results will immediately become known to everyone in the institution.(34)

The Work of the National Working Group
At the first meeting of the National Bleach Distribution and Anonymous HIV Testing Working Group, a model for anonymous testing in the prison setting was presented to the Group by Alison McConnell, who has been carrying out an anonymous HIV testing program in a provincial prison in Saskatchewan for some years. The Group recognized the importance of offering anonymous testing to prisoners, but identified a number of issues that needed further discussion and analysis, such as the costs of such a program and the feasibility of undertaking anonymous testing in institutions located in provinces where such testing is not available outside prison. In particular, the Group felt that making anonymous testing available should be accompanied by efforts to increase the quality and accessibility of testing and counselling undertaken by prison medical staff. It agreed that the introduction of anonymous testing cannot be separated from:

- steps to improve HIV testing as it is currently offered; and
- steps to introduce non-nominal testing.

It further agreed that the issue of testing cannot be separated from the issue of confidentiality, and that efforts to better protect confidential medical information need to be an absolute priority: prisoners need to feel that they themselves will be able to decide when to disclose the information about their serostatus to others. In the Group's view, the best incentive for inmates to come forward for testing and to disclose their serostatus is availability of care, treatment and support. Obviously, prisoners who feel that they will not be stigmatized and discriminated against, and will have access to care, treatment and support should they test positive, will much more likely want to find out their HIV status. Therefore, the Group emphasized the need to actively discourage discrimination against prisoners living with HIV/AIDS, and to offer them care, treatment and support equivalent to that available outside.

The Group started working on a plan for action including, among many other things:

- preparation of a brochure on HIV testing and confidentiality for staff,
- addressing issues such as medical confidentiality and its importance, the absence of a "need to know" prisoners' HIV status, and the risk or absence of risk of transmission of HIV;
- training for health-care staff: according to the Group, all health-care staff need to receive training about HIV/AIDS, the different testing options, pre- and post-test counselling, and confidentiality; community groups and persons living with HIV should be delivering part of the training;
- training for all new CSC employees: according to the Group, training about HIV/AIDS needs to become part of core training of all new CSC employees, including correctional officers. In particular, they need to learn about how to deal with prisoners living with HIV/AIDS and to respect their rights and dignity; the absence of risk of HIV transmission from most contact with inmates; and the need to respect medical confidentiality;
- identification of problems in each institution: in every institution, health-care staff should meet to discuss and review how medical information is handled. The goal would be to identify what barriers exist to protecting medical information, document them, and identify possible solutions for overcoming them;
- development of model procedures for the protection of medical records against disclosure, and setting up a strict enforcement scheme;

- development of standard procedures for escorts, establishing clear guidelines indicating whether and, if yes, in which cases, medical information is to be disclosed to escorts.

Barriers

However, the Group had its last telephone conference in the early fall of 1995, and work on this initiative has since been suspended. While it is expected that work will resume late in 1996 or early in 1997, the success of the initiative is threatened by the confusion existing within CSC as to whether and, if yes, in which cases disclosure of an inmate's HIV status is justified. As evidenced in a legal opinion of 30 January 1996 prepared by CSC Legal Services,(35(and in a letter by Jacques Roy, former Chief of Health Services, CSC, the Correctional Service is taking the view that "health information about offenders is CSC property and that it is up to CSC to decide the appropriate use that shall be made of it."(36) It is suggested that "all health professionals in the employ of or under contract to CSC have a duty to disclose any health information they are aware of and/ or which is in their possession, where that information is relevant to release decision-making or where there is reason to believe the offender presents a serious or immediate threat to their own safety or to that of any other person."(37)

Comment

Disclosure of an offender's HIV status is justified in some exceptional cases, but
allowing for disclosure in other cases would be contrary to Canadian law, to CSC's response to ECAP's Final Report, and to the advice of the Working Group. In particular, such disclosure would be counterproductive because it would deter inmates from seeking voluntary testing for HIV, or from disclosing information about their HIV status to medical services or anyone else in the institution. While emphasizing the importance of offering anonymous testing to inmates, it would seriously undermine efforts to increase the quality and accessibility of testing and counselling undertaken by prison medical staff.

An Inmate Peer Health-Promotion Project

Background

In its report, ECAP stressed the importance of educating prisoners about HIV/AIDS and recommended that:

- all inmates receive written information about HIV/AIDS;
- as part of the reception program, every inmate be offered educational sessions about HIV/AIDS;
- educational sessions about HIV/AIDS be available to inmates on a regular basis;
- participation in educational sessions about HIV/AIDS at entry into the prison system be mandatory for all inmates, and participation in subsequent educational sessions be voluntary but strongly encouraged;
- education take into account and respond to the needs of prisoners with disabilities, from different cultural and linguistic backgrounds, and with different levels of literacy.(38)

The Committee emphasized that peer education and educational sessions delivered by external organizations would be better received than education by CSC staff, and added: "Although development of good in-house educational programs is essential, any such program should be supplemented by input from external groups and peer-led educational efforts, and should be developed in conjunction with external groups and input from prisoners and staff."(39) Therefore, the Committee further recommended that:

- external, community-based AIDS, health or prisoner organizations be encouraged and funded to deliver or supplement educational sessions about HIV/AIDS;
- inmates be encouraged to develop and assisted in delivering their own peer education, counselling and support programs; and
- in each institution, CSC create or designate one or more inmate job positions as peer health counsellors, and provide for appropriate training, support and evaluation.(40)

In its response to ECAP's Report, CSC agreed to "build on and improve educational programs already in place" by emphasizing HIV/AIDS education on entry and on a regular basis during incarceration; and encouraging and supporting community based AIDS, health or prisoner groups to provide education sessions.(41) CSC further agreed to pilot-test a

program of paid inmate peer health promotion.

The Inmate Peer Health-Promotion Pilot Project

AIDS New Brunswick (AIDS NB), a community-based HIV/AIDS prevention and support group that had already undertaken education and support work at Dorchester Penitentiary, submitted a proposal for the pilot project. The proposal was approved for funding, and work started in February 1995.

As stated by Caroline Ploem, Coordinator of the 15-month "CAN" Project (Cons AIDS Network Peer Education Project), the Project was aimed at "developing, implementing and evaluating a sustainable peer-education and support model in which inmates provide their fellow inmates with the necessary information, motivation and skills to prevent HIV and other communicable diseases and provide support to those living with HIV/AIDS."(42) The Project was the first of its kind to be pilot-tested in Canada, and may be adapted for use in prisons throughout the country.

It involved developing and implementing an AIDS-related training curriculum for inmates interested in becoming peer educators. Twenty-four inmates applied to take part in the training program; eleven fulfilled the recruitment criteria and were accepted as trainees. These inmates participated in a four-week training program that was delivered in an interactive and prisoner-centred format. As stated by Ploem,

[t]he level of interest, enthusiasm and commitment among the group was obvious. Attendance was excellent, and none of the participants dropped out. All inmates successfully completed the extensive and comprehensive month-long training program, implemented over a course of approximately 120 hours.(43)

Following the training, two inmates were hired in paid positions as full-time coordinators of the CAN program, and have received four additional weeks of one-on-one support and training. The coordinators play a supervisory role and are responsible for the coordination, ongoing education and supervision of the other inmates who completed the training program and are now fulfilling their roles as peer educators.

The coordinators, in conjunction with the peer educators, have developed and launched various AIDS prevention and support initiatives. In addition to distributing condoms and information, by means of pamphlets, books, audiovisual materials, and discussions, they provide one-on-one HIV/AIDS prevention education and support. Group information and interactive workshop sessions are also conducted throughout the prison, utilizing a variety of interactive and prisoner-centred educational and awareness strategies, including games and contests. The coordinators also produce a monthly newsletter, attend a support group for prisoners with HIV/AIDS, correspond in writing with HIV-positive prisoners in other institutions in the Atlantic Region of CSC, and staff an office 50 hours a week.

An evaluation of the program is being conducted through a knowledge, attitudes and behaviour (KAB) questionnaire administered prior to and three months following the implementation of the program. The questionnaires were administered verbally in small groups by staff from AIDS NB, with the assistance of peer educators, and completed by 118 and 80 inmates respectively. Qualitative analyses regarding the content and process of the peer-led educational program strongly support its benefits. The quantitative analyses regarding the impact of the peer education and support initiatives on the general prison population's knowledge, attitudes and behaviours will be available in the summer of 1996.

A training manual has been prepared to provide other community-based organizations and prisons with guidelines regarding the setting up, implementation, evaluation and sustaining of peer education and support programs in correctional facilities. In addition to suggested facilitation strategies, the manual includes a number of overheads, hand-outs and exercises developed specifically for inmate AIDS peer education.

A critical component of this Project was the involvement of a number of key players. HIV-positive and HIV-negative inmates played an instrumental role throughout all phases of the Project. Ploem also worked with a national advisory committee and a local prison advisory committee. According to Ploem, the CAN Project was generally very well accepted by inmates, prison administration and staff: "Content and process evaluations of the training program strongly support its benefits in enhancing the knowledge, attitudes and skills of all participants."(44)

Revised Commissioner's Directive 821: Infectious Diseases

Background
In its report, ECAP criticized several of the provisions of Commissioner's Directive 821, Management of Inmates with Human Immunodeficiency Virus (HIV) Infections, and recommended that they be changed or reworded.

A Revised Directive
At the time of writing, a thoroughly revised version of Directive 821 was being finalized and was expected to be adopted soon. The new Directive takes much but not all of ECAP's recommendations and criticism into account.

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Too Little, Too Slow: Ongoing and Growing Criticism of CSC's Response

Rejection of Critical Recommendations

> It frustrates me greatly that only those of ECAP's recommendations were accepted that are considered to be "politically correct" and would upset as few politicians and public sentiments as possible. I do not believe that the decision-makers considered the lives of those who would be most affected by their decisions, many of whom will be infected as a result of the refusal to accept the other recommendations.
> If there is to be any hope of reducing the spread of HIV in prisons, it will be necessary to reconsider the decisions made.(45)

CSC has been praised for its decision to implement national bleach distribution and to increase access to HIV testing, for funding the inmate peer health-promotion project, for revising Commissioner's Directive 821 and, generally, for accepting many of ECAP's recommendations.

However, it has been criticized for rejecting other critical parts of ECAP's plan. In particular, CSC refused to

- authorize the use of tattooing equipment and supplies in the institutions, to make educational materials on how to tattoo safely available to inmates, and to instruct inmates who offer tattooing services to other inmates about how to use tattooing equipment safely;
- remove prohibitions against consensual sexual activity between inmates;
- study the feasibility of prison health services being provided by outside agencies;
- provide methadone maintenance programs, claiming that there "is no medical indication to do so in federal correctional facilities and that there are relatively few methadone programs outside CSC institutions to support methadone-dependent inmates following release"; and
- pilot-test needle-exchange programs in prisons.

According to PASAN, CSC

> has chosen to ignore the issue of injection drug use and the high risk of HIV transmission through needle use within the prison context. How can CSC admit that there is a drug problem in the prisons and still refuse to even try a pilot needle exchange program for prisoners? This contradiction will cost lives.(46)

Similar criticism has come from organizations such as the Canadian AIDS Society(47) and the Kingston AIDS Project,(48) and from physicians and representatives of the media. An editorial in the Vancouver Sun of 2 April 1994 called the "prison

system guilty of AIDS complacency," and added that

> [i]f any lesson should be learned from the continuing outcry over the Red Cross['s] sluggish response to the threat of AIDS transmission through the blood supply, it's that such attitudes [as expressed in CSC's response to the Report] can be lethal.(49)

Respondents to the Discussion Paper also criticized CSC's refusal to accept some of ECAP's most important recommendations. According to the Inmate Committee of one institution in the Pacific Region of CSC,

> [i]t certainly does seem ridiculous for Corrections Canada to supply condoms and not syringes. It is our opinion that much more people are in danger of contracting HIV/AIDS through intravenous drug use than through sexual practices.(50)

Respondents emphasized the absurdity of CSC's response to the issue of tattooing. As noted above, CSC agreed to permit inmates to engage professional tattooing services at their own expense. Apparently, and for obvious reasons, no inmate has so far taken advantage of this opportunity. According to Ploem, "[g]iven prison wages and the fact that tattooing is so much a part of the prison culture, engaging professional tattoo artists is clearly unrealistic."(51(Inmates agreed, pointing out that the average inmate earns about $40 in pay every two weeks, and that "it is ridiculous to suggest that we could possibly afford to hire a professional tattoo artist."(52) At the same time, tattooing remains a prevalent activity: in CSC's Inmate Survey, 45 percent of participating inmates responded that they had a tattoo done in prison.(53) Because ECAP's recommendations were rejected, tattooing continues to put inmates at risk of contracting infections: eight percent of inmates who had had tattoos done in prison said that they did not think that the equipment was clean and safe for use.(54)

Uneven Implementation

Perhaps of greatest concern to me lately has been that CSC has accepted many of ECAP's recommendations and publicly states that condoms are available in institutions, that bleach is made available in one institution officially and in others unofficially, and that confidentiality of medical information is respected. The untold truth, however, is altogether different: for example, in many institutions condoms are available only occasionally, and no water-based lubricant is available. With regard to the issue of confidentiality, there is much I could say; frankly, I have grown tired of repeating how the importance of keeping medical information confidential does not seem to be understood, and how often and in how many ways confidentiality is not respected.(55)

Apart from rejecting some of ECAP's most important recommendations, CSC has neglected to ensure that some of the recommendations it accepted be implemented in every institution.

Examples include:

Condoms, Dental Dams and Lubricant
Condoms are not easily and discreetly accessible in many institutions, and lubricant is often not available at all even where condoms are easily accessible. This was confirmed by the results of CSC's Inmate Survey: when asked whether condoms were readily available in their institution, 56 percent of respondents said yes, but up to 21 percent (in the Prairies Region of CSC) said no, while the remainder did not know.(56) Many respondents to the Discussion Paper also complained about lack of accessibility:

Presently at William Head there exists a condom dispenser within the inmate waiting room area of the Health Care Unit. That there is access to condoms within the prison gives us some consolation, however, it is situated in plain view of the nursing staff, or whoever else might be on the other side of the one way glass. Anyone wanting the condoms must then worry about being seen by staff, and may opt not to use the protection in fear of being discriminated against.(57)

Condoms are not readily available, even though the CSC pacified everyone in 1994 by claiming they were being issued on a regular basis...[C]ondoms were available for perhaps a year and then it basically ceased. When requesting information about

them, it was suggested that...[they were] not available due to budget cuts for all departments.(58)

> I am still waiting to see the Water Based Lubricants being made available as they continue to say they are willing and intending to!(59)

As stated by Dr Christiane Richard in her response to the Discussion Paper, "wardens of institutions, administrators at all levels, with values and beliefs different from those put forward in ECAP's report, resist implementing measures that would lead to easy and wide access to condoms, either by moving forward very slowly, or by neglecting to follow up on implementation, or by attaching a very low priority to them."(60)

Confidentiality
In some prisons, the administration, correctional officers, and escorts still insist on being informed by health-care staff about every prisoner known to them to be HIV-positive. Confusion about confidentiality of HIV-related medical information has increased since the release of a legal opinion written by CSC's Legal Services.(61) The opinion seems to imply that CSC has an obligation to release information about an inmate's HIV status in a fairly wide range of cases, contrary to the recommendations in ECAP's Final Report and Background Materials. Insecurity about whether or not they should disclose medical information is particularly great among professionals working for CSC who are subject to obligations of confidentiality imposed by their professions.

The legal opinion has also had an impact in the area of parole supervision: since February 1996, both PASAN and the HIV/AIDS Legal Clinic Ontario (HALCO) have been receiving calls from parolees whose parole officers have been demanding to know their HIV status, saying that they would then be notifying their sexual partners if they admitted to being HIV-positive. The two organizations later found out that the legal opinion had been distributed to area supervisors of parole offices around Ontario, apparently leaving individual supervisors to set their own local policies based upon their interpretation of the document. In the downtown Toronto region, this resulted in parole officers being instructed to enquire about the HIV status of parolees and, if necessary, engage in partner notification.

PASAN, HALCO, and many other provincial and national organizations have since expressed their concern about the effects of this directive for people on parole, especially those who are HIV-positive.

Experimental and Non-Conventional Therapies
Experimental and non-conventional therapies are sometimes not accessible to inmates living with HIV. All PHAs who I have spoken with indicate that requests for alternative homeopathic procedures for dealing with chronic pain, for example, brought on by HIV/AIDS have been refused because of budget restraints.(62)

Compassionate Release
ECAP's recommendation that prisoners with progressive life-threatening diseases, including AIDS, regularly be released earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety, has been unevenly implemented.
Such examples of uneven implementation have been deplored not only by prisoners, but also by health-care staff, who have complained that CSC is not enforcing its own rules. It has been suggested that CSC release clear guidelines and enforceable national standards and that prison administrations be held accountable for their timely and consistent implementation.

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A War on Drugs, But Not on AIDS

In its Final Report, ECAP emphasized that "it is unrealistic to presume that injection drug use can ever be fully suppressed in prisons, despite strong and persistent efforts by CSC to prevent drug use by preventing drugs from entering the institutions and through education about drug use and treatment of drug users."(63)

ECAP found that most administrators, staff and prisoners concur in this assessment. Consequently, the Committee examined in great detail what might be done in federal prisons to reduce the harms from drug use, and recommended a variety of measures directed at achieving this aim, including methadone maintenance programs and a pilot project for needle distribution in at least one institution.

Instead of implementing these recommendations, only a few months after the release of ECAP's Final Report CSC announced a "strategy to combat drugs in federal penitentiaries" that in many ways is inconsistent with ECAP's recommendations. As part of CSC's strategy:

- the use of random urine testing for drug use has been increased "substantially" in federal institutions;
- searches of visitors are undertaken more frequently;
- specially trained drug-detection dogs are used;
- better training in drug detection and in the laws governing search and seizure is being undertaken;
- visitors attempting to bring drugs into institutions not only risk facing criminal charges, but may be barred from further visits to federal penitentiaries;
- it has become "more likely" that charges will be laid against inmates engaged in the trafficking of drugs;
- steps are being taken to "draw to the attention of the judiciary the serious impact of drug trafficking and drug abuse in federal penitentiaries"; and finally,
- a commitment has been made to offer inmates better access to drug treatment programs.

In her response to the Discussion Paper, Ms Lynn Ray, National President of the Union of Solicitor General Employees, suggested that even tougher measures should be taken to control the flow of drugs into institutions: "There needs to be a coherent practical and manageable approach to controlling the influx of drugs into institutions."(64) Many, however, oppose such measures, with the exception of better access to drug treatment programs, on the grounds that they are extremely costly, intrusive and, ultimately, may be ineffective and even counterproductive.

Costs: Allocation of Scarce Resources

Although it is now generally accepted that the spread of HIV is a greater danger to individual and public health than drug use itself, in 1995-96 CSC spent

- $1,200,000 for its urinalysis program;
- $1,000,000 for the other components of its Drug Strategy; but only
- $175,000 for its entire AIDS Program (at the Ottawa National Headquarters).

In addition, CSC spent $5,656,324 (in 1994-95) for substance abuse offender treatment programs in the institutions and the community, and an unknown sum to cover the costs of HIV/AIDS drugs, and the cost of education and training of staff and inmates about HIV/AIDS.(65) Clearly, CSC attaches a much higher priority to its drug strategy than to its fight against HIV/AIDS and other infectious diseases: it has implemented a drug strategy, but no AIDS strategy, and spends more than ten times as much on its drug strategy as it does on its HIV/AIDS program. The urinalysis program alone costs more than appropriate public health responses to drug use, namely evaluated drug reduction and rehabilitation programs in all prisons, would cost.(66)

Reduction of Drug Use

The long-term effects on levels of drug use in prisons of the repressive measures that are part of the drug strategy remain to be seen. With regard to drug testing, it should in theory reduce the amount of drug use in prisons because people should be dissuaded from using drugs through fear of disciplinary action. Data provided by CSC show that from the fourth quarter of 1993 to the fourth quarter of 1994 there has indeed been a drop in the percentage of inmates testing positive for drugs, from 33 to 21 percent. However, without more information, it is impossible to draw sound conclusions from these data, as they are not broken down according to institution and reasons for testing.(67) Far from indicating that levels of drug use are decreasing,

these data could merely indicate a broadening of the sample base from a group in which drug users were over-represented to a true representation of the population, in which all members of the population had an equal chance of being represented. Further, while the percentage of positive test results decreased initially, it has since remained fairly stable: in the first quarter of 1995, 17.5 percent of 5074 tests and in the last quarter 17 percent of 7239 tests were positive.

Table: Drug Testing in Federal Prisons

Quarter	Negative Results	Positive Results	Total of Tests	% of Positive Tests
4Q93	315			
156		471		33%
1Q94	762			
279		1041		26%
2Q94	1272			
500		1772		28%
3Q94	2025			
650		2675		24%
4Q94	3070			
829		3899		21%
1Q95	4183			
891		5074		17.5%
2Q94	4758			
944		5702		16.5%
3Q95	5268			
1041		6309		16.5%
4Q95	5997			
1242		7239		17%
TOTAL	27650			
6532		34182		19%

That the urinalysis program may, if at all, have led to a slight decrease in drug use, has been confirmed by inmates participating in CSC's Inmate Survey:

- Only 13 percent responded that there had been "a large decrease" in drug use; and
- 32 percent responded that there had been a "slight decrease."
- However, according to a majority of inmates (55 percent), the urine-testing program had "no impact" on drug use among inmates.(68)

Importantly, even if there has indeed been a decrease in drug use, this should not be overvalued: because of HIV/AIDS, prisons cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy. Reduction of drug use is an important goal, but reduction of the spread of HIV and other infections is more important: "the spread of HIV is a greater danger to individual and public health than injection drug use itself."(69) At a minimum, because of the connection between drug use and the spread of HIV and other infectious diseases - in particular hepatitis C - prisons need to take an integrated approach to HIV/AIDS and drug use, recognizing that every decision taken in the area of drug policy will have an impact on the system's ability to fight HIV and other infectious diseases.

Increased Harms

There is a fear that, because of more frequent random urine testing and more severe penalties, inmates' drug use, rather than diminish, may shift from drugs (such as marijuana) that are detectable in urine for up to one month, to drugs (such as cocaine, heroin, PCP and LSD) that have much shorter windows of detection. As a result, injection drug use may increase, and with it

the risk of HIV transmission and other harms from drug use.(70) ECAP had expressed its concern that measures such as those now being undertaken by CSC as part of its Drug Strategy "may create risks or harms that outweigh the benefit being sought, namely the reduction of drug use"(71) and had suggested "that in any decision about the extent to which they [drug-testing programs] should be implemented, consideration be given to these concerns."(72)

An examination undertaken by CSC of patterns in drug use seems to show that the relative proportion of the types of drugs used by offenders has not changed much during the last five quarters. Only the first quarter of 1995 is somewhat different from the other four quarters, but "this may simply be an anomaly, seasonal difference, or change in drug usage as a result of supply and demand":(73)

(table)

According to CSC, "it would be fair to conclude that there has not been a switch among offenders from softer drugs to harder drugs."(74)

Nevertheless, responses to the Discussion Paper and the results of CSC's Inmate Survey support the view that some inmates have indeed switched to less detectable drugs:

- while 42 percent of responding inmates said that, in their view, inmates have not switched to drugs "that are less detectable but generally more addictive,"
- 30 percent were undecided, and a significant
- 28 percent said that inmates have switched to less detectable drugs.(75)

This is consistent with the responses to the Discussion Paper:

> We agree that urinalysis testing is encouraging some inmates to change their drug of choice from marijuana and hashish to harder drugs like cocaine and heroin because they are flushed out of your system faster, thus making random detection much harder. There is also a good portion of inmates that really do not care and will take their chances with random testing. In my opinion, this strategy is not reducing the amount of drugs in prison, instead it is increasing the amount of "hard" drugs available.(76)
> We, too, hear frequently from prisoners that urinalysis testing has caused some to change their drug of choice from marijuana to heroin because heroin is detectable in urine for a much shorter period of time than cannabis. (77)

Conclusion

CSC has failed to follow ECAP's recommendations and to adopt a more pragmatic approach to drug use and to recognize that the idea of a drug-free prison is no more realistic than the idea of a drug-free society. Its drug strategy and, in particular, the urinalysis program are expressions of an outdated war-on-drugs approach to drug use, which because of the advent of HIV/AIDS cannot be rationally justified: it fails to focus on the harms from drug use rather than drug use itself.

The costs of this approach are high, its benefits unproven:
- If levels of drug use in prisons have been reduced, which remains to be proven, then there has only been a marginal reduction, accompanied by a likely increase in harms from drug use for at least some users.
- Many of the prisoners who test positive for drug use are already known to staff as being drug users: the program provides little new information to staff and administration.
- It requires taking very invasive measures that are resisted not only by inmates, but often also by staff: for example, inmates have to urinate on command and in full sight of staff.

Concerns about the effect of urinalysis programs and, generally, CSC's Drug Strategy, have been well expressed in the response to the Discussion Paper by Graham Stewart:

> We have been critical of the present strategy which emphasizes enforcement and control at the expense of prevention and treatment. We feel that the evidence relating to the benefits of the "war on drugs" approach which emphasize[s] enforcement and control is questionable at best. The costs include loss of family contact, employment/training and other "privileges" which can improve the prisoners chances of success on in the community on release and...more injection drug use which increases the risk of very serious health problems - HIV/AIDS and Hepatitis C.... A further concern relates to prisoners who want to stop using drugs but are reluctant to go for treatment for fear that their admission of drug use will affect their privileges within the institutions and their chances for release on parole.
>
> Our primary concern about the CSC Drug Strategy is that it takes precedence over everything else [emphasis in the original] including preventing the spread of fatal diseases such as HIV/AIDS and Hepatitis C within prisons and, through those infected prisoners who are released, into the community. Within the community at large, programs are available to provide injection drug users with clean needles even though it could be seen as condoning illegal activity because health professionals have clearly laid out the benefits of these harm reduction strategies, the costs of relying on enforcement strategies alone and the risk to everyone of doing nothing. We feel the CSC should take the same objective cost/benefit approach.(78)

Further, as observed by a German commission that studied the problems raised by drug use in prisons, "far too much value is usually given in day-to-day life in prisons to urinalysis programs and the results they provide": prisoners spend much time and energy on trying to devise new methods and mechanisms that will ensure that their drug use will not be detected; and staff and the administration, in the day-to-day decisions they have to make about inmates, attach too much value to often-flawed results of testing. The commission concluded that urinalysis programs are not cost-effective and, indeed, are counterproductive, and therefore recommended that they be discontinued.(79)

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The Response of Provincial Prison Systems to ECAP's Report

Although ECAP was not mandated, and therefore did not attempt, to review issues raised by HIV/AIDS in provincial prisons in Canada, in its Final Report the Committee emphasized that
most of the efforts that need to be undertaken to reduce or prevent HIV infection in federal correctional institutions also need to be undertaken at the provincial level and that many, if not all, of its recommendations could be implemented also in provincial prisons. ECAP certainly encourages provincial prison systems to consider this.(80)

Coordination and Collaboration

ECAP pointed out that there is a clear need for coordination and collaboration in responding to HIV/AIDS in prisons. The Committee felt that, particularly in the area of education and prevention, "coordination of federal and provincial efforts will be important to ensure consistency of information, and that the means necessary to prevent HIV infection will be available to all provincial and federal inmates."(81) It therefore encouraged CSC and the provincial correctional systems to collaborate closely on the issues raised by HIV/AIDS and by drug use in prisons.
The need for coordination and collaboration was also emphasized in the responses to the Discussion Paper. For example, PASAN expressed the view that "[o]ne of the most difficult roadblocks in our work has been the lack of collaboration between provincial correctional systems and between provincial and federal prison systems." PASAN continued by saying that there is an obvious need for "all provincial and federal prisons to act in unison."(82) [emphasis in the original]

Two Different Worlds?

It is difficult to establish to what extent ECAP's Final Report may have influenced provincial systems' activities in the area of HIV/AIDS and drug use. Some systems still claim that provincial and federal prisons are two different worlds, and that what needs to be undertaken in federal prisons is not necessary in provincial prisons. In some responses to the Discussion Paper, it was suggested that the differences between federal and provincial correctional services be more clearly distinguished:

[I]t is important to be aware that each service manages a very different population. For example, in Alberta the average length of stay in custody is only 44 days. The high turnover of the offender population poses some unique challenges, for example to create a fully sustainable peer support network. Additionally, the circumstances that would lead to infection in prison are not as pronounced as those in a federal penitentiary.(83)

That provincial and federal systems are two different worlds, however, is true only to some extent. Admittedly, the short average stay of inmates in provincial prisons makes it difficult (but not impossible) to implement a peer education model such as that piloted in the federal system. Therefore, respondents to the Discussion Paper have suggested other, similar programs in which community-based AIDS service organizations and peer speakers provide education to inmates and staff of provincial prisons.(84) In contrast, the short average stay of inmates in provincial prisons does not justify reluctance to implement other harm-reduction measures, such as making condoms and bleach available to inmates: there may be fewer high-risk activities in some provincial prisons, but the risk of HIV transmission is nevertheless present and warrants that in all provincial, as in federal prisons, condoms and bleach be easily accessible to prisoners. The same is true for other preventive measures, such as sterile needles and methadone. This was acknowledged by participants at a training program for health services staff working in detention centres under Québec jurisdiction, held in November 1995. They stressed the need to facilitate prisoner access to condoms, observing that current measures for distributing condoms - which in Québec, as in Ontario and Alberta provincial prisons, are given only upon the express request of a prisoner - are worth "absolutely nothing." They also stressed the need to make sterile needles and syringes available to inmates who use injection drugs.(85)

Provincial Systems Respond to the Discussion Paper

The need for the implementation by provincial prison systems of ECAP's recommendations was acknowledged by the vast majority of respondents to the Discussion Paper.

The following are a few examples:

- According to the Deputy Minister of Health and Social Services of the Northwest Territories, Mr Ken Lovely, the Discussion Paper "effectively describes the main concerns and rationale for immediate action to prevent the further spread of HIV and other bloodborne pathogens within the prison system." He added that, "[i]n principle, the Department agrees with the conclusions and recommendations contained in [the] document."(86)
- The Executive Director of Saskatchewan Corrections wrote that the recommendations in the Discussion Paper would assist Saskatchewan Corrections "to work in co-operation and consultation with Saskatchewan Health to implement in our secure correctional facilities as many preventative and harm-reduction measures as possible." He added: "The preventative measures recommended in this report are availability of bleach and implementation of a needle exchange system. These ideas will be considered by Saskatchewan Corrections."(87)
- The Hon. Russell King, Minister of Health and Community Services of New Brunswick, said that the conclusions concerning the provision of sterile injection equipment may be of concern to correctional officials, but added: "However, from a purely public health perspective, needle exchange programs in general can be supported. Such programs are being increasingly recognized as an effective public health strategy for the reduction of infection among Injectable Drug Users" [sic].(88)

Models to Follow

It is important to note that a few provincial systems have already undertaken encouraging measures aimed at preventing HIV transmission, and should serve as examples for those systems that have thus far failed to do so. In particular, in provincial institutions in British Columbia, condoms have been easily accessible for many years. In addition, as early as 1992, the British Columbia provincial system issued a policy directing that bleach also be made available to inmates. Adoption of this policy

has not led to any "incidents of misuse presenting security breaches, no known damage to septic fields, or any evidence to indicate an increase in needle use,"(89) and in April 1995 a revised policy was approved, requiring that bleach be freely available, readily accessible, and distributed in a way that ensures anonymity and minimizes risk of injury. Further, in April 1996 Dr Diane Rothon, Director of Health Services for the British Columbia Corrections Branch, in an affidavit filed in the Supreme Court of British Columbia, stated that she expected

that a formal change in the policy of the Corrections Branch on the use of methadone in prisons will be coming in the very near future. The change in policy will recognize the validity of the harm reduction model for inmates. I fully expect that the controlled use of methadone in prisons will become more widespread than it is at present.(90)

Finally, British Columbia has also undertaken an innovative educational program on HIV/AIDS and infectious diseases, carried out by health educators contracted jointly to federal and provincial correctional services, in an attempt to ensure "uniformity and consistency of information, consistently delivered throughout all correctional facilities."(91)

Reaction to Provincial Systems' Response

The lack of action of many provincial systems, and the lack of coordination between the various provincial and between the federal and the provincial systems, are a serious concern. This has caused increasing dissatisfaction and frustration. For example, at the First National HIV/AIDS and Prisons Workshop in Kingston in August 1995, participants from across Canada expressed outrage at the lack of easy access to condoms, bleach, and other preventive measures in most provincial systems, and renewed the call for action and collaboration.

Conclusion

CSC and, to a lesser extent, provincial prison systems have made some progress in dealing with HIV/AIDS in prisons. As stated in the Discussion Paper,

CSC should be congratulated on its decision to make bleach and anonymous testing available in prisons. This represents a significant step forward in the fight against the spread of HIV in federal penitentiaries. CSC is acknowledging that it has a responsibility to protect the health of inmates, staff, and the public; that measures to prevent the spread of HIV, such as making bleach available, do not conflict with its drug strategy; and that making bleach available does not mean condoning drug use. CSC is starting to take some of the steps that are necessary to reduce the spread of HIV. However, as shown above, much remains to be done: many of the recommendations consistently made by national and international committees and organizations, including PASAN, ECAP, and the World Health Organization, have not been accepted; other recommendations have been accepted, but are not being implemented or are being done so unevenly.(92)

Eight months after the release of the Discussion Paper, concerns persist. As long as CSC will not accept all recommendations put forward by ECAP and other national and international committees and organizations, and as long as implementation of these recommendations does not happen as part of a comprehensive plan - but rather as a series of "stand-alone" activities that do not address the issue of organizational change within CSC and do not lay the foundations that would ensure the viability of all HIV/AIDS-related initiatives - CSC will fail to adequately address the issues raised by HIV/AIDS and drug use.

With regard to provincial systems, many still fail to recognize even the need to take seriously the recommendations made by national and international committees and organizations, and refer to the fact that, on average, inmates tend to spend only 30 to 40 days in provincial prisons - a fact that may decrease problems and risks, but does not eliminate them and the need for action.

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FOOTNOTES

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57 Response to the Discussion Paper by Salisbury & Smith, supra, note 4.

58 Response to the Discussion Paper by JE Wonnacott, dated 19 January 1996.

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60 Response to the Discussion Paper, supra, note 3.

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67 Testing is undertaken where there are "reasonable grounds"; as a result of a random selection process; as a requirement for participation in a prescribed program or activity involving contact with the community, or substance abuse program; to provide three consecutive negative urine samples after being found guilty of a disciplinary offence under section 40 (k) of the Corrections and Conditional Release Act (section 40 (k) reads: "An inmate commits a disciplinary offence who takes an intoxicant into the inmate's body"); or to monitor compliance with an abstinence condition.

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88 Response to the Discussion Paper, dated 12 January 1996.

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90 Affidavit in the case of R v McMullen, Supreme Court of BC, No CC960346.

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HIV/AIDS in Prisons: Final Report

by Ralf Jürgens

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New Developments

In the 16 months between the release of ECAP's Final Report and that of the Discussion Paper, several new developments occurred in Canadian and other prison systems. These developments reinforce the need for measures aimed at preventing HIV transmission in prisons, and increase their urgency:

- a 40 percent increase in the number of known cases of HIV/AIDS in federal correctional institutions;
- an increase in the number of prisoners living with symptomatic HIV infection or AIDS in prisons, requiring more extensive and costly medical care;
- increasing evidence of high-risk behaviours in prisons;
- increasing evidence that, as a result of such behaviours, HIV is being transmitted in prisons;
- very high hepatitis C seroprevalence rates in prisons, as evidenced by three Canadian studies that revealed hepatitis C seroprevalence rates of between 28 and 40 percent;
- legal action undertaken by prisoners in two Australian states against their prison systems for failing to provide measures to prevent the spread of HIV;
- reports on HIV/AIDS in prisons issued in other countries, reinforcing the consensus that more needs to be done to prevent the spread of HIV in prisons and to care for prisoners living with HIV/AIDS;
- a pilot project of needle distribution in prisons in Switzerland, demonstrating that sterile needles can be distributed in prisons safely and with the support of inmates, staff, prison administrations, politicians, and the public.

Since then, the following developments have occurred:

- a further, although slight, increase in the number of known cases of HIV/AIDS in federal correctional institutions;
- progress and delays in the implementation of some of the harm-reduction measures promised by CSC;
- the release of the report of the Commission of Inquiry into Certain Events at the Prison for Women in Kingston, highlighting systemic shortcomings within CSC, the absence of a culture respectful of individual rights, and an unwillingness to be responsive to outside criticism and to engage in honest self-criticism - issues and problems that also affect CSC's response (or lack of

response) to HIV;
- the release of the results of CSC's Inmate Survey, confirming that high-risk behaviours are prevalent and that "the problem of AIDS is especially high behind bars";(93)
- legal action undertaken by a prisoner in British Columbia against the provincial prison system for failing to provide her with methadone; and
- an increase in the number of prisons and prison systems in which sterile needles and syringes are made available to prisoners, and the release of a study demonstrating the positive effects of making them available.

The following text provides an update on the developments in the Discussion Paper and discusses the new developments.

Increase in Known HIV/AIDS Cases

Forty-Six Percent Increase over Two Years

During the month of March 1996, 159 inmates were known to be living with HIV or AIDS in federal prisons in Canada.(94) This represents a substantial increase (close to 46 percent) from the 109 inmates with HIV or AIDS who were known to be living in federal prisons as of April 1994. It means that more than one percent of inmates are known to be living with HIV/AIDS. In some institutions, particularly in the Québec region of CSC, more than five percent of inmates are known to be HIV-positive. As stated by Trudi Nichol, Project Coordinator of the Bleach Pilot Project, "[t]he rate of HIV infection is growing at an alarming rate."(95)

In provincial prisons, the situation is similar. Studies undertaken in prisons in British Columbia, Ontario and Québec have all shown that HIV seroprevalence rates in prisons are much higher than in the general population, ranging from one to 7.7 percent.(96) As in federal institutions, the numbers of prisoners with HIV or AIDS in provincial prisons are on the rise. As pointed out by Nichol, many of these inmates will eventually make their way to the federal prison system. As a result, "health care costs are going to rise drastically in the next few years and anything we can do to prevent this is a bonus."(97)

The Future

During the last eight months, the increase in known cases of HIV and AIDS in federal institutions seems to have slowed down. Nevertheless, the number of prisoners living with HIV/AIDS in federal and provincial prisons in Canada will continue to increase. As observed in ECAP's Final Report, worldwide, the prevalence of HIV infection in prisons has been found to be closely related to the proportion of inmates who injected drugs prior to their imprisonment, and to the prevalence of HIV infection in their community.(98) Over the last years, Canada has been experiencing an increasing epidemic of HIV among injection drug users, with many new infections occurring, particularly in the major centres - Vancouver, Toronto and Montréal. Because the prevalence of HIV infection among injection drug users

outside prisons is growing at an alarming rate, and because many injection drug users spend years of their lives in provincial and federal prisons, we already know that the number of prisoners with HIV or AIDS will continue to grow.

In addition, the above numbers represent only the prisoners with HIV or AIDS who are known to prison authorities. In fact, many more inmates are living with HIV, but may not be aware of it themselves because they have not been tested, or may not want to disclose their HIV status for fear of being discriminated against by fellow inmates and staff.

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Increase in the Number of Sick Inmates

> The situation with regard to HIV/AIDS in prisons is changing: "Until recently, most prisoners with HIV were in early stages of the disease. Lately we are seeing more and more prisoners - both newly admitted and long-term - with advanced stages of HIV disease."(99)

This reflects the evolution of the HIV/AIDS epidemic in Canada, mirroring the rise of infection rates among intravenous drug users (IVDUs): an increasing number of IVDUs, many of whom spend at least part of their lives in prison, are developing AIDS and becoming sicker.

Prisoners in early stages of the disease normally do not require anything other than monitoring of the progression of their disease and psychosocial support. For many, imprisonment has resulted in an improvement of their general health status, due in large part to reduced drug consumption, better nutrition resulting in weight gain, and ready access to medical and dental facilities.

Today, prison health services are increasingly faced with having to deal with further-advanced stages of the disease and their manifestations. While the numbers are rising, they are still relatively small, meaning that the prison physicians who provide services for them are relatively inexperienced. The resulting problems can be managed if the physicians recognize that they cannot provide the necessary specialized services and treatment, and refer prisoners early enough to outside clinics that provide HIV-specific care for persons with HIV/AIDS.

However, problems are sometimes not recognized. Most prisoners are regarded as relatively fit young persons, with drug dependency as their only health problem. Nurses and doctors who work with prisoners deal well with well-demarcated chronic illnesses such as diabetes, cancer, arthritis, or easily recognized emergencies such as acute myocardial infarction or trauma, but the HIV-positive patient with a low CD4 count, who may look well but not be well, is a challenge. For example, it is difficult for health-care staff to appreciate that the headache of a well-looking prisoner, still able to lift weights, is due to a life-threatening cryptococcal meningitis. This difficulty is enhanced by the fact that some prisoners have a tendency to try to manipulate health-care staff, who as a result can be more reluctant to

"believe" the inmate and to intervene immediately by, for example, making referrals or prescribing medication.
Problems are likely to increase in the years to come: "unfortunately, the rise in the number of seriously ill patients - with other serious infectious diseases and/or with HIV - coincides with cuts to health-care budgets."(100)

Increasing Evidence of High-Risk Behaviours in Prisons

Mr. P is a 43 year old male serving life. He has 20 years in on his sentence. He started using injectable drugs after he was incarcerated; this was his method of dealing with his loneliness. Mr. P states his early experiences were with anyone willing to share a hit. After watching one of his peers die of AIDS two years ago, Mr. P has his own rig (which is seven years old) and he shares it with no one.

Mr. S is a 37 year old male serving nine years for drug-related crimes. Mr. S does not use injectable drugs but has found a market for his 13 rigs inside the institution. Mr. S rents out his needles for one hour at a time for three to five packages of cigarettes. Three packages of cigarettes rents a needle older than two years. Five packages of cigarettes rents a needle less than two years old. Mr. S has needles that are less than six months old but they go strictly for cash or stamps valued at $50-100 depending on the demand. All his needles are cleaned with bleach (when he can steal it) or toilet bowl cleaner (if he has no bleach).(101)
Such anecdotal evidence of the existence and extent of injection and other drug use in prisons is confirmed by a number of scientific studies undertaken in Canada and elsewhere. Results of some of these studies were reported in ECAP's Final Report.(102) ECAP concluded that injection drug use is prevalent in prisons, and that the scarcity of needles often leads to needle sharing. During its prison visits, the Committee was told on some occasions by inmates that injection drug use and needle sharing are frequent and that sometimes 15 to 20 people will use one needle without cleaning it between each use.(103) Many CSC staff, in their responses to a questionnaire ECAP sent them, also acknowledged that drug use is a reality in federal correctional institutions, saying that "drugs are part of prison culture and reality," that "drug use is widespread in institutions," that there does not seem to be a way to ensure that there will be no use of drugs, and that there are "many needles in the prisons."(104)

Since then, results of other studies have confirmed the prevalence of injection drug use and other risk behaviours in prisons.

Scotland: Results of Three Studies

In a first study of drug-using behaviour in Scottish prisons, 11 percent of a purposive sample of 234 prisoners had injected during their current sentence, while 32 percent were injecting prior to imprisonment. However, of those who were injecting in prison, 76 percent were sharing equipment, while only 24 percent of those who were injecting prior to imprisonment were sharing.(105)

In a second Scottish study, 76 of 227 prisoners (33 percent) had injected drugs at some time in their lives, and 33 (15 percent) admitted to injecting in prison. While injectors tended to use drugs on a daily basis outside prison, they would normally inject only weekly or monthly while in prison. However, all those who had injected in prison had shared equipment at least sometimes. Twenty prisoners had always shared it, compared to only two prisoners who had always shared outside.(106)

In a third study, aimed at determining prevalence of HIV infection and risk behaviours among male inmates in a prison in Glasgow, half of IDU inmates reported having injected while incarcerated and six percent had started to inject while incarcerated. The study concluded:

> A consistent harm-reduction policy is needed across prisons in the United Kingdom to avoid transmission of blood-borne viral infections. Drug injecting inside prison is common, a proportion of IDU inmates having first injected while in prison, and much higher rates of hepatitis have been reported in association with injecting while incarcerated compared with that for IDUs who only injected outside prison.(107)

Australia

NSW - HIV Risk Behaviours in Prison
In a study of 181 prisoners in New South Wales, Australia, 40 percent of respondents reported having engaged in one of three HIV risk behaviours in prison: one-quarter reported injecting, one-sixth reported sharing tattooing equipment, and one-twelfth reported having engaged in oral or anal sex while in prison. Respondents indicated that they were aware of a mean of 10 injectors but aware of a mean of only four syringes on their wing, a strong indication that inmates were sharing syringes. Two-thirds of respondents reported a history of drug injecting, and almost half of all respondents had injected in prison at some time. One-quarter of respondents reported that they had injected in the prison where they were surveyed, one-fifth reported sharing syringes and just under one-fifth reported cleaning syringes with a disinfectant when sharing.(108)

NSW - HIV Risk Behaviour before, during and after Imprisonment
In a study to assess HIV risk behaviour of injection drug users before, during and after imprisonment in New South Wales, reports of injecting were more common before entry and after prison discharge than during incarceration. However, reported syringe sharing was more common during imprisonment (over 60 percent) than before entry or after prison discharge (about 20 percent). The researchers pointed out that

> [i]mprisonment did not prevent IDUs from injecting drugs. The proportion injecting drugs in prison and the frequency of injection was less than in the community. However, IDUs

> in prison had limited opportunities to inject without sharing syringes. Also, imprisonment may facilitate the mixing of IDUs with others from diverse social and geographic backgrounds. Engaging in risk behaviours under these circumstances would have considerably greater public health impact than risk behaviour of IDUs in the community which now generally occurs in restricted social networks.(109)

They concluded:

> The results of this study indicate that prisons may play a more critical role in the spread of HIV infection among and from IDUs than has generally been acknowledged. The rapid turnover of prison populations, the mixing of prisoners from diverse backgrounds and the impediments to introduction of effective prevention strategies suggests that prisons may be far more significant in terms of public health measures to control HIV and other infectious diseases than previously acknowledged.

United States

New York - Self-Reported Risk Behaviours

Mahon conducted a focus-group study among 50 inmates in state prisons and city jails in New York, in which prisoners and former prisoners reported frequent and tragic instances of unprotected sex and often-desperate injection drug use with used injection equipment being used behind bars.(110)One woman summarized the prevalence and range of sexual activity described by participants in the study when she stated:

> Male CO's are having sex with females. Female CO's are having sex with female inmates, and the male inmates are having sex with male inmates. Male inmates are having sex with female inmates. There's all kinds, it's a smorgasbord up there.(111)

With regard to injection drug use, participants stated that it was "very common" in prisons and jails and that drugs enter the system through a variety of routes, including correctional and medical staff, visitors, and personal mail. Drugs and drug paraphernalia were more scarce behind bars than on the street, and this scarcity increased the level of desperation among active drug users, heightened the value of drugs and drug paraphernalia and transformed them into a form of currency. Participants indicated that they could obtain an array of drugs, including heroine, cocaine and marijuana. They further indicated that syringes were relatively difficult to find in prison and therefore were almost always shared. Several participants indicated that they believed they became HIV-infected from sharing needles in prison.

Delaware - Sexual Activity

Saum et al report that studies of sexual contact in prison have shown "inmate involvement to vary greatly."(112) In her own study of the nature and frequency of sexual contact between male inmates in a Delaware prison, respondents were questioned extensively about sexual activities they themselves engaged in, directly observed, and heard about "through the grapevine." Saum concluded that "although sexual contact is not widespread, it nevertheless occurs," and that most sexual activity is consensual.

Indiana - HIV Risk in Rural Jails

Research undertaken by Kane and Dotson indicates that, although rural jail administrators and staff may have hoped that their facilities were free from the HIV/AIDS epidemic taking place in prisons and large urban jails, they may only be lagging behind and are not at all immune to increasing rates of HIV infection among their inmate populations.(113) The data show that rural jails in Indiana do house a population at risk for HIV infection. In particular, 23 percent of inmates have used needles to inject drugs at some point in their lives.

The Netherlands - Low Levels of Risk Behaviour?

Van Haastrecht et al undertook research to determine levels of sexual and injection drug use behaviour of injection drug users during and immediately following imprisonment in the Netherlands. Within the (non-prison) setting of a cohort study on HIV/AIDS among injection drug users in Amsterdam, participants were interviewed about their sexual and injection drug use behaviours during the last period of imprisonment in the previous three years and about injection drug use in the week following release from prison. Between April 1994 and January 1996, 497 injection drug users were interviewed: 35 percent were HIV-positive, and 191 (41 percent) reported a period of imprisonment in the previous three years. Mean duration of last period of imprisonment was 3.6 months. Any use of heroine, cocaine, and cannabis during imprisonment was reported by 36 percent, 20 percent, and 55 percent respectively; 84 percent received methadone treatment at least part of the time. Only five injection drug users (three percent) reported having injected in prison, and no injection equipment was used that had already been used by someone else. Vaginal/anal sex was reported by two of the men and none of the women in the study. Relapse to drug injecting during the week following release from prison was reported by 77 (41 percent) study participants, in 82 percent of cases on the very day of release. Most (62 percent) took their first shot alone, and all except one reported having used a sterile needle for their first shot.

The study concluded by saying that, "contrary to findings from other countries, low levels of HIV risk behaviours occur among imprisoned IDUs in the Netherlands. Although noninjecting use of cocaine and heroine in prison is quite common, drug injecting is rare, presumably because of a lack of available needles and syringes." They further concluded that, therefore, "there appears to be no ground for increasing the availability of clean injection material in Dutch prisons."(113a) As reported in the Canadian media, under the particular circumstances revealed by the prisoners who participated in the study, a needle program could be counterproductive.(113b) These circumstances are: in contrast to Canada, all prisoners in the Netherlands are housed in single cells, which significantly reduces the possibility of syringes circulating among inmates; in contrast to Canada, 84 percent of inmates received methadone treatment at least part of the time they spent in prison, which has been shown to reduce levels

of injection drug use; as a result of these and other factors, lower levels of HIV risk behaviours occurred among the participants in the study than, eg, among prisoners in federal institutions in Canada (see infra). Further, even in the Dutch context, the conclusions of the Amsterdam study need to be read with caution. Indeed, apart from not being applicable to prisons in Canada and most other countries, they may not be applicable to many Dutch prisons: another Dutch study seems to contradict, at least in part, its results. In a study of 701 drug users in Rotterdam (of whom 494 were injection drug users), 57 of 492 injection drug users tested HIV-positive, for a prevalence rate of 12 percent. Importantly, imprisonment constituted an independent risk factor for a positive test result among injection drug users (never OR=1; once OR=1,96 [0.61 - 6.28]; more than once OR=3,40 [1.36-8.52]), providing evidence that risk behaviours do occur in prisons in the Netherlands and constitute an important factor in the spread of HIV.(113c)

Canada

Montréal - Risk Behaviours Among Incarcerated Men and Women

In a study of risk behaviours among incarcerated men and women in medium-security provincial correctional institutions in Montréal, 73.3 percent of all men and 15 percent of all women reported drug use while incarcerated; of these, 6.2 percent of men and 1.5 percent of women injected drugs, mainly cocaine. Sex in prison was reported by 6.1 percent of the men and 6.8 percent of the women. The researchers who undertook the study concluded that "[r]isk behaviours are prevalent in prison, reinforcing the need for aggressive policies to prevent the intramural spread of HIV.(114)

Québec City - Evidence of Needle Sharing

In another study, of HIV prevalence among inmates of a provincial prison in Québec City, twelve of 499 male inmates admitted injecting drugs during imprisonment, of whom 11 shared needles and three were HIV-positive.(115)

British Columbia - High Rates of High-Risk Behaviours

In a federal institution in British Columbia, as reported above, Nichol found even higher rates of high-risk behaviours, with 63 percent of inmates reporting that they had received a tattoo or piercing while in prison, 67 percent reporting IV drug use either in prison or outside (with 17 percent reporting drug use only in prison), and 18 percent reporting that they had shared a needle with someone who has tested positive for HIV.(116)

Dorchester Penitentiary - Lower, But High Rates of Risk-Behaviours

In another federal institution, Dorchester Penitentiary in New Brunswick, Ploem found lower, but still high rates of high-risk behaviours, with 62 percent of inmates reporting that they had received a tattoo while in prison, 7.5 percent reporting IV drug use in prison, and 9 percent reporting having engaged in

sexual activity while in prison.(116a)

Results of CSC's Inmate Survey

Inmates participating in CSC's Inmate Survey were questioned about injection drug use, sexual activity, and tattooing. Results confirm that risk activities are prevalent.

Injection Drug Use

Eleven percent of those who responded (85 percent of the entire sample) indicated they had injected an illegal/non-prescription drug since coming to the particular institution in which they were currently incarcerated; of these, only 57 percent thought that the equipment they used was clean, while 17 percent thought that it was not clean and the rest did not know. Self-reported injection drug use was particularly high in the Pacific Region of CSC, with 23 percent of inmates reporting injection drug use.(117)

Further, respondents were asked to estimate the percentage of inmates at their institution who had injected at least one illegal drug in the week prior to completing the questionnaire. Twenty-eight percent reported none, while the majority (54 percent) reported between one and 25 percent. The remaining 18 percent responded that between 26 and 100 percent of inmates had injected.

Needle Sharing

Respondents were asked to estimate what percentage of inmates who injected drugs shared their needles. Twenty-five percent reported none; 43 percent indicated between one and 25 percent; 32 percent reported that between 26 and 100 percent of inmates who injected shared their needles. When asked what percentage of inmates cleaned their needles, 20 percent indicated none, while 45 percent responded between one and 25 percent. The other 33 percent reported that between 26 and 100 percent of inmates cleaned their needles.(118)

Sexual Behaviour

Six percent of respondents indicated that they had had sex with another inmate since coming to the institution in which they were currently incarcerated; of these, only 33 percent reported using condoms.

Respondents were also asked to estimate the percentage of inmates at their institution who have sex with other inmates (and the percentage of inmates who have anal intercourse):

- 19 (20) percent reported that inmates do not have sex (anal intercourse) with other inmates;
- 69 (70) percent indicated that between one and 25 percent have sex (anal intercourse) with other inmates; and
- 12 (10) percent responded that between 26 and 100 percent have sex (anal intercourse) with other

inmates.

Tattooing and Piercing

Forty-five percent of respondents said that they had a tattoo done in prison, and 17 percent had been pierced.

HIV Risky Practices Scale

In the Survey Report, four questions were combined to produce an "HIV Risky Practices" scale: "The questions focused on the proportion of inmates who had injected drugs, not used a condom during sex and thought tattooing and/or piercing equipment they had used was not clean."(119) Using this scale, 26 percent of all inmates had engaged in risky practices; such practices were more prevalent in the Pacific Region (33 percent) and in maximum-security institutions (30 percent).

Perceived Risk of Infection

Forty-six percent of inmates said that they felt inmates are in more danger of contracting HIV in prison than they are in the community, while only 31 percent disagreed, and 23 percent were undecided.

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Increasing Evidence of HIV Transmission in Prisons

Until recently, few data were available on how many prisoners become infected while in prison.(120) According to Hammett et al, the available data from the US suggested that transmission does occur in correctional facilities, but at quite low rates.(121) For example:

- Castro et al found that 0.3 percent of a sample of over 2300 initially seronegative male Illinois inmates had seroconverted after spending one year in prison.(122)
- Brewer et al found that two of 393 Maryland prisoners had seroconverted after two years in prison.(123) Applying the results of the study to the entire prison population, Hammett et al estimated that 60 HIV infections occur annually in Maryland prisons.(124)
- Several other US studies have found annual seroconversion rates of less than 0.5 percent.
- In the US Federal Bureau of Prisons, 52 cases of seroconversion had been identified as of 1992. However, all but four of these occurred during the first six months following intake testing, suggesting that at least some of the individuals had been infected, but were in the "window period" when they entered the prison system.

The results of these studies have sometimes been used to argue that HIV transmission in prisons is rare,

and that consequently there is no need for increased prevention efforts. However, as pointed out by Hammett et al, regardless of the rates of HIV seroconversion documented in studies, it is clear that sex and drug use continue to occur in prisons and that they represent high-risk activities for transmission of HIV. Anecdotal evidence that HIV transmission is occurring in prison is abundant. For example, a Louisiana inmate who tested positive for HIV in 1989 reported he was infected through sexual intercourse and/or needle sharing with a cellmate during an eight-month period in which they did "every unsafe thing you could do."(125) In a survey conducted by the Deutsche AIDS-Hilfe, about 17 percent of HIV-positive participants stated that they believe they acquired HIV infection while in prison.(126)

Recent events suggest that the extent of HIV infection occurring in prisons has been underestimated. Since the release of ECAP's Final Report in March 1994, evidence of HIV transmission in prisons in Scotland, the United States, Australia, and other countries has been published, providing compelling reasons for the need to take HIV transmission in prisons seriously. In Canada, there have thus far been no documented cases of HIV transmission in prisons. However, the only reason for this is the absence of research in this area: everyone knows that HIV transmission is in fact occurring.

The following is a review of the published reports.(127)

Scotland: The Outbreak of HIV Infection in Glenochil Prison

In 1994, a study undertaken in Glenochil prison for adult male offenders in Scotland provided definitive evidence that outbreaks of HIV infection can and will occur in prisons unless HIV prevention is taken seriously.(128)

The Outbreak Study
Following the diagnosis of eight cases of acute hepatitis B infection and two apparently recent seroconversions to HIV infection among prisoners, a public health initiative was launched in which prisoners were offered confidential counselling and testing for HIV.

There had been 636 inmates at the prison between 1 January and 30 June 1993; 378 inmates (59 percent) were still incarcerated when the initiative was launched. Among the 258 inmates who were not included in the study, most (74 percent) had been transferred to another prison and the rest had been released.

Of the 378 inmates still incarcerated, 227 (60 percent) came forward for counselling; uptake of counselling ranged from 43 percent to 84 percent in the 11 subunits in Glenochil. Anecdotal reports suggest that many of those who declined counselling were injectors from one subunit where injecting was particularly prevalent.(129)

Of the 227 inmates counselled, 76 (33 percent) had a history of injecting; 33 of these admitted injecting in Glenochil, while 43 admitted having injected at some point in their lives, but not in Glenochil. Of the latter, 34 were tested, but none tested positive.
In contrast, of the 33 inmates who declared that they had injected in Glenochil prison, 27 were tested and 12 were found to be HIV-positive; the remaining 15 tested negative but were still in the window period. A further two Glenochil injectors had been diagnosed HIV-positive two months previously,

giving a total of 14 HIV-positive drug injectors. Of the 14 HIV-positive inmates, definitive evidence of HIV transmission in prison existed for eight inmates. Another six infections also possibly occurred in prison, but acquisition of infection outside prison could not be ruled out.

The true number of infections was probably even higher: based on discussions with prison medical officers, the Scottish Affairs Committee calculated that the total number of prisoners infected in prison during that period could lie between 22 and 43 inmates. They also acknowledged that 258 inmates were missed by the study because they were either transferred or released within the six- month study period and that some of these may also have been infected.(130)

Why Did It Happen?(131)
Following the outbreak, 12 HIV-positive inmates and 10 other drug injectors were interviewed about their risk behaviours in prison.

Quantitative data about drug-use patterns and needle and syringe sharing had been collected at the time of the outbreak. The aim of the interviews was to gain more information about the nature and dynamics of risk-taking within the prison's drug-injecting culture, in order to provide a greater understanding of how the outbreak occurred and of how a similar incident could be avoided in future.

Injecting, Sharing and Cleaning
At the counselling session, prisoners were asked about their injecting and needle-sharing practices both inside and outside prison:

- Seven of the injectors had begun their injecting careers in Glenochil. For the rest, frequency of injecting was found to be lower in prison compared with outside. Outside, injecting tended to be on a daily basis, compared with an average of weekly or monthly while in Glenochil.
- However, although frequency of injecting was greatly reduced in prison, the opposite applied with regard to sharing injecting equipment; only two prisoners always injected with used equipment outside prison, as opposed to at least 20 inside. All Glenochil injectors had shared there at least sometimes.
- Almost all claimed always to clean their equipment prior to use. However, the methods they used were mostly ineffective, the majority usually rinsing with hot or cold water. One of the prisoners who definitely contracted HIV in Glenochil claimed always to clean needles and syringes with bleach prior to injecting.

In-Depth Interviews
Once this basic information about injecting, sharing and cleaning practices had been collected and analyzed, and in order to obtain as full as possible an account of risk-taking within the prison, in-depth interviews were undertaken with 22 inmates, including all but one of those diagnosed as HIV-positive. The interviews aimed at elucidating details of sharing networks, the availability and condition of injecting equipment, and the procedures used to clean it.

From the interviews emerged a vivid description of random sharing with a limited number of needles and syringes, which were mostly blunt, broken, or fashioned out of a variety of materials. What follow

are verbatim accounts from the prisoners themselves.

> You wouldn't believe it. It was like something out of the Bronx. The cells were packed with junkies waiting on a hit.
>
> There was only one set of syringes in the hall and there was estimated to be about fifteen or twenty users.
>
> I've seen, in my cell, seven or eight people waiting to use one set of tools at one time.

Most inmates claimed always to clean used equipment, but circumstances in prison mitigate against this being carried out effectively, even if sterilizing equipment is made available. Because prisoners can be accosted at any moment by prison officers, injecting and cleaning is a hurried affair:

> When you're cleaning it [injecting equipment] there are usually a few waiting for it. I've seen boys just jumping up and giving it a couple of flushes with cold water and then on to the next boy. A few times I've noticed a few wee clots of blood still down at the bottom of it.

Even if bleach is available, it may remain either unused or ineffectively used:

> They wouldn't use bleach. If you are sitting in a cell and hurrying before lock up, you just give them a quick flush out, have your hit and on to the next one.

Effectiveness of Bleach as a Decontaminant

The effectiveness of bleach as a decontaminant for injecting equipment has been questioned on both biological and behavioral grounds.(132) Drug injectors have been shown to underestimate the time required for sterilizing purposes. The chance of effective decontamination is likely to be decreased even further when the equipment used is as follows:

> There was one time I was using this green spike and it was actually bending because it was so blunt. I had to get someone to force it in.
>
> My arms are in some mess, big bruises and big massive holes. The spikes were sharpened on wee bits of sandpaper.
>
> We were all cleaning them out but I reckon we were catching it off the needle with it being corroded on the inside and maybe blood was clinging to it. Or the plunger - we had to get a plastic bag and stretch it over and get a bit of thread and tie it round. But the plastic bag would split when it was stretched over and I reckon the virus was in that

because I've seen - it wasn't exactly fungus, but it was getting that way.

Shooting galleries and random sharing have been shown to be high-risk factors in the transmission of HIV.(133) That there was a shooting gallery in Glenochil is undoubtedly the case.

Reasons Behind the Outbreak

Commenting on the reasons behind the outbreak of HIV infection at Glenochil institution, Taylor and Goldberg said:

In Scottish prisons, bleach tablets are now available and detoxification programs have been implemented in some establishments, including Glenochil. But the two principal and highly successful means of HIV prevention - needle and syringe exchange schemes and methadone maintenance - are not available. If HIV transmission is to be most effectively prevented, however, harm-reduction methods that are implemented in the community should also be implemented in prisons.(134)

They continued by saying that prison staff are "understandably concerned" about the possible security risks deriving from the wider availability of needles and syringes in the prison environment, and that - even with the success of the pilot needle and syringe exchange schemes in Swiss prisons - there will still be resistance to such a solution at both political and cultural levels in many other countries. Nevertheless, they concluded that, if another outbreak of the type reported from Glenochil is to be avoided, the "same efforts that have gone into preventing HIV transmission among drug injectors outside prisons must be given to the prevention of spread inside":

The illegality of drug taking and the lifestyle of crime that many injectors adopt to support their drug use means that drug injectors spend large parts of their life in prison. For some injectors, prison provides the opportunity to cease drug use, at least for the duration of their sentence. This in turn means that some come out of prison healthier than when they went in. On the other hand, for those who continue, prisons continue to be an extremely high-risk environment.(135)

After the outbreak, Gore and Bird pointed out that under current circumstances "a prison sentence, prohibiting access to clean needles for injectors, may become a death sentence." They emphasized that "HIV education alone is not enough to escape the death sentence of HIV transmission," and added:

If politicians had the humanity to grant prisoners the same rights to reduce their risk of HIV infection as the rest of the population then prison services could help inmates to stop endangering each other, and they could deliver those rights without risking disorder in the prisons. Practical initiatives are impeded for lack of political will and legal reform."(136)

Gore and Bird concluded by emphasizing that - as shown by research - "inmates are more likely than the outside population to have injected drugs, to have had many female sexual partners, and to have had sex with other men."(137) The clear public health implication of this is that prisoners have a greater need than the general population for practical means of harm reduction. Apart from urging prison systems to make such means available, Gore and Bird urge prisons to develop a public health protocol that can be implemented when HIV transmission occurs in a prison: "This protocol must guarantee prisoners the right to medical confidentiality while ensuring that accurate epidemiological information is collected. (138)

Australia: A Network of HIV Infection

Evidence of HIV transmission occurring in the prison setting was also found in prisons in Australia.

Dolan reported Australia's first confirmed case of custodial seroconversion, a 32-year-old man imprisoned continuously from before 1980 until after 1990. Prison medical records confirmed that his serum tested negative for HIV antibodies in July 1987 but positive in November 1989. His first reported experience of homosexual contact and drug injection occurred in prison. The prisoner with whom the man reported sharing needles later died of an AIDS-related illness, as did a second prisoner with whom he reported having sexual contact in 1988. Dolan emphasized that high-risk behaviours and limited opportunities for reducing risk in prisons increase the potential for HIV transmission, and added that rapid turnover of prison populations may mean that the chance of detecting such transmission is reduced. She concluded by saying that greater emphasis on prevention of HIV infection in prisons is required, "including syringe disinfection and possibly needle and syringe exchange programs, drug treatment programs (especially methadone maintenance) and provision of condoms."(139)

Based on the first confirmed case, Dolan later investigated an apparent network of HIV infection among Australian inmates. Nine injection drug users and their prison contacts were traced, prison records and medical files were checked, and likelihood of acquiring HIV infection in prison was rated on:

- testing negative and positive in prison;
- documented probable primary HIV infection more than 28 days after prison entry;
- transfer to a particular prison wing during a crucial one-month period; and
- reported syringe sharing in prison.

The investigation showed that a possible total of seven injection drug users were infected in prison, leading Dolan to conclude, once again, that "HIV transmission in prisoners may be underestimated by current surveillance methods," and that "HIV prevention in prison needs reconsidering in the light of new evidence."(140)

Another case of custodial seroconversion was reported in Queensland.(141)

United States: Strong Evidence for HIV Transmission in Prisons in Florida

Mutter and colleagues identified 556 prisoners in the Florida Department of Corrections who had been continuously incarcerated since 1977. The medical records of these prisoners were reviewed to determine whether they had been tested for HIV and, if tested, whether the results were positive. Eighty-seven of the 556 prisoners had undergone testing for HIV infection. Of these, 18 (21 percent) were found to be HIV-positive, providing strong evidence for transmission of HIV in prison.(142)

France - Imprisonment as a Risk Factor

In a study of HIV seroprevalence and risk-factor information conducted in prisons in southeastern France, 20 percent of participants were intravenous users, 51 percent of whom reported needle-sharing prior to incarceration (researchers were not allowed to collect information about risk behaviours in prison). The most disturbing result was that, when controlling for age, sex and available risk-factor information, HIV seroprevalence was significantly higher among prisoners who had been incarcerated previously (19.9 versus 4.4 percent). According to the researchers, one hypothesis is that incarceration is a risk factor in itself - the likelihood of HIV infection increases with the frequency and duration of incarceration: "Given the low level of preventive strategies in French prisons, imprisonment is a high-risk situation."(143) The researchers concluded by saying that the fight against the spread of AIDS must include an efficient preventive strategy inside prisons themselves: "preventive measures such as easy access to condoms for inmates, supplying bleach to IVDUs, implementing syringe-exchange programmes and preventing the illicit introduction of drugs, should be established or improved as a matter of urgency."(144)

Thailand: Dramatic Increase of HIV Infection After Amnesty

In 1987, HIV infection among injection drug users presenting for drug treatment in Bangkok rose from two percent before 9 February to 27 percent by 7 March.(145) The dramatic increase closely followed an amnesty on the King's birthday, when numerous prisoners were released. Substantial HIV transmission in prison was thought to be behind the high HIV incidence. The study was only suggestive of transmission having occurred in prison, but indicated that the extent of transmission can potentially be enormous.

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Hepatitis C

Hepatitis C seroprevalence rates in Canadian prisons are very high, mirroring the fact that injecting drug users are over-represented in prisons and that reported levels of seroprevalence among them are high in the community. While most hepatitis C positive inmates come to prison already infected, the potential for intramural spread is high: hepatitis C is much more easily transmitted than HIV, and transmission has been documented in prisons in Canada,(146) Germany, and the US. As expressed by the authors of

one Canadian study,

> Hepatitis C seropositivity in [the prison] population likely represents a marker for intravenous drug use. Infection may well have occurred prior to incarceration, but this finding [high hepatitis C seroprevalence rates] does indicate a significant population with a propensity to high-risk behaviour. It also indicates a considerable burden of ill health which will fall, initially, on the prison medical services but, ultimately, on provincial health care systems.(147)

New Cases of Hepatitis in Federal Prisons in Canada

From January to August 1995, 223 new cases of active hepatitis C and 22 new cases of hepatitis B were reported in federal prisons in Canada.(148) In 1996, the number of new cases has increased substantially: from January to April alone, 167 new cases of active hepatitis C and 19 new cases of hepatitis B were reported.(149)

Studies in Canadian Prisons

Three studies undertaken in Canadian prisons revealed hepatitis C seroprevalence rates of between 28 and 40 percent.

Prison for Women

In the first study, undertaken at the Prison for Women in Kingston, 39.8 percent of the 86.9 percent of inmates who participated tested positive. This was a voluntary, linked, anonymous, cross-sectional study that was carried out in conjunction with a study of HIV seroprevalence in the same population. In the study, no attempt was made to evaluate risk behaviour because it was made clear by inmate representatives that this would jeopardize participation.(150)

Joyceville Institution

In the second study, undertaken at Joyceville Institution, a medium-security federal penitentiary near Kingston, 27.9 percent of the 68.9 percent of inmates who participated tested positive.(151) An increasing awareness of hepatitis C among inmates of other penitentiaries in the area led to a rise in the number of prisoners requesting testing. In the study, hepatitis C testing was offered on a voluntary nominal basis to the entire population of the penitentiary. The seropositivity rate is somewhat lower than that found at the women's prison. According to the authors of the study, this may reflect a different exposure to risk prior to incarceration in female compared with male prisoners.

Male Inmates in British Columbia

A third study of male inmates in British Columbia showed a prevalence of 28 percent.(152)

Studies in Prisons Internationally

Similar figures are reported from other prison systems.

Australia

In prisons in Victoria (Australia), 39 percent of 3627 prisoners tested had been exposed to hepatitis C; 46 percent had a history of injecting drugs. Prevalence of hepatitis is as high as 50 percent in prisons in New South Wales (NSW).(153)

US: Maryland

Among male inmates in a study of prevalence and incidence of hepatitis C in Maryland, 38 percent had antibodies to the hepatitis C virus (HCV) upon entry into prison. In the study, 87 percent of HIV-positive persons were also HCV-seropositive. Of 164 initially seronegative inmates, two seroconverted. (154)

US: Connecticut

Among female inmates in a study on hepatitis C prevalence and incidence in Connecticut's sole intake facility for women, 32 percent of a random sample of 174 inmates, 76 percent of 162 injection drug users, and 46 percent of 154 non-injection drug users who reported sex with injection drug users tested positive for antibodies to HCV. During a one-year follow-up, three of 13 HCV-negative injection drug users became HCV-positive.(154a)

Germany

Results of a study undertaken in the prison for women in Vechta, Lower Saxony, (Germany), showed that at least 20 women had definitely been infected with hepatitis while in prison.(155)

In the study, 1032 health records were examined to evaluate data on the prevalence of HIV, hepatitis A, B and C, and syphilis among female prisoners between 1992 and 1994. About one-third of the study population were injection drug users (IDUs), and 74 percent had been tested for the above-mentioned infectious diseases at least once.

- HIV prevalence was 4.9 percent among IDUs and 0.5 percent among non-IDUs;
- prevalence of hepatitis B was 78 percent among IDUs and 12.7 percent among non-IDUs; and
- prevalence of hepatitis C was 74.8 percent among IDUs and 2.9 percent among non-IDUs.

Records of prisoners who underwent at least two tests for the same disease were examined to determine

whether seroconversion had occurred during uninterrupted prison sentences. For 41 IDUs, seroconversion could be documented; of these, 20 (48.8 percent) had definitely been infected with hepatitis while in prison.

Alarming Potential for Rise of HIV

The rates of hepatitis C seroprevalence found in these studies are disturbingly high. Hepatitis C is generally spread by either blood transfusion or by use of contaminated injection equipment, with sexual transmission being a more remote possibility. In the prison population, seropositivity for hepatitis C likely represents a marker for IV drug use at some time in the majority of those testing positive and "suggests an alarming potential for the rise of HIV."(156) According to the authors of two of the Canadian studies, results of the studies "would emphasize, yet again, the need to implement the harm-reduction strategies outlined in the report of the Expert Committee on AIDS and Prisons."(157) It will further be necessary to

> explore both the specific circumstances of infection, primarily related to drug use and perhaps sexual activity, and the independent risk of tattooing and other skin piercing activities. The incidence of infection among inmates while in prison will also have to be examined.(158)

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Legal Action by Prisoners

Three recent cases have raised the issue of governments' responsibility for the health of prisoners in their care.

The Australian "Condom Case"

As discussed in more detail by Malkin in Appendix 1, infra, in New South Wales (NSW) in Australia, 50 prisoners launched a legal action against the state for non-provision of condoms.(159) Their lawyer noted that "[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded."(160) Since then, at least in part because of the legal action, the NSW government has decided to make condoms available in three prisons on a trial basis. While the legal action is ongoing and remains to be determined, the prisoners involved have decided not to push the case while the condom trials are ongoing. If, as a result of the trials, there is general introduction of condoms in NSW jails, the case will likely be dropped.

The Australian Seroconversion Case

A prisoner who seroconverted while in a maximum-security institution in Queensland, Australia, launched an action for damages for negligence against the Queensland Corrective Services Commission (QCSC). This was one of a number of cases brought against the QCSC that alleged misconduct in the treatment of HIV-positive prisoners. The facts of the case were that:

- prisons in Queensland do not supply condoms or syringes;
- prison staff have searched for and confiscated such items;
- prisoners are tested for HIV on entry, after three months, after six months, then annually, and on discharge;
- the prisoner in question was a long-term prisoner who had several negative tests before testing positive;
- all parties accept that the seroconversion happened in prison;
- correctional authorities first said that the prisoner had given first aid to another prisoner who had cuts on his hands;
- it was then alleged that he had been playing volleyball and had been exposed to the blood of a seropositive prisoner;
- subsequently, seropositive prisoners were banned from playing contact sports; and
- some suspect that the prisoner contracted HIV through unprotected sex and/or injection drug use and that the case therefore raises the question of prisons' duty to provide condoms, bleach, and sterile needles.(161)

While at least one of the cases brought against the QCSC is ongoing and set for hearing in September 1996, the action for damages has been dropped because the case was funded by Legal Aid and would have been too costly to pursue.

The British Columbia Methadone Case

In April 1996, an HIV-positive woman was sentenced to 21 days imprisonment at the Burnaby Correctional Centre for Women (BCCW) in British Columbia. At the time of her sentence, she was on a methadone maintenance program supervised by her primary-care physician. In accordance with a longstanding BC Corrections Branch policy, the BCCW refused to provide her with methadone. As a result of this refusal, she petitioned the British Columbia Supreme Court for relief in the nature of habeas corpus.(162)

The petition to the Court argued that, under the circumstances the petitioner found herself in, her detention was illegal. It raised several constitutional arguments based on the Canadian Charter of Rights and Freedoms. In response to the petition, and despite the position it had originally taken, the BCCW arranged for a staff doctor to examine the petitioner, and he prescribed methadone for her. After this, she withdrew her petition seeking habeas corpus.

Importantly, in affidavit material filed in this case, the Director of Health Services for the BC Corrections Branch indicated that the BC Corrections policy would be changed to recognize the validity of the harm-reduction model for prisoners and to allow for methadone treatment of prisoners in certain

circumstances.

The petitioner's primary-care physician has since stated that, although no precedent was set in law by the case, "it was a precedent that was set by deed." He continued by saying that he expects that in future Corrections will act accordingly, and that "[w]e are certainly ready to repeat a court challenge at a moment's notice if necessary."(163)

Conclusion

These cases show the willingness of prisoners to take legal action against government inaction. Both in the Australian condom case and the Canadian methadone case, legal action has provided the catalyst necessary for the institution of long-recommended changes and reasonable responses to HIV by prison authorities. Courts have not even had to pronounce on the substantive issues raised in the cases: governments and correctional authorities, at least in part because of the cases, have acted before the courts forced them to do so.

Reports on HIV/AIDS in Prisons

Since ECAP's Report was released in March 1994, reports on HIV/AIDS in prisons have been published in several other countries. Generally, these reports contain recommendations very similar to those issued by ECAP, reinforcing the consensus that more needs to be done to prevent the spread of HIV in prisons and to care for prisoners living with HIV/AIDS.

The Netherlands

The Dutch National Committee on AIDS Control (NCAB) released a 90-page report called AIDS and Detention: The Combat Against AIDS in Penitentiary Institutions in the Netherlands.(164) In the report, concern is expressed about the present state of HIV/AIDS policy in prisons in the Netherlands. The NCAB points out that many prisoners belong to societal groups - such as drug users, prostitutes, marginal youth, migrants - that are especially vulnerable to contracting HIV infection. Prisons are considered as an opportunity to reach these groups through education and prevention activities. According to the authors, AIDS policy in prisons should correspond to AIDS policy in the wider society, and to the WHO Guidelines on HIV Infection and AIDS in Prisons.

United Kingdom

In June 1995, the Prison Service of England and Wales released its Review of HIV and AIDS in Prison. (165) The report contains 39 recommendations in the areas of research, staff and prisoner education, prevention, risk reduction and harm minimization, counselling, psychological and social care, and medical aspects of HIV in prison. Among other things, it recommends that cleansing agents (washing-up

liquid and Milton sterilizing tablets), and condoms, dental dams, and lubricant be made easily accessible to prisoners.

All of the Committee's recommendations have been accepted, with one exception: condoms will not be made easily accessible, but will remain available only on prescription "if in the clinical judgment of the doctor there is a risk of HIV infection." At a time when many prison systems worldwide make condoms easily accessible to inmates - and when experience has shown that this can be done without creating any problems and with support from management, staff, and prisoners - this is hardly understandable.

The report places emphasis on multidisciplinary teamwork to address the issues raised by HIV/AIDS in prisons. It is evidence of the existing international consensus with regard to HIV/AIDS in prisons. Many of its recommendations are the same as, or at least similar to, those previously issued by other committees and by the World Health Organization, with one exception: it does not recommend setting up needle-exchange programs in prisons in England and Wales. The report fails to deal convincingly with this issue: the Committee considered recommending the setting up of needle-exchange schemes, but

> felt that such an approach would be fraught with difficulty and would fit uneasily with the duty of prison authorities and staff to detect the smuggling of drugs into prison and to prevent drug misuse during custody. The conflict between encouraging prisoners to use an exchanges scheme and detecting illicit drug use would have no easy resolution.

However, and in complete contradiction to this argument, the Committee goes on to say that

> the probability of HIV infection amongst drugs users in prison is such that the Prison Service should make available to clandestine injectors the means of effectively sterilising needles.

Admittedly, making sterile needles available in prisons is more difficult than making bleach available, but in terms of the conflict invoked by the Committee there is no difference between making needles and bleach available: both are an acknowledgment that drug use occurs in prisons, and both create a conflict between the prison system's mandate to prevent drug use and its responsibility to prevent the spread of HIV.

Australia: A Community Policy on Bloodborne Diseases

A number of community groups in New South Wales (NSW) have joined forces and produced a policy on the prevention and treatment of bloodborne diseases such as HIV and hepatitis C, in the prison system.(166) The policy was launched on 18 September 1995. It reflects the interests of a wide range of community-based organizations, including the AIDS Council of NSW (ACON), a drug-user association, the Hepatitis C Council of NSW, a prisoners action group, and a group of transgender persons.

According to Geoffrey Bloom, Policy Advisor for ACON, all measures proposed in the policy "must be implemented before NSW can say that it is doing all that it can to fight the epidemics."(167)

Among many other things, the policy recommends that:

- all prisoners have "free, confidential access to new injection equipment on a strict exchange basis"; drug equipment be "excluded from communal spaces within the prison, except for transport to and from a point of exchange"; prisoners be provided with information and education about the correct use of injecting equipment; prisoners "known to have this equipment should not be subject to discriminatory treatment or harassing cell searches";
- prisoners have access to bleach, and to sterilization equipment of a clinical standard for tattoo guns and body-piercing equipment;
- there be no limit to the number of prisoners who have a history of opiate use having access to the prison methadone program;
- positive prisoners be given information about and access to all existing treatments, complementary therapies, and alternative and natural therapies available outside prison;
- requests from seriously ill positive prisoners for compassionate early release be considered promptly.

The policy also addresses an issue that underlies many of the problems raised by HIV/AIDS in prisons - current drug laws that result in many drug users being sentenced to prison, where they continue using and run an increased risk of contracting HIV. In order to decrease the number of drug users sentenced to prison, it recommends a variety of changes to drug laws.

Scotland: A Report on Drug Use and Prisons

According to the report, the primary objective of prison is secure custody for those sentenced by the courts:

> Such deprivation of liberty constitutes the punishment which is imprisonment. Drug rehabilitation should not be seen as a primary objective of prisons, and for drug users to be sent to prison on that basis would be a retrograde step.(168)

The report urges governments and prison systems to address the possible adverse effects of sending drug users to prison, in particular the potential impact of prisons in increasing risk in terms of HIV and AIDS:

> This involves both examining what happens to drug users in prison, and after they are released. A coalition of services is required to liaise with prisons to minimise the harm which results to prisoners, to lessen the impact on prisons, and reduce the risk to public health.(169)

The report concludes that it

> would be advantageous if prison authorities were to adopt the aims and objectives of a harm reduction response to drug use and HIV. This would involve a pragmatic response, and the realisation that the idea of a drug free prison does not seem to be any more realistic than the idea of a drug free society, and that stability may actually be better achieved by moving beyond this concept. In addition, adopting a harm reduction perspective puts prisons in the best position to ensure that they are not identified with major areas of concern for public health, such as the spread of HIV.(170)

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Needle Exchange in Prisons

> The FOPH [Swiss Federal Office of Public Health] is of the opinion that inmates should have the same possibilities as people outside prisons to protect themselves against HIV infection. Making sterile needles and syringes freely available is now part of AIDS prevention measures for injection drug users. The same rights - to have access to clean needles and syringes, and to counselling and medicosocial help - apply to inmates.(171)

Background

In Canada as elsewhere, providing sterile needles to inmates has been widely recommended as a health measure necessary to reduce the spread of HIV in prisons.(172) In its Final Report, ECAP observed that the scarcity of drug-injection equipment in correctional facilities almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment:

> Some injection drug users have stated that the only time they ever shared needles was during imprisonment and that they would not otherwise have done so. Access to clean drug-injection equipment would ensure that inmates would not have to share their equipment.(173)

The Committee concluded that making injection equipment available in prisons will be inevitable, particularly because of the questionable efficacy of bleach in destroying HIV.(174) As jointly stated by the Centers for Disease Control and Prevention, the Center for Substance Abuse Treatment, and the National Institute on Drug Abuse, "based on recent research, bleach disinfection should be considered as a method to reduce the risk of HIV infection from re-using or sharing needles and syringes (and other injection equipment) when no other safer options are available."(175) The centers emphasized that sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and

syringes.

ECAP therefore recommended that "research be undertaken that will identify ways and develop measures, including access to sterile injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use in federal correctional institutions."(176)

ECAP's recommendation - which is consistent with the recommendation of many national and international committees and organizations - has since been repeated in a number of other reports and in an Australian study on bleach availability and risk behaviours in prisons in New South Wales.(177) That study is important because it was the first in the world to allow the independent monitoring of a bleach distribution program for prisoners. It investigated the access of prisoners in New South Wales to disinfectants for syringe decontamination and the prevalence of injection drug use, syringe sharing, tattooing and sexual activity in prison. It found that three years after the distribution of disinfectants began, 62 percent of inmates still found it difficult to gain access to them. It concluded that "[e]ven if an acceptable and effective form of disinfectant was identified, operational problems may still compromise the effectiveness of a syringe cleaning program for prisoners... ." The study pointed out other shortcomings of a syringe disinfecting program, such as uncertainty about whether other bloodborne viruses such as hepatitis B and C can be effectively and rapidly decontaminated from injecting equipment with the use of bleach. It concluded that other prevention measures need to be explored and that one such measure that requires consideration is piloting a syringe-exchange program in prisons.

One year later, a follow-up study found that there had been significant improvement in easy access to bleach from the first study: 56 percent of respondents found it easy to obtain one of the two forms of bleach (Milton tablets and liquid bleach) available in prison. Nevertheless, the study found shortcomings in the bleach program and again recommended that consideration be given to a pilot study of syringe exchange in prisons.(178)

While CSC rejected ECAP's recommendation to undertake such a pilot study, an increasing number of prisons worldwide has established - or is planning to do so in the near future - needle and syringe exchange programs. The following is a review of these programs.

Switzerland: A Tale of Pragmatism

The Hindelbank Pilot Project

> The distribution of sterile needles, a preventive measure which has proved effective outside of the penitentiary environment for many years, has up to now not crossed the threshold of prison doors. The primary argument against such a strategy has traditionally been the apparent incompatibility of such a protective health measure with the illegal status of drugs. The controversy resulting from this dilemma has, above all, been marked by speculations and fears concerning the possible repercussions of introducing this pragmatic measure to a prison environment.

> An attempt to dispel such uncertainties was one of the primary objectives of the pilot project created at the Hindelbank Penitentiary, which among other measures included the distribution of sterile syringes. The target of the project was by no means to give 'a green light' for the consumption or misuse of drugs. Instead, the project's aim was to reduce the associated health risks faced by the prisoners.(179)

A one-year pilot AIDS prevention program including needle distribution started at Hindelbank institution for women in June 1994. One year later, a decision was taken to continue the program because evaluation by external experts demonstrated clear positive results:

- the health status of prisoners improved;
- no new cases of infection with HIV or hepatitis occurred;
- an important decrease in needle sharing was observed;
- there was no increase in drug consumption; and
- needles were not used as weapons.

Hindelbank Institution

Hindelbank Institution is the only prison for women in the German-speaking parts of Switzerland. It can house up to 110 inmates in its six divisions. During the year in which the pilot project took place, 99 women entered and 112 left the prison, for a mean occupancy rate of 87. The majority of the prisoners have been sentenced for narcotics offences, and one-third of prisoners reported having consumed heroin or cocaine before their incarceration.

History of the Project

At the end of the 1980s, because of the appearance of HIV/AIDS, health-care workers at the institution became concerned about the increased harms deriving from injection drug use and began requesting that new and more effective preventive measures be implemented.(180) In 1988, the institution's health-care services - without having obtained permission from the competent authorities - decided to hand out sterile injection equipment to injection drug users, on their request. When authorities became aware of this decision, they prohibited the handing out of injection equipment. As a result, a physician of the institution decided to poll inmates on drug use and needle exchange. He found that almost all the women who were injection drug users had exchanged needles with other inmates. Armed with this information, he proposed, with the agreement of the director of the institution, launching a pilot project to provide sterile equipment to inmates. At first the proposal ran up against opposition, but thanks to the collaboration of the Swiss Federal Office of Public Health, authorization was finally granted in 1994. After a fairly long process of political decision-making and a short preparatory phase, the pilot project was launched at Hindelbank on 13 June 1994.

Aims of the Project

The aims of the pilot project were as follows:(181)

- to study the feasibility of needle distribution in the prison environment;

- to make sure that the project is accepted by all persons concerned (inmates and staff);
- in the short term, to reduce the harms from drug use;
- in the short term, to prevent infection or reinfection by dangerous pathogenic agents (HIV, hepatitis B virus, hepatitis C virus, etc); and
- in the medium or long term, to reduce the number of new drug users and of former users who relapse.

Further, with the help of the independent scientific evaluation, the project aimed at:

- assessing the impact of the project on drug use, risk behaviours, and, generally, the health of inmates; and
- drawing conclusions and making recommendations regarding the application of the adopted measures in other institutions.

Methods

The methods used to achieve these goals were directed to all inmates and included demonstrations, group meetings that used exercises, role playing, consultations with the project director and his co-workers, a hotline for discussion of problems, supplementary prevention measures, and written and audiovisual materials.

The provision of sterile syringes was basic to the project. During their first interview with the project director or his co-workers, inmates received a syringe, which could not, however, be used for injection purposes. The secretariat of the institution provided new inmates with such a syringe, together with instructions in their mother tongue, upon their arrival. With the help of this subterfuge (a real syringe without a needle), or with a syringe that had already been used, inmates could operate an automatic dispenser to get a sterile, ready-to-use needle. Automatic dispensers were installed in each of the six sections of the institution, in different locations - such as showers, toilets, storage areas, etc - that are easily accessible by prisoners. Prisoners were allowed to keep one (but not more) piece of injection equipment, but only in a designated toilet cabinet.

Evaluation

Evaluation was undertaken by a group of external experts. Structured interviews were carried out with the prisoners and the personnel before launching the project, and three, six and twelve months thereafter. The interviews included questions concerning the socio-cultural context of the individual, consumption of drugs (past and present), risk behaviours, the level of knowledge concerning AIDS and hepatitis, and the acceptance and use of preventive measures. Additional data were also gathered, eg, the number of needles distributed, the number and nature of sanctions, particular incidents, and the results of the prisoners' medical examinations.

A total of 137 prisoners and 48 staff participated in at least one interview; 70 staff answered a questionnaire.

Drug Use

One third of prisoners interviewed admitted to using heroin or cocaine while in prison, with three-fourths doing so by injection.(182) Only women who already used drugs on a regular basis before entering Hindelbank continued to do so once in prison. Among women who used heroin or cocaine in the month preceding their incarceration, three-fourths continued to do so once in prison.

The number of prisoners using heroin or cocaine while in prison has not fluctuated significantly since the installation of the needle-dispensing machines. The frequency of consumption and the manner of absorbing drugs (smoking, injecting, sniffing) also remained more or less the same during the course of the project. Finally, there was only one case of overdose at Hindelbank during the course of the project, whereas there had been 16 cases in one year, two years before the project started.

Distribution of Needles

During one year, 5335 needles were distributed, an average of 14 per day (with a maximum of 78 and a minimum of 0), or one needle per prisoner every six days. The use of needles decreased during the second half of the project.

Utilization of needles seemed to depend primarily upon two factors:
- the availability of drugs; and
- prisoners' capacity to purchase them.

Consumption of drugs, and need for needles, typically increased during a period of several days after prisoners received their wages and whenever larger than usual quantities of drugs were available in the institution.

Sharing of Needles

> Between 1989-1992, 14 studies were conducted in Switzerland concerning the effects of the distribution of sterile syringes to drug consumers (outside of the penitentiary system). All of the above studies revealed a marked decrease in the sharing of used syringes. The same observations have been made on an international level.
>
> The evaluation of this preventive measure at Hindelbank supports the above findings. (183)

In May 1994, before installation of the distribution machines, eight of 19 intravenous drug users declared having shared needles with other drug users. One year later, only one individual continued sharing. Generally, after installation of the machines, needles were shared only when the machines were out of order or when a situation of trust had been established between friends who knew themselves to be HIV-negative. Decrease of sharing was gradual:

- before the project started, eight prisoners declared sharing;
- after three months, four prisoners declared sharing;
- after six months, two declared sharing; and

- after 12 months, one declared sharing.

Medical Examinations
Upon their arrival at the prison, 94 women underwent a voluntary blood analysis. A high percentage tested positive:

- 6 percent for HIV;
- 73 percent for hepatitis A;
- 48 percent for hepatitis B; and
- 37 percent for hepatitis C.

Fifty-one of the women were re-tested at the time of their release from prison; no new infections were diagnosed. This result is significant, but should nevertheless be taken with caution because only a fairly short period of time had passed since the first test.

Acceptance of the Prevention Measures
Only about 20 percent of staff did not agree with the installation of the needle distribution machines; the vast majority either agreed or "totally agreed." As expressed in the final report about the project,

> a clear majority of staff at the institution has in the meantime approved of prevention measures including distribution of sterile needles, even if this approval is not dictated by feelings but by reason.(184)

It should be emphasized that during none of the phases was any active resistance shown. Further, the intervention gave rise to open discussions about what had gone on that would previously not have been talked about:

> It is an important step when it comes to motivating staff to look more, and more deeply, into questions relating to infectious diseases and drug use and, in this respect, to develop greater competence.... [P]reviously, the various sections would have tended to hide the drug-related problems they had with their inmates and would have pointed out other sections, whereas now it almost goes without saying that there is an exchange of experiences.(185)

According to the project director, concrete statements such as the following helped to overcome the resistance of some staff, and to explain to them why sterile needles need to be made available:

- Many inmates are in the Hindelbank institutions because of violations of drug laws. Some have continued to use drugs although they have been submitted to insecurity-producing tactics. Where fraud is concerned, wealth of imagination seems to have no bounds; in spite of the controls, "dope" is always available.

- The statements made by women when they were consulted in relation to the prevention project highlighted what had been understood from the outset: women who were never drug-dependent don't need them and don't have to refuse to use them because they're afraid of dependency developing rapidly, independent of the availability of syringes. For women who used drugs or who still do, the fear of damage to health from the use of unclean syringes is not a reason to abstain. When they are in withdrawal, they look for, find, and use drugs, whether or not the available syringes are clean or already used.
- The HIV/drug prevention project did not promote the use of drugs. Abstinence remains the goal. This involves a long journey during which the question is one of avoiding further harms - health policy measures, not drug policies.
- The project is an attempt to live with contradictions and to find compromises after weighing the judicial benefits.
- With regard to infectious diseases, the aim of an HIV/drug prevention project does not only concern AIDS, but also other dangerous pathogenic agents such as the hepatitis B and C viruses.
- An HIV/drug prevention project in a penal institution likely has repercussions with respect to the state of health of the rest of the population.(186)

Conclusions
The evaluation report concludes:

> The results of the pilot-project undertaken at Hindelbank Institution do not provide any argument against the continuation of the distribution of sterile syringes. The fears expressed at the beginning - that drug use would increase, that needles would be used as weapons or accidentally cause injuries, etc - were unjustified.(187)

According to the report,

> the feasibility of distributing needles and syringes, the positive consequences it had on the sharing of needles, and the considerable acceptance of the project by inmates and staff... lead to the conclusion that the distribution of sterile needles and syringes could also be justified in other prisons.

The Future of the Project
Following the evaluation, the prison authorities have decided to continue the project.

Oberschöngrün: Distribution of Sterile Injection Equipment at a Men's Prison

Hindelbank was not the first institution to distribute sterile injection equipment to inmates, but was the first to scientifically evaluate such a program. It was in another Swiss prison, the Oberschöngrün prison for men, that sterile injection equipment first became available to inmates in 1993. Oberschöngrün is a

minimum-security institution housing approximately 75 prisoners, of whom 10 to 15 "seek to use illicit drugs on a daily basis, so as not to go into withdrawal."(188)

History

> Dr Franz Probst, a part-time medical officer, working at Oberschöngrün prison in the Swiss canton of Solothurn was faced with the ethical dilemma of as many as 15 of 70 inmates regularly injecting drugs, with no adequate preventive measures. Unlike most of his fellow prison doctors, all of whom feel obliged to compromise their ethical and public health principles daily, Probst began distributing sterile injection material without informing the prison director. When this courageous but apparently foolhardy gesture was discovered, the director, instead of firing Probst on the spot, listened to his arguments about prevention of HIV and hepatitis, as well as injection-site abscesses, and sought approval from the Cantonal authorities to sanction the distribution of needles and syringes. Thus, the world's first distribution of injection material inside prison began as an act of medical disobedience.(189)

Results

Three years later, distribution is ongoing, has never resulted in any negative consequences, and is supported by prisoners, staff, and the prison administration:

> Distribution of syringes is giving altogether satisfactory results. Given the fact that HIV tests are not mandatory, it is impossible to precisely evaluate the effect of distribution on the transmission of the virus. However, a reduction in the number of cases of hepatitis and the complete absence of new abscesses has been observed. Nothing indicates that drug use has increased as a result of these measures.(190)

According to the warden, Mr Fäh, initial scepticism by front-line 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.(191)

Fäh continued by saying that staff have been told not to use the fact that they may see injection equipment in a prisoner's medical cabinet as a reason for asking him to submit to urinalysis: "Because inmates trust this, they keep the syringes in the cabinet - and this in turn increases staff's safety."

About 700 sterile injection units are handed out yearly by Dr Probst, at a cost of only 400 Swiss francs (approximately CDN$440), "much less than would be the costs of caring for the cases of hepatitis and abscesses we avoid by handing out sterile equipment."(192) A decision was taken not to install dispensing machines, as at Hindelbank, for two reasons: fear that inmates in a prison for men would vandalize the machines, leaving injection drug users without supply when needed. Further, prisoners who obtain injection equipment from Dr Probst feel that this better ensures anonymity than if they had to retrieve equipment from a dispensing machine: nobody else knows why they visit the physician, nobody can see them while they are with him, and he is bound by a professional obligation of confidentiality not to reveal who obtains equipment from him. From the physician, who comes to the institution once every week, inmates can obtain more than one injection unit at a time, and distribution is not undertaken on a strict one-for-one basis (one used against one new, sterile, unit). As emphasized by Mr Fäh,

> it is more important to make sure that prisoners who are injection drug users can always use sterile equipment than to insist on a one-for-one exchange scheme. We have a fairly good return rate, and are not concerned about not all equipment being returned to Dr Probst. What we do care about is safety of staff - and staff has not been exposed to any hidden needles.(193)

Rationale

Fäh emphasizes that the objective of making sterile injection equipment available to inmates is not the legalization of drugs, but rather the prevention of AIDS:

> Knowing the danger that HIV infection represents, we cannot give up distributing syringes because we would thereby be forcing drug-using inmates to shoot up with dirty needles - which is an ethical issue.(194)

Discovered in the course of urine testing or cell searches, the possession and/or consumption of drugs (but not the possession of injection equipment, provided it is kept in the designated cabinet in the inmate's cell) is still a ground for disciplinary measures. In 1993, a total of 623 urine probes were analyzed to detect prisoners' drug use: 194 tested positive, 412 tested negative, and 17 had been "faked." Urine is tested only for traces of opiates, cocaine, barbiturates, amphetamines, methadone, and benzodiazepines, but not for traces of cannabis products. This decision was taken because use of cannabis products is not considered a safety and discipline problem in the institution and because of fear that prisoners using cannabis products would switch to other, more harmful, drugs if testing for traces of cannabis was undertaken.

In a pamphlet describing the reasons why injection equipment is distributed in the institution, the administration concludes that

> our goal is and will remain to prevent inmates from using drugs, or to reduce their drug consumption.... Since we began making injection equipment available, we have not

noticed any significant reduction or increase in drug use. But surely we have done something useful for the health of our inmates, and for prevention of the spread of HIV in general.(195)

Geneva: Availability of Injection Equipment in Men's Prisons

As announced by Prof Harding at the interdisciplinary symposium on harm-reduction strategies in prisons in Berne, Switzerland, on 3 March 1996, distribution of sterile injection equipment to injection drug users started in at least one prison for men in Geneva on 1 March 1996. The equipment is made available through health-care services, and is exchanged on a one-for-one basis.

Lessons from the Swiss Experience

One of the issues debated at the symposium on harm reduction strategies in prisons in Berne was whether the results of the Swiss experience could be applied to other prison systems - or whether there was anything "special" about Switzerland and/or the institutions in which sterile equipment has thus far been made available, that would make it impossible elsewhere. After days of debate, experts from around the world agreed that the lessons learned in Switzerland could indeed be applied elsewhere.

Staff Safety Issues
In Switzerland as elsewhere, one of the major potential obstacles to the success of needle distribution programs has been the attitudes of prison staff. At Oberschöngrün, prison officers were fully involved in the decision to trial the needle exchange, while officers at Hindelbank were less involved and initially more hostile to the program. In both cases, attitudes to needle exchange in prison became more positive over time.

The "clash of values" that occurred when prison officers and managers first considered the possibility of providing needles and syringes in prisons was minimized by ensuring that needle exchange was established as a health activity carried out by the prisons' health service rather than an activity carried out by custodial staff. Further, as emphasized by Dr Margaret Rihs-Middel, Co-ordinator of Drug Research and Evaluation at the Swiss Office of Public Health in Berne, the involvement of staff in the decision to proceed was very important to the success of the program, as were rules about where needles can be kept to increase safety for custodial staff.(196)

The Swiss experience has shown that sterile injection equipment can be made available in a manner that is non-threatening to staff and indeed seems to have increased staff's safety; it has further shown that staff can be brought to understand that making sterile injection equipment available to inmates does not mean condoning drug use and "giving up" on drug use in prisons, but is a pragmatic health measure that is warranted by the fact that prison authorities have a responsibility to:

protect the general public: preventing the spread of HIV in prisons and, after release of the prisoners, to the general public, is a vital part of this; and
protect the health of inmates in their custody: prisoners are in prison as punishment, not to

> contract a deadly disease.

Because staff don't feel threatened by the distribution of sterile injection equipment, and because they understand the rationale behind it, they are supportive of it.

Applicability to Different Institutional Settings

There is not one Swiss model of distribution of sterile injection equipment. Thus far, every institution has chosen its own model: installation of dispensing machines, one-for-one exchange, or distribution through the physician or health-care services. What can and should be done in a particular institution depends on many factors, including, but not limited to, the size of the institution, the extent of injecting drug use, the security level, whether it is a prison for men or for women, the commitment of health-care staff, and the "stability" of the relations between staff and inmates. In Switzerland, it has been understood that a measure such as making sterile injection equipment available could not, and does not necessarily have to be, introduced in all institutions at the same time and in the same fashion, but can be undertaken immediately, easily, and at low cost, with good results, in some institutions. In other institutions, other measures may be more feasible and are being introduced, such as methadone maintenance programs or the establishment of drug-free wings.

Judicial Admissibility

Making sterile syringes available in prisons in Switzerland was preceded by a study and consultation phase dealing with the complex range of legal and policy issues this measure raises. As part of the process, the Swiss Federal Office of Public Health requested that the Federal Office of Justice examine the judicial admissibility of the measure. In a report tabled in July 1992, the Federal Office of Justice concluded that the provision of sterile syringes and the making available of disinfectants in prisons was judicially admissible and compatible with responsible health policy.

In its opinion, the Office of Justice held that "drug use in prison establishments is a reality."(197) According to the Office, it could be stopped only through very strict measures that would not be compatible with a liberal enforcement of sentences. The Office acknowledged that

> drugs are rather easily introduced into prisons, but not syringes, which are a rare commodity, and this means that they are often exchanged between prisoners dependent on drugs.

The report analyzes the meaning and scope of the right of prisoners to adequate medical assistance in prisons, and favours a broad interpretation that includes prevention:

> Such medical assistance should not be available only when a disease has already spread... but it is necessary to attempt to prevent the transmission of this disease through adequate preventive measures.... The provision of sterile syringes is...one, if not the most important, strategy for preventing the transmission of HIV/AIDS to IV drug users. As in civilian life,

> it is clear that AIDS prevention for those serving sentences is not entirely dealt with simply through the provision of sterile injection equipment, but that it...must also include measures involving therapy, withdrawal and substitutes. Nevertheless, the provision of sterile syringes is the most urgent measure.

Because abstinence in prisons is not achievable, prison establishments must, according to the report's authors, adapt their internal health policy. They conclude that, if prison establishments wish to fulfil their duty to provide medical assistance, the provision of syringes and disinfectants is recommended and that the establishments will have to comply.

The report also examines the issue of the punishability of those who provide sterile syringes, including the punishability of prison staff responsible for providing syringes and the punishability of drug-using prisoners, and compatibility with criminal law. The authors note that the criminal liability of staff comes into play only in cases of complications due to negligent handling in the provision of syringes and that, furthermore, the availability of syringes in a prison establishment does not in any way affect the punishability of drug use. The report concludes that, because drug use remains a punishable act, "if one wishes the provision of syringes to be a success...it must be done anonymously."

Finally, the authors deal with the question of predicting whether such measures could put prison staff in danger:

> The argument has been put forward that the syringes provided...could be used as weapons by prisoners against staff and that for this reason the provision of syringes must necessarily be rejected. This argument, although far from insignificant, is nevertheless an insufficient reason to prohibit the provision of syringes. Even now, syringes are circulating in prison establishments; staff have already had to deal with this danger for some time. Moreover, this is a problem with which staff are already confronted, in the sense that prisoners have many opportunities to obtain weapons or to make them themselves.

Swiss Pragmatism

The Swiss approach to drug use in general and to drug use in prisons in particular is one characterized by pragmatism and by the desire to reduce the harms from drug use. Accepting that many years of experience with a "war-on-drugs" approach to drug use outside and in prisons have demonstrated that drug use is here to stay - and that governments do not only have a responsibility to reduce levels of drug use, but first and foremost to reduce the harms from drug use - common sense, pragmatism and cost-effectiveness have become the guiding principles of health policy in the area of drugs and HIV. Politicians, the public, the media, and those working in prisons are supporting the new, pragmatic approach, because adherence to the ideal directed at eradicating drug use has proven to increase the harms to drug users and to society and, generally, is extremely costly, without resulting in the hoped-for reduction of drug use.

In particular, with respect to prisons, all stakeholders have:

- faced the fact that drugs are consumed in prisons;
- faced the fact that needles and syringes are used (and shared) in prisons;
- accepted that HIV prevention is more important than upholding "morality";
- realized that provision of sterile injection equipment is not contrary to staff's mandate, and provides more security for staff and inmates; and
- realized that harm reduction is more cost-effective than total prohibition.

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Programs in Other Countries

As a result of the positive experiences in Swiss prisons, more and more prison systems around the world are announcing that they will also make sterile injection equipment available. At the symposium on harm-reduction strategies in prisons in Berne, representatives of several German prison systems, as well as the Spanish system, presented their programs or talked about their intention to start one soon - probably the best evidence that the lessons learned in Switzerland can be applied elsewhere.

Germany: Lower Saxony(198)

In November 1994, the Minister of Justice of Lower Saxony established a panel of experts charged with investigating whether measures such as provision of sterile needles in prisons could result in an improvement in the health of inmates. The Minister was concerned with the high prevalence of infectious diseases, in particular hepatitis and HIV, among drug-using inmates in Lower Saxony. The panel of experts consisted of prison directors and personnel, some representatives of drug- and HIV/AIDS-service organizations, and one general practitioner. The recommendations of the experts(199) served as the basis for a cabinet decision by the Government of Lower Saxony, giving a green light to the implementation of a two-year pilot project for the distribution of sterile injection equipment and provision of communicative methods of prevention, in a women's prison with 170 inmates in Vechta and a men's prison with 230 inmates in Lingen.

At the time of writing, distribution had started at Vechta, using four of the same dispensing machines used at Hindelbank since 1994. Distribution at the men's prison was expected to start during the summer of 1996.(200) Cooperation between the two prisons in Lower Saxony and the Swiss prisons started a while ago and includes exchange of staff between Hindelbank and Vechta.

The projects will be scientifically evaluated, with two main aims:

- to present an objective and realistic account of the projects; and
- to assess the usefulness and efficacy of the measures undertaken, beyond the various interests of

> the persons and institutions involved.

According to the recommendations given by the panel of experts, scientific evaluation aims at "closing the gap in the knowledge about drugs, drug usage, and infections with HIV and hepatitis in prisons on the one hand and, on the other, at achieving generalizable and practically relevant recommendations for the effective prevention of AIDS and hepatitis infections."

Germany: Hamburg

In Hamburg, distribution of sterile injection equipment in a prison for men with a capacity of 300 started in May 1996. At the symposium in Berne, the participant from the Hamburg prison system emphasized that the decision was warranted by the fact that, outside prisons, drug policy had changed over the last years, emphasizing harm reduction rather than abstinence, and including wide availability of injection equipment and methadone programs:

> The press, all political parties, and the public are seeing the positive results of this shift in policy: there are fewer deaths related to drug use, less criminality, the costs of drug policy have diminished, and persons dependent on drugs are healthier than they used to be. The gap between what was being done outside and inside prisons was getting bigger and bigger, and people started to see that this was counterproductive.

He continued by saying that

> staff are members of the public as well. They started seeing that what was done outside is to the benefit of all, drug users and the public, and started questioning themselves whether it would not be possible and beneficial to extend harm-reduction measures to prisons. (201)

In 1995, a commission mandated, by Hamburg's Senator for Justice, with the development of a drug policy for prisons, emphasized that

> the state has a legal obligation to care for prisoners in its custody. This includes not only activities directed at caring for the sick, but measures directed at preventing threats to the health and well-being of prisoners.(202)

It continued by saying that, where the goal of abstinence cannot or cannot yet be reached, saving the lives of inmates who inject drugs needs to have a higher priority than achieving a drug-free prison environment. The commission recommended distribution of injection equipment in prisons as an "absolutely necessary health-prevention measure," referring to results of studies showing the correlation

between rates of hepatitis and HIV among injection drug users and their length of stay in prisons.(203) Commenting on some of the arguments against making sterile injection equipment available in prisons, the commission said that drug use would likely not increase in prisons as a result of making equipment available: it depends on the availability of drugs, not of injection equipment; and that acceptance of the measure would increase over time, according to the principle "learning by doing." After extensive meetings with staff, the commission noted that, while a majority of health-care staff already support needle distribution, many correctional officers are resistant, "out of a mixture of fears and information deficits." It acknowledged that the issues raised by correctional officers need to be taken seriously, but said that - in view of the very serious and potentially life-threatening consequences that inaction would have for inmates and the public - these issues should not "be allowed to be the decisive factor in decision-making":

> For reasons of health prevention, and because of the legal responsibility and ethical obligation of prison systems, distribution of sterile injection equipment in prisons has become an absolute necessity. In the unanimous view of the Commission, prolonged inaction could not be justified.(204)

The commission recommended that prisoners be allowed to have no more than one injection unit in their possession; and that there be a requirement to store it in a place where it cannot pose any danger to others, and to dispose of it in an "appropriate way." Further, the commission recommended that clear guidelines be established according to which possession of one injection unit, when kept in the designated way, cannot be subject to disciplinary measures, while injection equipment kept in any other way can be taken away from prisoners.

Germany: Berlin

As reported in the German media, the Senator of Justice of Berlin has expressed her intention to implement a needle-exchange program in a prison for women.(205)

Spain

At the symposium in Berne, representatives of the Spanish prison system announced that distribution of sterile injection equipment would be piloted in a prison in Northern Spain where a methadone maintenance program is already available to inmates.

Australia

A recent study by the Australian National Drug and Alcohol Research Centre (NDARC) found that needle and syringe exchange is feasible in Australian prisons.(206) As a result, the Australian Federation of AIDS Organizations (AFAO) is calling for pilot programs of needle and syringe exchange in prisons across Australia.(207)

Introduction of syringe-exchange programs in Australian prisons had previously been recommended by the Community Policy on Prisons and Blood Borne Communicable Diseases.(208)

Both the then Australian Minister of Health, Dr Carmen Lawrence, and the then President of the Australian Medical Association (AMA), Dr Brendan Nelson, had also urged that "serious consideration be given" to introducing syringe exchanges in prisons.

The study was conducted to consider the issues raised by syringe-exchange programs in prison and to assess their possible benefits, adverse consequences and the feasibility of implementing them. This was done by documenting - in facilitated discussion groups - issues raised by key stakeholders in the New South Wales (NSW) prison system.

The researchers asked groups comprising correctional officers, prison health-care staff, ex-inmates, community agencies, and politicians to provide information on likely safety issues associated with an exchange program. The groups

- emphasized the necessity for effective, broad-range treatment and harm-minimization programs in prisons for injection drug users;
- questioned the implementation and effectiveness of existing HIV prevention programs; and
- addressed the likely impact on the wider community.

Based on the discussions undertaken, the researchers concluded that syringe exchanges in prisons are feasible, but only under certain conditions. In particular, they pointed out that the cooperation of prison staff would have to be secured before implementation of a syringe-exchange program could be considered. Among other things, they recommended that a working committee with representation from health-care and correctional officers discuss syringe exchanges in prisons to identify an option that does not represent any risk to staff and is acceptable to correctional officers.

The researchers found that conditions such as the following would be needed before considering a syringe-exchange pilot:

- establishment of a specialist drug-treatment wing;
- special training for custodial and health staff;
- policy of strict one-for-one distribution of needles and syringes;
- selection of distribution option by a joint committee of custodial and health staff and inmates, from the following: (1) vending machine; (2) nursing staff; (3) outside agency; (4) injection room; and
- assessment of the pilot by measurements such as increase/decrease in risk of infections to staff or inmates or visitors, from assault or from occupational or accidental injury.

The researchers further recommended that

- bleach be made available to all prisoners;
- all inmates be assessed and offered methadone maintenance treatment if suitable;
- peer educators be trained;
- a pilot syringe-exchange program be rigorously evaluated; and
- for evaluation purposes, participants be tested for hepatitis B and C and HIV every six months.

AFAO welcomed the study's overall findings, and its Acting National President used the release of the report to call for trials of syringe-exchange programs in prisons across Australia, expressing support for the report's recommendations that condoms, methadone, and bleach should also be made available.

Since then, the AMA has also renewed its call for needle-exchange programs for prisoners. In its February 1996 Position Statement on Blood Borne and Sexually Transmitted Viral Infections, the AMA states that "[e]ffective prevention among prison populations requires the establishment of preventative education programs, needle exchange programs for intravenous drug users and safe sex programs for those involved in high risk sexual behaviour."(209)

Methadone Maintenance Treatment

Background

Treatment with methadone as a substitute for opiate use has been adopted in a number of prison systems worldwide. It is seen as an AIDS-prevention strategy that allows people dependent on drugs an additional option to get away from needle use and sharing. There are ample data supporting the effectiveness of methadone maintenance treatment (MMT) in reducing high-risk injecting behaviour and in reducing the risk of contracting HIV.(210) There is also compelling evidence that MMT is the most effective treatment available for heroin-dependent IDUs in the community in terms of reducing mortality,(211) heroin consumption,(212) and criminality.(213) Further, in most countries where it has been introduced, MMT attracts and retains more heroin injectors than any other form of treatment.(214) Finally, there is evidence that people who are on MMT 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."(215)

Community methadone programs have rapidly expanded in a number of countries in recent years, including Canada (in particular, British Columbia),(216) and many national and international organizations have recommended the introduction or expansion of MMT in prisons.(217) It has been suggested that methadone is the best available option to prevent needle sharing in prisons,(218) and that increasing the number of places available for MMT in prisons should be considered as a matter of urgency for HIV-positive drug-dependent prisoners.(219)

In light of this, ECAP recommended that

> [i]n order to reduce the risk of infection from drug-injecting,...the options for the care and treatment of drug users include access to methadone. Studies should be undertaken to establish the most effective ways of implementing methadone maintenance programs in penitentiaries. Once implemented, these programs should be evaluated, with participation of inmates and experts independent of CSC.(220)

This recommendation was rejected by CSC because, as mentioned above, according to the Service there is no "medical indication" to provide MMT for opioid-dependent inmates, and "there are relatively few maintenance programs outside CSC institutions to support methadone-dependent inmates following release."(221)

While CSC rejected ECAP's recommendation, a small but increasing number of prison systems worldwide are offering MMT to inmates and a study undertaken in NSW suggests that the reduction of injecting and syringe sharing demonstrated in MMT in community settings also occurs in prisons.(222)

Finally, as part of a national experiment with prescribing of heroin and other drugs to users - to determine whether this will reduce users' criminal activity and their risk of contracting and spreading HIV and other infections - eight inmates in one prison in Switzerland are being maintained on heroin, so far with good results.

The following is a review of methadone provision in prisons internationally.

Methadone Provision in Prisons Internationally(223)

As pointed out by Dolan and Wodak, few papers have appeared documenting the existing provision of methadone in prison systems.(224) Their review, based on correspondence with prison authorities in a number of countries, indicates that MMT has been implemented in prisons in at least four countries, while methadone detoxification is provided in at least eight countries.

Australia: New South Wales

In approximately half of the prisons in NSW (a combination of maximum, medium and minimum security centres), prison methadone maintenance treatment (PMMT) is provided to prisoners. An assessment by health-service staff is required prior to any inmate becoming eligible for entry into the methadone program, which started as a pilot pre-release methadone program with the major aim of reducing recidivism. As it expanded, its goals came to include the continuation of community-based treatment, and the prevention of the spread of HIV and hepatitis in prisons. More recently, achievement of the latter goal has become its major aim, as it has for methadone treatment in the community.(225)

According to the HIV/AIDS Policies, Procedures and Management Guidelines for NSW correctional centres, there are two broad objectives for the corrections methadone program:

1. Harm reduction to minimize the spread of infectious/communicable diseases which are secondary to injecting drug use. This is especially important in the correctional setting where there is no access to needle exchange programs.

2. Maintenance program to be tailored to the individual treatment needs of each inmate.(226)

A Methadone Policy and Procedures Manual has been developed to effectively administer the program. At the time of writing, it was intended to expand the PMMT because demand vastly exceeded supply, opposition from correctional staff was waning, and concern existed about transmission of HIV and hepatitis among inmates.

Other Countries

US: Rikers Island, New York City
In the US, the only PMMT program is on Rikers Island, New York City.

Spain
In Spain, half of all inmates at the Modelo prison in the region of Catalonia are treated with methadone maintenance.(227) Initially, prisoners were only considered for PMMT if they had AIDS, were already on methadone or had been diagnosed as psychotic, but in an attempt to reduce HIV transmission in prison, entry criteria have since been expanded to include HIV-negative inmates.

Switzerland
According to a survey undertaken by a Swiss working group on methadone,(228) treatment with methadone is offered in a majority of Swiss prisons. Most prisons allow prisoners already on MMT at the time of their entry into prison to continue the treatment, with a majority allowing continuation for an unlimited period of time, while some prisons only allow for continuation for a limited time. In addition, slightly less than half of prisons allow prisoners to start MMT in prison.

The working group recommended that in all prisons opioid-dependent prisoners be allowed to continue MMT started in the community, and to start MMT under the same conditions and eligibility criteria as outside prison. It emphasized that the vast majority of institutions in which MMT is available had reported that they had never encountered any difficulties with PMMT.(229)

A project that started in both prisons in the canton of Basel in January 1996 aims at further facilitating access to methadone programs and other treatment or therapy for drug use. The project contains a flexible methadone program and includes the possibility of injecting methadone with sterile needles provided by the institution. Results of this project are expected by the end of 1996.(230)

Germany
In some prisons in Hamburg, prisoners who were on methadone maintenance before coming to prison are allowed to continue in prison. Further, a limited number of inmates have been granted permission to start MMT in prison.(231)

The commission mandated by Hamburg's Senator of Justice with the development of a drug policy for prisons recommended that PMMT programs become available in all institutions. According to the commission, the positive outcomes achieved with MMT outside prisons will also likely be achieved in prisons. In particular, the commission recommended that:

- prisoners on MMT before imprisonment always be allowed to continue MMT during imprisonment;
- opioid-dependent prisoners be granted permission to start MMT while in prison;
- psychosocial support for inmates in MMT be adequate; and
- measures be taken to ensure that prisoners on MMT be able to continue MMT after imprisonment. (232)

Methadone maintenance treatment is available or will also become available in prisons in other German länder. For example, at the harm-reduction symposium in Berne, a representative of Schleswig-Holstein announced that MMT would become available in prisons in the region.

Denmark

Methadone treatment is regularly offered to opioid-dependent inmates who received such treatment before incarceration. According to a letter received from the Danish Ministry of Justice,

> [s]uch treatment is mainly offered to inmates, who are expected to stay less than one year in prison. It is essential that the decision about prescription of methadone is taken in close cooperation with the treatment centre outside prison, who [sic] is going to treat the inmate after release.(233)

Canada

In Canada, methadone is rarely prescribed to anyone in prison, but this may change as a result of a recent court case. As mentioned above, in April 1996 an HIV-positive woman was sentenced to 21 days' imprisonment at the Burnaby Correctional Centre for Women (BCCW) in British Columbia. At the time of her sentence, she was on a methadone maintenance program supervised by her primary-care physician. In accordance with a longstanding BC Corrections Branch policy, the BCCW refused to provide her with methadone, but later reversed that decision after the woman petitioned the British Columbia Supreme Court for relief in the nature of habeas corpus.(234) Among other things, the petitioner argued that not allowing her to continue on the program contravenes s 15 of the Canadian Charter of Rights and Freedoms:

> Generally, BC Corrections Branch provides prisoners with appropriate medical treatment for illness and injury. Because of her dual status as an HIV-positive and a methadone-addicted person, methadone maintenance was the appropriate medical treatment for the Petitioner. Therefore, the policy not to provide her with methadone is a distinction based on her physical condition, because if she had any other condition, she would have been

> provided with the appropriate medical care.

In response to the petition, the BCCW filed affidavit material challenging the Petitioner's physician's opinion that methadone withdrawal is contra-indicated for HIV-positive methadone-addicted patients and that the Petitioner's physical integrity was endangered by her withdrawal. Nevertheless, it arranged for a staff doctor to examine the Petitioner, and he prescribed methadone for her. In affidavit material filed in this case, the Director of Health Services for the BC Corrections Branch indicated that BC Corrections policy would be changed to recognize the validity of the harm-reduction model for prisoners and to allow for methadone treatment of prisoners in certain circumstances.

In another recent case,234a a man with a long-standing, "serious heroin problem," who had committed a number of acquisitory crimes and had been in treatment, without success, several times already, was convicted to two years minus one day imprisonment - and thus to imprisonment in a provincial prison in Québec - because that prison had agreed to provide him with methadone treatment. The defense in the case had submitted that it was necessary to deal with the root causes of the man's crimes, namely his heroin addiction, and that treatment with methadone was essential to overcome that addiction. To the author's knowledge, this was the first case in which an accused in a criminal case was sentenced to a term of imprisonment with the specific aim that he be allowed to undergo methadone treatment.

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Rationale for Prison Methadone Maintenance Treatment (PMMT)

> Cycles of drug use, crime, arrest, imprisonment, release, return to drug use followed by further criminality are a recurrent pattern in the lives of many IDUs. This criminal cycle, the potential for blood borne infections within prison and the now compelling evidence favouring the effectiveness of community MMT are strong grounds for considering PMMT [reference omitted].(235)

The main aim of methadone maintenance, as stated by Gore,

> is to help people get off injecting, not off drugs. Methadone dose reduction - with the ultimate goal of helping the client to get off drugs - is a longer term objective [reference omitted].(236)

With the advent of HIV/AIDS, the arguments for PMMT 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 among prisoners and to the public.

Generally, there is abundant evidence that injecting drug users are over-represented in the prison

population. Their concentration among inmates suggests that targeting treatment at this population is likely to be cost-effective. Unless treated, prisoners who are injecting drug users are likely to continue injecting in prisons or to relapse to injecting on their release, and hence to re-offend and return to prison. Further, imprisonment is stressful and drug withdrawal can only exacerbate this stress. Methadone treatment has been demonstrated to effectively reduce withdrawal symptoms.

Methadone also can be prescribed in prison settings for detoxification and pre-release, which have different aims: the main aim of detoxification is to get prisoners off drugs, while pre-release methadone programs aim to improve linkages to community programs that provide continuity of treatment, reduce deaths from overdose, and reduce criminal recidivism.

Obstacles

> Prison authorities generally respond to concerns about drug use in prison by recommending more stringent detection measures and more severe penalties for illicit drugs discovered within prisons. These measures are often in conflict with rehabilitative components of the prison system. However, injectable drugs still seem to find their way into more tightly controlled environments in circumstances which are likely to further exacerbate the hazardousness of risk episodes although such risk episodes may be less frequent. One of the major obstacles to introduction of PMMT is that implementation is tantamount to an admission by prison authorities that injectable drugs cannot be completely kept out of correctional facilities.(237)

Forced Abstention

Another obstacle to PMMT mentioned by Dolan and Wodak is that prison authorities generally consider that imprisonment should be a time when injection drug users are forced to abstain from drug use for their own and the community's benefit:

> Methadone is considered by many correctional staff as just another mood altering drug, the provision of which further delays the necessary personal growth required to move beyond a drug centred existence.(238)

Absence of Education about Rationale

Many prison staff and some prison systems, including CSC, have not well understood the rationale behind MMT. As pointed out by Hall et al,(239) in the absence of education about its rationale, some prison staff regard the program as "pandering" to addicted prisoners by giving them free access to an opioid drug; they believe that its main rationale is the reduction of recidivism rather than the prevention of HIV transmission in prison. Similarly, CSC, in its response to ECAP's recommendations, said that there was "no medical indication" to provide methadone maintenance, neglecting to consider the potentially life-saving effect of such programs, and taking a very conservative approach that seems to

have been shaped before the advent of HIV/AIDS. In contrast, those in favour of PMMT emphasize that making methadone maintenance available is necessary to save lives: it would reduce injection drug use and the resulting risk of HIV infection. In other words, methadone maintenance may not be completely harmless, but its possible harms are insignificant when compared with the much bigger harms resulting from injection drug use - HIV/AIDS and hepatitis C in particular.

Objection on Moral Grounds

Some also object to methadone treatment on moral grounds, arguing that it merely replaces one drug of dependence with another. For example, a vocal minority of participants at the Kingston HIV/AIDS and Prisons Workshop vehemently opposed making methadone available to prisoners, saying that "methadone does not really help people to get off drugs" and that "those in methadone maintenance programs only exchange one sort of dependence, that on narcotic drugs, against another, that on methadone." If there were reliably effective alternative methods of achieving enduring abstinence, this would be a meagre achievement. However, 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 MMT] 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.(240)

Evaluation

> Most benefits demonstrated for methadone detoxification and maintenance in the community are likely to be generalisable to prisons. However, these benefits should not be assumed because the institutional environment and stringent security requirements of correctional facilities makes the generalisability of community MMT research to prisons uncertain. Therefore research is required evaluating methadone used for detoxification, maintenance and pre-release purposes.(241)

Reduction in Injecting and Sharing

Dolan et al evaluated the effectiveness of MMT in reducing HIV risk behaviour among prisoners. Their study suggests that

> reduction of injecting and syringe sharing demonstrated in MMT in community settings also occurs in prisons. However, inmates need a daily dose of at least 60 mg of methadone and treatment is required for the duration of incarceration for these benefits to be realised in prison.(242)

In 1993, Dolan et al interviewed 185 ex-prisoners with a history of injecting drug use in New South Wales (NSW), of whom 64 reported being in MMT before, during and after their period in prison, while 80 reported receiving no treatment during any of the three time periods:

- IDUs who reported receiving MMT in the three months before prison were significantly less likely to report daily injecting (42 versus 60 percent) and syringe sharing (13 versus 26 percent) than IDUs not in MMT; and
- IDUs who had been in MMT during imprisonment reported significantly fewer injections per week than IDUs not in MMT, but only when the maximum methadone dose exceeded 60 mg and if MMT had been provided for the entire duration of imprisonment.

Dolan et al concluded that "MMT has an important role to reduce the spread of HIV and hepatitis in prison."

In Spain, significant reductions in sharing of injection equipment have been noted in IDU inmates in PMMT compared with a control group.(243) In NSW, inmates receiving PMMT reported decreases in drug use, drug-related prison violence, crime following release, and considered that the PMMT was more effective in preventing HIV in prison than in the community.(244)

Benefits for Staff and the Public

PMMT has been shown to benefit correctional systems. It has reduced anxiety of correctional staff,(245) who perceived inmates receiving MMT to be less irritable and easier to manage and who also reported no conflict between treated and untreated inmates. Methadone detoxification of heroin-dependent prison entrants in Switzerland was reported to reduce tension and facilitate custodial management.(246) As emphasized by Dolan and Wodak,

> Reduced transmission of blood borne viral infections and easier to manage prisons are important gains for society as a whole. Lower prevalence of blood borne viral infections among prison inmates means a safer occupational environment for correctional staff.(247)

No Black Market for Methadone

In NSW, three studies provided no evidence of "standover" tactics or a black market for methadone. (248) In Switzerland, urinalysis showed that only seven percent of inmates on PMMT had used heroin, and in Scotland prisoners in a drug-reduction program had used fewer drugs than a control group.(249)

Heroin Maintenance Treatment

As mentioned above, in Oberschöngrün institution in Switzerland a heroin prescription program was started in 1995.

The Swiss National Experiment

The program is part of a national experiment with prescribing of heroin and other drugs to users that aims to determine whether such prescribing will reduce users' criminal activity and their risk of contracting and spreading HIV and other infections.(250) It started in January 1994, with sites in eight cities. In each city, the program offers accommodation, employment assistance, treatment for disease and psychological problems, sterile syringes, and counselling. Users are in regular contact with health workers and links to drug-free treatment. Some programs started off by giving some users heroin and others morphine or injectable methadone. It was soon found, however, that most users preferred heroin, which is provided up to three times a day for a small daily fee. The preliminary reports on the program suggest that heroin maintenance is efficacious. It has not resulted in a black market of diverted heroin and the health of the addicts in the program has clearly improved. The authorities have concluded from these preliminary data that heroin causes very few, if any, problems when it is used in a controlled manner and is administered in hygienic conditions. Based on these findings, the Swiss government expanded the program to more than 1000 users in 1995 (approximately 800 slots for heroin, 100 each for morphine and injectable methadone).

Heroin Maintenance at Oberschöngrün

> Over the course of the last few years, the penal institution at Oberschöngrün has been increasing faced with drug-using inmates. It was their dependency that led them to commit their offences. Repression is not sufficient to prevent drug consumption in prison. At Oberschöngrün, experience has shown that 90 percent of drug users relapse after release from prison. This is far from section 37(1) of the SPC, according to which "[i] mprisonment shall be carried out in such a way as to have an educative effect on the inmate and to prepare his return to a free life."
>
> The controlled prescribing of heroin, authorized last June by the FOPH for eight inmates, should provide for the psychological and physical stabilization of the prisoners involved, and this is an indispensable condition for as good as possible a future reintegration into society. The director, Peter Fäh, is of the opinion that "[a]bstinence remains the most important goal, but reality shows that heroin dependency is a disease and that it cannot be cured with the same ease as a broken leg."(251)

Heroin maintenance at Oberschöngrün started in September 1995 with a three-month pilot involving four inmates. Since January 1996 and until 31 December 1996, up to a maximum of eight inmates participate in the project. To be eligible for participation, inmates have to:

- be 20 years of age or older;
- have been dependent on heroin for a minimum of two years;
- have been in treatment, without success, in the past;

- have "deficits in the social sphere"; and
- have sufficient time left in the institution.

Participants live in a separate unit of the institution, work seven days a week, starting at 5:30 am, participate in group discussions and individual psychosocial counselling, and inject themselves with heroin three times a day under medical supervision. The main aims of the project are to:

- establish the feasibility of heroin maintenance in prisons;
- implement harm-reduction measures in prison;
- assist the institution in solving its drug-related problems; and
- study its advantages and disadvantages, for clients and institution, as compared with methadone maintenance.

First results, released at the symposium in Berne on 28 February 1996, show that clients appreciate the medical and psychological support received, but are afraid that they might become more dependent on heroin, or that they will not be able to continue on heroin maintenance once the pilot ends or once they are released from prison. The warden, however, is confident that the program will continue and hopes that it can even be extended to allow for participation of more inmates. According to him, positive results include a marked improvement in the participants' work performance, a factor that has had an important role in bringing staff on side. When he visited Oberschöngrün, the author of this report was told on numerous occasions that staff have been impressed by the work performance of prisoners in the heroin maintenance program.

Detailed results of the project will be available at the end of 1996.

Heroin Maintenance in Other Countries

Heroin maintenance is offered in an increasing number of countries,(252) but Oberschöngrün remains the only prison worldwide in which it is available.

United Kingdom

In a tradition dating back to the 19th century, physicians in the United Kingdom prescribe drugs to users. In many regions, drug- dependency clinics or community drug teams offer flexible prescribing regimes ranging from short-term detoxification to long-term maintenance. The majority of clients receive oral methadone, but some receive injectable methadone, others injectable heroin, and a small number receive amphetamines, cocaine or other drugs. These drugs are dispensed through local pharmacists.

In the Mersey region, where prescribing and other harm-reduction programs are well-established, anecdotal evidence suggests that drug-related health problems and acquisitive crime have decreased as a result of these services. In particular, the level of HIV infection among drug injectors in the region is very low.

Other Countries

The Netherlands, several German cities, and the Australian Capital Territory are also preparing to institute heroin maintenance programs.

Canada

In Canada, as a result of the recommendations contained in the BC Chief Coroner's report,(253) various agencies are working with community groups to determine the feasibility of prescribing programs as one part of their strategy to deal with drug-related harms.

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Release of CSC's Inmate Survey

Results

Since the publication of the Discussion Paper, CSC has released the results of its survey of 4285 inmates. The survey confirmed fears that "the problem of AIDS is especially high behind bars."(254) As reported above, it provided evidence that at least 26 percent of inmates had engaged in "risky practices" at their current institution. In particular:

- 11 percent of inmates considered themselves at high risk for HIV because they have injected drugs since being incarcerated;
- 13 percent had been tattooed while in prison and were not sure whether the equipment was safe;
- 6 percent had consensual sex while in prison, often without using a condom;
- 3 percent of inmates had been sexually assaulted behind bars, and an additional six percent had been pressured to provide sexual services; and
- 28 percent of respondents believe that as a result of CSC's urinalysis program, inmates have switched to drugs that are less detectable but generally more addictive (and used by injecting).

Background

According to the survey, "[b]oth legislative requirements and recommendations from the Expert Committee on Aids and Prisons (ECAP) have provided the impetus for conducting the National Inmate Survey on behalf of the Correctional Service of Canada (CSC)." The survey, the first of its kind in Canada, was conducted during the fall of 1995 in federal prisons across Canada. The results of the survey

> are expected to enhance CSC's knowledge of federal inmates in a number of new areas.

> Especially relevant and innovative within this survey are questions that gather information on HIV/AIDS, specifically behaviour which places inmates at risk of infection including sexual practices and illegal substance use within their own institution. Ultimately, these findings will provide important information for future direction in a number of key areas, including institutional operations, offender programming and policy development.(255)

The CSC Report continues by saying that "ECAP recommended an in-depth study on drug use and other AIDS risk-taking behaviours in order to determine what must be done to prevent the transmission of the virus among inmates and ultimately protect the wider community."(256) This statement very seriously misrepresents ECAP's recommendation. In reality, ECAP had recommended:

> In order to prevent the transmission of infectious diseases, in particular HIV, due to the sharing of unclean injection equipment, and because injection equipment may not be effectively or consistently cleaned by bleach, ECAP has concluded that access to sterile injection equipment by inmates must be addressed by CSC. Therefore, ECAP recommends that research be undertaken that will identify ways and develop measures, including access to sterile injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use in federal correctional institutions. This research should be carried out with the active involvement of Health Canada and by individuals independent of but in collaboration with CSC. It should be preceded by consultation with inmates, staff, community groups and independent experts. It should include one or more scientifically valid pilot projects, and should be accompanied by planning, communication and education that will expedite making sterile injection equipment available in the institutions.(257)

The Service had rejected this recommendation and only accepted to "participate with Health Canada and public health authorities in a program of research on injection drug use, and other high-risk behavior, and on prevention strategies." While ECAP would, in principle, not have objected to a study such as that now undertaken by CSC, it certainly did not think that the study was necessary "to determine what must be done to prevent the transmission of the virus among inmates and ultimately protect the wider community." Rather, ECAP released 88 recommendations aimed at doing exactly that: prevention of transmission among inmates and protection of staff and the wider community. Further, it urged CSC to act immediately, without further delay, and without awaiting the results of further research that would likely only confirm what was already known: risk behaviours are prevalent in prisons.

Conclusion

Two years after the release of ECAP's Final Report, the results of the section on HIV/AIDS in CSC's inmate survey only confirm ECAP's assessment of the situation with regard to HIV/AIDS and drug use in federal prisons. They are useful because, once again, they provide clear evidence of the need to act, but they would not have been necessary for the purpose of determining what must be done to prevent the

transmission of HIV among inmates and to the public: CSC could and should have acted before.

Release of the Report of the Arbour Commission

> [I]n the imposition of punishment, all authority must still come from the law....A guilty verdict followed by a custodial sentence is not a grant of authority for the State to disregard the very values that the law, particularly criminal law, seeks to uphold and to vindicate, such as honesty, respect for the physical safety of others, respect for privacy and for human dignity. The administration of criminal justice does not end with the verdict and the imposition of a sentence. Corrections officials are held to the same standards of integrity and decency as their partners in the administration of criminal law. (258)

The Commission's Report

The Commission of Inquiry into Certain Events at the Prison for Women in Kingston condemned the actions of CSC in a 1994 incident in which male correctional officers strip-searched women prisoners. In a 300-page report released in April 1996, the Honourable Louise Arbour, Commissioner, criticized CSC for a disturbing lack of commitment to the ideals of justice, and concluded that "there is nothing to suggest that the Service is either willing or able to reform without judicial guidance and control." During her investigation, Justice Arbour heard that even though the prisoners' treatment in this particular case frequently violated Canadian law and prison regulations, nobody inside CSC did anything about it: "Instead, it produced an internal investigation report that whitewashed some actions, ignored others, and blamed the prisoners for everything that went wrong."(259)

Immediately following the release of the report, the former Commissioner of CSC, Mr John Edwards, resigned. He has since been replaced by former Commissioner Ole Ingstrup. Early in June 1996, CSC announced that it would adopt several recommendations of the report, while saying that some of the report's most controversial recommendations required further study. In an interview, Solicitor General Herbert Gray said: "I saw the basic point of the Arbour report was that the correctional service had to work within the context of the rule of law in carrying out its responsibilities."(260)

Justice Arbour's objective in bringing forward recommendations on various aspects of corrections touched upon by the inquiry was to "assist the correctional system in coming into the fold of two basic Canadian constitutional ideals, towards which the rest of the administration of criminal justice strives: the protection of individual rights and the entitlement to equality."(261)

The Relevance of the Report to HIV/AIDS

While Justice Arbour's report does not deal with issues raised by HIV/AIDS, it highlights systemic shortcomings within CSC, the "absence of a culture respectful of individual rights,"(262) and an

unwillingness to be responsive to outside criticism and to engage in honest self-criticism - issues and problems that also affect CSC's response (or lack of response) to HIV.

As stated by Justice Arbour,

> [i]n its Mission Statement, the Correctional Service of Canada commits itself to "openness", "integrity", and "accountability". An organization which was truly committed to these values would, it seems to me, be concerned about compliance with the law, and vigilant to correct any departures from the law; it would be responsive to outside criticism, and prepared to engage in honest self-criticism; it would be prepared to give a fair and honest account of its actions; and it would acknowledge error. In this case, the Correctional Service did little of this. Too often, the approach was to deny error, defend against criticism, and to react without a proper investigation of the truth.(263)

With regard to HIV/AIDS, CSC showed remarkable openness by allowing an external body, the Expert Committee on AIDS and Prisons, full access to its institutions and, after two years of study, the publication of its Final Report containing 88 recommendations about what CSC should do to prevent the further spread of HIV in its institutions and to staff and the public. Openness was also evidenced by the fact that CSC agreed to fund this study as a follow-up to ECAP's recommendations.

Nevertheless, the Service has responded very defensively to ECAP's Report, and the public and the media have been misinformed over the last years about the true extent of CSC's response to ECAP's Report and the initiatives undertaken by CSC to implement it. The Service tends to refer to its official response to ECAP's Report, but has been silent about the fact that, while many recommendations have been accepted, only few have been implemented, while little or nothing has been done to implement the others - nor has a system been put in place to make this possible. Admittedly, as shown in this Report, positive developments have taken place, but this has happened thanks to the dedication of some individuals, mainly in health-care services, and to the involvement of and funding by Health Canada, rather than a true and widespread change in attitude on the level of CSC's management and correctional staff. With respect, CSC has been fairly unresponsive to outside criticism, and little prepared to engage in honest self-criticism, or to give a fair and honest account of its actions in the area of HIV/AIDS and drug use.

Another problem referred to in Justice Arbour's report, the "absence of a culture respectful of individual rights," is also evident in the area of HIV/AIDS and drug use. First and foremost, the principle of equivalence of care, requiring that all prisoners receive health care, including preventive measures, equivalent to that available in the community, is poorly understood. Secondly, infringements of prisoners' rights may be justified because of imprisonment. However, in every case, CSC needs to justify the infringement: it must be necessary, likely to be effective, and the least invasive and restrictive means available to prevent harms that cannot otherwise be prevented. Widespread disclosure of HIV-related medical information, such as envisaged by CSC as a result of a legal opinion by CSC,(264) does not satisfy these criteria, and is only one example of a situation in which little understanding of legal rights of prisoners is demonstrated. As pointed out by Justice Arbour, education is necessary, education that

emphasizes "the supremacy of the Canadian Charter of Rights and Freedoms and the fact that all authority comes from the law."(265)

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233 Response to the Discussion Paper by A Reventlow, dated 7 March 1996.

234 See McLeod, supra, note 162. The following text is an edited version of McLeod's article.

234a R v M Povilaitis, unreported judgment of 27 June 1996 (Superior Court, Criminal Division, Province of Québec, no 450-01-004040-965, Gérald Desmarais J).

235 Dolan & Wodak, supra, note 211 at 86.

236 Response to the Discussion Paper by S Gore, received April 1996.

237 Dolan & Wodak, supra, note 211 at 88-89.

238 Ibid.

239 Methadone Maintenance Treatment, supra, note 224 at 197.

240 Ibid.

241 Dolan & Wodak, supra, note 211 at 93.

242 Methadone Maintenance Reduces Injecting, supra, note 222.

243 Dolan & Wodak, supra, note 211 at 91, with reference.

244 Ibid, with reference to S Bertram, A Gorta. Inmates' Perceptions of the Role of the NSW Prison Methadone Program in Preventing the Spread of Human Immunodeficiency Virus. Sydney: Evaluation of the NSW Department of Corrective Services Prison Methadone Program. Study no 9. Research and Statistics Division, 1990.

245 Ibid, with reference to Magura et al, supra, note 224; A Gorta. Monitoring the NSW Prison Methadone Program: A Review of the Research 1986-1991. Sydney: Research Publication Department of Corrective Services Publication no 25, 1992; C Herzog et al. Methadone Substitution as an AIDS-Preventive Measure in the Prison Environment. Paper presented at the European Symposium on Drug Addiction & AIDS, Siena, Italy, 4-6 October 1993.

246 Ibid, with reference to Shewan et al, supra, note 215, and Herzog, supra, note 245.

247 Ibid at 93.

248 Ibid at 91, with reference to S Wale, A Gorta. Views of Inmates Participating in the Pilot Pre-Release Methadone Program. Sydney: Process Evaluation of NSW Department of Corrective Services Pre-Release Methadone Program Study no 2. Research and Statistics Division, 1987; A Gorta. Results of Gaol Urinalyses January - June 1987. Sydney: Process Evaluation of NSW Department of Corrective Services Pre-Release Methadone Program Study no 2. Research and Statistics Division, 1987; S Bertram. Results of Gaol Urinalyses Update: July - December 1989. Sydney: Process Evaluation of NSW Department of Corrective Services Pre-Release Methadone Program Study no 10. Research and Statistics Division, 1991.

249 Ibid, with further references.

250 Harm Reduction Around the World, supra, note 216. The following text is excerpted from Riley's article.

251 Projet-pilote de prévention, supra, note 188.

252 The following survey is taken from Harm Reduction Around the World, supra, note 216.

263 See AIDS and Overdose Deaths in British Columbia, supra, note 216.

254 K Makin. Prisons Haunted by Fear of Violence. The Globe and Mail, 7 June 1996, at A6.

255 CSC National Inmate Survey: Final Report, supra, note 117 at 1.

256 Ibid at 2.

257 ECAP. Summary Report, supra, note 15 at 21 (Recommendation 6.3(6)).

258 The Honourable Louise Arbour, Commissioner. Commission of Inquiry into Certain Events at the Prison for Women in Kingston. Ottawa: Public Works and Government Services Canada, 1996, at XI.

259 H Hess, Reforms to Prison System Announced. The Globe and Mail, 5 June 1996, at A8.

260 Ibid.

261 Commission of Inquiry, supra, note 258 at XI-XII.

262 Ibid at 93.

263 Ibid at 173.

264 See supra at 15.

265 Commission of Inquiry, supra, note 258, at 182.

HIV/AIDS in Prisons: Final Report

by Ralf Jürgens

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RESPONSIBILITY OF PRISON SYSTEMS

> The courts, through critical, investigative, and thorough examination of prison administration action, can ensure that individual rights do not become secondary to public fear and ignorance.(266)
>
> Recent developments highlight the importance of putting the search for legal redress on the legal and political agenda. This is a strategy that can be used to compel changes in governments' and prison authorities' behaviour: it can be argued that their unwillingness to take all reasonable and necessary steps to reduce the possibility of transmission of HIV in prisons amounts to careless conduct, and that they must be made accountable for this conduct through the use of...legal action....(267)

In light of the developments described in the previous section of this document, and the lack of decisive action by prison systems and governments to reduce the risk of spread of HIV, hepatitis C and other infections among inmates, to staff and the public, individuals and organizations in Canada have started raising questions concerning the legal responsibility of prison systems for transmission of HIV in prisons: do governments and prison systems have an obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV, even if they "voluntarily" engage in illegal or forbidden behaviours (drug use and sexual activity); can they be held liable for not providing condoms, bleach, and sterile needles and for the resulting transmission of HIV in prisons?

In order to stimulate discussion on these issues, the Project organized a plenary and a workshop on legal and ethical issues raised by HIV/AIDS in prisons at the First Canadian HIV/AIDS and Prisons Workshop, and also undertook the following activities:

- a survey of the literature;
- an analysis of international law;
- an analysis of Canadian law.

A Literature Review

While a majority of articles and reports recommend that prison systems should make condoms, bleach,

and sterile needles accessible to prisoners, until recently little had been written on the legal responsibility of governments and prison systems to provide prisoners with the means that would allow them to protect themselves against contracting HIV infection. The first articles addressing this issue in the Canadian context were appended to the Discussion Paper. For inclusion in the Final Report, they have been slightly updated (see I Malkin and R Elliott, Appendices 1 and 2).

Prevention Equals Coercion?

Two early US articles argue that HIV/AIDS prevention programs have a constitutionally mandated place within the US prison system, born out of a prisoner's right to personal security. According to the first, (268(prison officials who ignore the risk and fail to respond to it with appropriate protective policies violate the constitutional proscription against cruel and unusual punishment. The second also addresses the question of prison authorities' liability for HIV transmission in prisons.(269) However, both suggest that coercive measures be taken to prevent the spread of HIV, and do not mention the possibility of making condoms, bleach, and sterile needles accessible to prisoners: the latter argues that "[s]egregating inmates with AIDS in medical infirmaries and housing seropositive and ARC inmates together provides protection to all inmates"; the former recommends that prison officials take "affirmative action consisting of mass screening, privilege-conscious segregation, and informative training."

Right to Preventive Measures

Academic Commentary

However, such coercive measures have been rejected by the vast majority of the other authors and reports, which argue that they are not only overly intrusive, but also costly and ineffective in curbing the spread of HIV. For example, Parts rejects testing and segregation and, instead, argues that the eighth amendment to the US Constitution

> requires that prison officials take affirmative steps to prevent the transmission of AIDS, including establishment of AIDS prevention programs entailing provision of condoms to sexually active inmates and clean needles or bleach for cleaning needles to inmates who use intravenous drugs.(270)

According to Parts, "in light of the threat presented by AIDS, specific effective preventive health measures are more than just a good idea; they are constitutionally required." He continues by saying:

> The eighth amendment prohibition of the infliction of "cruel and unusual punishments" has been interpreted by the Supreme Court to prohibit "deliberate indifference to the serious medical needs of prisoners." This prohibition has been applied by lower courts as incorporating a substantive guarantee of a basic level of effective medical care, which precludes denial of preventive as well as curative measures, and denial of treatment for

> voluntary as well as involuntary encountered health risks.
>
> Since prevention is the only effective means of combatting AIDS, preventive measures are necessary medical care and required by the eighth amendment. Some methods aimed at limiting the spread of AIDS in prison have failed; others are destined to be merely incomplete solutions. An AIDS-prevention program entailing distribution of prophylactic devices offers constitutionally required protection for prisoners at risk of contracting AIDS [references omitted].(271)

Parts rejects the three central objections that can be raised to the argument that the eighth amendment requires preventive measures to control HIV infection in prisons:

First, he rejects the objection that constitutional protections do not apply to preventive medical care, saying that - if the harms posed by a disease can only be avoided by preventing the disease itself - an affirmative obligation to protect the health of prisoners must extend to cover preventive care.(272)

Second, he rejects the objection that constitutional protections do not apply to voluntarily encountered disease risks, for two reasons:

- The eighth amendment guarantee of medical care does not require that a prisoner involuntarily encounter a health risk: "The state can punish people for the act that causes the need for medical care, but cannot punish them...by denial of that care."(273)
- The high-risk activities involved in the spread of AIDS are not strictly voluntary.

Third, he rejects the objection that constitutional protections are outweighed by the state interest in regulating high-risk activities, such as sexual behaviour and intravenous drug use, in prisons:

> If the state interest is to be afforded any independent consideration, there are a number of salient factors to consider which diminish the importance of the state interest in the instant situation. First, the requirement of preventive medical care does not prevent the prison officials from enforcing regulations concerning homosexual activity or drug use. Second, the measures that are discussed in this article [making condoms and bleach/sterile needles available to inmates] do not facilitate violations that would not have otherwise been possible. And third, if the reason that the preventive measures are necessary is that prison programs designed to stop prohibited activities are a failure, it seems very tenuous to base a state interest on the continued use of a failing policy.(274)

World Health Organization

The World Health Organization also emphasizes that "[a]ll prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination," and that the general principles adopted by national AIDS programs "should apply

equally to prisons as to the general community."(275)

International Positions

Acknowledging this so-called equivalency principle, the Swiss Federal Office of Justice concludes that provision of sterile syringes in prisons is judicially admissible and compatible with a responsible health policy: "If prison establishments wish to fulfil their duty to provide medical assistance, the provision of syringes and disinfectants is recommended."(276) A legal opinion prepared by a lawyer in Berne, Switzerland, in 1994 agrees and suggests that, based on Swiss law, the state has "a duty to make sure that persons dependent on drugs are provided with sterile injection equipment while in detention."(277) Similarly, the commission mandated, by the Senator for Justice of Hamburg, Germany, with the development of a drug policy for prisons, concluded that "the state has a legal obligation to care for prisoners in its custody," and that this includes not only "activities directed at caring for the sick, but measures directed at preventing threats to the health and well-being of prisoners."(278)

In contrast, in New South Wales in Australia, inmates had to take the government to court over their inability to access condoms in prisons.(279) Commenting on the case, one author suggested that the issue of providing protective means to prisoners would be more appropriately dealt with by swift legislation than by court action:(280)

> There is no question of balance in relation to the provision of condoms in prisons - the case for their availability is overwhelming and the failure to make them available is absolutely contradictory to proper public policy.(281)

As mentioned above, trials relating to condom distribution have since started in three prisons in NSW - at least in part because of the legal action undertaken by the prisoners - and it is expected that they will lead to condom distribution in all prisons in the state.

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International Law

Prisoners' Rights as Persons(282)

> It is generally accepted in the international community that a set of minimum standards should apply to imprisonment. These standards are designed to ensure that the inmates are humanely treated, that their responsibility and dignity is maintained, and that they are prepared as much as reasonably possible for reintegration in the community at the end of their term of imprisonment. The standards which the international community has generally accepted are contained in the United Nations Standard Minimum Rules for the

> Treatment of Prisoners, which were first adopted in 1955. While Canada, and the Correctional Service in particular, are not obliged to conform to the specific terms of the UN Rules in the management of prisons, those rules are accepted as international norms and minimum standards, and departures from them generally only occur where there is a reasoned justification.(283)

By its very nature, imprisonment involves the loss of the right to liberty. However, a prisoner "retains all civil rights which are not taken away expressly or by necessary implication."(284) As JUSTICE, the British Section of the International Commission of Jurists, has commented, a prisoner "loses his right to liberty, and his rights are diminished so far as they are incompatible with that loss and his obligation to live in a prison subject to its discipline. That is obvious. It is hardly less obvious that he retains other rights, subject only to that necessary diminution. ..."(285) This has been reaffirmed by the 1990 Basic Principles for the Treatment of Prisoners,(286) which state that the human rights of prisoners must be respected "except for those limitations that are demonstrably necessitated by the fact of incarceration." Moreover, it has been argued that the dependent status of prisoners gives rise to a need for recognition of special rights of prisoners.(287) As prisoners' rights as human persons are necessarily curtailed to some extent, they are also entitled to more protection.(288) This view is, however, not unquestioned. Many consider that prisoners have forfeited their claim to respect for their human rights by committing an offence. Traditionally, prisoners were regarded as losing all their rights upon imprisonment.(289) This often corresponds to the reality of prison life, where "[a]lmost every aspect of a prisoner's daily life consists of 'privileges' which can be easily withdrawn for administrative or punitive reasons."(290) The delineation of which rights are retained, the extent of their "necessary diminution," and the nature of the new special rights that might be acquired, becomes necessary.(291)

Other than debarring "cruel, inhuman or degrading treatment or punishment," neither the Universal Declaration of Human Rights nor the European Convention on Human Rights includes provisions expressly governing the conditions of imprisonment. However, Article 10(1) of the International Covenant on Civil and Political Rights sets forth the right of "persons deprived of their liberty" to be treated with "dignity" and with "respect for the inherent dignity of the human person." The Covenant was adopted by the UN General Assembly in 1966, and entered into force in 1976. It requires all the rights and freedoms it defines to be respected for "everyone," including persons deprived of their liberty by process of law. The Human Rights Committee stated that "the humane treatment and respect for the dignity of all persons deprived of their liberty is a basic standard of universal application which cannot depend entirely on material resources" and that "ultimate responsibility for the observance of this principle rests with the State as regards all institutions where persons are lawfully held against their will (prisons, hospitals, detention camps, correctional institutions)."(292) The Covenant does not, however, set out in detail the entitlements of prisoners and the standards by which prisons should be run. For these, we must turn to the 1955 United Nations Standard Minimum Rules for the Treatment of Prisoners. These are a set of specific rules regarding the treatment of prisoners that are generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions. The Standard Minimum Rules deal with a range of specific issues, including accommodation, personal hygiene, clothing and bedding, food, medical services, discipline and punishment, instruments of

restraint, complaint procedures, contact with the outside world, religion, etc. The value of the Standard Minimum Rules is that they very specifically lay out requirements aimed to ensure that prisoners are treated in a humane manner and with respect for their human dignity. European Prison Rules were adopted by the Council of Europe in 1987. As is true for the Standard Minimum Rules, they are not binding in law. They are intended as a guideline for national administrators and courts, and have been referred to as "the manifestation of...moral and philosophical standards."(293)

Right to the Highest Attainable Standard of Health(294)

> The states' duty towards health care does not end at the gates of the prisons. Prisoners have a right to health care.(295)
>
> Because prisoners have reduced possibilities to protect their health, seek medical advice, or choose an appropriate diet, the states' responsibility for their health acquires an additional dimension, and they are entitled to more protection.(296)

As has been asserted in a large number of declarations and covenants(297) and the Constitution of the World Health Organization, "[e]very person has a right to the highest attainable level of physical and mental health that would enable him/her to carry out a productive life, without any distinction.(298) In 1981 the General Assembly of the United Nations endorsed the "Global Strategy for Health for All by the Year 2000" that had been adopted earlier by the World Health Assembly. With the agreement of the Global Strategy, the governments of WHO Member States committed themselves to strive toward an improvement in overall health status by the year 2000 and to a reduction of inequalities in the provision of health care.

The right to health in international law should be understood in the context of the broad concept of health set forth in the WHO Constitution, which defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."(299) This definition has important conceptual and practical implications for states' obligations regarding the right to health: the right to health is inextricably linked to the enjoyment and exercise of other human rights. The health status of individuals and groups benefits from the promotion and protection of all human rights, and measures to promote health and prevent disease enable people to better enjoy and exercise other human rights. Conversely, the enjoyment and exercise of other human rights is compromised when the right to health is not a priority concern of states.(300)

Medical care constitutes only one aspect of the broader concept of health and is a necessary but not sufficient means of realizing the right to health. Individuals have a right to medical services and treatment, but health policies that focus exclusively on services and treatment have only limited effect: they only respond to manifestations of ill-health at an individual level. The contemporary public health approach emphasizes primary health care, which accordingly provides for promotive, preventive, curative, and rehabilitative services. Primary health care thus encompasses actions to create and sustain the underlying preconditions for health. Essential or minimum primary health care includes, among other things, information on prevailing health problems and methods for their prevention and control.

Indeed, prevention efforts are central to the aim of creating the underlying preconditions for health, and are therefore core duties under international law. In order to assist and fulfill the right to health, states need to ensure, to the maximum extent possible, that everyone has the means to protect and preserve his or her health.(301)

The states' duty toward health does not end at the gates of prisons.(302) The 1955 Standard Minimum Rules devote sections 22-26 to medical services. Sections 22(1), 24 and 25(1) require prisons to provide prisoners with all necessary medical care. Section 22(2) further demands that "sick prisoners who require specialist treatment...be transferred to specialized institutions or to civil hospitals." Moreover, because prisoners have reduced possibilities to protect

their health, seek medical advice, or choose an appropriate diet, the states' responsibility for their health acquires an additional dimension, and they are entitled to more protection. This responsibility is reinforced by the basic principles of protecting human rights of persons in the custody of the state.(303)

As stated in the Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment, "[d]amage incurred because of acts or omissions by a public official contrary to the rights [of prisoners] shall be compensated according to the applicable rules on liability provided by domestic law."(304) This liability is, however, rarely recognized, let alone enforced. Early attempts by prisoners in the US to hold prison authorities responsible for the HIV infection they acquired in prison, and which they alleged to be a consequence of the failure of prison authorities to prevent HIV transmission in prison, did not result in a clear articulation of the obligations of prison authorities: prison authorities were held to have discretion with respect to decisions that could harmfully affect the health of prisoners and would only be liable in cases where gross negligence or deliberate indifference resulting in damage to health could be proven.(305)

There is consensus that the same standards of health care and protection that apply outside prisons should also apply to prisoners, and it has been stated that prisoners shall have access to health-care services available in the country without discrimination on the grounds of their legal situation.(306)

Responding to HIV/AIDS

> The general principles adopted by national AIDS programs should apply as much to prisons as to the general community.(307)
>
> All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community.(308)

The international community has developed a number of recommendations concerning HIV/AIDS in prisons, recommendations that stress the importance of preventing further transmission of HIV infection.(309)

Eighth United Nations Congress

The Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in 1990, adopted a resolution on HIV/AIDS in prisons, stressing the need to address problems relating to HIV/AIDS in prisons. It recommended that member states take steps toward the development of a policy on AIDS prevention and control in prisons based on the WHO Global AIDS Strategy, as part of their national AIDS prevention and control strategy.

WHO 1987 Statement
In its 1987 Statement from the Consultation on Prevention and Control of AIDS in Prisons,(310) the World Health Organization stressed that "[c]ontrol and prevention of HIV infection must be viewed in the context of the need to improve significantly overall hygiene and health facilities in prisons." It recognized that in many countries there "may be substantial numbers of prison inmates who have a history of high-risk behaviours, such as intravenous drug use [and] prostitution" and that "situational homosexual behaviour may occur." According to WHO, these considerations impose upon prison authorities a "special responsibility" to inform all prisoners of the risk of HIV infection from such behaviours." Most importantly, WHO emphasized that the general principles adopted by national AIDS programs should apply as much to prisons as to the general community.

WHO 1993 Guidelines

In 1993, WHO released revised guidelines. According to them,

- all prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality;
- preventive measures for HIV/AIDS in prisons should be complementary to and compatible with those in the community: "Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release"; and
- prison administrations have a responsibility to define and 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.(311)

As Dr Michael Merson, then Director of the Global Programme on AIDS, stated, the new guidelines "emphasize the link between prisons and the world outside." He added that "[i]ndividuals have the right to health care, including preventive care, whether they are incarcerated or not" and that "if prisoners have access to the same effective prevention methods that are available outside prison, this will benefit everyone."(312)

European Committee for the Prevention of Torture
In 1993, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or

Punishment (CPT) devoted a chapter of its third report to defining "the main issues pursued by CPT delegations when examining health care services for prisoners."(313) As pointed out by Bertrand and Harding,(314) the Committee has thus created a de facto set of guidelines for prison medical services, whose essential elements are: access to a doctor with the direct support of a fully equipped hospital service; equivalence of care to that available in the community; respect of the principles of confidentiality and patient's consent to treatment; and adequate preventive health care.

Conclusion

There are a large number of international instruments that deal with rights of prisoners, prison health services, and HIV/AIDS in prisons. Generally, prisoners retain all civil rights that are not taken away expressly or by necessary implication of their loss of liberty. In particular, there is agreement that prisoners have a right to health, and in the context of HIV/AIDS, this includes giving prisoners the means to protect themselves from exposure to HIV. Because prisoners have reduced possibilities of protecting their health, and because this results from state action, the state has a special responsibility for the health of prisoners. This responsibility is reinforced by basic principles of protection of human rights of persons in the custody of the state. Recommendations on HIV/AIDS in prisons developed by the international community are consistent in favouring "equivalence of treatment of prisoners," stressing the importance of prevention of transmission of HIV in prisons, and suggesting that condoms, bleach, and sterile needles be available to prisoners.

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Canadian Law

> Given the increasing dangers posed by HIV and hepatitis in prisons, brought into focus by cases of seroconversion in custody, there is more reason than ever to utilize a legal approach...in the attempt to achieve substantive change in correctional policy: prisoners may be able to demonstrate the need for changes in prison authorities' and governments' behaviour by instituting an action in negligence. Prisoners could also raise important constitutional law arguments based on Canadian Charter of Rights and Freedoms violations.(315)
>
> It bothers me that the government of Canada cannot recognize the similarities to the mistakes that were made regarding the handling of infected blood by the Canadian Red Cross and how they are being duplicated here with these issues. The government's attitude of "wait and see" and/or deliberate downplaying of the severity of this problem, can only serve to escalate the already "epidemic proportion" rates of sero-prevalence in our prisons. The fact that they [the governments] have been made aware of the serious nature of the problem, and how best [emphasis in the original] to deal with it, yet continue to refuse or delay the implementation of the proper measures to rectify it, clearly...is an outright act of

> negligence. If the government cannot grasp this idea, then perhaps lawsuits are our only available recourse.(316)

Case Law

In Canada, there have so far been no cases in which prisoners have initiated legal action in order to force prison authorities to provide them with preventive means, or to secure damages for having contracted HIV in prison. However, as mentioned above, there has recently been a case in which a prisoner in British Columbia undertook legal action against the provincial system for failing to provide her with methadone.(317) Further, there are a few decisions by human rights tribunals and courts in which prison systems have been held to contravene provincial human rights acts and the Canadian Charter of Rights and Freedoms for failing to deal adequately with HIV-positive prisoners.(318) In particular, the Ontario District Court, in the case of R v Downey,(319) held in 1989 that detention centres in Toronto were failing to come to grips with the detention of people with HIV/AIDS by not providing adequate treatment and by not educating staff about HIV/AIDS. The Court found that the prisoner in the case at issue was not receiving adequate treatment for his disease, and held that this constituted cruel and unusual treatment, in violation of s 12 of the Charter. The Court ordered that he be released on his own recognizance. Since then, conditions in Canadian prisons have improved markedly with respect to the treatment of prisoners with HIV/AIDS. Nevertheless, in a judgment released on 16 May 1996, an Ontario judge refrained from imposing a penitentiary sentence against a woman with AIDS "because of the lack of facilities in federal institutions in this province for the custody and care of inmates infected with HIV/AIDS."(320) According to the judge, "[i]f the minimum custodial term in this case was a penitentiary sentence, the court would be required to impose a sentence that could result in a breach of Section 12 of the Charter of Rights." He continued by saying:

> The incidence of HIV/AIDS is so great that it is a worldwide menace. A significant number of persons in federal custody may be infected with it. The healthy prisoners should be protected from infection.
>
> A person like the defendant who would bite a police officer could be a menace in an institution unserviced by specialized HIV/AIDS support staff.
>
> When released, having served their sentences, under present conditions HIV/AIDS infected prisoners could well constitute a danger to the Canadian society.
>
> The outlook for the defendant in a federal institution is bleak.

This case and the 1989 case are important: they show that Canadian courts are willing to closely scrutinize the action or inaction of prison authorities in the area of HIV/AIDS. If courts are willing to hold that not providing those already infected with adequate care constitutes a violation of their constitutional rights, they may be willing to hold that denying incarcerated people the opportunity to prevent infection in the first place is also unconstitutional.(32 1)

Tort of Negligence

Can the tort of negligence be used to prevent prisoners' exposure to HIV? This is the question addressed by Malkin in Appendix 1 of this document. As stated by Malkin:(322)

> Because many prisoners engage in unsafe activities, they run the risk of contracting HIV/AIDS; this risk, and the spread of the virus, could be diminished substantially if it were not for the negligent conduct and choices of governments and prison administrators....At issue here are the legal consequences of their carelessness and an important legal avenue prisoners in Canada may use in order to challenge that carelessness. Simply put, it is unreasonable for a prison authority to assert that because it does not want to be seen to encourage same-sex or drug-use activity in prison, it can pretend that it does not occur, and not provide measures to contain its spread. Because administrators manifestly cannot guarantee an environment free from the danger of infection, there is not only a moral duty to face up to that danger and address it, but a legal one as well. Its non-fulfilment amounts to negligence.

According to Malkin, in the prison context the primary objective of an action in negligence

> would not necessarily be to secure damages for a prisoner whose seroconversion is causally linked to a prison authority's negligence. Rather, an action in negligence could be used as a means through which institutional improvements can be effected: prisoners may find the pursuit of a legal action valuable, as a means to persuade prison authorities to provide them with the reasonable and necessary means that will allow them to protect themselves from contracting HIV in prison.

In order for an action in negligence to succeed, a plaintiff would need to prove

- that he or she was owed a duty of care by the defendant;
- that the standard of care owed was not met; and
- that the breach caused actual harm.

Further, even if a plaintiff could establish a cause of action to the satisfaction of the court, the defendant would still have the opportunity to negate the plaintiff's case by raising one of a number of possible defences. Malkin's analysis shows that a complainant may well succeed, but for him, success in the traditional sense is not entirely the issue in these circumstances:

> The purpose and value of bringing a legal action in negligence includes the possibility of judicial recognition of a duty of care owed by prison systems to prisoners in their custody,

> and of the breach of this duty by non-provision of preventative measures. Further, the value of such an action would not be limited to the individual case; rather, it could set a higher standard for what constitutes reasonable behaviour, with a view to improving conditions of detainment. In addition, even if a prisoner fails, the expenses facing the authorities in having to defend claims of this nature may prove to be a factor weighty enough to tip the balance in favour of changed policies.

Malkin concludes that

> while legislation would certainly be a far better means by which to institute harm-reduction measures than court action, litigation and the threat of it may provide a reason for legislators' effecting improvements. The action, by and of itself, cannot compel the introduction of the necessary legislative initiatives. However, in conjunction with other strategies it may fuel reform. Regardless of actual outcomes, policies may change as a result of embarrassing publicity.

Violation of Constitutional Rights

Can the argument be made that denying prisoners access to sterile needles and/or bleach is a violation of their constitutional rights? This is the question addressed by Elliott in Appendix 2 of this document.

As Elliott states, three sections of the Charter may provide a home for prisoners' right to protection, and might be used to seek the implementation of needle exchanges and distribution of bleach kits in prisons:

Section 7: Rights to Life and Security of the Person

According to Elliott, decisions in two major cases by the Supreme Court of Canada suggest that prisoners' right to protect against HIV infection could be framed as an aspect of the right to "security of the person."(323)

Section 7 offers a "preventative" legal remedy. It may be invoked to prevent future harm resulting from state action, such as future transmission among prisoners of HIV, hepatitis C, or other bloodborne diseases.

An argument would have to be made that the denial of access to sterile needles and/or bleach violates prisoners' security of the person. Evidence would have to be presented to establish:

- the relationship between injection drug use, needle-sharing and HIV transmission in prisons; and
- that denying access to sterile needles and bleach directly contributes to the risk of HIV infection.

According to Elliott, "there can be no doubt that there is a clear connection between the impugned state action (the denial of access to sterile needles and/or bleach) and the increased risk of HIV infection."

The next step would be to show that the infringement of the rights to life and security of the person is not "in accordance with the principles of fundamental justice." Elliott concludes:

> If those principles are intended to promote the dignity and well-being of the individual and society - and presumably this is a fundamental purpose of constitutional rights such as liberty and security of the person - could denying people the right to self-preservation be consonant with notions of 'fundamental justice'?

Section 12: Cruel and Unusual Punishment

An argument could also be made that denying prisoners sterile needles and/or bleach constitutes "cruel and unusual treatment or punishment." According to Elliott, it could be argued that denying prisoners the right to protect themselves against HIV infection is not a legitimate purpose of punishment and is therefore contrary to s 12.

Section 15: Equality Rights

Finally, an argument could be made that it constitutes "discrimination" within the meaning of s 15 of the Charter to deny prisoners access to protective methods that those on the outside can access.

If a breach of one of the above rights could be established, the state would seek to justify, under s 1 of the Charter, the prohibition on needles and bleach, most likely by arguing that its goal is to prevent IV drug use in prisons and to protect the safety of correctional officers and of inmates. In order to rebut these claims, evidence would be needed to establish that there is no "rational connection" between the policy of prohibiting needles and bleach and the goal of preventing drug use. According to Elliott, this evidence can be provided. First, studies indicate that, despite the lack of sterile equipment, drug use continues among prisoners, and needle sharing increases because of the shortage of injecting equipment. Second, implementing a needle-exchange program will not threaten the safety of guards. Furthermore, Elliott points out that denying prisoners access to sterile needles and bleach may not satisfy the Oakes requirement that constitutional rights be impaired "as little as possible." As he states, placing captive persons at increased risk of HIV infection is hardly a minimal impairment of the right to protection.

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Criminal Negligence?

Can the argument be made that denying prisoners access to sterile needles and/or bleach constitutes criminal negligence? This is an argument addressed by one of the respondents to the Discussion Paper. He writes:(324)

> In your discussion paper, you examined the possibility of civil suits against prison

authorities for the tort of negligence (page 47).

One further means to get authorities to respond the crisis of HIV/AIDS and hepatitis in prisons, and one certain to be controversial, lies in private criminal prosecutions. These are prosecutions launched by private individuals rather than by Crown prosecutors. One could argue that prison authorities and government officials who know the extreme risks of HIV infection in prisons and yet who do little or nothing to reduce the risks are criminally negligent.

The Criminal Code defines criminal negligence. It states:

219. (1) Everyone is criminally negligent who
(a) in doing anything, or
(b) in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section, "duty" means a duty imposed by law.

Section 220 of the Code makes it an indictable offence, punishable by up to life imprisonment, to cause death by criminal negligence. Section 221 makes it an indictable offence, punishable by up to ten years' imprisonment, for criminal negligence causing bodily harm.

According to Oscapella, the argument in support of a private prosecution for criminal negligence might be as follows:

(i) prison authorities and government officials have a legal duty to safeguard those under their control.
(ii) they know that drug use, including injection drug use, is widespread in prisons, putting inmates at risk of HIV and hepatitis infection from injecting drugs or from having sex with persons who have become infected by injecting drugs.
(iii) Even though inmates may be committing institutional offences by injecting drugs or by having intercourse, prison officials and politicians know that this activity cannot be stopped. The legal duty of prison authorities and politicians to safeguard prisoners should therefore extend to finding other means to prevent the spread of HIV infection. This could include any or all of the following:

- education about safe injection practices
- enhanced treatment facilities to help users stop using
- the provision of condoms
- the provision of bleach kits
- the provision of injection equipment
- the provision of substitutes that can be taken orally or smoked.

> If prison officials and politicians fail to take some or all of these measures, it might be argued that they are criminally negligent for any injury (for example, HIV or hepatitis infection) or death (from AIDS or hepatitis) that results....

He concludes by saying that, once an individual launches a private prosecution, the Attorney General of the province may decide to take over conduct of the case:

> Sometimes the Attorney General will continue with the prosecution. However, the Attorney General may equally decide to "stay" the charges or withdraw them.
>
> If a prosecution for criminal negligence were successful, Parliament and prison authorities would clearly have to reconsider the laws and policies that increased the risk of HIV infection in prisons. This might even include a reconsideration of drug laws that are directly or indirectly (through compelling users to commit crimes to get money for high-priced black market drugs) responsible for drug users going to prison.

Conclusion

This analysis of Canadian law shows that while courts have so far not had to deal with the issue of whether prison systems can be held responsible for cases of HIV transmission in prisons, they have in two instances already held that prisons were failing to deal adequately with HIV/AIDS, resulting, in one case, in an HIV-positive prisoner being released from prison and, in the other, in a judge refusing to impose a penitentiary sentence against a person with AIDS. Canadian constitutional law, the law of negligence, and, as argued by one respondent to the Discussion Paper, criminal law could potentially be used to force prison systems to introduce long-overdue harm-reduction measures, or to hold them liable for not providing them and for the resulting transmission of HIV in prisons.

In their response to the Discussion Paper, prisoners have indicated that, if necessary, they would indeed resort to legal action. For example, representatives of the Inmate Committee of one institution expressed agreement with the idea to "pressure the authorities into supplying prisoners with a 'full range' of protective devices...through legal means," saying that they "view the present policy concerning hypodermic syringes as a blatant disregard for human life," and that "responsibility should fall squarely on their [the authorities'] shoulders."(325)

Inmates from another institution said that

> if I were to contract a fatal disease in prison due to negligence on the part of C.S.C. to provide me with the necessary prevention material and education, (that we are...entitled to on the street), I would personally hold C.S.C. fully responsible and liable.(326)

It remains to be hoped that recourse to legal action will not become necessary. As stated by one respondent to the Discussion Paper, it would be "a shame if incarcerated persons were obliged to have recourse to the courts in order to claim and have recognized certain rights, in particular with regard to access to preventive means for protecting oneself against VIH transmission."(327)

There can be no question that the issue of providing protective means to prisoners would be more appropriately dealt with by swift action by correctional systems than by court action: the case for access, by prisoners, to the same means of prevention that are available on the outside is overwhelming and the failure to make them available is absolutely contradictory to proper public policy.(328)

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FOOTNOTES

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267 I Malkin, Appendix 1 at 1.

268 Note. Sentenced to Prison, Sentenced to AIDS: The Eighth Amendment Right to be Protected from Prison's Second Death Row. Dickinson Law Review 1988; 92: 863-892.

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273 Ibid at 242-43.

274 Ibid at 248-49. For another article examining the US situation, see N Mahon. HIV Transmission and Advocacy for Harm Reduction in US Prisons and Jails. Canadian HIV/AIDS Policy & Law Newsletter 1995; 2(1): 24-25.

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279 See supra, note 159.

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289 See ibid at 95.

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292 Human Rights Committee. General Comment 7[16], Article 7, and 9[16], Article 10, UN Doc

CCPR/C/21/Rev 1 of 19 May 1989.

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HIV/AIDS in Prisons: Final Report

by Ralf Jürgens

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RECOMMENDATIONS FOR ACTION

> Prisoners and prison staff should benefit from HIV prevention information and education, care and support, and confidentiality, at the same level as provided in the community. Policies should be based on the real risk factors actually occurring in prisons. The special needs of women, juvenile and foreign prisoners should be addressed. HIV positive prisoners should not be subject to segregation, isolation and other forms of discrimination. Prisoners should be protected from rape and coerced sex.(329)
>
> Canada is fortunate in that the prevalence of HIV infection in federal correctional institutions is still relatively small. However, it is at least ten times higher than that among Canadians in general. **There is no room for delay or complacency in responding to this threat**. Much has been done, and the Correctional Service of Canada deserves recognition for this, but more needs to be done. The [Expert] Committee [on AIDS and Prisons] has identified ways in which the Correctional Service of Canada can strengthen its efforts to prevent HIV transmission and harms from this infection and from drug use in its institutions. The opportunities are here to act decisively and in so doing, to help promote and protect the health of inmates, staff and all Canadians.(330) [emphasis added]

The following recommendations for action are directed to the federal and provincial prison systems. For the most part, they are not new: they are consistent with the recommendations made in the Discussion Paper and by participants at the First [Canadian] National HIV/AIDS and Prisons Workshop,(331) and build upon the recommendations issued by many national and international committees and organizations, in particular the work undertaken by ECAP, PASAN, and WHO. They are not meant to be comprehensive, but rather to update some of the recommendations made by ECAP, and to express the frustration felt by many about the federal and provincial systems' lack of action. Indeed, there is a consensus in Canada that, more than for new recommendations, there is a need for action: the 88 recommendations in ECAP's Final Report, the comprehensive strategy proposed by PASAN in 1992, and WHO's 1993 guidelines contain most of the elements necessary for an effective HIV/AIDS prevention and care strategy; they should be read together with the following recommendations.

The urgency with which action is needed is also not new, and was well expressed by Dr Gilmore, Chairman of ECAP, at the time of the release of ECAP's Final Report, in his above remarks. However,

since Dr Gilmore made his remarks, implementing these recommendations has become even more urgent, and unless CSC and provincial prison systems now act quickly and decisively, they may be held morally and legally responsible for the consequences of their inaction for prisoners, staff, and the public. As expressed in a statement by UNAIDS,

> the situation is an urgent one. It involves the rights to health, security of person, equality before the law and freedom from inhuman and degrading treatment. It must be urgently addressed for the sake of the health, rights and dignity of prisoners; for the sake of the health and safety of the prison staff; and for the sake of the communities from which prisoners come and to which they return.(332)

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Underlying Issues: Commitment, Resources, Accountability and a Long-Term, Strategic Approach

In order to adequately respond to the many issues raised by HIV/AIDS and other infectious diseases - hepatitis C in particular - in prisons, the approach to implementing the recommendations made by ECAP, PASAN, WHO, and other national and international organizations needs to undergo considerable change.

At the federal level - while it is true that some positive initiatives are being undertaken or planned, such as bleach distribution, introduction of non-nominal and anonymous HIV testing, and the pilot inmate peer education project - instead of implementing a longer-term strategy to deal with the many issues raised by HIV/AIDS and drug use, CSC is taking a piecemeal approach, demonstrating a clear lack of coordination, commitment, inspiration, and vision. As a result, the Service is falling further and further behind in the fulfillment of commitments made in its official response to ECAP's Final Report, and is sometimes clearly breaching those commitments.

The former Commissioner of CSC, Mr John Edwards, recognized that the approach to implementing ECAP's recommendations needs to change:

> We can no longer consider their successful implementation as a series of "stand alone" activities but must also address the issue of organizational change within CSC in order to ensure the viability of various HIV/AIDS-related initiatives. We believe that increased staff and inmate education and a greater emphasis on accountability will ensure that change is permanent and that programs such as bleach kit distribution are fully integrated into the day to day operations of our institutions.(333)

However, this acknowledgment of a deeper, underlying problem in the implementation of ECAP's recommendations has not led to a change in CSC's approach. Implementation remains a slow, piecemeal

process, with a few dedicated individuals carrying forward and making possible individual activities, but little support and often considerable opposition from the organization and, sometimes, from individual wardens.

CSC may have committed itself to implementing many of ECAP's recommendations, but has failed to create the conditions that would allow for faster and more consistent implementation. The process leading to bleach distribution in all institutions is a good example of how initiatives can be successfully prepared and undertaken. At the same time, for over one year now, the bleach distribution program has used up nearly all the few resources of CSC's National AIDS Program, leading to severe delays in the implementation of other initiatives, such as improved access to HIV testing and programs for aboriginal inmates and women inmates. These delays have been severely criticized by many respondents to the Discussion Paper. One respondent said that, in her view, "[t]he whole issue of turning things into 'programs' needs to be addressed": "Everytime CSC develops a 'program' they appear to fail. As recently as 1992, bleach was freely available as a cleaning agent throughout institutions. It was then removed from the system except in laundries and now years are being spent in determining the best way to implement a 'bleach kit program'."(334)

Provincial systems share many of the same problems and, with few exceptions, most notably British Columbia, they have been even more reluctant than CSC to face the reality of HIV, hepatitis, and drug use in prisons: sometimes they do not provide even the most basic preventive means that would allow prisoners to protect themselves from contracting HIV and other infectious diseases.

Recommendation 1

In order to prevent the further spread of HIV and other infectious diseases in prisons, and to provide better care, support and treatment for inmates with such diseases, Canadian federal and provincial prison systems need to:

1.1 take a proactive rather than reactive approach to the issues raised by HIV/AIDS, hepatitis, tuberculosis, and drug use in prisons;

1.2 engage in a long-term, coordinated, strategic planning process;

1.3 coordinate their efforts and collaborate more closely;

1.4 staff and resource their AIDS and infectious diseases programs adequately;

1.5 involve prisoners and staff in the development of all initiatives taken to reduce the spread of HIV and other infectious diseases;

1.6 ensure even implementation of initiatives by releasing clear guidelines and enforceable standards, by monitoring implementation, and by holding prison administrations accountable for timely and consistent implementation; and

1.7 evaluate all initiatives with the help of external experts.

Because prisoners come from the community and return to it, and because what is done - or is not done - in prisons with regard to HIV/AIDS, hepatitis, tuberculosis, and drug use has an impact on the health of all Canadians, Health Canada and provincial health ministries need to:

1.8 take a more active role and work in closer collaboration with the federal and provincial correctional systems to ensure that the health of all Canadians, including prisoners, is protected and promoted.

Research

> [T]here should be a recommendation to monitor HIV (and perhaps also hepatitis C) in prisoners, both to monitor prevalence levels among prisoners and also to try and estimate the number of new infections that occur while in prison.(335)

Research undertaken in Canadian federal and provincial prisons has provided evidence that levels of HIV infection in prisons are at least ten times higher than in the general population;(336) that hepatitis C seroprevalence rates are very high;(337) and that risk behaviours are prevalent in Canadian prisons.(338) Thus far, there has been no research done in Canada to estimate the number of new infections that occur in prisons; experience from other countries shows that such research is difficult but not impossible to undertake.

It is clear that no further research is needed for the purpose of establishing what measures are needed to better protect prisoners, staff, and the public from the further spread of HIV and other infectious diseases in prison. Research used to delay necessary action is therefore strongly opposed. However, research can and should be encouraged if its objective is to monitor the evolution of the epidemics of HIV and hepatitis in Canadian prisons, or to evaluate and improve existing and future interventions.

Recommendation 2

2.1 In order to monitor the evolution of the epidemics of HIV and hepatitis in Canadian prisons, and to evaluate and improve existing and future initiatives, research should be encouraged and funded by provincial and federal prison systems and health ministries. This research should provide information about seroprevalence, risk behaviours, and transmission of infections in prison, and help to improve necessary interventions to prevent the further spread of infectious diseases, and to care for infected prisoners. Research that serves the primary function of delaying necessary action is strongly opposed.

2.2 Research should be carried out with the active involvement of Health Canada and provincial health ministries and by individuals independent of, but in collaboration with, the federal and provincial prison systems. It should be preceded by and undertaken with consultation with inmates, staff, community groups and independent experts.

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Testing and Confidentiality

> C.S.C. has to realize and understand that most inmates are extremely wary about anything to do with confidentiality and C.S.C. If C.S.C. does not lighten up on their attitudes towards disclosure of medical information to staff, then we will never know the true status of HIV seroprevalence in prisons. By disregarding the confidentiality aspect, they are restricting potential HIV positive inmates from receiving the proper medical care and attention that they deserve, because they will not get tested out of fear of repercussions from C.S.C. staff. This is also, in fact, adding to the transmission of HIV by unaware HIV-positive inmates who are reluctant to get tested. Anonymous testing is the only real option here.(339)

CSC should be congratulated for its decision to make anonymous testing for HIV available to prisoners in federal prisons, but needs to start acting on its promise - more than one year has passed since it was first made and announced. Once implemented, making anonymous testing for HIV available to inmates in federal prisons will allow those who have so far been reluctant to be tested because of concern that test results will not remain confidential to come forward for testing. For the same reasons, anonymous testing should also be made available to inmates in provincial prisons. At the same time, in both federal and provincial prisons it will be important to make testing offered by prison health-care staff more accessible and acceptable to prisoners, by offering them the option of non-nominal testing, by training prison health-care staff in the delivery of pre- and post-test counselling, and by better protecting the confidentiality of medical information. Protecting confidentiality is of paramount importance; many prison officials and staff continue to insist on a "need to know" the HIV status of prisoners. In prisons, as outside, there are some situations in which disclosure of confidential medical information to a third person may be justified. However, such disclosure will only be justified in rare, exceptional cases, "when an individual assessment shows that disclosure is necessary, likely to be effective and the least invasive and restrictive means available to prevent harms that cannot otherwise be prevented."(340) As recommended by ECAP, cases in which disclosure may be justified need to be clearly defined, in collaboration with inmates and independent experts.

Recommendation 3

3.1 CSC should finally act on its promise to make anonymous testing for HIV

available to prisoners in federal prisons; where it is not already available, such testing should also be made available to inmates in provincial prisons.

3.2 The federal and provincial prison systems need to make testing offered by prison health-care staff more accessible and acceptable to prisoners, by offering them the option of non-nominal testing, by training prison health-care staff in the delivery of pre- and post-test counselling, and by better protecting the confidentiality of medical information.

3.3 Disclosure of offender medical information is justified only in exceptional cases, when it is clearly necessary, likely to be effective, and is the least invasive and restrictive means available to prevent harms that cannot otherwise be prevented. The federal and provincial prison systems, in collaboration with inmates and independent experts, including the Privacy Commissioner of Canada and provincial equivalents, need to clearly define such exceptional cases.

3.4 A brochure on HIV testing and confidentiality for staff should be prepared, addressing issues such as medical confidentiality and its importance, the absence of a "need to know" prisoners' HIV status, and the risk or absence of risk of transmission of HIV.

3.5 In each institution, health-care staff should meet to discuss and review how inmate medical information is handled. The goal would be to identify what barriers exist to protecting medical information, document them, and identify possible solutions for overcoming them.

3.6 Model procedures should be developed for the protection of medical records against disclosure, and a strict enforcement scheme should be set up.

3.7 Standard procedures for escorts should be developed, establishing clear guidelines indicat-ing whether and, if so, in which cases medical information is to be disclosed to escorts.

Educational Programs for Inmates

Hopefully, documentation regarding the various successes of the CAN project [see supra at note 42ff] will convince staff and prison administrators of the necessity of creating paid inmate peer educator positions. Although AIDS peer education can be done on a voluntary basis, the effectiveness, viability and sustainability of such initiatives requires at least two paid inmate coordinators.(341)

Education of inmates remains one of the most important efforts to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in prisons. As emphasized by ECAP, it should not be limited to written information, but include ongoing educational sessions, and should be delivered or supplemented by external, community-based AIDS, health or prisoner organizations. In addition, wherever possible, inmates should be encouraged and assisted in delivering their own peer education, counselling and support programs, and inmate job positions as peer health counsellors should be created.

CSC accepted ECAP's recommendations and agreed to "build on and improve educational programs already in place" by emphasizing HIV/AIDS education on entry and on a regular basis during incarceration, and by encouraging and supporting community-based AIDS, health or prisoner groups to provide education sessions. Nevertheless, little if anything has been done to ensure national implementation of this recommendation. HIV/AIDS education often remains limited to the handing out of a brochure or showing of a video, while educational sessions delivered on entry and on a regular basis thereafter, delivered or supplemented by external groups, remain the exception. In many provincial prison systems, although they emphasize the importance of education - often to the detriment of other preventive measures - the situation is not different: education is provided, but rarely is this done in educational sessions and with external input.

Another matter of concern is that, while CSC has funded a pilot inmate peer health promotion project, the importance of peer education programs is still not fully understood by correctional authorities and staff. Staff and prison administrators need to be informed and educated about the importance of peer education efforts, pointing out that they are cost-efficient and potentially life-saving programs. Further, a plan needs to be developed to ensure that the lessons of the pilot project be applied in institutions across Canada, and institutions need to be provided with the means that will allow them to create paid inmate peer educator positions.

While it is true that implementing peer-education programs may be more difficult in provincial than in federal prisons, provincial prison systems should nevertheless explore to what extent peer education initiatives can be undertaken in their institutions. Where the establishment of peer education programs will not be feasible, external input from community-based AIDS, health or prisoner groups will be all the more important.

Recommendation 4

Education of inmates remains one of the most important efforts to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in prisons. CSC urgently needs to act on its promise to improve existing educational efforts, and provincial systems also need to improve education about HIV/AIDS, hepatitis, tuberculosis, and drug use provided to inmates. In particular:

4.1 Education should not be limited to written information or showing of a video, but include ongoing educational sessions, and should be delivered or supplemented by external, community-based AIDS, health or prisoner organizations.

4.2 The results of and lessons learned in the pilot inmate peer health promotion project undertaken at Dorchester Penitentiary should be widely distributed and applied to other institutions: wherever possible, inmates should be encouraged and assisted in delivering peer education, counselling and support programs, and inmate job positions as peer health counsellors should be created.

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Preventive Measures for Inmates

The [Discussion Paper's] conclusion is in line with the [Canadian Human Rights] Commission's position that individuals in prison should not be denied the means to protect themselves from HIV/AIDS.(342)

UNAIDS [the Joint United Nations Programme on HIV/AIDS] is well aware that the provision of the means of prevention in prisons raises difficult issues. Sex in prisons is often illegal, and by providing condoms, prison authorities fear they are condoning sex. This raises the issue of whether or not the right to privacy protects sex between two consenting adults in prison. However, given the reality that such sex does occur, is there not a duty to reduce the harm that might result from it and should not prisoners have the ability to protect themselves from that harm?

Similarly with drug use in prison, this is clearly illegal, yet it does go on. On the outside, it has been found that effective prevention of transmission of HIV through injecting drugs involves a multi-pronged approach: reducing drug use, reducing injecting drug use, reducing the use of unclean drug-injecting equipment, and providing drug users with condoms. Such comprehensive programmes, including those that involve needle exchange, have proven effective on the outside. Initial studies show that they also work in prisons. They not only do not result in increased drug use or security incidents, they also reduce transmission of HIV.

Much more work needs to be done to find effective means to reduce transmission of HIV by sex and drugs in prisons. But the failure to provide the basic measures, such as information, education and the means of prevention available on the outside, violate prisoners' rights to health, security of person and equality before the law. It could also be said to constitute cruel and inhuman treatment. Though sex and drug-use in prison may be bad, spreading HIV is worse. It becomes a decision whether to take practical steps based on the reality of prisons to reduce the harm of the greater evil, HIV.(343)

Condoms, Dental Dams, Lubricant

Making condoms, dental dams, and water-based lubricant easily and discreetly accessible to inmates in all federal and provincial prisons is an immediate priority. Respondents to the Discussion Paper have expressed outrage that some provincial prison systems still do not make them available, and criticized the fact that in many provincial and some federal prisons, although available, they are difficult to obtain. Barriers to obtaining condoms, dental dams, and lubricant need to be removed. In a recent study of inmates' views on harm-reduction tools in Canadian prisons, Calzavara et al found that, although condoms and dental dams were available, and although a fairly high percentage of inmates reported engaging in sexual activity, very few inmates had ever used a condom in prison. Common barriers identified to use were: fear of being labelled as gay, fear of being suspected of transporting drugs, and the perceived low risk of same-sex activity, especially among females.343a This clearly shows that making condoms available alone is not enough: they need to be easily and discreetly accessible, so that inmates do not have to ask for them and fear of being identified as gay or drug users; and education needs to be undertaken to emphasize the need for using condoms when engaging in sexual activity, and to empower inmates to use them.

Recommendation 5.1

Without any further delay, condoms, dental dams, and water-based lubricant need to be made easily and discreetly accessible to inmates in all federal and provincial prisons, in different locations throughout the institutions, and without inmates having to ask for them.

Bleach

CSC needs to be congratulated for its recent decision to make bleach easily and discreetly available in all institutions. In implementing distribution of bleach, the lessons learned from implementing condom distribution should be taken into account: clear directives need to be established to ensure that bleach distribution is implemented quickly and evenly in all institutions. Further, making bleach available alone will not be enough: inmates need to be educated about the necessity of always cleaning their injection equipment, and efforts need to be made to ensure that bleach is in fact easily and discreetly accessible to all inmates. Inmates will not use it if they fear being identified as drug users. Finally, all provincial systems in which bleach is currently not made available to inmates need to follow suit and make bleach available.

Recommendation 5.2

Bleach needs to be made easily and discreetly accessible to inmates in all federal and provincial prisons, and inmates need to be educated about the necessity of always cleaning injection equipment before and after its use.

Sterile Needles

> As a recovering addict, it is hard for me to advocate a needle-exchange program for anyone, in particular prisoners. However, when I consider the amount of needle sharing that I have witnessed over the years spent in prison, and how many new infections they may have caused, I find myself more concerned with the human lives than the "correctness" of providing needles to prisoners.(344)
>
> CSC must avail [itself] of all methods to prevent the spread of HIV and other infectious diseases within federal institutions, and this includes the expeditious implementation of a clean needle exchange program. This is, without question, a health issue, and must be dealt with accordingly - ensuring the health interests of the inmate are given the ultimate priority.(345)
>
> In C.S.C.'s response to the ECAP report, commissioner John Edwards pointed out that C.S.C. has a public health responsibility to the communities to which these offenders return. As quoted "Whatever concerns we have [about making bleach available to inmates] are superseded by public health concerns." If the commissioner truly believes this then why would his approach to a needle exchange be any different, especially since ... there are serious doubts as to the efficacy of bleach in destroying HIV?(346)

In its Final Report, ECAP stated that making sterile injection equipment available to inmates would be inevitable.

Because of the new developments described in this document, the introduction of needle-exchange programs in Canadian prisons is even more pressing today than at the time of the release of ECAP's Final Report. It is also more realistic because results of the Swiss pilot project and three years of experience with making needles available in a Swiss prison for men have demonstrated that sterile needles can be made available in prisons safely with good results, and that prison staff can be brought to accept and even support needle-exchange programs.

In Canada, many prison staff are already in favour of making sterile injection equipment available to inmates: staff who responded to the questionnaire distributed to them at Matsqui Institution as part of the bleach pilot project asked, "Why are we wasting our time giving out bleach? Why aren't we just doing a needle exchange?"(347) And in a survey undertaken by ECAP two years ago, 15 percent of correctional officers and 31 percent of health-care staff responded that they were in favour of making a needle-exchange program available to prisoners.(348) Staff understand that many of the makeshift items that inmates use in place of needles to shoot drugs, such as pieces of light bulbs, are no less dangerous than syringes, and that their safety could be increased, rather than decreased, by making sterile injection equipment available. As stated by Mahon,

> Clearly, in any setting with skin-piercing objects and a high rate of HIV infection, safety remains a concern. But rather than using the potential threat to safety as a rationale for dismissing the idea of needle exchange behind bars, it should be used as a primary consideration in program design.(349)

Most respondents to the Discussion Paper agreed that sterile injection equipment should be made available in prisons, and suggested that CSC and provincial systems face the inevitable: sterile needles need to be made available in prisons in the interest of prisoners, staff, and the public.

As recommended by ECAP and PASAN, prison systems and governments should start immediately to put in place the measures that will make needle distribution possible. These include:

- consultation with prison staff and the unions - staff's safety and other concerns need to be taken into account and staff need to be involved in the planning and implementation of the programs;
- education of prisoners, staff, and the public about (1) the fact that making needles available in prisons does not mean condoning drug use or giving prisoners the right to use drugs, but is a pragmatic and necessary health measure that will better protect prisoners, staff, and the public; and (2) the benefits to society from making needles available - prevention of the spread of HIV among prisoners and to society, and avoidance of health-care costs related to it; and
- selection of prisons in which pilot projects can be undertaken.

These pilot projects should be designed taking into consideration the lessons learned by the prison systems in which sterile injection equipment is already made available to inmates, need to be tailored to the culture of the particular institutions in which they are undertaken, and should be started without any further delay.

Recommendation 5.3

In an effort to further reduce the harms from injection drug use and because injection equipment may not be effectively or consistently cleaned by bleach, sterile injection equipment needs to be made available in federal and provincial prisons. This does not mean condoning drug use or giving prisoners the right to use drugs, but is a pragmatic and necessary health measure that will better protect prisoners, staff, and the public.

Prison systems and governments should start immediately to put in place the measures that will make needle distribution possible. These include:

- **consultation with prison staff and the unions - staff's safety and other concerns need to be taken into account and they need to be involved in the planning and implementation of the programs;**
- **education of prisoners, staff, and the public about (1) the fact that making needles available in prisons does not mean condoning drug use or giving prisoners the right to use drugs, but is a pragmatic and necessary health measure that will better protect prisoners, staff, and the public; and (2) the benefits to society from making needles**

available - prevention of the spread of HIV among prisoners and to society, and avoidance of health-care costs related to it; and

- **selection of prisons in which pilot projects can be undertaken.**

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Methadone Maintenance Treatment (MMT)

> Implementation of PMMT [prison methadone maintenance programs] is likely to offer most of the benefits of community MMT programs without significant additional problems from adaptation of MMT to the prison environment. The effectiveness in reducing heroin use, criminality and the spread of HIV, as well as the safety, minimal side-effects and low cost of community Methadone Maintenance Treatment programs have become increasingly accepted in the last decade...(350)

As stated by Dolan and Wodak, methadone maintenance is a medically indicated form of treatment that should be available to opioid-dependent persons regardless of whether they are outside or inside prison. Equivalence of medical care should mean that, at a minimum, prisoners who have been receiving methadone on the outside may continue to receive it inside if that is their wish and their practictioner's wish/decision.(351) Further, where MMT is a treatment option available to opiod-dependent persons outside prisons, it should also be made available to them in prisons: because of the principle of equivalence of medical care, prisoners have a right to the same treatments available to persons outside prisons.

Recommendation 5.4

Prisoners who have been in methadone maintenance treatment on the outside should always be able to continue to receive such treatment in prison. Further, where such treatment is a treatment option available to opioid-dependent persons outside prisons, it should also be made available to them in prisons.

In addition, opioid-dependent prisoners should have other treatment options, including methadone detoxification programs with reduction-based prescribing, which should be routinely offered to all opioid-dependent prisoners on admission.

Tattooing and Piercing Equipment

CSC's response to ECAP's and PASAN's recommendations with regard to tattooing and piercing have been heavily criticized as "absurd" and unrealistic. Because both activities are prevalent in prisons and represent high-risk activities for the transmission of HIV and other infectious diseases, tattooing and piercing equipment and supplies should be classified as hobby-craft equipment and be authorized for use in all federal and provincial institutions.

Recommendation 5.5

Tattooing and piercing equipment and supplies should be classified as hobby-craft equipment and be authorized for use in all federal and provincial institutions.

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Responding to Drug Use

The Need for a More Pragmatic Approach

Federal and provincial prison systems need to adopt a more pragmatic approach to drug use, acknowledging that the idea of a drug-free prison is no more realistic than the idea of a drug-free society and that, because of HIV/AIDS and hepatitis C, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy. Reduction of drug use is an important goal, but reduction of the spread of HIV and other infections - in particular, hepatitis C - is more important: unless prison systems act aggressively to reduce the spread of infections, there may be slightly reduced rates of drug use in prisons, but many more prisoners living with HIV/AIDS and/or hepatitis C and other infections. At a minimum, they need to coordinate their efforts in the areas of HIV/AIDS and of drug use, to make sure that any programs they undertake with the aim of reducing drug use does not result in an increase in harms from that use.

Urinalysis Programs

Particular concern exists with regard to urinalysis programs, which should be evaluated by external experts in terms of their impact on drug use and HIV prevention efforts, but also their cost effectiveness. At a minimum, testing for traces of cannabis products should be stopped. This would substantially reduce the costs of urinalysis programs and ensure that inmates fearing detection would not switch from relatively harmless cannabis products to other, more harmful drugs used by injecting. This approach is already used, for example, in prisons in Switzerland and Germany. Commenting on it, the warden of one prison has said:

> There is no question in my mind that it would be a mistake to test for marijuana. The tests are very expensive and inmates might use more dangerous, less detectable drugs. And then, to be honest, use of marijuana does not really bother staff. They can live with it, it does not create any problems. We have to be pragmatic, and focus on AIDS as the major

problem.(352)

Drug Treatment

Apart from methadone detoxification and maintenance programs for opioid-dependent prisoners, more innovative treatment approaches should be offered to prisoners. For example, in some prisons, so-called drug-free wings should be established to allow prisoners with the motivation to stop drug use a more realistic option to do so.

Recommendation 6

Federal and provincial prison systems need to adopt a more pragmatic approach to drug use, acknowledging that, because of HIV/AIDS and hepatitis C, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy: reduction of drug use is an important goal, but reduction of the spread of HIV and other infections - in particular, hepatitis C - is more important.

At a minimum, they need to coordinate their efforts in the areas of HIV/AIDS and of drug use; allow for evaluation of existing education, treatment, and, where applicable, urinalysis programs, by external experts; and offer a greater variety of treatment options to inmates, including in drug-free prisons or wings.

Education of Staff

I cannot over-emphasize the need for on-going education for both staff and inmates. As CSC coordinator for the AIDS Peer Counselling Project in Dorchester Penitentiary, I am appalled at the lack of progress in terms of knowledge/attitudes since the arrival of our first HIV+ inmate nine years ago.(353)

As said by ECAP, education about HIV/AIDS "is the most important effort to promote and protect the health of staff and prevent transmission of HIV and other infectious agents in...correctional institutions. (354) Educational programs for staff remain a priority. As identified by CSC's National Bleach Distribution and Anonymous Testing Working Group, all health-care staff need to receive training about HIV/AIDS, hepatitis, and tuberculosis, the different HIV testing options, pre- and post-test counselling, and confidentiality, and community-groups and persons living with HIV should be delivering part of the training; and training about HIV/AIDS needs to become part of core training of all employees, including correctional officers. In particular, they need to learn about how to deal with prisoners living with HIV/AIDS and to respect their rights and dignity, the absence of risk of HIV transmission from most contact with inmates, and the need to respect medical confidentiality.

In addition, all staff need to be educated about drugs, drug use, and the concept of harm reduction; at

least part of this training should be delivered by community groups and users or ex-users.

Recommendation 7

7.1 Health-care staff need to receive ongoing training about HIV/AIDS, the different testing options, pre- and post-test counselling, and confidentiality; community groups and persons living with HIV should be delivering part of the training.

Training programs should also include sections on hepatitis, tuberculosis, and other infectious diseases.

7.2 Training about HIV/AIDS, hepatitis, tuberculosis, and other infectious diseases needs to become part of core training of all prison staff, including correctional officers. In particular, staff need to learn about how to deal with prisoners living with HIV/AIDS and to respect their rights and dignity, the absence of risk of HIV transmission from most contact with inmates, and the need to respect medical confidentiality. Community groups and persons living with HIV should be delivering part of the training.

7.3 All staff need to be educated about drugs, drug use, and the concept of harm reduction; at least part of this training should be delivered by community groups and users or ex-users.

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Protective Measures for Staff

ECAP made a long list of recommendations directed at ensuring that the safety of staff in correctional institutions be guaranteed, including better education for staff and regular review of access to and use of protective materials and equipment. Staff present at the 1995 Kingston National HIV/AIDS and Prisons Workshop welcomed these recommendations and urged CSC to act upon them. Further, they agreed that measures to reduce HIV infection among inmates were also in their own interest.

Continuing to make sure that staff's workplace is safe will be crucial. 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. CSC and provincial prison systems will have to address staff's concerns in these areas.

With regard to the introduction of measures to prevent the spread of HIV in prisons: staff need to be involved, from the beginning, in the planning and implementation of such measures, in order to ensure that their safety concerns be a primary consideration in their design.

Recommendation 8

8.1 Prison systems need to continue to regularly review staff access to and use of protective materials and equipment.

8.2 Staff's concerns about overcrowding in the institutions and understaffing need to be addressed by the federal and provincial correctional systems: overcrowding and understaffing - not measures to prevent the spread of HIV in prisons - constitute the real threat to their safety.

8.3 Staff need to be involved from the beginning, in the planning and implementation of measures to prevent the spread of HIV and other infectious diseases in prisons, in order to ensure that their safety concerns be a primary consideration in their design.

Health Care

> Prisoners have a right to be provided the basic standard of medical care available in the community.(355)

Most prison health-care services do their best to provide inmates living with HIV or AIDS with optimal care, and often inmates are referred to outside specialists for HIV-specific diagnosis and treatments. However, on some occasions, the Project has heard from inmates that they were receiving care and treatment of significantly lower quality than that received before coming to prison, or before being referred to the particular institution at which they were currently staying.

Further, a variety of other concerns have been raised, such as: (1) the increase in the number of sick inmates - prisons are not equipped to deal with inmates who require long-term, ongoing care and treatment; (2) the difficulty of obtaining narcotics routinely given for pain relief to patients on the outside - in prison, these narcotics are often denied even to those in severe pain; and (3) the difficulty of accessing investigational drugs or nonconventional therapies, although in its response to ECAP's Final Report CSC promised to facilitate inmates' access to specialized or experimental treatments. Specifically with regard to inmates living with HIV or AIDS, a recommendation was made by respondents to the Discussion Paper that (1) it be ensured that inmates have easy access to the HIV/AIDS Treatment Information Network;(356) and that (2) health promotion strategies that would prevent or slow down the progression from HIV to AIDS - such as proper nutrition, vitamins, regular exercise, adequate ventilation, etc - be emphasized:

> Such initiatives provide HIV positive prisoners with better opportunities for remaining healthier longer, and should be viewed as a right instead of a privilege. Staff need to be educated about the importance of these strategies.(357)

Generally, respondents suggested that one of the major problems with correctional health care is that it is not proactive, and does not emphasize early detection and health promotion and prevention, but intervention "after the fact," in the form of a daily sick-call system..

Recommendation 9

9.1 Efforts need to be undertaken in federal and provincial prisons to ensure that prisoners receive care, support and treatment equivalent to that available outside. This includes, but is not limited to:

(1) making sure that inmates in pain have equal access to narcotics routinely given for pain relief to patients on the outside;

(2) allowing inmates equal access to investigational drugs or nonconventional therapies;

(3) ensuring that inmates have equal access to the HIV/AIDS Treatment Information Network;

(4) emphasizing health promotion strategies for all prisoners, but in particular for prisoners living with HIV or AIDS, in order to slow down the progression of their disease;

(5) making sure that complaints from individual inmates about lack of medical care or access to support and treatment in a particular institution be dealt with appropriately; and

(6) assessing health-care services in each institution in consultation with outside experts to ensure that the expertise necessary for the medical care, support, and treatment of inmates with HIV or AIDS is available, accessible and efficient.

9.2 In the longer term, correctional health care needs to evolve from a reactive sick-call system to a proactive system emphasizing early detection, health promotion, and prevention.

Compassionate Release

[T]here is a need for clear guidelines on how to handle appeals for early release due to HIV. At present, appeals are handled on a case-by-case basis, with no consistency between cases. Decisions are made in isolation by prison officers and Parole Board members.(358)

As said in the Discussion Paper,

> [a]t the Kingston Workshop, participants were told about some inmates dying in prison or being released just before they died, to their deathbed. More needs to be done to ensure that inmates with progressive life-threatening diseases who do not represent a threat to public safety be released earlier in the course of their disease.(359)

The Chairman of the National Parole Board responded by saying:

> [T]he recommendation in the ECAP report which is directly relevant to the Board is the recommendation which calls on CSC to "regularly recommend to the National Parole Board the release of inmates with progressive, life-threatening diseases, including AIDS, earlier in the course of their disease, before they are terminally ill, and wherever they do not constitute a threat to public safety." I am aware that CSC has accepted this recommendation and I note the recommendation on page 59 of your discussion paper that more needs to be done to ensure that this recommendation is implemented. We have been and will continue to work closely with CSC to ensure that as many inmates as possible are adequately prepared for and released in a timely manner.(360)

Recommendation 10

> **Continued efforts need to be undertaken to ensure that inmates with progressive life-threatening diseases, including AIDS, be released from prison earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety. This should include, but not be limited to, education of all involved in decisions about early release, about the position taken by CSC in response to ECAP's report.**

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Women Inmates

> Effective education and prevention programs targeted specifically for female inmates must be developed, implemented and evaluated.(361)

In its Final Report, ECAP acknowledged the special needs and concerns of women inmates with regard to HIV infection and AIDS, and recommended the following:

> (1) CSC should ensure that there are educational and prevention programs specifically

targeted to women inmates, including information about pregnancy and HIV transmission from mother to child, women's health problems, and the risk of transmission of HIV and other infections from sexual activities.

(2) CSC should ensure that there are programs that will help to empower women inmates and decrease their vulnerability to abuse in general and to HIV infection and drug use in particular.

(3) CSC should ensure that community and peer input into these programs is provided.

(4) CSC should ensure that adequate counselling and support for pregnant inmates are available.

As emphasized in the Discussion Paper, not much - if anything at all - has been done in response to these recommendations, although CSC accepted them in its official response to ECAP's report. This lack of action has been heavily criticized by respondents to the Discussion Paper and by participants at the First National HIV/AIDS and Prisons Workshop, who emphasized the need for education and prevention programs specifically designed for female inmates, and were of the opinion that society and prison systems were generally failing the needs of women in Canadian prisons.

Recommendation 11

The federal and provincial prison systems need to take immediate action to develop and implement effective education and prevention programs targeted specifically to female inmates.

Aboriginal Inmates

As with women inmates, not much has been done to respond to the needs of aboriginal inmates. Concern also persists about the hyperincarceration of aboriginals in Canadian provincial and federal prisons. In its Final Report, ECAP had recommended the following:

(1) CSC should ensure that, in accordance with its policy, Aboriginal inmates have access to traditional healers, healing ceremonies and medicines.

(2) Educational and prevention programs should be developed that will respond to the specific needs of Aboriginal inmates.

(3) Aboriginal groups and Elders/Healers should be encouraged to deliver these programs.

(4) CSC in collaboration with Health Canada and others should fund Aboriginal groups

and Elders/Healers to provide this education.

(5) Because peer education has been found to be one of the most effective means of educating people about HIV infection and AIDS, Aboriginal inmates should be encouraged and assisted in developing their own peer education, counselling and support programs.

Recommendation 12

The federal and provincial prison systems need to take immediate action to develop and implement effective education and prevention programs targeted specifically to aboriginal inmates.

Young Offenders

[T]here is much research that needs to be done in terms of youth in institutions.(362)

Many young offenders are at high risk of contracting HIV, but little is being done by provincial prison systems to address this risk. In response to this, PASAN recently released a young offender HIV/AIDS strategy containing numerous recommendations directed at reducing the risk of the spread of HIV and other infectious diseases among young offenders.

Recommendation 13

The recommendations in PASAN's comprehensive HIV/AIDS strategy for young offenders should be implemented.

Drug Policy

In my opinion, the need for changing the way in which Canadian laws deal with drug users must be continually underscored. Sentencing "non-violent" drug users to prison is clearly not the answer. Effective harm reduction and treatment programs have and will continue to be the only viable means of dealing with drug use.(363)

Many of the problems raised by HIV/AIDS in prisons are the result of Canada's drug policy, which instead of providing drug users with much-needed treatment, care, and support, criminalizes their behaviour and puts many of them in prison. The financial and human costs of this policy are enormous, and prison systems are burdened with a problem society fails to deal with, and that they are even less equipped to deal with. As WHO has stated, "[g]overnments may...wish to review their penal admission policies, particularly where drug abusers are concerned, in the light of the AIDS epidemic and its impact

on prisons."(364) Indeed, as emphasized by ECAP,(365) 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.

Recommendation 14

Reducing the number of drug users who are incarcerated needs to become an immediate priority. In order to reduce the problems created by HIV, other infectious diseases, and drug use in prisons, alternatives to imprisonment, particularly in the context of drug-related crimes, need to be developed and made available.

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CONCLUSION

> Prisoners are the essential captive audience. With such an audience, effective HIV prevention and care programmes can be implemented. But there needs to be the political will, the knowledge, and the resources to devote to these issues. UNAIDS calls on governments to address the needs of prisoners in a non-discriminatory and comprehensive manner.(366)
>
> Unless governments and the prison systems finally act upon the recommendations, courts or a commission such as that currently examining the safety of Canada's blood supply may one day have to explore why not enough was done to prevent HIV infection in prisons, although everyone was aware of the risks and knew the measures that could be taken to reduce them.(367)
>
> The transmission of HIV or any other serious disease cannot be tolerated. Given that all we can do is restrict, not suppress, the entry of drugs, we feel it is our responsibility to at least provide sterile syringes to inmates. The ambiguity of our mandate leads to a contradiction that we have to live with."(368)

Although the prevalence of HIV among Canadian prisoners is at least 10 times higher than in the general community, far from enough is being done to prevent the spread of HIV infection in prisons and to provide prisoners living with HIV or AIDS with adequate treatment, support and care. Provincial and federal prison systems have taken steps in the right direction, and there can be no question that the situation with regard to HIV/AIDS in prisons in Canada has improved over the years. However, many of ECAP's and PASAN's recommendations - including some recommendations CSC agreed with in its response to ECAP's report - have not been implemented, putting prisoners, staff, and members of the public at risk of their lives.

If federal and provincial prison systems want to fulfil their moral and legal obligations, they need to reconsider their response (or lack of response) to the recommendations made, and implement a longer-term strategy to deal with the many issues raised by HIV/AIDS and drug use - instead of pursuing the current piecemeal approach, characterized by a lack of coordination, commitment, inspiration, and vision.

They will also have to adopt a more pragmatic approach to drug use in prisons. As the Scottish report on Drug Use and Prisons pointed out, "the idea of a drug free prison does not seem to be any more realistic than the idea of a drug free society," and "stability may actually be better achieved by moving beyond this concept."(369) Contrary to the belief of some, making available to inmates the means that are necessary to protect them from HIV transmission does not mean condoning drug use in prisons; rather, it is a pragmatic measure acknowledging that protection of prisoners' health needs to be the primary objective of drug policy in prisons. Furthermore, introducing harm-reduction measures is not incompatible with a goal to reduce drug use in prisons: making sterile needles available to drug users has not led to an increase in drug use, but to a decrease in the number of injection drug users contracting HIV and other infections.(370) Similarly, making methadone available to some users does not mean giving up on the ultimate goal of getting people off drugs; rather, it is a realistic acknowledgment that for some 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, link with needed services, and reduce the risk of their becoming infected with HIV.

Outside prison, harm-reduction measures such as needle exchange and methadone maintenance programs have been introduced because of the realization that they are necessary for the common good and to protect drug users and society in general from the spread of HIV. This has been accepted by police forces in many countries, including Canada, which, although continuing their fight against drugs, allow and even promote needle exchanges and other harm-reduction approaches. As the Head of the Merseyside Police Drug Squad, Mr Derek O'Connell, has stated:

> As police officers, part of our oath is to protect life. In the drugs field that policy must include saving life as well as enforcing the law. Clearly, we must reach injectors and get them the help they require, but in the meantime we must try and keep them healthy, for we are their police as well.... People can be cured of drug addiction, but at the moment they cannot be cured of AIDS.(371)

Clearly, prison systems also have a moral and legal responsibility to do whatever they can to prevent the spread of infectious diseases among inmates and to staff and the public, and to care for inmates living with HIV and other infections. Currently, they are failing to meet this responsibility, because they are not doing all they could: measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment and methadone maintenance available to injection drug users, are not being undertaken in Canadian prisons, although other prison systems have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrations, politicians and the public.

It is to be hoped that governments and the prison systems in Canada will act without prisoners having to undertake legal action to hold them responsible for the harm resulting from their refusal to provide adequate preventative means. Prisoners, even though they live behind the walls of a prison, are still part of our communities and deserve the same level of care and protection that people outside prison get: they are sentenced to prison, not to be infected. This has recently been re-emphasized in an April 1996

statement by the Joint United Nations Programme on HIV/AIDS (UNAIDS) to the United Nations Commission on Human Rights:

> [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.(372)

If governments and prison systems do not take proper steps, they risk being condemned as irresponsible and morally negligent in the safekeeping of prisoners. As Justice Kirby stated, we owe it to the prisoners, and we owe it to the community, to protect prisoners from infection in prison:

> This requires radical steps before it is too late....The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is...unpalatable.... As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society."(373)

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HIV/AIDS in Prisons: Final Report

by Ralf Jürgens

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Appendix 1

The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody

by Ian Malkin

Abstract

Do prisoners have a right to the means that would allow them to protect themselves against contracting HIV and other diseases in prisons? Can prison systems be forced to provide condoms, bleach, and sterile needles? Can and should the law be used to achieve change in prison HIV/AIDS policies?

The following article by Ian Malkin discusses these questions. In particular, the author analyzes whether in Canada the tort of negligence can be used to prevent prisoners' exposure to HIV.

About the Author

Ian Malkin is Senior Lecturer, University of Melbourne, Australia. This paper was first presented at the First Canadian Workshop on HIV/AIDS in Prisons, held in Kingston on 20 August 1995, and published as Appendix 1 of HIV/AIDS in Prisons: A Discussion Paper. For inclusion in the Final Report, it has been updated and slightly revised. Thanks to Ralf Jürgens for his assistance, and to Simon Chesterman for his invaluable work as research assistant and his contributions in writing some sections of this paper. A detailed version of the original paper, focusing on the situation in Australia, was published in Melbourne University Law Review 1995; 20: 423-480; a shorter version of the paper can be found in the Canadian HIV/AIDS Policy & Law Newsletter 1995; 2(1): 19-22.

Contents

Introduction

Prisons detain a large number of injecting drug users, gay men, lesbians, and individuals who identify as "straight" but who engage in same-sex activities. These individuals are among the most marginalized and disadvantaged in the community, and imprisonment heightens their marginalization. Because many prisoners engage in unsafe activities, they run the risk of contracting HIV/AIDS; this risk, and the spread of the virus, could be diminished substantially were it not for the negligent conduct and choices of governments and prison administrators.

At issue here are the legal consequences of their carelessness and an important legal avenue prisoners in Canada may use in order to challenge that carelessness. Simply put, it is unreasonable for a prison authority to assert that because it does not want to be seen to encourage same-sex or drug-use activity in prison, it can pretend that it does not occur, and not provide measures to contain its spread. Because administrators manifestly cannot guarantee an environment free from the danger of infection, there is not only a moral duty to face up to that danger and address it, but a legal one as well. Its non-fulfilment amounts to negligence.

Recent developments highlight the importance of putting the search for legal redress on the legal and political agenda. This is a strategy that can be used to compel changes in governments' and prison authorities' behaviour: it can be argued that their unwillingness to take all reasonable and necessary steps to reduce the possibility of transmission of HIV in prisons amounts to careless conduct, and that they must be made accountable for this conduct through the use of a legal action in negligence.

The Problem and the Need for a Remedy

The problems posed by HIV/AIDS and other infections in prisons are immediate and grave.

Seroconversion in Prisons

Seroconversion in prisons has become a documented reality. Examples include the following:

- In 1994, Scottish researchers documented as many as eight cases of custodial seroconversions.(1)
- Dolan reported Australia's first confirmed case of custodial seroconversion, warning that "a disturbingly high number of HIV transmissions might have occurred," adding that, "given the prevalence of infection and the prevalence of risk behaviour it would appear that the potential [for further seroconversions] is enormous."(2)
- Another case of custodial seroconversion was reported in Queensland, Australia.(3)
- Mutter and colleagues identified 556 prisoners in the Florida Department of Corrections who had been continuously incarcerated since 1977. The medical records of these prisoners were reviewed to determine whether they had been tested for HIV and, if tested, whether the results were positive. Eighty-seven of the 556 prisoners had undergone testing for HIV infection. Of these, 18 (21 percent) were found to be HIV-positive, providing strong evidence for transmission of HIV in prison.(4)

In Canada, there have thus far been no documented cases of HIV transmission in prisons. However, the only reason for this is the absence of research in this area: everyone knows that HIV transmission is in fact occurring.

Spread of Hepatitis C

There is evidence of the rapid spread of hepatitis B and C in prisons and, by extension, of potentially rapid transmission of HIV: hepatitis C is generally spread by either blood transfusion or by use of contaminated injection equipment, with sexual transmission being a more remote possibility. In the prison population, seropositivity for hepatitis C likely represents a marker for IV drug use at some time in the majority of those testing positive and suggests an alarming potential for the rise of HIV.(5)

- From January to August 1995, 223 new cases of active hepatitis C and 22 new cases of hepatitis B were reported in federal prisons in Canada. The number of new cases further increased in 1996: from January to March 1996, 124 new cases of active hepatitis C and 16 new cases of hepatitis B were reported.(6)
- Three studies undertaken in Canadian prisons revealed hepatitis C seroprevalence rates of

between 28 and 40 percent:
- In the first study, undertaken at the Prison for Women in Kingston, 39.8 percent of the 86.9 percent of inmates who participated tested positive.(7)
- In the second study, undertaken at Joyceville Institution, a medium-security federal penitentiary near Kingston, 27.9 percent of the 408 participating prisoners tested positive.(8)
- A third study of male inmates in British Columbia showed a prevalence of 28 percent.(9)

- Similar figures are reported from other prison systems. For example, in prisons in Victoria (Australia), 39 percent of 3627 prisoners tested had been exposed to hepatitis C; 46 percent had a history of injecting drugs. Prevalence of hepatitis is as high as 50 percent in prisons in New South Wales (NSW).(10)

The Australian "Condom Case"

Fifty Australian prisoners launched a legal action against the State of NSW for non-provision of condoms.(11) Their lawyer noted that "[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded."(12) The action was instituted by the Aboriginal Legal Service. In it, the prisoners seek "various orders and other relief" to ensure access to condoms within prison.

Until recently, the policy of the correctional system of NSW, like that of all other Australian systems (the Belconnen Remand Centre in the Australian Capital Territory being the only exception), was to oppose condom distribution, although the authorities were aware that sexual activity occurs in prisons. Reliance was placed on education as the primary harm-reduction measure. The prisoners argued that the decision not to supply condoms or permit their possession or use by male prisoners

- was so unreasonable as to constitute an improper exercise of power;
- gave rise to a writ of habeus corpus (a written order requiring the investigation of the legitimacy of a person's detention); and
- constituted a breach of the duty of care owed by the Department to the prisoners.

In a judgment handed down on 19 October 1994, Justice Dunford dismissed the first two grounds; with respect to the third ground, the Court held that the claim must be redrafted, to be brought in the name of four aggrieved inmates rather than as a class action on behalf of 50. The prisoners appealed Dunford J's decision, arguing they should be able to:

- rely on the writ of habeus corpus;
- rely on the Magna Carta; and
- continue their proceedings as a class of 50 rather than amend their pleadings and claims.

In a judgment delivered on 8 August 1995, the NSW Court of Appeal dismissed habeus corpus arguments after canvassing British, Canadian, and US decisions. It also dismissed, rather summarily, contentions premised on the contravention of the Magna Carta. Finally, it dismissed the third ground of

appeal, concluding that Dunford J's reasons for restricting the number of plaintiffs involved a proper exercise of discretion. These reasons were to ensure that an appropriate variety of factual issues be litigated, that guidelines consequently be set for future litigants and cases, and that the case be managed efficiently.

However, although all three grounds in the appeal were dismissed, the Court's decision did not foreclose continuation of the proceedings: the arguments based on negligence remained intact. Importantly, while the Court cited Dunford J's decision on this point in some detail, it did not in any way criticize the substance of what he said. Referring to his decision, the Court stated:

> His Honour saw no reason why in an appropriate case the Court would not grant an injunction to restrain the tort of negligence, even without proof of damage. Accordingly, if the appellants were able to establish by evidence that the failure by the Department to permit their use of condoms constituted a breach of the duty of care owed to them, they might be entitled to injunctive relief.

The Court concluded: "What remains to be done is for the appellants to apply to the Common Law Division to amend their statement of claim in a way which accords with Dunford J's orders and the conclusions I have reached."(13)

The prisoners sought special leave to appeal to the High Court of Australia on the questions of habeas corpus and Magna Carta. This appeal failed, but the prisoners announced that they would go to trial to argue their case on the more limited grounds allowed.

Since then, at least in part because of the legal action, the NSW government has decided to make condoms available in three prisons on a trial basis.(14) While the legal action is still ongoing and remains to be determined, the prisoners involved have decided not to push the case while the condom trials are ongoing. If, as a result of the trials, there is general introduction of condoms in NSW jails, the case will likely be ceased.

The Australian "HIV Transmission Case"

The prisoner who contracted HIV while in a maximum-security institution in Queensland (15) launched an action for damages for negligence against the Queensland Corrective Services Commission (QCSC). This was one of a number of cases brought against the QCSC that alleged misconduct in the treatment of HIV-positive prisoners. While at least one of these cases is ongoing and set for hearing in September 1996, the action for damages has been dropped because the case was funded by Legal Aid and would have been too costly to pursue.

The Canadian "Methadone Case"

In April 1996, an HIV-positive woman was sentenced to 21 days' imprisonment at the Burnaby

Correctional Centre for Women (BCCW) in British Columbia. At the time of her sentence, she was on a methadone maintenance program supervised by her primary-care physician. In accordance with a longstanding BC Corrections Branch policy, the BCCW refused to provide her with methadone. As a result of this refusal, she petitioned the British Columbia Supreme Court for relief in the nature of habeas corpus.(16)

The petition to the Court argued that, under the circumstances the petitioner found herself in, her detention was illegal. It raised several constitutional arguments based on the Canadian Charter of Rights and Freedoms. In response to the petition, and despite the position it had originally taken, the BCCW arranged for a staff doctor to examine the petitioner, and he prescribed methadone for her. After this, she withdrew her petition seeking habeas corpus.
Importantly, in affidavit material filed in this case, the Director of Health Services for the BC Corrections Branch indicated that the BC Corrections policy would be changed to recognize the validity of the harm-reduction model for prisoners and to allow for methadone treatment of prisoners in certain circumstances.

The petitioner's primary care physician has since stated that, although no precedent was set in law by the case, "it was a precedent that was set by deed." He continued by saying that he expects that in future Corrections will act accordingly, and that "[w]e are certainly ready to repeat a court challenge at a moment's notice if necessary."(17)

Conclusion

These developments leave no room for complacency. They show two things: the increasing dangers posed by HIV and hepatitis C in prisons, and the willingness of prisoners to take legal action against government inaction. Already, both in the Australian condom case and the Canadian methadone case, legal action has provided the catalyst necessary for the institution of long-recommended changes and reasonable responses to HIV by prison authorities. Courts have not even had to pronounce on the substantive issues raised in the cases: governments and correctional authorities, at least in part because of the cases, have acted before the courts forced them to do so.

The Potential Usefulness of a Legal Action in Negligence

Given the increasing dangers posed by HIV and hepatitis in prisons, brought into focus by cases of seroconversion in custody, there is more reason than ever to utilize a legal approach involving an old, somewhat flexible proceeding in the attempt to achieve substantive change in correctional policy: prisoners may be able to demonstrate the need for changes in prison authorities' and governments' behaviour by instituting an action in negligence. Prisoners could also raise important constitutional law arguments based on Canadian Charter of Rights and Freedoms violations.(18)

The tort of negligence gives rise to a private action or civil claim. An action in negligence is initiated by the aggrieved individual (not by the police or the Crown, if a particular act can be characterized as

criminal in nature) who alleges that she or he has a cause for complaint. The complainant, or plaintiff, contends that she or he suffers harm or damage that was caused by a wrongful, careless, or unreasonable act or omission of another person, entity, or institution (the defendant in the proceedings).

The law of negligence is about balancing interests - a defendant's conduct on the one hand, and the rights of those affected by that conduct on the other. During the last several years, the law of negligence has struggled to resolve disputes in contexts far removed from those traditionally seen to be the site of careless activity, such as transportation accidents. It has taken on the role of ombudsman (19) and standard-setter, in an attempt to formulate and shape desirable behaviour. It can also act as educator, deterrer and compensator, and is being used increasingly by various elements of the community who otherwise have nowhere to turn to seek redress. At the very least, these marginalized, disenfranchised individuals are using the law of negligence to make significant public statements.

Examples of novel situations in which the tort of negligence has been used include David Milgaard's recent action against Saskatchewan Crown prosecutors and police for negligently failing to disclose evidence tending to exculpate him of his murder conviction in 1970;(20) the malpractice claim instituted against a physician by Robert and Jane Sanders for the "wrongful birth" of their son, born with Down syndrome;(21) 36 civil suits filed against the BC Social Services Ministry by adults who claim they were sexually abused in foster homes or other governmental residential programs, and who wish to hold the government accountable for its behaviour.(22) In these cases, the legal action in negligence has been used to make significant public statements: the cases have received publicity and have put the authorities on the spot.

In the prison context, the primary objective of an action in negligence would not necessarily be to secure damages for a prisoner whose seroconversion is causally linked to a prison authority's negligence. Rather, an action in negligence could be used as a means through which institutional improvements can be effected: prisoners may find the pursuit of a legal action valuable, as a means to persuade prison authorities to provide them with the reasonable and necessary means that will allow them to protect themselves from contracting HIV in prison.

The law of negligence can provide a check on how well (or badly) duties are fulfilled, and gauge whether behaviour ought to be changed. This is particularly important in the prison context, where the relationship of dependence - respecting a prisoner's every need - is fundamental to existence and survival. Prison authorities have in fact been found negligent in several cases, albeit in quite different circumstances.(23)

Elements of the Tort of Negligence

In order for an action in negligence to succeed, the plaintiff needs to prove that he or she was owed a duty of care by the defendant, that the standard of care owed was not met, and that the breach caused actual harm.

Duty of Care

Without question, prison authorities owe a duty of care to those in their custody, based on the proximate relationship of custodian and detainee. There is, however, one possible stumbling block, which is dependent on the court's characterization of the specific decision under consideration: the authorities may argue that prisoners' complaints concern policy or planning decisions of government, dictated by resource implications or politics, and that therefore no duty is owed. Although this arose in the Australian "prison condom case," it was not fatal to the claim.(24) In that case, Dunford J was unwilling to allow a challenge to the "policy decision" not to provide condoms in prisons, arguing that judicial review of an issue involving "political considerations" would lead to "political power [passing] from the parliament and the electorate to the courts." However, he continued by saying that "different considerations would apply if the prisoners claimed a breach of the duty owed to them as individuals"; although a policy decision in itself may not be reviewable by the Court, its effect - a breach of duty of care owed to the prisoners - is.

Breach of the Duty of Care

Establishing a breach of duty - a failure to exercise the degree of care that is reasonable in the circumstances - may be difficult. The central question is: what constitutes reasonable behaviour on the part of prison authorities? Answering it requires authorities to abandon arguments drawn from moralizing and breast-beating, compelling them to engage in a dialogue embracing notions of responsibility, practicality, and confrontation of harm and danger.

The measures currently in place to contain the spread of HIV in Canadian prisons are as follows: all systems provide some educational programs, and offer voluntary HIV testing to prisoners; most provide condoms, but rarely are they easily and discreetly accessible; in some systems, condoms are not available at all; lubricant is often not available even where condoms are available; some systems provide bleach; no system provides syringes or sterile needles. The Expert Committee on AIDS and Prisons (ECAP), the Prisoners with HIV/AIDS Support Action Network (PASAN), and many other national and international organizations have all urged that more needs to be done: in particular, that easy access to condoms, lubricant, and bleach be provided, and that the provision of sterile needles be at least piloted without any further delay.(25) Similarly, in Australia it has been suggested that the following be provided: information; equipment, such as bleach and latex gloves, easily accessible to inmates and staff for infection-control procedures; sterile needles and syringes, supported by a policy and practice that threatens no reprisals against injecting drug users; safe disposal facilities for injecting equipment; condoms; sexuality education programs that openly, non-judgmentally and explicitly talk about institutional sexual behaviour, and address issues concerning possible barriers to practising safe sex for both men and women.(26)

The issue is: could prison authorities be held liable in negligence for failing to comply with the standard of reasonable care expected of them, if they persist in refusing to provide access or easy access to condoms, dental dams, lubricant, bleach, and sterile needles in prisons? Unlike previous HIV-related litigation, where claims focused on what hospitals and blood banks ought to have known at particular

dates in the past, in this context there is no doubt that prison authorities have not only for several years been able to foresee the likely harm of their policies, but in fact have known of the existence of HIV/AIDS and how it is transmitted in prisons. The issue, then, relates not simply to the prison authorities' knowledge of the risk of transmission, but to their actual conduct, which seems premised on wilful blindness to these recognized dangers. This should all weigh quite heavily in a prisoner's favour.

On the one hand, in determining whether conduct is negligent or not, immeasurable values such as community concepts of justice, health, life, and freedom of conduct are taken into account: they favour a prisoner's contention that she or he has been wronged. On the other hand, the authorities may contend that the need to manage institutions effectively - embracing fears of labour-related strife - justifies their inaction. However, the seriousness of the risk of not providing effective, inexpensive measures favours a finding of carelessness: as Jürgens notes, because of the gravity of the matters at issue, a strong public health, harm-reduction approach must be taken as the only reasonable response to the risk of transmission.(27) The consequences of not providing effective preventative measures - infection and eventual death - are too grave to allow for much empathy for prison managers, regardless of the pressures they face, including those of an industrial nature. Refusal to provide effective preventative measures amounts, in legal terms, to conduct falling below the standard of care expected of the reasonable custodial authority. It is a careless response - or, rather, non-response - to a foreseeable risk of harm. In fact, it may be argued that because of the special relationship prison administrators have with inmates, their duty to those under their care is heightened.

A court's ultimate finding cannot be predicted with confidence. Knowledge of measures used elsewhere, as well as the recommendations of bodies such as the World Health Organization, can be helpful in assessing what constitutes a reasonable response. A fact-finder could hold that the conduct of virtually all Canadian prisons falls below what could reasonably be expected of them. Regard would be had to the fact that many prisons worldwide provide easy and discreet access to condoms, dental dams, lubricant, and bleach. These prisons undermine the assertion that the provision of these measures is impractical or dangerous; they provide an example of prisons that have adopted a policy that recognizes the potential for harm, and seeks a constructive, reasonable engagement with the problem rather than a denial of its existence. Provision of sterile needles has been successfully piloted in Switzerland, and more and more prisons, in Switzerland and elsewhere, are also starting to make sterile needles available to inmates. This is particularly important: evaluation of the Swiss program has demonstrated that provision of sterile needles in prison is not merely the product of the imagination of pie-in-the-sky, ivory-tower academics or committees who could be said to have little appreciation of the actual difficulties associated with implementing such a measure. We now know that a sterile needle-distribution program in prison can realistically and successfully be implemented.(28) In fact, because some concern has been voiced regarding use of bleach,(29) the only reasonable response to the risk of transmission from IV drug use may be the one that seems hardest to swallow: do on the inside what is done on the outside - provide sterile needles. The fact that most systems do not provide syringes would be an inadequate response to an allegation of carelessness: while examples of similar conduct may be helpful, they do not determine findings of fault. Poor practices do not excuse failures to do what a reasonable enterprise ought to do. Therefore, the refusal to implement the most efficacious, widely recommended harm-reduction measures constitutes culpable conduct.

Has the Claimant Suffered Harm?

Traditionally, claimants have to have suffered actual harm before they can bring a negligence action; the "gist of the action" is damage. The relief granted has always been in the form of damages. However, in the Australian "prison condom case," Dunford J made some remarkable comments that dramatically affect the nature of the action: he stated that there appears to be no reason why the court should not grant an injunction in an appropriate case, even without proof of damage.(30) As the plaintiffs' lawyers argued,

> [i]f the plaintiffs contract HIV or hepatitis in consequence of the continuing breach of the duty of the defendant, their losses will be irreparable, and damages will scarcely be a suitable alternative remedy. The plaintiffs ought not wait until they have compensable injury before they can take action in respect of the defendant's continuing breach of the duty of care.(31)

Causality: Is the Harm the Result of the Breach?

A court certainly has the opportunity to resolve causality in the plaintiff's favour, depending on the facts of the particular case. However, the potential stumbling blocks should not be underestimated. Were it not for the failure to provide a prisoner with sterile needles, bleach, dental dams, or condoms, depending on the nature of the behaviour in a particular instance, would a prisoner have contracted the virus? No. Of course, a negative response assumes there is evidence that the prisoner was HIV-negative prior to incarceration for a period longer than the six-month "window period" and that the infection occurred in prison. From a litigation perspective, the prisoner recently identified as having seroconverted while in prison would obviously be the plaintiff best able to litigate successfully. The argument that the measures might not have been used has been raised: however, this does not address making them available - thereby empowering the individual prisoner (rather than the authorities) to make the decision to use or not use them. A problem with establishing causality would arise only if in the course of an action it could be demonstrated that the measures would not have been used. Authorities also may argue that the true cause of infection is the plaintiff's own behaviour, especially where education addressing risk reduction is provided; in response, it may be contended that the provision of education programs without providing condoms, dental dams, lubricant, bleach, and needles is inadequate. Further, a defendant will not necessarily be relieved of responsibility simply because of the plaintiff's own culpable conduct. The latter would not necessarily be sufficient to negate the claim; rather, it may result in apportionment.

Defences

Even if a plaintiff can establish a cause of action to the satisfaction of the court, the defendant still has the opportunity to negate the plaintiff's case by raising one of the following defences (in assessing the defences that may be raised, situations involving consensual behaviour need to be separated from those

that are non-consensual; the latter are less frequent than the former, despite suggestions to the contrary by the tabloids, TV talk-shows and other popular mythmakers).

Voluntary Assumption of Risk

The most troublesome hurdle in a plaintiff's case may be the authorities' expected argument that - in situations involving consensual behaviour - the sufferer "voluntarily assumed the risk" of injury. However, this defence is not insurmountable, and courts have been loath to give effect to it because of its harshness in result. For example, whether a plaintiff "freely and willingly" ran the particular risk is contentious. If a drug-dependent prisoner shared an unclean needle, it could hardly be argued that she or he "voluntarily assumed the risk" of infection: the addiction negates free will and volitional behaviour. In situations involving consensual, unprotected sexual activity, the issue is far more complex, but courts have in the past been prepared to recognize the complexity of human will and the importance of a broad understanding of the circumstances in which decisions are made. Of course, the authorities and perhaps the public and courts may have little "sympathy" for a plaintiff who engages in risky behaviour. But no one is asking for sympathy; rather, the demands are for reasonable, responsible conduct on the part of custodians. Further, a detainee's vulnerability in comparison to the power enjoyed by prison management cannot be ignored where the plaintiff's "free and willing" behaviour is at issue.

Contributory Negligence

The authorities may argue that a prisoner's own act of practising unsafe sex or using injecting drugs with unclean instruments should be considered a failure to take care with respect to her or his own safety. The courts may hold the prisoner contributorily negligent and apportion damages. To do so, however, would be to unrealistically assess the true dynamics of prison life: because of imprisonment, there is less opportunity for prisoners to truly take care of their own safety, as they are virtually totally dependent on the authorities for their care.

Illegality

Because drug use and sexual activity are prohibited in prison, it might be argued that a prisoner's illegal conduct defeats her or his claim. This defence should fail: unless the infringed law itself states (or implies) that a civil claim cannot be brought for an injury sustained while committing the prohibited act, the mere fact that the prisoner acted illegally does not disallow the action. Prison regulations are intended to serve institutional management efforts rather than to preclude civil recovery. The Supreme Court narrowly circumscribed the availability of illegality as a defence:

> Its use is justified where allowing the plaintiff's claim would introduce inconsistency into the fabric of the law, either by permitting the plaintiff to profit from an illegal or wrongful act, or to evade a penalty prescribed by criminal law. Its use is not justified where the plaintiff's claim is merely for personal injuries sustained as a consequence of the negligence of the defendant.(32)

Here, a prisoner neither profits from infringing the regime's rules, nor evades penalties in doing so; the illegal conduct is legally irrelevant. As Jürgens states:

> The fact that prisoners put themselves at risk of contracting HIV by engaging in sexual activity and drug use, both prohibited in prisons, is not a sufficient excuse for not acting. This has been understood outside prisons, where needle exchanges have been set up with government approval and funding.(33)

The Value of the Common Law - and Its Limits

"Will the complainant succeed?" Possibly. But success in the traditional sense is not entirely the issue in these circumstances. The purpose and value of bringing a legal action in negligence includes the possibility of judicial recognition of a duty of care owed by prison systems to prisoners in their custody, and of the breach of this duty by non-provision of preventative measures. Further, the value of such an action would not be limited to the individual case; rather, it could set a higher standard for what constitutes reasonable behaviour, with a view to improving conditions of detainment. In addition, even if a prisoner fails, the expenses facing the authorities in having to defend claims of this nature may prove to be a factor weighty enough to tip the balance in favour of changed policies. Of course, this is not intended to minimize important factors in all HIV-related litigation, such as the expenses facing the litigants themselves, and the fact that "a person who is actually suffering from AIDS ... may not have the physical or emotional strength to instruct counsel, attend discovery proceedings and be subjected to the rigour of a trial."(34) A prisoner's opportunity to enforce "common law duties is curtailed by limited access to legal aid, and probably by their own reluctance to become involved in legal disputes with their custodians. In the case of prisoners with HIV/AIDS it may be additionally unattractive because of the stresses associated with involvement in legal proceedings."(35)

However, in order to make a statement, some individuals may be willing to endure the rigours of litigation. And while legislation would certainly be a far better means by which to institute harm-reduction measures than court action, litigation and the threat of it may provide a reason for legislators' effecting improvements. The action, by and of itself, cannot compel the introduction of the necessary legislative initiatives. However, in conjunction with other strategies it may fuel reform. Regardless of actual outcomes, policies may change as a result of embarrassing publicity. In Australia, it is at least in part because of the publicity generated by the prisoners' condom case that condom distribution is now being piloted: the federal health minister criticized prison authorities' resistance to providing preventative measures, stating that "[p]eople are sentenced to jail, not to be infected," and that "they deserve the same level of care as people outside get."(36) And in Canada, the methadone case may help to accelerate implementation of methadone maintenance treatment in provincial prisons in British Columbia and in the other prison systems.(37)

Conclusion

As the recently reported cases of custodial seroconversion demonstrate, prisons are potential breeding grounds of HIV infection, endangering the health of inmates, staff, and the public. Prison system's unusually conservative stance with regard to provision of harm-reduction measures is frustrating, demoralizing, and negligent. Admittedly, some prisons in Canada have started providing easy access to condoms, dental dams, lubricant, and bleach; however, other prisons lag far behind. With respect to provision of sterile needles, the response of Canadian prison systems is similar to those of other systems, with the exception of some Swiss, German, and Spanish prisons; however, as noted earlier, doing what others do can nevertheless be negligent and does not justify carelessness. As Justice Kirby stated:

> We must ready ourselves, as a civilised community, to ensure that prisoners are not unnecessarily exposed to acquiring a fatal condition whilst in prison. If we do not take proper steps, we will stand condemned as irresponsible and morally negligent in the safekeeping of prisoners.... We owe it to the prisoners - but if this is unconvincing, we owe it to the community - to protect prisoners from infection whilst in prison. This requires radical steps before it is too late.... The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is...unpalatable. As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society.(38)

If a negligence action can help demonstrate to the public and authorities the need to respond to the risk of the spread of HIV and hepatitis in prisons, then instituting proceedings will have proven worthwhile. However, as noted earlier, one of the problems with using the law of negligence as it is traditionally understood, and not as suggested by Dunford J in the Australian prison condom case, is that damage must have occurred. In more and more countries, with the recognition of documented cases of custodial seroconversion, this requirement has been satisfied. An after-the-fact remedy can now be pursued, if the sufferers wish to do so. It seems inevitable that such cases will be instituted by prisoners, in Canada and elsewhere, who have seroconverted while in prison and who would have used condoms or bleach or syringes had they been available. They will sue the authorities for their failure to satisfy the reasonable level of care owed to them by the refusal to provide preventative measures. The problem is real. Only the most irresponsible authorities and governments would persist - at their potential legal peril - in refusing to provide measures that would prevent the grave harm of custodial seroconversion. Courts are now in a position of being able to legally condemn the authorities' inaction.

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HIV/AIDS in Prisons: Final Report

by Ralf Jürgens

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Appendix 2

"Prisoner's Constitutional Right to Sterile Needles and Bleach"

by Richard Elliott

Abstract

Do prisoners have a right to the means that would allow them to protect themselves against contracting HIV and other diseases in prisons? Can prison systems be forced to provide condoms, bleach, and sterile needles? Can and should the law be used to achieve change in prison HIV/AIDS policies?

The following article by Richard Elliott discusses these questions. In particular, the author analyzes whether the argument can be made that denying prisoners access to sterile needles (and bleach) is a violation of their constitutional rights.

About the Author

Richard Elliott is an articling student in Toronto and a member of the Canadian HIV/AIDS Legal Network. This paper was first presented at the First Canadian Workshop on HIV/AIDS in Prisons, held in Kingston on 20 August 1995, and published as Appendix 2 of HIV/AIDS in Prisons: A Discussion Paper. For inclusion in the Final Report, it has been updated and slightly revised. A shorter version of the paper can be found in the Canadian HIV/AIDS Policy & Law Newsletter 1995; 2(1): 22-24.

Contents

Introduction

Despite evidence that sharing of contaminated needles to inject intravenous drugs is frequent among prisoners, the Correctional Service of Canada (CSC) and all provincial prison systems still deny prisoners access to sterile needles; many systems even deny access to bleach. Can the argument be made that denying prisoners access to sterile needles (and bleach) is a violation of their constitutional rights?

Arguably, three sections of the Canadian Charter of Rights and Freedoms may provide a home for prisoners' right to protection, and might be used to seek the implementation of needle exchanges and distribution of bleach kits in prisons.

Prisoners' Rights to Protection

Section 7: Right to Life and Security of the Person

Decisions in two major cases by the Supreme Court of Canada suggest that prisoners' right to protection against HIV infection could be framed as an aspect of the right to "security of the person" (under s 7 of the Charter, "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice").

The Case Law

In Singh v Minister of Employment and Immigration, [1985] 1 SCR 177, Wilson J held that s 7 encompasses freedom from the threat of physical punishment or suffering as well as freedom from the punishment itself, and cited with approval the finding in Collin v Lussier, [1983] 1 FC 218 (TD) that security of the person is infringed not only by an actual impairment of health but also by a likelihood that health would be impaired.

In R v Morgentaler, [1988] 1 SCR 30, she held that state interference with bodily integrity offends the right to security of the person, and Dickson CJC also ruled that s 7 "extends to state-imposed limitations upon the ability of persons to obtain beneficial medical treatment where those limitations do not adequately take into account the needs, priorities and aspirations of those persons." Beetz J concurred

that s 7 is violated where such a limitation endangers a person's life or health.

In light of these cases, the argument could be made that the denial of access to sterile needles (and bleach) violates prisoners' security of the person by increasing the likelihood of HIV infection. (The violation of the right to life is simply an extension of this argument, given that HIV infection is held to be ultimately fatal.)

Section 7: A "Preventative" Legal Remedy

Section 7 offers a "preventative" legal remedy. It may be invoked to prevent future harm resulting from state action (eg, future transmission among prisoners of HIV or other bloodborne diseases, such as hepatitis C). Granted, the Supreme Court's decision in Operation Dismantle Inc v R (1988), 45 CCC (3d) 57 establishes that s 7 does not impose a duty on the government to refrain from any act that might lead to consequences that deprive or threaten to deprive individuals of their life and security of the person: "a duty of the federal Cabinet cannot arise on the basis of speculation and hypothesis about possible effects of government action." The context of the Operation Dismantle case is significant in understanding this conclusion. The Court found that foreign policy decisions of other nations - including their reactions to the federal Cabinet permitting the US to test cruise missiles in Canada - "are not capable of prediction, on the basis of the evidence, to any degree of certainty approaching probability."

The government's denial of access to sterile needles (and bleach) is different: the probable results of this governmental (in)action are much clearer and more predictable. Furthermore, the uncertainty arising from variables outside the control of domestic government that so plagued the Court in Operation Dismantle is absent here; the prison environment is one in which exclusive state control could not be more apparent.

While Operation Dismantle's claim was unsuccessful, and the Court took a conservative approach to s 7, the decision nonetheless affirmed that s 7 can be applied to prevent predictable harms. Dickson CJC, writing for the Court, was careful to point out that a governmental duty to refrain from acts that endanger s 7 rights does arise "where it can be said that a deprivation of life and security of the person could be proven to result from the impugned government act." He added:

> I am not suggesting that remedial action by the courts will be inappropriate where future harm is alleged. The point is that remedial action will not be justified where the link between the action and the future harm alleged is not capable of proof.

Connection between the Denial of Access to Sterile Needles (and Bleach) and the Increased Risk of HIV Infection

The success of an argument that the denial of access to sterile needles (and bleach) violates prisoners' security of the person will depend heavily on the evidence presented to establish:

- the relationship between injection drug use, needle-sharing and HIV transmission in prisons; and

- that denying access to sterile needles (and bleach) directly contributes to the risk of HIV infection.

Research demonstrating this link abounds, establishing that:

- HIV seroprevalence in prisons is higher than in the general population; and
- the reason for this is the over-representation in prisons of persons with high-risk factors for HIV infection, in particular a history of injection drug use.

HIV Seroprevalence in Prisons

CSC's own statistics indicate that from January 1989 to March 1996, the number of reported cases of HIV/AIDS in federal prisons rose from 14 to 159. In its 1990 report, the Parliamentary Ad Hoc Committee on AIDS stated that the official CSC figures had to be taken "with reservation" because they include only cases of HIV infection and AIDS known to CSC. According to the Committee, "the actual numbers must be so vastly different as to make these statistics a mockery."(1)

At least seven studies of HIV seroprevalence among incarcerated populations have been undertaken to date in Canada. All studies showed that HIV seroprevalence rates in prisons are much higher than in the general population. Studies that collected data on inmates' risk behaviours were further able to show that seroprevalence rates among prisoners with a history of injection drug use are significantly higher than among prisoners with no such history:

- A 1989 study of 248 women in a medium-security provincial prison in Québec found that 52 percent of participants were injection drug users (IDUs) and 25 percent indicated prostitution as their main source of income just prior to incarceration. The overall HIV seroprevalence rate was 7.7 percent, while the rate among IDU prisoners was 14.6 percent. All those who tested HIV-positive were IDUs.(2)
- A 1991 study among 588 men in two Québec provincial correctional institutions found HIV seroprevalence rates of 4.7 percent and 2.0 percent respectively; 7.6 percent of inmates with a history of injection drug use were HIV-positive, compared to only 0.4 percent of inmates with no such history.(3)
- The first study undertaken in a federal prison - Joyceville Institution in Ontario - found a seroprevalence rate of 1 percent among the 50 percent of inmates who volunteered for testing. The authors of the study noted that this could be an underestimate because "bias due to high-risk individuals choosing not to participate must be considered."(4)
- A 1994 study of inmates in the federal Prison for Women in Kingston found an HIV seroprevalence rate of 0.9 percent; the researchers also noted that 40 percent of participants were infected with the hepatitis C virus. In the prison population, seropositivity for hepatitis C likely represents a marker for IV drug use at some time in the majority of those testing positive and suggests an alarming potential for the rise of HIV in the future.(5)
- A 1994 study conducted in all adult BC provincial prisons found an overall HIV seroprevalence

rate of 1.1 percent. Among women the rate was 3.3 percent, which was held to be due to the higher proportion of injection drug users among women inmates. Those reporting a history of injection drug use were four times more likely to be HIV-positive than those who did not (2.4 versus 0.6 percent).(6)

- A 1993 study carried out among over 12,000 people entering Ontario jails, detention and youth centres, found HIV seroprevalence rates of 1 percent among adult men and 1.2 percent among adult women. Rates were highest among those with a known history of injection drug use. Among adult men, IDUs had a rate of 3.6 percent compared to a rate of 0.6 percent among non-IDUs. Among adult women, 4.2 percent of IDUs were HIV-positive, compared to 0.5 percent of non-IDUs.(7)
- A 1994 study of 618 inmates at the Centre de détention de Québec found HIV prevalence rates of 2.2 percent in men and 7.6 percent in women. Overall participation rate was 95.8 percent (618/645). All positive men were IDUs, for a prevalence of 8.3 percent (11/132) in this group. Prevalence was 15.9 percent (10/63) among male IDUs admitting previous needle sharing and 1.4 percent (1/69) among other IDUs. Twelve male inmates admitted injecting drugs during imprisonment, of whom 11 shared needles and 3 were HIV-positive.

  HIV prevalence in men admitting sexual intercourse with men was 9.6 percent (5/52). Among HIV-positive women, 7 were IDUs and 2 had had sexual contact with male IDUs. HIV prevalence was 15.6 percent (7/45) in female IDUs. Among 41 women engaged in prostitution, 29 were IDUs. All 5 HIV-positive prostitutes were IDUs.(8)

Drug Use and Sharing of Injection Equipment in Prisons

Evidence exists to show not only that rates of infection are much higher among prisoners - in particular, those with a history of injection drug use - than in the general population, but also that high-risk activities, such as the sharing of injection equipment among prisoners, are prevalent. This is not surprising, given that the primary societal response to drug use is criminalization and incarceration; after the US, Canada has the highest per capita rate of incarceration for drug-related offences.(9) A 1989-90 CSC study found that more than 10 percent of prisoners reported using drugs every day in the six months prior to incarceration, and over 53 percent of all federal inmates were classified by CSC as having a serious substance abuse problem.(10)

A study of users of Vancouver's needle-exchange program found that almost all IDUs share needles at some point in their lives. The study identifies the lack of readily available and affordable sterile injecting equipment as one of the primary reasons for sharing.(11) A 1991 Toronto study found that over 80 percent of IDUs using that city's needle-exchange program had been in jail overnight or longer since they began injecting drugs; 25 percent of these reported sharing injecting equipment while in custody.

Data from other jurisdictions bear out the concerns raised. In the US, statistics collected by the Department of Justice indicate that roughly one-quarter of state prisoners had used needles to inject drugs. Seroprevalence varied across prison systems, reaching 17 percent among incoming New York state prisoners. In 1991, 28 percent of all deaths in state prisons were attributable to AIDS. Of prison

inmates who were tested for HIV,

- 0.8 percent of those who said they never used drugs,
- 2.5 percent of those who ever used drugs,
- 4.9 percent of those who used needles to inject drugs, and
- 7.1 percent of those who shared needles

were HIV-positive, leading to the unsurprising conclusion that "needle use further increased the likelihood of being HIV positive."(12)

The World Health Organization (WHO) collected data showing an overall seropositivity rate in excess of 10 percent in prisons of member states of the Council of Europe, reaching nearly 26 percent in prisons in Spain. WHO also noted that the overall rate of seroprevalence in prison in these countries is closely related to the proportion of drug-dependent prisoners.(13)

In the UK, a study found that three-quarters of those who injected in prison reported sharing needles and syringes; the mean number of times equipment was shared was 12. Furthermore, those who injected in prison were significantly more likely to share equipment than when in the community; only 45 percent reported sharing equipment prior to being incarcerated, whereas 73 percent reported sharing while incarcerated.(14) Another study of London IDUs found that 79 percent of those who had injected while incarcerated had shared equipment.(15) A study of inmates in Edinburgh, Scotland found that 92 percent of those who were HIV-positive had injected in prison, and 85 percent had shared needles while on the inside.(16)

The predictable outcome of such patterns was seen in an outbreak of HIV and hepatitis B in a Scottish prison in 1993. Overall, 7 percent of the inmates were HIV-positive; all those testing positive had injected and shared needles while in prison. The investigators concluded:

> Sharing needles and syringes was undoubtedly the behaviour responsible... [R]eports of between 20 and 30 inmates using the same needle and syringe indicate that random sharing occurred.(17)

The Principles of Fundamental Justice

In light of the existing evidence, there can be no doubt that there is a clear connection between the impugned state action - the denial of access to sterile needles (and bleach) - and the increased risk of HIV infection. Once this connection is established, the next step will be to show that the infringement of the right to life and security of the person is not "in accordance with the principles of fundamental justice."

What exactly those principles are is rather unclear, although the Court said in the B.C. Motor Vehicle Reference, [1985] 2 SCR 486 that they "are to be found in the basic tenets of our legal system." If those principles are intended to promote the dignity and well-being of the individual and society - and

presumably this is a fundamental purpose of constitutional rights such as liberty and security of the person - could denying people the right to self-preservation be consonant with notions of "fundamental justice"?

Section 12: Cruel and Unusual Punishment

There is also an argument to be made that denying prisoners sterile needles (and bleach) constitutes "cruel and unusual treatment or punishment" (under s 12 of the Charter, "[e]veryone has the right not to be subjected to any cruel and unusual treatment or punishment"). According to the Supreme Court of Canada in Miller and Cockriell v The Queen, [1977] 2 SCR 680, a punishment violates s 12 if it is "so excessive as to outrage standards of decency." This test of "gross disproportionality" between the effect of a punishment and what would have been appropriate has been affirmed in subsequent cases.

In R v Smith, [1987] 1 SCR 1045, it was held that a punishment violates s 12 of the Charter if it either

- "outrages the public conscience" or is "degrading to human dignity," or
- goes beyond what is necessary to achieve a valid social aim, "having regard to the legitimate purposes of punishment and the adequacy of possible alternatives."

In the subsequent case of R v Goltz (1991), 67 CCC (3d) 418 (SCC), the Court noted that the nature and conditions of a sentence, and not merely its duration, must be considered in determining whether it is cruel and unusual.

The case could be made that denying prisoners the right to protect themselves against HIV infection is not a legitimate purpose of punishment. Furthermore, research such as that detailed above indicates that alternative approaches to dealing with IV drug use among prisoners, based on a harm-reduction model, are more rational and effective than a blanket denial of access to sterile injection equipment.

The prohibition appears even more excessive in light of the federal Corrections and Conditional Release Act, which states that the correctional system's operating premises include the protection of inmates, the safe and humane care of offenders, and the provision of programs to achieve these ends. The Act also affirms that offenders retain the rights and privileges enjoyed by all members of society, except for those necessarily restricted as a consequence of their sentence. This principle has also been recognized by courts: "A prisoner retains all civil rights which are not taken away expressly or by necessary implication": Raymond v Honey, [1982] 1 All ER 756 at 759 (HL). Those on the outside are free to access needle-exchange programs; why should denying prisoners access to such programs be a necessary consequence of imprisonment?

A s 12 argument was successfully advanced in the case of R v Downey, (1989) 42 CRR 286 (Ont Dist Ct). There the Court ruled that Toronto detention centres were failing to provide facilities providing adequate treatment for detained people with HIV/AIDS; consequently, the accused's detention constituted cruel and unusual treatment, and he was ordered released on his own recognizance. While

this case dealt with access to adequate care for those already infected, it is nonetheless important; it suggests that a court may accept that denying incarcerated people the opportunity to prevent infection in the first place is also unconstitutional.

Section 15: Equality Rights

This last argument is closely related to a potential equality rights argument: does it constitute "discrimination" within the meaning of s 15 of the Charter to deny prisoners access to protective methods that those on the outside can access? Under s 15(1), "[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." In order to succeed, it would have to be shown that the status of being incarcerated is a prohibited ground of discrimination analogous to those enumerated in s 15. The case law interpreting s 15 indicates that this would require showing that not only are prisoners treated differently than non-prisoners, but that this distinction imposes disadvantages upon prisoners or denies them benefits available to others.

There is a distressing trend in recent decisions to limit the protection of s 15 only to "discrete and insular minorities" or to groups or individuals who can demonstrate some sort of stereotyping, vulnerability to prejudice, or historical disadvantage apart from the distinction being challenged. Even achieving this recognition may not suffice, as demonstrated by the recent decision in Egan and Nesbit, 25 May 1995, Doc. 23636 (SCC) denying recognition of same-sex relationships. Such an interpretive approach in effect renders s 15 static, allowing the courts to address past discrimination but precluding the recognition of new target groups or new categories of discrimination. Such a result stands in opposition to numerous statements that the interpretation of s 15 must be "context-dependent" and that all Charter rights need to be interpreted generously and purposively.

However, there is still room to argue that these conditions are not necessary requirements for concluding that a distinction is "discriminatory" within the meaning of s 15, but merely "indicia of discrimination" (in the words of Wilson J in R v Turpin, [1989] 1 SCR 1296 at 1333) that assist in the interpretive task. Even if s 15 is interpreted narrowly so as to necessarily require evidence of historic disadvantage in order to find a given legal distinction "discriminatory," evidence could be put forward showing that prisoners do constitute such a group.

Section 1: The State's Justifications for Violating Prisoners' Charter Rights

If a breach of one of the above rights can be established, the state will seek to justify the prohibition on needles (and bleach) under s 1 of the Charter, most likely arguing that its goal is to prevent IV drug use in prisons and to protect the safety of correctional officers and inmates (according to s 1, the Charter

"guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society").

In order to rebut these claims, evidence will be needed to establish that there is no "rational connection" between the policy of prohibiting needles (and bleach) and the goal of preventing drug use (as required by the Supreme Court in R v Oakes (1986), 24 CCC (3d) 321). This evidence can be provided:

- First, the studies cited above (and others) indicate that, despite the lack of sterile equipment, drug use continues among prisoners, and needle-sharing increases because of the shortage of injecting equipment.
- Second, implementing a needle-exchange program will not threaten the safety of guards: if needles were to be exchanged one-for-one (one used for one sterile needle), there would be no net increase in the number of needles in the prison population. In fact, such a needle-exchange program would likely improve correctional officers' safety, reducing their chances of suffering a needle-stick injury with a contaminated needle. Even if provision of needles were to increase the overall number of needles in the possession of inmates, rules could be established to safeguard staff safety, as demonstrated in the Swiss pilot project.(18)

Furthermore, it should be pointed out that denying prisoners access to sterile needles (and bleach) may not satisfy the Oakes requirement that constitutional rights be impaired "as little as possible": placing captive persons at increased risk of HIV infection is hardly a minimal impairment of the right to protection, be it framed as a claim under s 7, s 12, s 15, or all three. In McKinney v University of Guelph (1990), 76 DLR (4th) 545 (SCC), it was held that courts must turn to available knowledge, including social science evidence, in assessing the question of minimal impairment: again, evidence of the effects of prohibiting the possession of sterile needles (and bleach) can be presented to establish the seriousness of the violation being challenged.

Conclusion

While the Charter offers a "preventative" legal remedy, and litigation could be used as a way to prevent future cases of HIV transmission, it seems that the strongest test case in which to advance the above Charter arguments would be one brought by a prisoner who was infected through needle-sharing while incarcerated. In such an instance, a court would be faced with an existing harm that is alleged to flow, at least in part, from the state's prohibition - as opposed to being asked to strike down government policy because of its potential for future harm.

Finally, regardless of which Charter provision(s) is/are invoked to advance the arguments, it is important to stress that the constitutional interest being litigated is not a "right" of prisoners to inject IV drugs, but the right of prisoners to protect themselves against HIV infection, given the reality - acknowledged by correctional systems - that drug use and needle-sharing occur in prisons.

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FOOTNOTES

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17-19 at 18; J Nelles, A Fuhrer. Drug and HIV Prevention at the Hindelbank Penetentiary. Abridged Report of the Evaluation Results. Berne: Swiss Federal Office of Public Health, 1995.

HIV/AIDS in Prisons: Final Report

by Ralf Jürgens

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Appendix 3

List of Submissions and Responses to the Discussion Paper

As part of his work, the Project Coordinator prepared HIV/AIDS in Prisons: A Discussion Paper. More than 500 copies of the Paper were distributed in Canada and internationally to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and by drug use in prisons an opportunity to review the Project's work and proposals and to provide further input into the Final Report.

Over 70 responses have been received from prisoners, staff, physicians, lawyers, ministries of health and of corrections, and national and international organizations. The following is a list of those who have provided the Project with comments, critiques, and suggestions about the issues addressed in the Discussion Paper.

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Appendix 4

The Joint Network/CAS Project on Legal and Ethical Issues Raised by HIV/AIDS

CONTENTS:

Partners in this project:
Canadian HIV/AIDS Legal Network
Canadian AIDS Society

The Joint CAS/Network Project on Legal and Ethical Issues Raised by HIV/AIDS started in January 1995 with a five-month development initiative and entered into its second phase in June 1995.

Phase I

During Phase I (January to May 1995), the following activities and initiatives were undertaken:

- Existing resources addressing legal and ethical issues raised by HIV/AIDS were researched and documented. These resources have been evaluated and listed in an annotated bibliography, and included in a literature review.(1)

- Key legal and ethical issues raised by HIV/AIDS in Canada have been assessed and prioritized.

After extensive meetings with over sixty persons living with HIV/AIDS, representatives from community-based organizations, lawyers, academics and government policy analysts active in the HIV/AIDS area, a list of eight topics was drawn up that includes legal and ethical issues identified as immediate priorities by the persons and organizations consulted. These are as follows:

(1) legal issues raised by HIV/AIDS in prisons;
(2) criminal law and HIV/AIDS;

(3) gay and lesbian legal issues;
(4) testing and confidentiality;
(5) discrimination;
(6) access to health care;
(7) drug laws and policies;
(8) laws and policies regulating prostitution.

- A detailed plan for the production of resource documents on these issues has been developed.

- Key people living with HIV/AIDS, representatives from community-based organizations, lawyers, academics, and government policy analysts active in the HIV/AIDS field have been identified who would be potential participants in the preparation of the resource documents.

- The Project Coordinator contacted and met with a wide variety of governmental and non-governmental organizations, institutions and professional associations, to seek partnership support for the Project.

Phase II

After completion of Phase I, funding was obtained from the AIDS Care, Treatment and Support Unit, Health Canada, the HIV/AIDS Prevention and Community Action Programs, Health Canada, the Correctional Service of Canada, and Justice Canada, to undertake Phase II of the Project.

The goals of Phase II are to:

- stimulate discussion on the local, regional and national levels on legal and ethical issues raised by HIV/AIDS;

- develop a series of discussion papers on the eight priority legal and ethical issues identified during the development initiative;

- organize a series of workshops on these issues across Canada; and

- produce comprehensive resource documents on these issues that will assist Canada in its efforts to prevent the further spread of HIV and to care for those infected and affected by it.

As of July 1996, the Project had started working on legal issues raised by HIV/AIDS in prisons, criminal law and HIV/AIDS, gay and lesbian legal issues, and testing and confidentiality; organized workshops on criminal law and HIV/AIDS and on gay and lesbian legal issues; and produced the following resources:(2)

- HIV/AIDS in Prisons: A Discussion Paper (November 1995)

- Criminal Law and HIV/AIDS: A Discussion Paper (April 1996)

- Bill C-8 - The Impact of Canada's Drug Laws on the Spread of HIV (April 1996)

- HIV/AIDS in Prisons: Final Report (September 1996)

- Gay and Lesbian Legal Issues: A Discussion Paper (Fall 1996)

- Canadian HIV/AIDS Policy & Law Newsletter (vol 1, nos 1-4; vol 2, nos 1-4)

- News from the Joint Project (issue 1, July 1995; issue 2, October 1995; issue 3, May 1996).

Most of these resources, and more information about the Joint Project, are also on the Canadian HIV/AIDS Legal Network's Website.

The Project Partners

Canadian HIV/AIDS Legal Network

The Network is the only national, community-based, charitable organization in Canada working in the area of policy and legal issues raised by HIV/AIDS. It was formed in November 1992 with the mandate to advance education and knowledge about legal, ethical, and policy issues raised by HIV/AIDS, and to promote responses to HIV infection and AIDS that respect human rights.
The Network provides services to persons living with HIV/AIDS, to those affected by the disease, and to persons working in the area by educating about, facilitating access to, and creating accurate and up-to-date legal materials on HIV/AIDS. It links people working with or concerned by relevant social and legal issues in order to limit the spread of HIV and to reduce the impact on those affected by HIV infection and AIDS.

In October 1994, the Network launched the Canadian HIV/AIDS Policy & Law Newsletter. The Newsletter is devoted to addressing the many legal, ethical and policy issues raised by HIV/AIDS. From the beginning, it has provided extensive coverage of issues raised by HIV/AIDS in prisons, in Canada and internationally. It serves as a means of educating policy-makers, lawyers and any other people with an interest in issues raised by HIV/AIDS about legal and policy developments, but also as a means of stimulating much-needed discussion about these issues.

Canadian AIDS Society

The Canadian AIDS Society is a national coalition that supports community action on HIV/AIDS issues in Canada. The Society represents more than 100 community-based organizations across the country,

providing the bulk of education, support and advocacy programs and services for individuals and communities affected by HIV/AIDS.

The role of the Society is to speak as the national voice and to act as a national forum for a community-based response to HIV infection and AIDS. The Society also undertakes advocacy on behalf of people affected by HIV and AIDS, acts as a resource on HIV and AIDS issues for its member organizations, and coordinates community-based participation in a national strategy to combat HIV and AIDS. The Society carries out this role through national initiatives in prevention education, treatment, care and support.

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FOOTNOTES

1 R Jürgens. Legal and Ethical Issues Raised by HIV/AIDS: Literature Review and Annotated Bibliography. Canadian AIDS Society and Canadian HIV/AIDS Legal Network. Montréal, 1995.

2 For more information, see "News from the Joint Project," issues 1, 2, and 3 (July 1995, October 1995, and May 1996); and R Jürgens. Legal and Ethical Issues Raised by HIV/AIDS: Project Report (1 June - 15 October 1995). Montréal: Canadian AIDS Society and Canadian HIV/AIDS Legal Network, 1995.

HIV/AIDS in Prisons: Final Report

by Ralf Jürgens

ISBN 1-896735-04-5

Appendix 5

"WHO Guidelines on HIV Infection and AIDS in Prisons" (1)

Contents

These guidelines were prepared on the basis of technical advice provided to the World Health Organization prior to and during a consultation of experts convened in Geneva in September 1992. The consultation included representatives of international and

nongovernmental organizations and government departments with a wide range of experience and background in the health, management, and human rights aspects of HIV/AIDS in prisons.

The guidelines provide standards -- from a public health perspective -- which prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by HIV/AIDS. It is expected that the guidelines will be adapted by prison authorities to meet their local needs.

"WHO Guidelines on HIV Infection and AIDS in Prisons"

A. General principles

1. All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.

2. The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community.

3. In each country, specific policies for the prevention of HIV/AIDS in prisons and for the care of HIV-infected prisoners should be defined. These policies and the strategies applied in prisons should be developed through close collaboration among national health authorities, prison administrations, and relevant community representatives, including nongovernmental organizations. These strategies should be incorporated into a wider programme of promoting health among prisoners.

4. Preventive measures for HIV/AIDS in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release.

5. The needs of prisoners and others in the prison environment should be taken into account in the planning of national AIDS programmes and community health and primary health care services, and in the distribution of resources, especially in developing countries.

6. The active involvement of nongovernmental organizations, the involvement of prisoners, and the non-discriminatory and humane care of HIV-infected prisoners and of prisoners with AIDS are prerequisites for achieving a credible strategy for preventing HIV transmission.

7. It is important to recognize that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should therefore participate actively in developing and applying effective

preventive measures, in disseminating relevant information, and in avoiding discrimination.

8. Prison administrations have a responsibility to define and 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.

9. Independent research in the field of HIV/AIDS among prison populations should be encouraged to shed light on -- among other things -- successful interventions in prisons. Independent examination by an ethical review committee should be carried out for all research procedures in prisons, and ethical principles must be strictly observed. The results of such studies should be used to benefit prisoners, for example by improving treatment regimens or HIV/AIDS policies in prisons. Prison administrations should not seek to influence the scientific aspects of such research procedures, their interpretation or their publication.

B. HIV testing in prisons

10. Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited.

11. Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre- and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support should be available when prisoners are notified of test results and in the period following.

12. Test results should be communicated to prisoners by health personnel who should ensure medical confidentiality.

13. Unlinked anonymous testing for epidemiological surveillance should only be considered if such a method is used in the general population of the country concerned. Prisoners should be informed about the existence of any epidemiological surveillance carried out in the prison where they are, and the findings of such surveillance should be made available to the prisoners.

C. Preventive measures

(i) Education and information

14. Prisoners and prison staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release. The information should be coordinated and consistent with that disseminated in the general community. Information intended for the general public (through posters, leaflets, and the mass media) should also be available to prisoners. All written materials distributed to prisoners should be appropriate for the educational level in the prison population; information should be made available in a language and form that prisoners can understand, and presented in an attractive and clear format.

15. Prison staff should receive HIV/AIDS prevention information during their initial training and thereafter on a regular basis.
16. Prisoners should receive HIV/AIDS education on entry, during their prison term, and in pre-release programmes. All prisoners should have an opportunity to discuss the related information with qualified people. Face-to-face communication, both in groups and on an individual basis, is an important element in education and information.

17. Consultation with, and participation of, inmates and staff in the development of educational materials should be encouraged.

18. In view of the importance of peer education, both prison staff and prisoners themselves should be involved in disseminating information.

19. Education on infection control should emphasize the principles of universal precautions and hygiene. The lack of any risk of HIV transmission as a result of normal everyday contact should be emphasized. Excessive and unnecessary precautions while handling HIV-infected prisoners should be avoided.

(ii) Sexual transmission

20. Clear information should be available to prisoners on the types of sexual behaviour that can lead to HIV transmission. The role of condoms in preventing HIV transmission should also be explained. Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention. They should also be made available prior to any form of leave or release.

21. Prison authorities are responsible for combating aggressive sexual behaviour such as rape, exploitation of vulnerable prisoners (e.g., transsexual or homosexual prisoners, or mentally disable prisoners) and all forms of prisoner victimization by providing adequate staffing, effective surveillance, disciplinary sanctions, and education, work and leisure programmes. These measures should be applied regardless of the HIV status of the individuals concerned.

(iii) Transmission by injection

22. As part of overall general HIV education programmes, prisoners should be informed of the dangers of drug use. The risks of sharing injecting equipment, compared with less dangerous methods of drug-taking, should be emphasized and explained. Drug dependent prisoners should be encouraged to enrol in drug treatment programmes while in prison, with adequate protection of their confidentiality. Such programmes should include information of the treatment of drug dependency, and on the risks associated with different methods of drug use.

23. Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons.

24. In countries where bleach is available to injecting drug users in the community, diluted bleach (e.g.

sodium hypochlorite solution) or another effective viricidal agent, together with specific detailed instructions on cleaning injecting equipment, should be made available in prisons housing drug users, or where tattooing or skin piercing occurs. In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this.

25. Prison health services must have adequate material and resources available to ensure that HIV transmission through the use of non-sterile equipment during medical procedures does not occur.

(iv) Use of other substances that may increase the likelihood of HIV transmission

26. Orally ingested or inhaled psychoactive substances, such as cocaine, solvents and alcohol, some of which are used to a considerable extent in different prison settings worldwide, may increase the likelihood of HIV transmission by impairing judgement and hindering the adoption of preventive measures by prisoners in circumstances where these measures would be required. Therefore, actual and potential users of psychoactive drugs should be made aware of this, as well as of other possible harmful effects and consequences of these substances in the broader context of health education.

D. Management of HIV-infected prisoners

27. Since segregation, isolation and restrictions on occupational activities, sports and recreation are not considered useful or relevant in the case of HIV-infected people in the community, the same attitude should be adopted towards HIV-infected prisoners. Decisions on isolation for health conditions should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public heath standards and regulations. Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds, and as provided for by public health standards and regulations. HIV-infected prisoners should have equal access to workshops and to work in kitchens, farms and other work areas, and to all programmes available to the general prison population.

28. Isolation for limited periods may be required on medical grounds for HIV-infected prisoners suffering from pulmonary tuberculosis in an infectious stage. Protective isolation may also be required for prisoners with immunodepression related to AIDS, but should be carried out only with a prisoner's informed consent. Decisions on the need to isolate or segregate prisoners (including those infected with HIV) should only be taken on medical grounds and only by health personnel, and should not be influenced by the prison administration.

29. Disciplinary measures, such as solitary confinement for prisoners, including perpetrators of aggressive, or predatory sexual, acts or those who threaten such acts, should be decided upon without reference to HIV status.

30. Efforts should be made to encourage among prisoners supportive attitudes -- towards, for example, those affected by HIV/AIDS -- in order to prevent discrimination and to combat fear about HIV-infected people.

E. Confidentiality in relation to HIV/AIDS

31. Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents.

32. Information regarding HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff, applying to disclosure the same principles as those generally applied in the community. Principles and procedures relating to voluntary partner notification in the community should be followed for prisoners.

33. Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoners' files, cells or papers to indicate their HIV status.

F. Care and support of HIV-infected 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.

G. Tuberculosis in relation to HIV-infection

41. The prison environment is often conducive to tuberculosis transmission and rates may be higher than in the general population. Furthermore, tuberculosis is increasingly associated with HIV/AIDS, so that the presence of HIV-infected prisoners may increase the risk of tuberculosis transmission. Vigorous efforts are therefore needed to reduce the risks related to the environment (e.g. by improving ventilation, reducing overcrowding, and providing adequate nutrition); to detect cases of tuberculosis as early as possible through screening for tuberculosis on entry and at regular intervals during imprisonment, and through contact tracing; and to provide effective treatment.

42. Diagnostic screening for tuberculosis in prison staff should also be made available. Treatment programmes for prisoners with tuberculosis should be available in prisons, and adequate follow-up should be ensured when treated prisoners are transferred or released.

43. Epidemiological surveillance of tuberculosis among prison inmates and prison personnel is needed. Special attention should be paid to the early detection of outbreaks of drug-resistant tuberculosis and their control by public health measures. In particular, strategies should be implemented to ensure that prisoners complete tuberculosis treatment regimens.

H. Women prisoners

44. 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.

I. Prisoners in juvenile detention centres

47. Health education programmes adapted to the needs of young prisoners should be organized to foster attitudes and behaviour conducive to the avoidance of transmissible diseases including HIV/AIDS. Decisions concerning children and adolescents, such as notifying parents of their children's HIV status, or obtaining consent to treatment should be taken on the same grounds as in the community, with due regard for the principle that the best interests of the child are paramount.

J. Foreign prisoners

48. The needs of foreign prisoners should be respected without discrimination. Prison authorities should be trained to respond to requirements such as assistance with languages, oral contact with families and counselling services. Adequate measures should be adopted to provide for the protection of HIV-infected foreign prisoners in the case of prisoner transfer/exchange programmes between different countries, extradition proceedings and other interchanges.

K. Semi-liberty and release

49. Prisoners should not be excluded from measures such as placements in semi-liberty hostels or centres, or any other type of open or low-security prison, on the grounds of their HIV status, nor should such placement be contingent upon disclosure of HIV status.

50. Community-based medical care, psychological support and social services should be organized for HIV-infected prisoners to facilitate their integration into the community after release.

L. Early release

51. If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom.

52. Prison medical services should provide full information on such prisoners' health status, treatment needs and prognosis, if requested by the prisoner, to the authorities competent to decide upon early

release. The needs of those prisoners without resources in the community should be taken into account in any early release decision.

M. Contacts with the community and monitoring

53. Cooperation with relevant nongovernmental and private organizations, such as those with expertise in AIDS prevention, counselling and social support, should be encouraged. HIV-infected prisoners should have access to voluntary agencies and other sources of advice and help.

54. Independent organizations concerned with prisoners' interests should have access to HIV-infected prisoners, if the prisoners so wish, and should draw attention to any instances of substandard care, discrimination, non-respect of ethical principles or deviation from established prison policies and procedures to ensure the humane treatment of prisoners.

55. Regular visits to, and supervision of, all prison establishments should be carried out by public health authorities independent of prison administrations.

56. Prisoners should be able to complain to an independent competent body about substandard treatment, discrimination or non-respect of basic ethical principles in relation to HIV/AIDS, and effective redress should be available.

N. Resources

57. Adequate resources for prison health care, for related staffing and for specific HIV/AIDS-related activities should be ensured by authorities. The resources made available should be used for preventive measures, counselling, outpatient consultation, medication, and hospitalization.

O. Evaluation and research

58. Studies concerning HIV/AIDS in prison populations are recommended in order to establish an adequate information base for planning policies and interventions in this field. Such studies could investigate for example the prevalence of HIV infection or the frequency of risk behaviours for HIV transmission.

59. The implementation of interventions by prison authorities to prevent the transmission of HIV and to provide to those affected by HIV/AIDS should be evaluated. Such evaluations should be used by prison administrations to improve the design and implementation of interventions.

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FOOTNOTE

1 World Health Organization. WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: WHO, 1993. Reprinted with the permission of WHO.