A note on terminology

The term ‘needle and syringe programs (NSP’s) is used in this paper to refer to programs that provide people who inject drugs (PWID) with access to sterile injecting equipment (needles and syringes, swabs, sterile water). Terms such as “needle exchange programs” (NEP) or “syringe exchange programs” (SEP) are used to describe some programs in other countries. For clarity the term NSP will be used in place of these terms. Use of the term NSP is consistent with the description of community-based programs in Australia. While in some prison-based NSP’s injecting equipment is exchanged on a one-for-one basis, most prison-based NSP’s reflect the services provided in the community: injecting equipment is distributed, information and the means for the safe disposal of syringes is provided, and additional services are also offered. NSP’s often provide other services that include health education, referrals, counselling and primary health care access.
Introduction

Prisons are extremely high-risk environments for the transmission of blood borne viruses (BBV), including HIV and hepatitis C (HCV), due to extremely high rates of incarceration for people convicted of drug related offences, continued illicit drug use and injection and poor access in prisons to the most effective means of BBV prevention for PWIDs – sterile syringes. Many PWID in prisons come from marginalised populations and are already at elevated risk of BBV transmission. High rates of BBV transmission in prisons are linked to the sharing of used injecting equipment, unsafe tattooing and piercing practices and to unprotected sexual encounters. Syringe sharing rates are significantly higher in prisons than among PWID in the general community.

Prisoner’s Right to Health Equivalence

The failure to provide access to essential HIV and HCV prevention measures to prisoners is contrary to Article 25 of the Universal Declaration of Human Rights:

“The obligation to respect the right to health requires States to, inter alia, refrain from denying or limiting equal access for all persons, including prisoners or detainees.”

Moreover, it is inconsistent with international instruments that deal with rights of prisoners, prison health services, and HIV/AIDS in prisons, including the United Nations' Basic Principles for the Treatment of Prisoners, the World Health Organization's (WHO) Guidelines on HIV Infection and AIDS in Prisons, the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommendations and other high level international documents. The Global Commission on Drug Policy specifically refers to the need for NSP and other harm reduction and BBV prevention approaches in prisons in its document “The Negative Impact of the War on Drugs.”

Harm reduction services offered in prison should reflect those provided in the community and is consistent with World Health Organization (WHO) Guidelines on HIV infection and AIDS in Prisons:

“All prisoners have the right to receive preventative measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status and nationality.”

Support and Evidence for Prison NSP from International Bodies

Following an exhaustive review of the international evidence, the WHO, the United Nations Office on Drugs and Crime (UNODC) and UNAIDS recommended in 2007 that “prison authorities in countries experiencing or threatened by an epidemic of HIV infections among people who inject drugs should introduce and scale up NSP’s urgently.” While Australia has avoided a massive HIV epidemic amongst PWID, it was only due to timely community-based NSP provision and investment in peer education. If HIV was to take hold within a prison population of PWID, the results could be catastrophic.

An analysis of studies of European Prison NSP’s “Ten Years of Experience with Needle and Syringe Exchange Programs in European Prisons” concluded that prison NSP’s are not only feasible but effective, especially when embedded within a comprehensive prison-based harm reduction and health-promotion strategy.

The evidence reveals that sterile needles and syringes are readily accepted by PWIDs in prisons and that it contributes to a significant reduction of syringe sharing. Prison-based NSP’s have been effective in reducing HIV and hepatitis C transmissions while at the same time, there is no evidence to suggest that prison-based NSP’s have serious, unintended negative consequences.
The most recent summary of the evidence from countries where prison NSP’s operate is the 2014 UNODC report “A Handbook for Starting and Managing Needle and Syringe Programmes in Prison and Other Closed Settings.”

The findings are consistent with those found in earlier studies and establishes that:

- Prison NSP are feasible and affordable across a wide range of prison settings;
- Prison NSP are effective in decreasing syringe sharing among people who inject drugs in prison, thereby decreasing the risk of BBV transmission (HIV, HCV) between prisoners and from prisoners to prison staff;
- Prison NSP are not associated with increased attacks on prison staff or other prisoners;
- Prison NSP do not lead to increased initiation of drug consumption or injection;
- Prison NSP contribute to workplace safety;
- Prison NP can reduce the incidence of abscesses;
- Prison NSP facilitate referral to available drug-dependence treatment programs;
- Prison NSP can be delivered successfully via a range of methods in response to staff and inmate needs;
- Prison NSP are effective in a wide range of prison systems;
- Prison NSP can successfully coexist with other drug prevention and drug dependence treatment programs.

**Prison NSP’s: Can They Work in the Australian Context?**

The WHO, UNODC and UNAIDS have concluded that “there is evidence showing that needle and syringe programs (NSP’s) are feasible in a wide range of prison settings, including in men’s and women’s prisons, prisons of all security levels, and small and large prisons.”

Prison NSP’s have been operating internationally for over 20 years with consistent, successful outcomes (see above “evidence supporting prison NSP”) outlined in rigorous evaluations. These evaluations provide an evidence-based opportunity for the establishment of a prison NSP in Australia; utilising the available evidence to assist in program design and operation.

**Security Issues: Does the Presence of an NSP Prevent the Ability to Monitor Contraband?**

Prisons with NSP’s continue to deem drug use an illegal activity and undertake usual security measures such as drug detection dogs, cell searches, drug screening urine analysis and other activities aimed to detect and deter drug use. This is similar to drug detection activities undertaken within Australian prisons. This demonstrates that the provision of sterile injecting equipment within prisons can occur without requiring any changes to the legality of drug use or activities undertaken to detect illegal drugs. Comparisons can also be drawn with community based NSP’s. Australian NSP’s were introduced into the general community in the late 1980’s without requiring changes to the laws relating to the possession, use, and supply or trafficking of illicit drugs or drug detection activities. This example can be replicated within the prison context where providing sterile needles as part of a BBV prevention and harm reduction strategy can co-exist without conflict or contradiction to existing laws and prison protocols relating to the possession, use and/or supply of illicit drugs or other contraband. Providing access for prisoners to harm reduction services is a health issue whilst the illegality of drug use and/or the possession or supply of illicit drugs are separate law and order issues.
There are many similarities between Australian prisons and those in countries such as Spain, Switzerland and Germany. The drug laws, prison protocols and drug detection activities within prison settings are similar, as are the profiles of prisoners who use drugs, in that high rates of BBVs are also found amongst these prison populations. Given this situation, AIVL and its member organisations believe when all is considered, there are a greater number of similarities between Australia and those countries currently operating NSP’s in prisons than there are differences. In this regard, we do not believe there is any credible evidence to suggest that it would not be possible to replicate the experience of successful models of prison NSP’s in other countries in the Australian prison context.

Drug Treatment Programs: Does the Presence of NSP Impede the Delivery of Drug Treatment?

Drug treatment programs are provided in combination with prison NSP in a number of countries. These treatment programs are similar to those provided in Australian prisons. The evidence supports the assertion that a prison NSP does not undermine or impede the provision of drug treatments but supports and facilitates access to services offered.

The most effective method for reducing HIV and HCV incidence among people who inject drugs is the combined provision of NSP and opioid substitution therapy (OST). OST is the most effective drug-dependence treatment for heroin dependence, but there are several circumstances in which prisoners cannot access or benefit from OST, including:

- It can take time to process and authorise a request for OST;
- Some people do not use or inject heroin but do inject cocaine or amphetamines (many times a day). These non-opioid users will not benefit from OST, and Prison NSP is therefore the only suitable harm reduction/prevention option available in the prison setting for these people;
- There are often limits on the number of prisoners enrolled in OST at any one time.

This highlights that offering OST alone is not sufficient to address transmission of BBV’s. Providing OST is only useful for heroin or opioid dependency and is not a harm reduction option for those who inject other drugs, including amphetamine type substances (e.g. crystal methamphetamine (“Ice”), speed, or cocaine).

International experience demonstrates that prison NSP can operate in conjunction with drug treatment programs without the aim of either program conflicting. In fact providing both increases effectiveness in reducing BBV transmission.

The provision of NSP and OTS in the community has shown to be an effective harm reduction response in improving health outcomes for people who inject drugs including the prevention of BBV’s.

NSP in Prisons: The Model Really Matters!

Important factors in the success of prison NSP’s include:

- easy and confidential access to the service;
- providing the right type of syringes; and
- building trust with the prisoners accessing the program.

There is a growing consensus that a service based on distribution is preferable to an NSP that only exchanges syringes on a strict one-for-one basis, although safe return of the used syringes should remain a fundamental aim. Compared with community services, prison NSP’s generally have a high rate of return of used needles and syringes, which can give the staff reassurance of a sustained interest in their workplace safety and security.
Prison NSP: Some of the Main Models Used

Various delivery models for the distribution of injecting equipment in closed settings have been implemented and evaluated in different countries. These include distribution by prison health staff, by peer educators, by external NGO staff and via dispensing machines. The 4 main models used in prison-based NSP’s are:

1. **Hand-to-hand by prison health staff, social worker, physician or nurse.** This method is used in several Spanish and Swiss prisons. The used syringes are either exchanged at the cell door or in the medical unit.

2. **Hand-to-hand by trained peers** (i.e., prisoners) to ensure confidential contact with prisoners who use drugs and access at almost all times e.g. Moldova.

3. **Hand-to-hand by external personnel or NGO’s** who also provide other harm reduction services.

4. **Automated dispensing machines** e.g., Germany and Hindelbank women’s prison, Switzerland (one-for-one exchange, starting with a dummy syringe as the first device).

Each of these models have advantages and challenges regarding differing levels of anonymity, confidentiality, supervision, monitoring and cost. These issues are explored below with each model.

1. **Hand-to-hand distribution by prison health staff**

   **Advantages:**
   - Provides personal contact with prisoners and an opportunity for access to health services and counselling;
   - Can facilitate outreach to and contact with previously unknown people who use drugs;
   - Prison maintains high degree of control over access to needles & syringes;
   - One-for-one exchange or multiple syringe distribution possible (as necessary, and as reflects individual prison policy).

   **Disadvantages:**
   - Lower degree of anonymity and confidentiality, which may reduce the participation rate (although high acceptance by prisoners is possible if confidentiality is maintained);
   - Access more limited, as syringes are available only during the established hours of the health service (this is particularly true if the prison follows a strict one-for-one exchange policy);
   - Creates possibility of proxy exchanges by prisoners obtaining syringes on behalf of those who do not want to participate in person due to lack of trust with staff.

2. **Hand-to-hand by trained peer volunteers**

   **Advantages:**
   - High level of acceptance by prisoners;
   - High degree of anonymity and trust, with lower fear of disclosure to prison authorities;
   - High degree of accessibility (peer outreach workers live in the prison units and are available at all hours);
   - Easy access to a wide range of harm reduction materials (condoms, paraphernalia, etc.);
   - Prisoner(s) in charge of the NSP can also provide information and deliver peer harm reduction and health promotion advice to other prisoners;
   - Can include peer-based overdose prevention, including access to naloxone.

   **Disadvantages:**
   - No direct staff control over provision and no formal monitoring system, which can lead to increased fears about workplace safety among staff;
• Selected prisoners might not provide reliable services to fellow prisoners;
• High turnover of prisoners and need for continuous training.

3. Hand-to-hand by external personnel or NGO’s who also provide other harm reduction services

Advantages:
• Provides a higher degree of confidentiality;
• Personal contact with prisoners and an opportunity for referral to health services and counselling;
• Facilitates outreach to and contact with previously unknown drug users;
• Prison can maintain a high degree of control over access to syringes;
• One-for-one exchange or multiple syringe provision are possible;
• Can facilitate continuity of care when prisoners are released.

Disadvantages:
• Access limited: syringes available during set hours or set times of the week (this is particularly true if the program follows a strict one-for-one exchange policy);
• Anonymity and confidentiality may be compromised by policies that require the external agency to provide information to the prison on prisoners’ participation;
• Potential that prison staff may mistrust the external organization providing syringes;
• External workers may experience more barriers in dealing with the prison bureaucracy than internal prison health staff;
• Turnover in NGO staff may result in a lack of program continuity and lack of a consistent “face” for the program for prisoners and prison staff.

4. Automated dispensing machines

Advantages:
• High degree of accessibility (often multiple machines are placed in various locations in the institution, which can be accessed outside the established hours of the medical service);
• High degree of anonymity, as there is no involvement with staff;
• High acceptance by prisoners;
• Strict one-for-one exchange (also included in disadvantages section).

Disadvantages:
• Machines are vulnerable to vandalism by prisoners or sabotage by staff who are not in favour of the program;
• Technical problems with functioning of the dispensing machines can make syringes unavailable for periods of time;
• Some prisons are architecturally unsuited to the use of dispensing machines (i.e., lack of discreet areas freely accessible to prisoners in which machines may be placed);
• Machines must be custom designed and individually constructed, so costs can be prohibitive for some prison systems;
• Purely technological solution, with no opportunity for education, advice or counselling;
• Requires close monitoring to ensure machines have always sufficient supplies;
• Strict one-for-one exchange.
As described above these models each have advantages and disadvantages that include: ease of access, acceptability confidentiality and confidence of prisoners to use the program, confidence in program by prison staff, technical issues; structural/architectural issues and so on. Given this situation there is a growing body of evidence to support “mixed” model approaches, where 2 or more models are utilised within the one prison based NSP. The UNODC supports the mixed model approach stating:

“As with a number of community-based NSP, providing a range of ways for prisoners to access needles and syringes is probably preferable to just one. A combination of a peer-distribution programme with a health-care staff programme and dispensing machines may prove most effective, since some prisoners may prefer one method of accessing a syringe at one time, and a different method at another”

**From the First Prison NSP to Current Prison NSP – What Has Been Learned Along the Way?**

The first prison NSP program was established in Switzerland in 1992 on an informal basis, without the consent of prison authorities, by a physician at the Oberschongrun men’s prison. This program gained formal consent and support of prison authorities in 1994 which prompted a pilot to be launched in Switzerland at Hindlebank women’s prison. In 1996 Germany launched its first prison NSP and in 1997 Spain introduced its first program. In these 3 countries alone a total of 19 prison NSP’s were in operation by 2000.

Results from the evaluations of pilot programs in Switzerland, Germany and Spain have shown that the aims of the programs have been achieved. These include:

- reduction in syringe sharing;
- subsequent reduction in BBV rates;
- no increase in drug use and;
- no syringes used as weapons.

Interview data have indicated that drug use patterns remained stable or decreased over time with no instances of prisoners commencing drug use being reported. Reports of syringe sharing dropped dramatically and were virtually non-existent at the end of most of the pilots.

*No seroconversions for HIV, hepatitis B or hepatitis C have been reported in these prisons operating NSP’s. Importantly, no instances of syringes being used as weapons have been reported in any program.*

The positive results from these programs, along with an urgent need to address the high BBV transmission risk environments prompted an additional 6 countries (Moldova, Kyrgyzstan, Belarus, Armenia, Iran, Luxembourg) to launch programs or pilot programs by 2006.

By 2011 a further 4 countries had implemented pilot programs (Portugal, Romania, Tajikistan, Afghanistan). Further reviews of prison NSP’s reflected the previous positive outcomes that include reductions in BBV transmissions and safer environment for both prisoners and staff. Despite the positive outcomes shown by prison syringe programs in 2014 there were just 7 countries with programs operating.

There is a strong rationale for establishing NSP in prisons. There is increasing evidence that experience of imprisonment is a strong predictor of HIV and hepatitis C transmission for the individual prisoners. Nor is this an issue confined to prison. A majority of prisoners serve short-term sentences, during which they are unable to access long term drug treatment, and return to the wider community having been at significantly higher risk of BBV transmission and subsequently more likely to pass on BBVs. For this reason prisons have been called HIV and HCV “incubators.”
The numerous reviews and evaluations that have been conducted of Prison NSP confirms that these programs are feasible and based on the data available they appear to be effective in reducing blood borne virus transmissions. Furthermore, there is no evidence to suggest that these programs have any serious unintended negative consequences.

Table 1: Summary of Programs at 2014

<table>
<thead>
<tr>
<th>Country</th>
<th>Total N. Prisons settings</th>
<th>Start Year</th>
<th>Implementation modality</th>
<th>N. Prison w/NSP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2006</td>
</tr>
<tr>
<td>Switzerland</td>
<td>114</td>
<td>1992</td>
<td>Dispensing machine/ NGOs/Health Service</td>
<td>7</td>
</tr>
<tr>
<td>Germany</td>
<td>185</td>
<td>1996</td>
<td>Dispensing machines</td>
<td>1</td>
</tr>
<tr>
<td>Spain</td>
<td>82</td>
<td>1997</td>
<td>Prison health service/ NGO</td>
<td>38</td>
</tr>
<tr>
<td>Moldova</td>
<td>17</td>
<td>1999</td>
<td>Peer based/NGO</td>
<td>7</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>17</td>
<td>2002</td>
<td>Peer based &amp; health service/NGO</td>
<td>11</td>
</tr>
<tr>
<td>Belarus</td>
<td>32</td>
<td>2003</td>
<td>—</td>
<td>1 pilot</td>
</tr>
<tr>
<td>Armenia</td>
<td>12</td>
<td>2004</td>
<td>—</td>
<td>3 pilot</td>
</tr>
<tr>
<td>Iran</td>
<td>253</td>
<td>2005</td>
<td>Health service</td>
<td>1</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>2</td>
<td>2005</td>
<td>Health service</td>
<td>1</td>
</tr>
<tr>
<td>Portugal</td>
<td>49</td>
<td>2007</td>
<td>—</td>
<td>0</td>
</tr>
<tr>
<td>Romania</td>
<td>45</td>
<td>2009</td>
<td>Health service</td>
<td>0</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>19</td>
<td>2010</td>
<td>—</td>
<td>0</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>?</td>
<td>2013</td>
<td>—</td>
<td>0</td>
</tr>
</tbody>
</table>

Switzerland

From 1992 to 2000 prison syringe exchange programs have been introduced in 7 (out of 114 total) prisons. Many of the programs have been adapted and updated in response to experience gained over the years. Prison NSP continue to operate without incident in the seven prisons identified.

The reason for the low numbers of Prison NSP programs compared to number of prisons appears to be largely attributable to the fact that most of the 114 prisons are very small with less than 50 inmates. An additional contributing factor is that the Swiss prison system is administered by cantons (areas or regions) that each have responsibility for prison and prisoner health. Administration of health services vary across the different cantons and as a result the decision to have an NSP rests with the individual prisons.

<table>
<thead>
<tr>
<th>Name Prison</th>
<th>Year Introduced</th>
<th>Model</th>
<th>Comments</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oberschongrun</td>
<td>1992</td>
<td>Distribution through medical unit</td>
<td>Formal/approved program started 1994</td>
<td>—</td>
</tr>
<tr>
<td>Hindlebank</td>
<td>1994</td>
<td>Dispensing machines located in 6 discrete locations</td>
<td>One for one exchange with new prisoners given dummy syringe</td>
<td>Prisoners provided with 5 additional points</td>
</tr>
</tbody>
</table>
Switzerland:

Lessons Learnt

Prison needle and syringe programs continue in Switzerland continue to operate without incident in the seven prisons identified above. Oberschöngrün prison has adopted a flexible approach to its program, and does not adhere to a strict one-for-one policy. This has not resulted in any security or safety problems.

Spain:

There are 69 prisons in Spain under the jurisdiction of the Spanish Ministry of the Interior. There are also a further 11 prisons that are administered by the government in the autonomous region of Cataluña. The first program was introduced in July 1997 in Basauri prison, Bilbao, in the Basque region. This was followed by pilot programs in Pamplona prison (1998) and the Orense and Tenerif prisons (1999). In June 2001 the Directorate General for Prisons ordered that needle exchange programs be implemented in all prisons. By the end of 2001, NSP was provided in 11 Spanish prisons. By the end of 2002 the number of prisons providing NSP had grown to 27; and by the end of 2003, to 30. At present, the mandate to institute NSP exists for all 69 prisons under the jurisdiction of Spain’s Ministry of the Interior, with the exception of psychiatric prisons and one high-security-level prison.

A Ten Year Evaluation of the Needle Exchange Program in the Spanish Prison at Ourense:

The results of the evaluation over ten years has shown a total of 15,962 syringes were supplied to 429 users, averaging around 20.2 users per month, with 11,327 (70.9%) returned. The prevalence of BBV reduced significantly with HIV prevalence rates decreasing from 21% in 1999 to 8.5% in 2009 and HCV prevalence from 40% to 26.1%. Surveys were conducted with inmates and civil servants with the results showing that most believe that the program did not increase intravenous drug use and improved hygienic living conditions in prison. The conclusions from this evaluation show that after ten years development of the NSP, there was a significant decrease in the prevalence of HIV and HCV in the prison population, and the program is accepted as beneficial by most of the inmates and staff participating in the survey.

The following table show results of surveys conducted with prison staff before the program started then at 6 months, 12 months and 10 years. These results highlight that changes in staff attitudes towards prison NSP can become favorable over time with experience gained from being involved and experiencing the first-hand positive benefits derived from the program.
Table 2: Distribution of prison officers according to position and opinion on NSP

<table>
<thead>
<tr>
<th></th>
<th>Before NEP (n 44)</th>
<th>6 months (n 47)</th>
<th>12 months (n 47)</th>
<th>10 years (n 55)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Officer groups</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveillance</td>
<td>72.8</td>
<td>83</td>
<td>83</td>
<td>87.3</td>
</tr>
<tr>
<td>Treatment</td>
<td>22.7</td>
<td>10.6</td>
<td>12.8</td>
<td>9.1</td>
</tr>
<tr>
<td>Administration</td>
<td>4.5</td>
<td>6.4</td>
<td>4.3</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Do you believe that the NEP has encouraged the use of intravenous drugs in the prison?

A lot/ Quite

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Before NEP (n 44)</td>
<td>47.8</td>
<td>17.1</td>
<td>25.5</td>
<td>18.9</td>
</tr>
</tbody>
</table>

Do you believe that the NEP has promoted conflict in the prison?

A lot/ Quite

<p>| | | | | |</p>
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<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Before NEP (n 44)</td>
<td>56.8</td>
<td>2.1</td>
<td>25.5</td>
<td>18.1</td>
</tr>
</tbody>
</table>

Has your opinion about the NEP changed since it was first implemented?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>72.3</td>
<td>57.5</td>
<td>47.3</td>
<td></td>
</tr>
<tr>
<td>Favorably</td>
<td>23.4</td>
<td>40.4</td>
<td>49.0</td>
<td></td>
</tr>
<tr>
<td>Unfavorably</td>
<td>4.3</td>
<td>2.1</td>
<td>3.6</td>
<td></td>
</tr>
</tbody>
</table>

Results all in percentages

Spain:

Lessons Learnt

The experience of NEP’s throughout Spanish prisons has been positive with goals including reduction in BBV and safer working environment being realised. This outcome is notable given the almost 20 years’ experience of operating NSP’s in Spain. The results from Ourense (above) show that staff attitudes towards prison NSP can change overtime to become favorable towards prison NSP.

Moldova:

Since 1999, local NGOs have provided prisoners with HIV/AIDS education and a wide range of harm reduction services, including psychological support, counselling, and distribution of clean injection equipment and condoms. More than two-thirds of adult prisoners sentenced in Moldova are incarcerated in facilities where they have access to harm reduction services. In all the prisons where harm reduction services are provided, the experience has been overwhelmingly positive. Needles have never been used as weapons against prison staff or fellow prisoners, drug use has not increased, and available data suggest a reduction in HIV and hepatitis C incidence.

First NSP Site Selection

NGO and prison officials agreed to implement an initial harm reduction project at Branesti prison, a medium and maximum-security prison with a population of approximately 1,000 men. Need was greatest in Branesti due to the relatively high levels of HIV and drug use, and authorities assumed the project would have a greater opportunity for success because the “newness” of the prisoners meant they were less hardened than those elsewhere. Branesti had the lowest average age (mid-20s) with a significant majority being imprisoned for the first time.
The program began in Branesti utilizing a model of distribution from medical staff at the prison. Uptake was slow, with less than 50 syringes exchanged over 5 months. NGO staff spoke with prisoners to learn that there was a reluctance to use the program as they did not believe it was truly anonymous. Another issue was the hours of operation being limited to times the medical unit was open. A decision was made to change the model to one of peer to peer distribution.

**Model**

The peer to peer model is now used in all programs throughout the country. Peer volunteers are selected and trained by an external NGO. Peer volunteers have a cabinet with supplies by their bed and collect information on number of supplies distributed and returned. Information on program participants is not collected with this method ensuring confidentiality and confidence of prisons in the program. Medical staff at the prison regularly conduct informal interviews with program participants to gauge satisfaction and identify any potential barriers to access or problems with the program.

**Moldova:**

**Lessons Learnt**

The experience and lessons gained through prison NSP have been summarised in a report entitled “Harm Reduction in Prison: The Moldova Model” published by International Harm Reduction Development Program. The following demonstrates that even when opposition exists programs can be successful, when there is a commitment to implement a prison NSP from government and top level prison officials.

“One of the most important lessons from the Moldova experience is that success of harm reduction initiatives can be greatly enhanced when top-level staff are engaged and proactive from the start. Both the director general and medical director of Moldova’s Department of Penitentiary Institutions have been strong supporters of the needle and syringe and methadone programs from early on. They were not afraid to use their authority to remove potential and existing obstacles. They ordered officials at local prisons to implement the needle and syringe project and cooperate fully with those providing the services—even if the officials opposed the project. This determination proved fortuitous; as positive results emerged from the project, attitudes among resistant staff moved from opposition to acceptance to support.”

This program included regular training with all staff on the benefits of prison NSP; with staff and prisoners being provided with education on the goals of the program - namely a reduction in BBV transmission making a safer working and living environment for all. Training is supplied by the NGO, Innovative Projects in Prisons (IPP), who receive funding for responsibility of operating and providing supplies to the program. Many staff gained valuable experience in the operation of the program which changed initial attitudes of resistance to support.

**Other Issues for Consideration:**

**Retractable Syringes:**

The introduction of retractable syringes into prison NSP is not supported by AIVL. Prison NSP’s should have equivalent standards and levels of services provided to those in the community. Retractable syringes do not meet the principle of equivalency as guaranteed at international law and in the WHO guidelines on HIV Infection and AIDS in Prisons:

“All prisoners have the right to receive health care, including preventative measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status.”
**AIVL Policy Position Paper 8 – Retractable Syringes includes the following concerns:**

- AIVL is concerned about the potential for retractable syringes to be re-used and be not fully functional. This means that while the unit can be re-used it is less likely for it to be able to be cleaned sufficiently (as compared to a regular syringe) and will place users at great risk of BBVs. This in turn may lead to an increase in the likelihood in sharing of equipment by individuals who will be reluctant to let the device retract for fear of not being able to re-use it.

- Retractable syringes may increase the need for users to inject each other and this may increase the chance for the transmission of BBVs. This is because individuals may struggle to learn and manage the retractable mechanism. This has the potential for undoing years of harm reduction work and peer education.

- Retractable syringes are unlikely to be accepted by people who inject drugs who will not accept inferior or ineffective equipment. If as AIVL predicts that large numbers of individuals will reject this technology then the potential for the re-using of equipment will greatly increase. This will result in increased health issues for individuals such as hepatitis C and HIV transmission, vein care problems, abscesses and other bacterial infections.¹⁷

These concerns were highlighted by prisoners in a recent study of retractable syringes in a Swiss prison NSP¹⁸ where from April to November 2010, 284 retractable devices were distributed to 28 of 2,050 inmates in the Champ-Dollon prison. Participants noted that preparation and injection process took more time (60 %), with some differing opinion about efficiency. In qualitative follow-up of participants there were complaints that retractable syringes were heavier than normal, complaints about the needle sharpness, describing that injections were more painful or more difficult, comparing the feeling to “injections with used needles.” They noted that if the injection failed, they actually lost the drug, because they needed to break the syringe to recover it i.e. no “second chances”. A participant pointed out that they could reuse syringes if they did not depress the plunger completely. Disassembled syringes were found in returned syringes which raises concerns around potential re-use but without the ability to clean efficiently with bleach. There must be tolerance for a program before PWID will utilise it. To set up an intolerable program will only ensure its failure.

Nor did the retractable syringes allay safety concerns amongst prison officers. Since the inception of NSP at Champ-Dollon, there has never been a case of a syringe used as a weapon. But despite more than 15 years of experience without incident, NSP is still perceived as potentially dangerous by the Prison Officers with 90% still being concerned that a used syringe could be used as a weapon.

**Needles and Syringes as Commodity:**

The current situation in Australia where there is no prison NSP has led to an “illicit market” in which syringes can be very expensive. Given the scarcity of needles within prison and a high demand this is not surprising. In prisons where NSP’s operate there has not been any “illicit market” reported where needles and syringes are accessible. This follows the standard market economy concept of supply and demand, where supply is low and demand high the product will fetch a high price. Where supply is able to match demand a high price, or indeed any price, will not be paid. Prison NSP’s are able to avoid an illicit trade in needles and syringes by ensuring that product supply is accessible and meets demand.

**Prison NSP - Reasons for Closures:**

The number of countries providing needle exchange programs within prisons have reduced over the last decade with reasons for closures including changes in government policy and funding cuts. Germany was one of first European countries to implement programs from 1996 with seven programs being implemented by 2000. Newly elected conservative governments decided to close six of these programs without consultation with staff.
The success of these programs gained support from prison staff who vocally protested the closures and engaged in lobbying to have them reinstated. These efforts were not successful and as a result there is currently only one program operating in Germany.\textsuperscript{19} Armenia, Belarus and Romania all saw their NSP services in prisons closed between 2012 and 2014.\textsuperscript{20} Armenia had 3 pilots operating in 2006 with Belarus having 1 pilot operational during the same period. Romania had 3 programs operating at 2011 with these having closed by 2013. Specifics on reasons for closures have not been made available apart from evidence of funding cuts across all areas of harm reduction for these countries. Portugal started 2 pilot programs in 2008/09 with the first years being unsuccessful in that no syringes were supplied during the first 12 months. These trials were continued into 2011 but have since closed as they were not able to gain the confidence of prisoners and were therefore not utilised. This last point demonstrates the critical importance of any program requiring acceptability for prisoners and the importance of the model adopted.

**Increased Safety for Prison Staff and Prisoners:**

As we have stated earlier, the assertion that needles would be used as weapons against prison staff or other prisoners is not supported by the evidence acquired through evaluation of prison NSP’s. Prison NSP’s have been operating internationally for over 20 years and during this time there have been no reported incidents of syringes being used as weapons.\textsuperscript{21} Contrary to the fears around prison NSP the evidence shows that they in fact increase safety for both prison staff and prisoners. Through providing a reduction in needle stick injuries along with reduced number of prisoners with BBV’s the prison environment is made safer for both prison staff and prisoners.

**Reduction in “Needle Stick” Injuries:**

It is difficult to ascertain the number of needle stick injuries that occur amongst Australian prison staff as this information is not made available by prison authorities or prison officers unions. Syringes are present within the Australian prison settings but considered contraband and therefore a prisoner found with a needle or syringe can face disciplinary action along with having the item confiscated. This situation leads to the inevitable hiding of needle and syringes within cells and common areas. These hidden needles pose a high risk for accidental needle stick injury by staff conducting cell searches and additionally pose a risk for other prisoners.

Prison NSP’s have strict rules around the storage and disposal of needles and syringes and most programs provide puncture proof containers which are kept in a designated place within the cell. This provides a much higher degree of safety in guarding against needle stick injury for prison officers than the current situation in Australia. The international evidence has shown that prisons operating NSP’s have a reduced number of accidental needle stick injuries.\textsuperscript{22} In addition, if there is a reliable supply of sterile syringes, the motivation to hide and retain used equipment diminishes, thus reducing the risk of accidental needle-stick injuries from hidden used syringes.

**Reduction in BBV Prevalence:**

Prison NSP’s are effective in reducing the sharing of syringes amongst people who inject drugs and therefore reduce the risk of BBV transmission\textsuperscript{23}. Hepatitis C is of particular concern within the Australian prison environment with studies showing 30 – 40% of all prisoners living with hepatitis C. These rates are even higher amongst women prisoners with estimates in the range of 50 – 70 %\textsuperscript{24}.

Community NSP’s were introduced as a harm reduction strategy to avert a HIV epidemic amongst people who inject drugs (PWID) and has been extremely successful in this respect. Although HIV rates amongst PWID and within the prison environment is relatively low, the current lack of access to sterile injecting equipment could see this situation change dramatically, with significant increases within a short period of time.
Conclusion:

The international experience demonstrates that prison NSP’s can be safely and effectively established in Australian prisons. A prison NSP has the potential to provide greater interaction for the prisoner with health services, harm reduction programs and drug treatment services, as demonstrated through international experience. It has the potential to dramatically reduce BBV transmissions.

International evidence also indicates that official prison NSP could offer greater safety for prison officers and prisoners alike. The current situation of high rates of BBV transmission along with high rates of needle and syringe sharing within the prison setting cannot be ignored and allowed to continue unchecked. This must be addressed through evidence-based NSP as an urgently needed harm reduction intervention. Furthermore, both parties most affected by this issue – prison workers and detainees should be involved in developing the solution. This solution is well within our grasp. Australia led the world in its response to HIV in the community. It is not too late to take a lead internationally on the issue of BBV’s in prison.

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Needle & Syringe Programs in Prisons

References:

1. Article 25 Universal Declaration of Human Rights and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). The obligation to respect the right to health requires States to, inter alia, refrain from denying or limiting equal access for all persons, including prisoners or detainees.


Additional Resources:

