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Evidence for action on HIV/AIDS  
 and injecting drug use

## POLICY BRIEF: REDUCTION OF HIV TRANSMISSION IN PRISONS

### BACKGROUND

The rates of HIV infection among inmates of prisons and other detention centres in many countries are significantly higher than those in the general population. Examples include countries in Western and Eastern Europe, Africa, Latin America and Asia. The available data on HIV infection rates in prisons cover inmates who were infected outside the institutions before imprisonment and persons who were infected inside the institutions through the sharing of contaminated injection equipment or through unprotected sex. Certain populations that are highly vulnerable to HIV infection have a heightened probability of incarceration because of their involvement in behaviours such as drug use and sex work.

### PREVENTION PROGRAMMES IN PRISONS

In 1993 WHO issued guidelines on HIV infection and AIDS in prisons [1]. They included the following paragraphs.

"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. The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community.

"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 on the treatment of drug dependency and on the risks associated with different methods of drug use. 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.

"In countries where bleach is available to injecting drug users in the community, diluted bleach or another effective viricidal agent,

together with specific detailed instructions on cleaning injecting equipment, should be made available in prisons housing injecting 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."

Since the early 1990s, various countries have introduced prevention programmes in prisons. Such programmes usually include education on HIV/AIDS, voluntary testing and counselling, the distribution of condoms, bleach, needles and syringes, and substitution therapy for injecting drug users. In 1991, 16 of 52 criminal justice systems surveyed in Europe had made bleach available, and by 1997 about 50% had done so. Various countries provide clean needles and syringes to inmates and implement substitution treatment. However, many of these programmes are small in scale and restricted to a few prisons. None of the countries where evaluations of such programmes have been carried out have reversed their policies.

### EVIDENCE

Four elements of prevention programmes in prisons have been studied extensively: the provision of bleach

<sup>1</sup> World Health Organization. HIV in prisons: A reader with particular relevance to the newly independent states. In: *WHO guidelines on HIV infection and AIDS in prisons*, Copenhagen: World Health Organization; 2001. p. 233-7.



for cleaning needles and syringes; needle and syringe programmes; methadone maintenance treatment; and the provision of condoms.

Although many countries make **bleach** available to injecting drug users in prisons, inmates do not consistently use it before they inject. Studies showed that between 4% and 85% of prisoners always used bleach to clean their injection equipment and that some inmates used inappropriate methods to clean needles and syringes.

Programmes **providing clean needles and syringes** in prisons were satisfactory in all studies reported. Usually, clean injection equipment was provided by prison health personnel or through automatic distribution machines. Drug consumption by inmates participating in such programmes was stable or decreased over time. Reported sharing of needles and syringes declined dramatically and was virtually non-existent at the conclusion of most pilot studies. No cases of inmates acquiring HIV, hepatitis B or hepatitis C were reported in any prison with a functioning needle and syringe programme. No serious unintended negative consequences were reported. There were no reported instances of initiation of injecting by inmates who did not inject before the introduction of a programme. The use of needles or syringes as weapons was not reported, contrary to what had been feared. Staff attitudes were generally positive but response rates in surveys varied [2].

**Substitution treatment programmes** in prisons are relatively easy to carry out and appear to have benefited drug-dependent inmates. By 1992 more than 10 countries had established such programmes [3, 4]. They reported a reduced frequency of illicit drug use in prison and reduced involvement in the prison drug trade. The literature also indicates that methadone maintenance reduces the frequency of injecting among drug-dependent inmates. Significantly fewer injections per week were reported than in injecting drug users not participating in a methadone programme. Self-reported syringe sharing was also lower among those receiving methadone in comparison with a control group, indicating a significant reduction in the risk of HIV transmission. Various other drug-dependence treatment modalities are being implemented in prison settings, including therapeutic community methods and group counselling. Evaluations of such programmes have also yielded promising results with respect to high-risk behaviour among drug-dependent inmates [5].

Where **condoms are made available** in prisons, this usually involves the use of automatic distribution machines. The evaluation of such programmes indicated that inmates use the machines. Studies have revealed low levels of harassment of users of the machines by other inmates and few incidents of improper condom disposal. The reported level of safer sex was high among those who had sex and there was no evidence of any unintended consequences as a result of condoms being available.

Most of the data on HIV prevention in prisons have been collected in developed countries, and are, strictly speaking, only valid for the countries where they were obtained. However, there is no evidence indicating that interventions implemented in developing countries or in countries with economies in transition would yield different results. Interventions would have to be adapted to the specific cultural circumstances of each country in which they were implemented.

## POLICY AND PROGRAMMING IMPLICATIONS

The prevention of HIV transmission in prisons is mostly hampered by the denial of governments of the existence of injecting drug use and sexual intercourse in prisons, rather than by a lack of evidence that key interventions work. There is ample evidence that drug use in general, injecting drug use in particular and sexual intercourse between inmates are widespread in such institutions. Furthermore, there are data indicating that the risk of HIV infection in prisons is usually higher than in the general community: prisons are a high-risk environment for HIV infection. Once this has been accepted, governments have a wide range of programme options for preventing HIV transmission in prisons.

The evidence shows that such programmes should include all the measures against HIV transmission which are carried out in the community outside prisons, including HIV/AIDS education, testing and counselling performed on a voluntary basis the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment. All these interventions have proved effective in reducing the risk of HIV transmission in prisons. They have also been shown to have no unintended negative consequences. The available scientific evidence suggests that such interventions can be reliably expanded from pilot projects to nationwide programmes.

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<sup>2</sup> Dolan K, Rutter S, Wodak A. Prison-based syringe exchange programmes: a review of international research and development. *Addiction* 2003;98:153-158.

<sup>3</sup> Harding T, Schaller G. *HIV/AIDS and prisons: update and policy review June 1992*. Geneva: University Institute of Legal Medicine; 1992.

<sup>4</sup> Jügens R. *HIV/AIDS in prisons: final report*. Montreal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society; 1996.

<sup>5</sup> Dolan K, Wodak A, Hall W. Methadone maintenance treatment reduces heroin injection in NSW prisons. *Drug and Alcohol review* 1998;17(2): 153-158

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