

## Harm reduction in prisons: a 'rights based analysis'

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**ABSTRACT** Throughout most of the world, the primary response to problems associated with illicit injection drug use has been to intensify law enforcement efforts. This strategy has contributed to an unprecedented growth in prison populations and growing concerns regarding drug-related harm within prisons. Despite the presence of international laws and guidelines that call for the protection of the health of prisoners, prison authorities have generally been slow to implement activities that have been proven effective in reducing drug-related harms in community settings. While a limited number of countries have made progress by implementing educational programmes, methadone maintenance therapy, bleach distribution and needle exchange, in most areas of the world, a substantially greater effort is needed to ensure that prisoners receive the same level of care offered in community settings. The current emphasis on security and abstinence from drugs within prisons is often regarded as incongruent with the goals and methods of harm reduction. However, available evidence indicates that most harm-reduction programmes can be implemented within prisons without compromising security or increasing illicit drug use.

### Background

Throughout most of the world the primary response to the health and social impacts of illicit drug use has been to intensify the enforcement of drug laws in an effort to limit the supply and use of illicit drugs (Wood *et al.*, 2003). The consequences of this policy approach include an unprecedented growth in prison populations and increasing concerns regarding drug-related harm within prisons (Drucker, 1999). Population-level increases in illicit drug use have also probably contributed to growth in prison populations in some settings, although evidence from other countries indicates that prison populations have grown despite reductions in illicit drug use nationally (Drucker, 1999).

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In most countries, prison populations are predominantly male, although in some countries the proportion of women in prison is increasing steadily (Richie *et al.*, 2001). As well, in many settings, individuals from racial minorities are drastically overrepresented in prisons (McDonald & Thomson, 1993; Drucker, 1999). Prior to their incarceration, prisoners throughout the world also typically contend with a variety of challenges that adversely affect health, including poverty, unemployment, a lack of social supports, various illnesses and a lack of appropriate medical support (McDonald & Thomson, 1993; Fasher *et al.*, 1997; Kale *et al.*, 1999; Duhamel *et al.*, 2001).

Despite the illegal status of drugs and the significant amounts of money and person hours invested in preventing the flow of drugs into prisons, drugs remain widely available in prisons and a substantial proportion of prisoners consume them. This is due in part to the fact that many prisoners come to penal institutions with established drug habits (Calzavara *et al.*, 2003). Also fuelling the demand for drugs in prisons is the high rate of initiation into drug use by prisoners (Polonsky *et al.*, 1994; Allwright *et al.*, 2000) seeking a means to cope in an overcrowded and often violent environment (Jürgens, 1996).

Similarly, the injection of illicit drugs—the most dangerous route of administration—is common within prisons (Dolan *et al.*, 1995), and is associated with severe and adverse health and social consequences (Wood *et al.*, 2003). Incarceration is a common event among injection drug users (IDUs). Evidence from the USA indicates that approximately 80% of IDUs have a history of imprisonment (Dolan, 1999), and a 12-city World Health Organization (WHO) study of HIV risk behaviour among IDUs found that between 60% and 90% of respondents reported a history of imprisonment since commencing drug injection (Ball, 1995). Available evidence indicates that a substantial proportion of drug users inject drugs while in prison, with 50% or more of drug users from several countries reporting injection while in prison (Carvell & Hart, 1990; Koulierakis *et al.*, 2000; Clarke *et al.*, 2001; Thaisri *et al.*, 2003). In one study in Russia where 20% of prisoners reported injecting drugs while in prison, 14% of these individuals stated that their first injection occurred within a penal institution (Frost & Tchertkov, 2002).

While IDUs typically inject less frequently in prisons (Shewan *et al.*, 1994; Dolan *et al.*, 1996), studies have demonstrated that the injections that occur tend to be carried out in a more 'high-risk' fashion than injections in community settings (Darke *et al.*, 1998; Malliori *et al.*, 1998). Because the supply of drugs fluctuates considerably and because drugs are primary currency within prisons, when available, drugs are often shared among several prisoners (Small *et al.*, in press). This is of particular concern since the intense security and surveillance in prisons can make it much more difficult to smuggle syringes than drugs into penal institutions (Lines, 2002a), making access to sterile syringes extremely limited. As a result, a single syringe will often circulate among a large group of prisoners (Shewan *et al.*, 1994; Allwright *et al.*, 2000; Koulierakis *et al.*, 2000).

Given the scarcity of syringes, prisoners have also been known to sharpen old syringes and to manufacture syringe substitutes out of hardened plastic and ballpoint pens (Small *et al.*, in press). These practices may all increase risk of venous injury, scarring, and bacterial and viral infections. A high incidence of these injection-related risk behaviours persists in prisons, since the interventions that have led to substantial reductions in these same risk behaviours in community settings often remain unavailable in prison (Rotily *et al.*, 2001; Thaisri *et al.*, 2003).

Worldwide, levels of HIV prevalence within inmate populations tend to be much higher than in the general population (Seaman *et al.*, 2000). HIV prevalence among prisoners varies considerably across settings, although several countries have reported rates in the range of 10–25% (Kallas *et al.*, 1998; Burattini *et al.*, 2000; Raufu, 2001; Babudieri *et al.*, 2003). The jurisdictions with the highest HIV prevalence in prisons (apart from countries with large heterosexual HIV epidemics) are areas where HIV infection in the general community is ‘pervasive among IV drug users, who are dramatically over-represented in correctional institutions’ (Hammett, 1988). Evidence of this trend was indicated by a recent US study, which found that an estimated 25% of all HIV-infected citizens pass through a correctional facility each year in America (Hammett *et al.*, 2002).

Incarceration has been associated with HIV infection in several countries (Rich *et al.*, 1999; Choopanya *et al.*, 2002; Tyndall *et al.*, 2003), and evidence of rapid spread of HIV infection has been observed within specific settings (Taylor *et al.*, 1995; Thaisri *et al.*, 2003). One early instance suggesting rapid HIV transmission in prisons was documented in Glenochil, Scotland in 1993 (Taylor *et al.*, 1995). While the data set was small, subsequent phylogenetic analysis of viral sequences indicated that the majority of these prisoners contracted HIV from a common source, further indicating that transmission had occurred within the prison (Yirrell *et al.*, 1999).

Hepatitis B and C have also increasingly been recognized as growing problems facing prisoners who inject drugs (Macalino *et al.*, 2004). Both forms of hepatitis are transmittable through sharing of syringes and other injection equipment such as cookers and filters (Hagan *et al.*, 2001), and recent investigations have reported actual or probable transmission of these blood-borne viruses within prison settings (Crofts *et al.*, 1993; Hutchinson *et al.*, 1998). As well, disproportionately higher prevalence of hepatitis B and C have also been observed among prisoners throughout the world (Chang *et al.*, 1999; Allwright *et al.*, 2000; Rahbar, 2004).

### **A rights-based approach to HIV/AIDS and injection drug use in prisons**

In order to ground this analysis in practice-oriented terms, a rights-based approach will be used to evaluate current responses to drug-related harm in prisons and to consider the obligations of governments to respond to these harms (Network, 200). Human rights are highly relevant to drug-related harm and the practice of harm reduction in two ways (Ezard, 2001). First, human rights violations can contribute or lead directly to drug-related harm. Second, human rights instruments and their articulations serve to illuminate the responsibilities of governments to respond to drug-related harm.

Few international laws deal specifically or explicitly with the conditions of imprisonment, although both the *Universal Declaration of Human Rights* (1948) and the *European Convention on Human Rights* (1950) prohibit cruel, inhuman or degrading treatment or punishment. As well, the *International Covenant on Civil and Political Rights* (1966) 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’ (article 10[1]). Commenting on the effect of the *Covenant*, the Human Rights Committee (1989) 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’ (Article 7) and that ‘ultimate responsibility for the observance of this principle rests with the state as regards all institutions where persons are held against their will (prisons, hospitals, detention camps, correctional institutions)’ (Human Rights Committee, 1989).

Although not legally binding on states, rules, guidelines and standards are also important because they express the moral and philosophical standards that should guide national administrators and courts, and often do so with a great deal of specificity. The international community has generally accepted that a set of minimum standards should apply to imprisonment, according to which prisoners retain all civil rights that are not taken away expressly or by necessary implication as a result of the loss of liberty flowing from imprisonment.

Like all other persons, prisoners are entitled to enjoy the highest attainable standard of health, as guaranteed under international law (Leary, 1994). Key international instruments reveal a general consensus that the standard of healthcare provided to prisoners must be comparable to that available in the general community. In the context of HIV/AIDS, health services would include providing prisoners with the means to protect themselves from exposure to HIV and other forms of drug-related harm. Recommendations on HIV/AIDS in prisons developed by the international community and national governments consistently support ‘equivalence of treatment’ of prisoners (Schaller & Harding, 1995; Wilson, 2004), and stress the importance of prevention of transmission of HIV in prisons, and suggest that prevention measures—including sterile syringes—be provided to prisoners. For example, Principle 9 of the *Basic Principles for the Treatment of Prisoners* states that ‘Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation’ (United Nations General Assembly, 1990). Likewise, in 1993, the WHO published its *Guidelines on HIV Infection and AIDS in Prisons*. The *Guidelines* (WHO, 1993) are clear that ‘[i]n 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’ (p. 6).

### **Policies and programmes to reduce HIV and related harm in prisons**

In recent years, the health-related risks arising from the sharing of injection equipment have prompted some countries to recognize the limitations of a strictly zero-tolerance approach to illicit drug use, and a growing number of prison systems have started undertaking efforts to address HIV/AIDS and injection drug use in prisons (Dolan *et al.*, 2003a). These measures typically include educational approaches, provision of bleach to sterilize needles and syringes, making sterile needles available, and methadone maintenance treatment.

### *Education*

Education has long been a key component of HIV prevention and harm-reduction programming in prison settings (Lines, 2002b). These approaches are the most widely employed methods of prevention due, in large part, to the fact that these are regarded as the least controversial approaches among prison officials (Polonsky *et al.*, 1994). Most educational programmes focus on providing knowledge about routes of HIV transmission and risks associated with illicit drugs (Vaz *et al.*, 1996; Ehrmann, 2002), and while many programmes are delivered by prison staff, some are also delivered by prisoners themselves (Vaz *et al.*, 1996).

As in community settings, harm-reduction education programmes in prisons are more likely to be effective if developed and delivered by peers (Broadhead *et al.*, 1995; Vaz *et al.*, 1996; Broadhead *et al.*, 1998). Peer educators can play a vital role in educating other prisoners, since drug use in penal institutions involves illegal practices, and therefore peers may be the only persons able to speak candidly to other prisoners about harm reduction. As well, peer educators, and the information they disseminate, are not likely to be viewed with the same suspicion as educational programmes provided by the penal institution. Peer educators are also more likely to be able to realistically discuss the alternatives to risk behaviour that are available to prisoners, and may be better able to judge which educational strategies will work within their penal institution given the informal power structure among prisoners.

Despite the widespread reliance on educational approaches by prison authorities, information on HIV and the harm associated with injection drug use is not enough. Clearly, information of this kind is not of much use to prisoners if they do not have the means (e.g. sterile syringes) to act on it. Although a few evaluations have indicated improvements in levels of knowledge and self-reported behavioural change as a result of prison-based educational initiatives (Muller *et al.*, 1995; Vaz *et al.*, 1996; Ehrmann, 2002), the effectiveness of current educational efforts in reducing HIV transmission among prisoners appears to be unknown.

### *Provision of bleach*

One strategy to reduce the risk of HIV transmission through the sharing of injection equipment is to provide liquid bleach, together with instructions on correct use, to sterilize needles and syringes (Abdala *et al.*, 2001). Making bleach available to prisoners has often been opposed on the grounds that it may be perceived as condoning an illegal act that has contributed to many prisoners being incarcerated in the first place (Godin *et al.*, 2001). It has also been argued that making bleach and information on how to clean injection equipment available may encourage non-users to experiment with injection drug use, and that bleach could be used as a weapon against staff (Godin *et al.*, 2001). However, the experience in those prison systems that have made bleach available to prisoners has shown that distribution of bleach does not compromise security within penal institutions (Jürgens, 1996).

According to a 1991 WHO-supported study, 16 of 52 prison systems surveyed in Europe made bleach available to prisoners (Harding & Schaller, 1992). Significantly,

none of the systems that adopted a policy of making bleach available in penal institutions has ever reversed the policy, and the number of systems that make bleach available has continued to grow every year (European Network on HIV/AIDS and Hepatitis Prevention in Prisons, 1997). Bleach is also available in many other prison systems, including in most Canadian prisons (Lines, 2002a) and in many prisons in Australia (Dolan & Wodak, 1999).

While the efficacy of using bleach to reduce the risk of HIV transmission has been established (Abdala *et al.*, 2001), bleach is not fully effective in reducing hepatitis C infection (Hagan & Thiede, 2003). Studies also indicate that many IDUs have trouble remembering how to properly disinfect syringes using bleach (McCoy *et al.*, 1994), and evidence from Australia indicates that a substantial proportion of prisoners do not avail themselves of bleach even when it is made available (Dolan *et al.*, 1998). The probability of effective decontamination is further decreased in prison as cleaning is a time-consuming procedure, and some prisoners may be reticent to engage in any activity that increases the risk that prison staff will be alerted to their illicit drug use. While offering bleach to prisoners is a positive step, problems with the uptake of these programmes, as well as the limited effectiveness of bleach in preventing hepatitis C infection, suggest that this intervention alone is clearly an inadequate response to drug-related harm in prisons.

#### *Methadone maintenance treatment*

Methadone is a long-acting synthetic opiate agonist that is easily absorbed when taken orally and has a half-life of approximately 25 hours, allowing once-daily administration (Lowinson *et al.*). Studies have demonstrated that methadone is successful in blocking the effects of opiate withdrawal symptoms (Senay & Uchtenhagen, 1990). As a result, methadone maintenance therapy (MMT) is effective in reducing major risks, harm and costs associated with untreated opiate addiction among patients attracted into and successfully retained in MMT (Bertschy, 1995; Rosenbaum *et al.*, 1996). Research to date has demonstrated that the use of MMT leads to reductions in heroin use, criminal activity, unemployment and mortality rates (Newman & Whitehill, 1979; Dole *et al.*, 1969; Strain *et al.*, 1999; Sees *et al.*, 2000; Sheerin *et al.*, 2004). MMT is also associated with reduced HIV and viral hepatitis transmission rates (Metzger *et al.*, 1993; Hartel and Schoenbaum, 1998; Gibson *et al.*, 1999). Several studies examining the relationship between MMT and HIV risk factors have also shown reductions in risk behaviours including injection drug use, needle sharing, number of sexual partners, engaging in sex without condom use and exchange of sex for drugs or money (Watkins *et al.*, 1992; Wells *et al.*, 1996; Sees *et al.*, 2000).

The introduction of MMT in penal institutions is another strategy that provides prisoners with an additional opportunity to get away from needle use and syringe sharing. This is consistent with the World Health Organization Guidelines on HIV/AIDS in Prisons, which recommend: 'Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison' (World Health Organization, 1993). This point is particularly relevant in light of findings indicating that people taken off methadone once incarcerated often return to narcotic use, usually within the penal institutions, and often via injection (Shewan *et al.*, 1994). Also consistent with



the principle of equivalence, it has further been recommended that initiation of MMT should also be available in prisons in countries where methadone maintenance is available in the community (World Health Organization, 1993).

Worldwide, an increasing number of correctional systems are now offering MMT to inmates (Byrne & Dolan, 1998; Goldberg *et al.*, 1998; Sibbald, 2002). However, some critics consider methadone as just another mood-altering drug, the provision of which delays the necessary personal growth required to move beyond a drug-centred existence (Jürgens, 1996). Some also object to MMT on moral grounds, arguing that it merely replaces one drug of dependence with another (Jürgens, 1996). However, given the poor outcomes associated with untreated opiate addiction (Fischer *et al.*, 1999), the lack of effective treatment options for those addicted to heroin (Fischer *et al.*, 2002), the substantial risks of HIV infection among untreated opiate-addicted prisoners, and the observed efficacy of methadone, it is clear that MMT has a role to play in reducing harm among prisoners.

A small number of evaluations of MMT programmes in prisons have indicated positive results (Dolan *et al.*, 1996; Dolan *et al.*, 2003b). For example, results from a randomized-controlled trial of the MMT programme in prisons in New South Wales, Australia indicated lower rates of heroin, injection drug use and syringe sharing among those enrolled in MMT compared with controls (Dolan *et al.*, 2003b). In Canada, the federal prison system expanded access to MMT after evaluations demonstrated that MMT has a positive impact on release outcome and on institutional behaviour (Sibbald, 2002).

There are several features and limitations associated with MMT and its implementation in prisons that should be noted. For example, previous studies have suggested that prisoners inject less frequently than IDUs in community settings (Shewan *et al.*, 1994), which raises questions concerning the appropriate methadone dose levels for prisoners. However, one study from Australia found that prisoners who were maintained on methadone dosing levels comparable to dosing levels provided in community settings reported lower levels of risk behaviour than prisoners who had received lower doses of methadone (Dolan *et al.*, 1996). A further consideration pertains to prison aftercare and community drug treatment services which may be confronted with prisoners wanting to maintain their methadone therapy on release from prison. While this may pose some logistical challenges for community services that have long waiting lists, prison medical services should be able to foster effective partnerships with methadone providers to ensure continuity of MMT for newly released prisoners, as has been demonstrated with the treatment of other chronic illnesses (Flanigan *et al.*, 1996; Hiller *et al.*, 1999). Other concerns relate to findings indicating that optimal treatment outcomes have generally been correlated with a number of programmatic factors including: sufficient methadone dosing, high level and quality of psychosocial care services, duration of treatment retention, and patient identification with the rules of the MMT programme and staff of treatment centres (Hunt *et al.*, 1986; Ball & Ross, 1991; McLellan *et al.*, 1993; Zule & Desmond, 1998; Koester *et al.*, 1999). An additional limitation to the overall effectiveness of existing MMT is its limited success in retaining patients in treatment. Studies of community-treated opiate addicts indicate that MMT programmes may lose one-third of their original treatment population within the first 12 months and another third within the

following 24 months (Newman, 1977; Mino *et al.*, 1998). Clearly, while MMT has proven effective for individuals who are attracted to and retained in treatment, innovative and flexible approaches must be implemented to ensure that the full potential of this approach is realized. Given the rigid routines and rules within prisons and the emphasis on abstinence from drugs, as well as the lack of psychosocial programmes, successful implementation of MMT in prisons presents unique challenges. For most institutions, substantial changes in way medical services are delivered within prisons would be required to ensure the optimal benefit of MMT programmes.

### *Needle exchange or distribution*

A cornerstone of harm reduction involves making sterile syringes available through needle exchange programmes (NEPs), which have been found to reduce risk behaviour and HIV and hepatitis C incidence (Hagan *et al.*, 1995; Des Jarlais *et al.*, 1996; Bluthenthal *et al.*, 2000). The specific biologic action of NEPs is a form of vector control, by reducing the time that needles spend in circulation (Drucker *et al.*, 1998). NEP is generally regarded as the single most important factor in preventing HIV epidemics among IDUs (Des Jarlais *et al.*, 1995). An international investigation of NEP found that in cities with needle exchange or distribution programmes HIV seroprevalence decreased by 5.8% per year, while HIV prevalence increased by 5.9% per year in cities without such programmes (Des Jarlais *et al.*, 1995).

The principle of equivalence dictates that NEPs be available to prisoners in countries that operate NEPs in community settings. However, many penal institutions have been reluctant to implement NEPs due to concerns that syringes may be used as weapons and that making sterile syringes available may serve to increase illicit drug use within prisons (Correctional Service of Canada, 1994). Despite these concerns, an increasing number of penal institutions have established and evaluated needle and needle exchange or distribution programmes. In Switzerland, prison-based NEPs were first implemented in the early 1990s (Dolan *et al.*, 2003a). Since then NEPs have been introduced in penal institutions in Germany, Spain, Moldova, Kyrgyzstan, and Belarus (Lines *et al.*, in press). A recent international review suggests that Italy, Portugal and Greece are also considering introducing NEPs within prisons (Dolan *et al.*, 2003a).

Reviews of European prison-based NEP evaluations have been highly favourable, indicating that all of the programmes reviewed were successful (Dolan *et al.*, 2003a, Lines *et al.*, in press). The programmes examined distributed syringes via a number of means including doctors, vending machines, drug counselling services, correctional staff or external staff. The evaluations indicated that the prison-based NEPs were associated with stable or decreased levels of drug use, declines in syringe sharing, as well as no new cases of HIV or hepatitis C infection. Similarly, it is noteworthy that the negative consequences of NEP that have been projected by prison officials and staff were not observed in any of the settings. Syringes were not used as weapons against guards or inmates, increases in injection drug use were not observed, and transition into injection drug use among prisoners was not reported. Staff attitudes towards NEP were also said to be to be generally positive.



While the growing favourable evidence concerning prison-based NEPs is encouraging, prisons should also be aware that the efficacy of NEPs can be greatly compromised as a result of programmatic shortcomings. The most obvious example of this comes from Vancouver, Canada where an explosive HIV epidemic was observed among local IDUs, despite the presence of a large NEP (Strathdee *et al.*, 1997). Recent studies have indicated that restrictive practices (e.g. limited hours of operation) partially explain how the epidemic occurred in the presence of a large NEP (Wood *et al.*, 2002). Therefore, in order to benefit from the protective effects of NEP, prisons must ensure that prisoners have easy access to adequate numbers of syringes at all times. Given the routines common to most prisons, this may require considerable innovation in terms of programming to ensure adequate coverage of NEP programmes, although experience has indicated that adequate coverage can easily be achieved through various means of syringe distribution (e.g. vending machines, use of peer workers). However, experience has also shown that methods must be tailored to the specific environment, as methods of distribution that have been effective in some settings have proved to be inadequate in others (Lines *et al.*, in press).

## Discussion

### 4

Correction is a public safety (law enforcement) rather than a public health activity (Brewer, 1991) and, therefore, prison life is not organized in accordance with healthcare needs. Prevention of disease and the provision of medical care in prisons, however, requires reconciling or balancing a medical model of prevention, diagnosis, care and treatment with the correctional requirements of custody and control (Dubler *et al.*, 1990). Prison systems and governments have argued that preventive measures such as those described above cannot be introduced in prisons for safety reasons, and that making them available would be tantamount to condoning drug use in prisons (Jürgens, 1996). Furthermore, the punitiveness inherent in the prison system, and security concerns, have often been seen as obstacles to effective prevention of drug-related harm within prisons (Dolan *et al.*, 1995; Hurley *et al.*, 1997). While the implementation of these programmes requires an acknowledgement that drug use in prison cannot be eliminated, as noted above, evaluations have demonstrated that fears regarding safety are not based on evidence (Lines *et al.*, in press).

As indicated previously, the efficacy of harm-reduction programmes has been found to be mediated by a variety of policies and programmatic factors, particularly those that involved restrictions on access or place demands on those accessing the programmes (Bertschy, 1995; Wood *et al.*, 2002). However, while successful implementation of harm-reduction programmes may present logistical challenges for prison, the promotion of health in prisons does not necessarily entail a lessening of the safety and the security within prisons. On the contrary, any measure undertaken to prevent the spread of HIV will benefit prisoners, staff and the public. First, it will protect the health of prisoners, who should not, by reason of their imprisonment, be exposed to excessive harms or resigned to a fate of otherwise avoidable HIV infection. Second, it has the potential to protect staff in correctional institutions since lowering the prevalence of infections in prisons will further

reduce risk of exposure. Finally, measures to prevent the spread of HIV in prisons also protect the public since most inmates are in prison only for relatively short periods of time and are then released into their communities. As such, in order to protect the general population, HIV/AIDS prevention and harm-reduction measures must be available in prisons. As well, by allowing confidential interactions between prisoners and medical staff, community-based organizations, and peers providing healthcare and education, many of the obstacles to successful implementation of harm-reduction programmes can be overcome.

Many prisoners are in prison because of drug offences or because of drug-related offences (Drucker, 1999). Preventing drug use is then seen as an important part of their rehabilitation. In the eyes of many, acknowledging that drug use is a reality in prisons would be to acknowledge that prison authorities have failed (Jürgens, 1996). However, 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’ (Shewan *et al.*, 1994). Therefore, making available to inmates the means that are necessary to protect them from drug-related harm acknowledges that protection of prisoners’ health needs to be the primary objective of drug policy in prisons. Furthermore, introducing preventive measures such as those described above is not incompatible with the goal of reducing drug use in prisons. For example, while evidence indicates that NEPs have been associated with remarkable preventive effects, they have not prompted increases in illicit drug use (Vlahov *et al.*, 1996). 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 acknowledgement that for some this requires time, and that MMT allows them to break the drug-and-crime cycle, reduce their contact with the shadow economy, link with needed services, and reduce the risk of their becoming infected with HIV. On the other hand, refusing to make bleach or sterile needles available to inmates, knowing that activities likely to transmit HIV are prevalent in prisons, could be seen as condoning HIV transmission among prisoners and to the community at large.

Despite the presence of various relevant international laws and guidelines, HIV prevention for injection drug users remains sub-optimal in most countries, and little has been done to prevent other harm related to injection drug use (Bollini *et al.*, 2002). Traditionally, concerns about disease transmission through injection drug use in prisons have been met with calls to further entrench the philosophy and practice of ‘zero tolerance’ (Dolan *et al.*, 1995). As such, increased penalties for drug use, tightened security measures to reduce the supply of drugs and heightened surveillance of individual drug users are often put forward as ‘law and order’ solutions to public health problems in prisons. In many systems, prisoners with HIV infection or AIDS were segregated from the rest of the prison population and were subject to a variety of discriminatory measures (Polonsky *et al.*, 1994). Implicit in these approaches to drug use in prisons are the notions that any amount of drug use is unacceptable and that abstinence is the only worthy goal. These notions persist despite an established body of literature demonstrating that addiction is a chronic and relapsing condition that is shaped by a multitude of behavioural and social-contextual characteristics that may not be amenable to abstinence-based programmes in all cases (Leshner, 1997).

A rights-based analysis indicates that governments have an obligation to honour the 'principle of equivalence', which states that prisoners are entitled to the same level of healthcare that is provided in the community. Furthermore, prisons are obligated to honour international human rights laws and guidelines which require that the health of prisoners is fully protected. Access to HIV-prevention and harm-reduction programmes implicates the right to health, given the evidence of their effectiveness at preventing severe harm associated with drug dependency and injection drug use in particular. The failure to provide measures that have repeatedly been shown to reduce drug-related harm, as well as the practice of punishing those addicted to drugs, perpetuates the discrimination and stigmatization of a group of highly vulnerable members of society.

Prisoners, even though they live behind the walls of a prison, are still part of the broader community and international law dictates that they are entitled to the same level of care and protection as people living outside prisons.

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