

3.5: Out of sight, out of mind? Harm reduction in prisons and other places of detention

About the authors:

Ralf Jürgens is a consultant working on issues related to health and human rights, including prisons, and a co-founder and former Executive Director of the Canadian HIV/AIDS Legal Network. Rick Lines is an expert in human rights, health and prisons and Deputy Director of IHRA. Catherine Cook is Senior Analyst in the Public Health, Research and Policy team at IHRA.

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

United Nations Commission on Human Rights (1996)¹

Introduction

The rates of HIV prevalence among prisoners and detainees^a are significantly higher than those in the general population in many countries. Hepatitis C virus (HCV) prevalence rates are even higher than those of HIV. Since the early 1990s a number of countries have introduced HIV prevention programmes in prisons. However, many of them are small in scale and restricted to a few prisons and even fewer pre-trial detention facilities. Most also exclude necessary evidence-based interventions, in particular needle and syringe programmes (NSPs) and opioid substitution therapy (OST). Even where countries have adopted harm reduction in their responses to drug-related harms outside prisons, they often fail to do so in prisons and other places of detention. To date, only ten countries have NSPs operating in at least one prison and less than forty countries have some form of OST in at least one prison. There is therefore an urgent need to introduce comprehensive programmes and to scale them up rapidly.

Prevalence of HIV and HCV in prisons

HIV surveillance has been the most common form of HIV research in prisons, although this has largely been restricted to high-income countries. Data from low- and middle-income countries are more limited, tend to be varied and unsystematic and, in many cases, are not recent enough to provide an accurate picture of the current situation in prisons.² Even in high-income countries, the precise number of prisoners living with HIV is difficult to estimate. Rates of HIV infection reported from studies undertaken in a single prison or region may not accurately reflect HIV prevalence in all prisons or regions within a country.

More thorough and systematic research is needed to provide an accurate picture of the current situation of HIV in prisons. Nevertheless, existing reviews show that HIV infection is a serious problem that requires immediate action. In many prison systems, rates of infection are several times higher than in the community outside prisons and this is primarily attributed to injecting drug use prior to incarceration.³ In other systems, elevated HIV prevalence rates reflect the high HIV prevalence rates in the general population.⁴ Everywhere, the prison population consists of individuals facing greater risk factors for contracting HIV (and HCV and TB) than the general population outside prisons. Such characteristics include injecting drug use, poverty, alcohol abuse and living in medically underserved and minority communities.⁵

Studies have shown HIV prevalence ranging from zero in a young male offenders' institution in Scotland⁶ and among prisoners in Iowa, United States,⁷ to 33.6% in an adult prison in Catalonia, Spain,⁸ to over 50% in a female correctional facility in New York

^a Different jurisdictions use different terms to denote places for detaining people who are awaiting trial, who have been convicted or who are subject to other conditions of security and to describe the various groups of people who are detained. Here, the term 'prisoner' is used for all places of detention and the term 'prisoner' describes all who are held in such places, including males and females detained in criminal justice and prison facilities during the investigation of a crime, while awaiting trial, after conviction and before sentencing, and after sentencing. Although the term does not formally cover persons detained for reasons relating to immigration or refugee status, those detained without charge and those sentenced to compulsory 'treatment' and 'rehabilitation' centres as they exist in some countries, most of the considerations in this paper apply to them as well.

City.⁹ As early as 1988 about half of the prisoners in Madrid¹⁰ and 20% of prisoners in New York City tested HIV positive.¹¹ The highest HIV prevalence reported among a national prison population was in South Africa, where estimates put the figure at 41.4%.² Conversely, some countries report zero prevalence; most of these are in North Africa or the Middle East.²

HCV prevalence rates in prisons are even higher than HIV rates. A 2004 review of all published studies of HCV in prisons estimated that 30% to 40% of all prisoners in the US were infected with HCV.³ While WHO estimates that about 3% of the world's population has been infected with HCV,¹² estimates of the prevalence of HCV in prisons range from 4.8% in an Indian jail¹³ to 92% in two prisons in northern Spain.¹⁴

Within prison populations, certain groups have higher levels of infection. In particular, the prevalence of HIV and HCV infection among women tends to be higher than among men.⁴

Drug use in prisons

Many prisoners have a history of drug use before they enter prison.¹⁵ In 1999, 68% of all new prison admissions in the US tested positive for an illegal drug in urine screening¹⁶ and similar findings have been reported across Europe,¹⁷ North America and Australia.¹⁸ In other parts of the world, the situation is less clear because of the lack of systematic research,^{19 20} but in many countries histories of drug use among prisoners are common. In fact, a large percentage of prison populations around the world have been sentenced for drug-related offences. These may be crimes related to drug production, possession, trafficking or use or crimes committed to acquire resources to purchase drugs. Many prison systems have seen increases in their population (and consequent overcrowding) attributable in large measure to a policy of actively pursuing and imprisoning those dealing with and consuming illegal substances.²¹

For people who inject drugs, imprisonment is a common event; studies from a large number of countries report that between 56% and 90% of people who inject drugs are imprisoned at some stage.^{22 23 24} Multiple prison sentences are more common for prisoners who inject drugs than for other prisoners.²⁵ The percentage of prisoners with a history of injecting drug use varies from prison to prison; studies have found, for example, that it was 11% in England,²⁶ but 64% in Australia.^{27 28}

Some people who use drugs prior to imprisonment discontinue their drug use while in prison. However, many carry on using, often with reduced frequency and amounts,²⁹ but sometimes maintaining the same level of use.^{30 31} Prison is also a place where drug use is initiated, often as a means to release tension and to cope with being in an overcrowded and often violent environment.^{32 33}

Injecting drug use in prison is of particular concern given the potential for transmission of HIV and HCV. Those who inject drugs in prisons often share needles and syringes and other injecting equipment, which is a very efficient way of transmitting both viruses.³⁴ A large number of studies from countries around the world report high levels of injecting drug use, including among female prisoners.^{35 36}

Although more research has been carried out on injecting drug use in prisons in high-income countries, studies from low- and middle-income countries have found similar results. In Iran, for example, about 10% of prisoners are believed to inject drugs while

incarcerated, with 95% reported to share needles.³⁷ Injecting drug use has also been documented in prisons in Eastern Europe and Central Asia,^{38 39 40 41 42} Latin America⁴³ and Sub-Saharan Africa.^{44 45}

HIV and HCV transmission resulting from drug use in prisons

A large number of studies from countries in many regions of the world have reported HIV and/or HCV seroconversion within prisons, or have shown a history of imprisonment to be associated with prevalent and incident HIV and/or HCV infection among people who inject drugs.⁴⁶

HIV infection has been significantly associated with a history of imprisonment in Europe (including among female prisoners) and also in the Russian Federation, Canada, Brazil, Iran and Thailand. Using non-sterile injecting equipment in prison was found to be the most important independent determinant of HIV infection in a number of studies.⁴ The strongest evidence of extensive HIV transmission through injecting drug use in prison has emerged from documented outbreaks in Australia, Lithuania, the Russian Federation and Scotland.^{28 32 47 48 49}

HCV infection by sharing of injecting equipment in prison has been reported in Australia and Germany.^{50 51 52}

Harm reduction in prisons: implementation, evidence and guidance

There are evidence-based interventions that can be put in place to reduce drug-related harms within prison populations and a wealth of international guidance on implementation. In fact, it could be argued that it is even more important that these programmes reach prisoners and detainees, given their increased vulnerability to HIV and HCV infection, than people outside prison. Prison health programmes have the potential to reach vulnerable people with a broad range of services that they may not be likely to access outside prison.

Table 3.5.1: Countries and territories with NSP or OST in at least one prison^b

Country/territory	Needle exchange in prisons	Opioid substitution therapy in prisons
ASIA		
India	x	✓
Indonesia	x	✓
Malaysia	x	✓
EASTERN EUROPE and CENTRAL ASIA		
Albania	x	✓
Armenia	✓	x
Belarus	✓	x
Croatia	x	✓
Czech Republic	x	✓
Georgia	x	✓
Hungary	x	✓
Kyrgyzstan	✓	x
Macedonia FYR	x	✓
Moldova	✓	✓
Montenegro	x	✓
Poland	x	✓
Romania	✓	✓
Serbia	x	✓
Slovenia	x	✓
MIDDLE EAST and NORTH AFRICA		
Iran	✓	✓
NORTH AMERICA		
Canada	x	✓
United States	x	✓
(Puerto Rico)	x	✓
OCEANIA		
Australia	x	✓
New Zealand	x	✓
SUB-SAHARAN AFRICA		
Mauritius	x	✓
WESTERN EUROPE		
Austria	x	✓
Belgium	x	✓
Denmark	x	✓
Finland	x	✓
France	x	✓
Germany	✓	✓
Ireland	x	✓
Italy	x	✓
Luxembourg	✓	✓
Malta	x	✓
Netherlands	x	✓
Norway	x	✓
Portugal	x	✓
Spain	✓	✓
Sweden	x	✓
Switzerland	✓	✓
United Kingdom	x	✓

^b Inclusion in this table does not indicate scope, quality or coverage of intervention. In Georgia, methadone is currently provided for detoxification over a maximum period of three months and not for long-term maintenance; however, expansion to a maintenance programme is being considered.

Needle and syringe programmes (NSPs)

The first prison NSP was established in Switzerland in 1992. Since then NSPs have been introduced in over sixty prisons in ten countries in Europe, Central Asia and Iran (see Table 3.5.1). In some countries, only a few prisons have NSPs, however, in Kyrgyzstan and Spain, NSPs have been rapidly scaled up and operate in a large number of prisons.^c

Germany remains the only country in which prison NSPs have been closed. NSPs had been successfully introduced in seven prisons by the end of 2000 and other prisons were considering implementing them. However, six of the programmes have since closed as a result of political decisions by newly elected conservative state governments, made without consultation with prison staff. Since the programmes closed, prisoners have gone back to hiding and sharing injecting equipment, thus increasing the likelihood of transmission of HIV and HCV.⁵³ Staff have been among the most vocal critics of the decision to close down the programmes and have lobbied the governments to reinstate the programmes.⁴

In most countries with prison NSPs, implementation has not required changes to laws or regulations.^d Across the eleven countries, various models for the distribution of sterile injecting equipment have been used, including anonymous syringe dispensing machines, hand-to-hand distribution by prison health staff and/or non-governmental organisation (NGO) workers and distribution by prisoners trained as peer outreach workers.⁵⁴

Systematic evaluations of the effects of NSPs on HIV-related risk behaviours and of their overall effectiveness in prisons have been undertaken in ten projects. These evaluations and other reports demonstrate that NSPs are feasible in a wide range of prison settings, including men's and women's prisons and prisons of all security levels and sizes. Providing sterile needles and syringes is readily accepted by people who inject in prisons and contributes to a significant reduction of syringe sharing over time. It also appears to be effective in reducing resulting HIV infections.⁴⁷ At the same time, there is no evidence to suggest that prison-based NSPs have serious, unintended negative consequences. In particular, they do not lead to increased drug use or injecting, and syringes are not used as weapons.⁵⁵ Evaluations have found that NSPs in prisons facilitate referral of people who use drugs to drug dependence treatment programmes.^{56 57}

Studies have shown that important factors in the success of prison NSPs include easy and confidential access to the service, providing the right type of syringes and building trust with the prisoners accessing the programme.⁴⁷ For example, in Moldova, a small number of prisoners accessed the NSP when it was located within the health care section of the prison, however, once prisoners could obtain sterile injecting equipment from fellow prisoners, trained to provide harm reduction services, the amount of equipment distributed increased significantly.⁵⁸

Ultimately, since most prisoners leave prison at some point to return to their community, implementing NSPs in prisons will benefit not only prisoners and prison staff, but also society in general. Therefore, experts and UN agencies recommend that NSPs should be introduced in prisons and other places of detention. Following an exhaustive review of the international evidence, WHO, UNODC and UNAIDS recommend that prison authorities in countries experiencing or threatened by an epidemic of HIV infections among injecting drug users should introduce and scale up NSPs urgently.⁵⁹

Bleach programmes

Programmes providing bleach or other disinfectants for sterilising needles and syringes to reduce HIV transmission among people who inject drugs in the community were first introduced in San Francisco in 1986.²⁴ Such programmes have particularly received support in situations where opposition to NSPs in the community or in prisons has been strongest. By 1991 sixteen of fifty-two prison systems surveyed had made bleach or other disinfectants available to prisoners, including in Africa and Central America.⁶⁰ Today, bleach or other disinfectants are available in many prison systems, including in Australia, Canada, Indonesia, Iran and some systems in Eastern Europe and Central Asia.^{4 55}

Evaluations of bleach programmes in prisons have shown that distribution of bleach or other disinfectants is feasible and does not compromise security. However, WHO concludes that the 'evidence supporting the effectiveness of bleach in decontamination of injecting equipment and other forms of disinfection is weak'.⁵⁶ While the efficacy of bleach as a disinfectant for inactivating HIV has been shown in laboratory studies, field studies cast 'considerable doubt on the likelihood that these measures could ever be effective in operational conditions'.⁵⁶ Moreover, studies did not find a significant effect of bleach on HCV seroconversion.^{61 62} For these reasons, bleach programmes are regarded as a second-line strategy to NSPs. WHO, UNODC and UNAIDS recommend that bleach programmes be made available in prisons where 'authorities continue to oppose the introduction of NSPs despite evidence of their effectiveness, and to complement NSPs'.⁶⁰

Opioid substitution therapy and other drug dependence treatments

The first experimental OST programme in prison, offering methadone pre-release to prisoners in New York City, was initiated in 1968.⁶³ The early literature noted that, in addition to Rikers Island in New York,⁶⁴ over the next twenty years such programmes either existed or had existed at some point at a prison in California (Contra Costa County), in Rotterdam in the Netherlands, at Wolds Remand Prison in the United Kingdom⁶⁵ and in Denmark and Sweden.⁶⁶

In Australia, a pilot pre-release methadone programme started in New South Wales in 1986 and was later expanded so that the pre-release programme became just one component of a larger prison methadone maintenance therapy (MMT) programme.⁶⁷ Initially, the programme focused on 'breaking the cycle of criminal activity associated with drug use'.⁶⁷ However, as early as 1987, it became the first prison MMT programme to move towards a HIV prevention strategy and to include the reduction of injecting heroin use and HIV and hepatitis B transmission among its objectives.⁶⁷

Since the early 1990s, and mostly in response to raising HIV rates among people who inject drugs in the community and in prison, there has been a marked increase in the number of prison systems providing OST to prisoners. Today, prison systems in nearly forty countries offer OST to prisoners, including most systems in Canada and Australia, some systems in the US, most of the systems in the 15 'old' European Union (EU) member states,⁶⁸ Iran and Indonesia (see Table 3.5.1).⁴ In Spain, according to 2009 data, 12% of all prisoners received MMT.⁶⁹ In most other prison systems, coverage is much lower.

^c A prison NSP has been introduced in a Portuguese prison but is currently not operating

^d In some former Soviet Union countries, regulations and later legislative changes were undertaken to allow for prison NSPs.

OST programmes are also provided in some of the states that joined the EU more recently (including Hungary, Malta, Slovenia and Poland), although they often remain small and benefit only a small number of prisoners in need.⁶⁹ A few systems in Eastern Europe and Central Asia have also started OST programmes (such as Moldova and Albania) or are planning to do so soon.⁵⁹

Reflecting the situation in the community, most prison systems make OST available in the form of MMT. Buprenorphine maintenance treatment is available in only a small number of systems, including in Australia⁷⁰ and some European countries.^{71 72}

Generally, drug-free treatment approaches continue to dominate interventions in prisons in most countries.⁷³ OST remains controversial in many prison systems, even in countries where it is accepted as an effective intervention for opioid dependence outside prisons. Often prison administrators are not receptive to providing OST, due to philosophical opposition to this type of treatment and concerns about whether the provision of such therapy will lead to diversion of medication, violence and/or security breaches.⁷⁴

A recent comprehensive review showed that OST, in particular with MMT, is feasible in a wide range of prison settings.⁷⁵ As is the case with OST programmes outside prisons, those inside prisons are effective in reducing the frequency of injecting drug use and associated sharing of injecting equipment, if a sufficient dosage is provided (more than 60 mg per day) and treatment is available for longer periods of time (more than six months) or for the duration of incarceration.^{60 76}

A four-year follow-up study to a randomised controlled trial of MMT versus waiting list control in prison examined the longer term impact of MMT on mortality, reincarceration and HCV and HIV seroconversion. Retention in treatment was associated with reduced HCV infection, while short MMT episodes (less than five months) were significantly associated with greater risk of HCV.⁷⁷

In addition, evaluations of prison-based MMT found other benefits for the health of prisoners participating in the programmes and for prison systems and the community. For example, reincarceration is less likely among prisoners who receive adequate OST, and OST has been shown to have a positive effect on institutional behaviour by reducing drug-seeking behaviour and thus improving prison safety.⁷⁸ While prison administrations initially raised concerns about security, violent behaviour and diversion of methadone, these problems have not emerged or have been addressed successfully where OST programmes have been implemented.⁴⁷

WHO, UNODC and UNAIDS recommend that 'prison authorities in countries in which OST is available in the community should introduce OST programmes urgently and expand implementation to scale as soon as possible'⁷⁹

While OST has become increasingly available in many prison systems at least in part because of its potential to reduce injecting drug use and the resulting risk of spread of infection, other forms of drug dependence treatment have not usually been introduced in prison with HIV prevention as one of their objectives. Consequently, there is little data on their effectiveness as an HIV prevention strategy.⁷⁶ Nevertheless, good quality, appropriate and accessible treatment has the potential of improving prison security, as well as the health and social functioning of prisoners,

and may reduce reoffending. Studies have demonstrated the importance of providing ongoing treatment and support and of meeting the individual needs of prisoners, including female prisoners, younger prisoners and prisoners from ethnic minorities.⁷⁶ Given that many prisoners have severe problems related to the use of illegal drugs, it is unethical not to provide people in prison with access to a wide range of drug treatment options.⁷⁷

WHO, UNODC and UNAIDS recommend that, in addition to OST, prison authorities provide a range of drug dependence treatment options for prisoners with problematic drug use, in particular for substances such as amphetamine-type stimulants. Given the lack of data, they recommend that evaluations of their effectiveness in terms of reducing drug injecting and needle sharing should be undertaken.^{76 78}

While drug-free or abstinence-based treatment should be considered as a necessary component element of comprehensive prison drug services, such programmes alone are insufficient to address the multiple health risks posed by injecting drug use and HIV transmission in prisons.

The interventions detailed above are not the only ones that contribute to addressing HIV and HCV in prisons. International guidelines recommend they be implemented in conjunction with the following necessary elements of a comprehensive programme: HIV/AIDS education; voluntary and confidential HIV testing and counselling; condom provision; prevention of rape, sexual violence and coercion; and HIV care, support and treatment, including antiretroviral therapy (ART).⁴

Effect of efforts to reduce drug supply in prisons

A broad range of search and seizure techniques and procedures are used by prison systems in an attempt to reduce the availability of drugs in prisons. These supply reduction measures include random cell searches, staff and visitor entry/exit screening and searches, drug detection dogs and other drug detection technologies, perimeter security measures and urinalysis programmes (often referred to as 'mandatory drug testing programmes' or MDT).⁷⁹

Many prison systems, particularly in high-income countries, place considerable and growing emphasis on these measures to reduce the supply of drugs. In particular, urinalysis has been adopted as policy in several prison systems to reduce the use of and demand for drugs in prison. Urinalysis, combined with self-report surveys of prisoners, is also used to obtain an estimate of the extent of drug use⁸⁰ as well as to target programmes and treatment services.⁸¹

Despite substantial investments in drug supply reduction measures, there is no evidence that they lead to reduced HIV risk. Indeed, mandatory drug testing programmes may increase prisoners' risk of HIV infection. Implementing such programmes appears to contribute to reducing the demand for, and use of, cannabis in prisons, but has little effect on the use of opiates. In fact, there is some evidence that a small number of people switch to injectable drugs to avoid detection of cannabis use through drug testing. Given that smoking cannabis presents no risk of HIV transmission while injecting opiates presents a significant risk

of HIV and other health risks, the evidence that some prisoners switch from cannabis use to use of more harmful drugs by injecting is cause for concern.⁷⁶

WHO, UNODC and UNAIDS recommend that 'improving the documentation and evaluation of supply reduction measures should be a priority for prison systems making substantial investments in such measures'. They further recommend that 'prison systems with MDT programmes should reconsider whether to include urinalysis testing for cannabis. At a minimum, they should make clear distinctions in punitive terms between those testing positive to cannabis and opiates.'⁷⁶

Taking action for prisoners: Conclusions and next steps

The importance of implementing HIV interventions, including NSPs and OST, in prisons was recognised early in the HIV/AIDS epidemic. After its first consultation on prevention and control of HIV in prisons in 1987,⁸² WHO responded to growing evidence of HIV infection in prisons worldwide by issuing guidelines on HIV infection and AIDS in prisons in 1993. With regard to health care and prevention of HIV, the guidelines emphasise that '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'.⁷⁹

Indeed, prisoners retain all rights that are not taken away as a fact of incarceration.^{83 e} Loss of liberty alone is the punishment, not the deprivation of fundamental human rights. Failure to provide access to evidence-based HIV and HCV prevention measures (in particular NSP and OST) to people in prison is a violation of prisoners' rights to the highest attainable standard of physical and mental health under international law, and is inconsistent with numerous international instruments dealing with the health of prisoners and with HIV/AIDS.⁸⁴

This situation was recognised in the 2006 framework for an effective national response to HIV/AIDS in prisons, jointly published by UNODC, WHO and UNAIDS. The document emphasises that governments and the international community have much to do to meet their 'obligations on human rights, prison conditions, and public health' and states that preventing 'the transmission of HIV in prisons is an integral part of reducing the spread of infection in the broader society'.⁸⁵ It stresses that public health can no longer afford to ignore prison health. HIV interventions are feasible and effective in prisons and implementation of these interventions in prisons is an important component of national HIV/AIDS programmes that can no longer be neglected.

Ensuring that prisoners are included in national scale-up efforts

Very little information exists about what is being done to ensure that prison systems are an integral part of national efforts to scale up access to comprehensive HIV prevention, treatment, care and support, and there are no published studies or even guidelines on this to date. Sustainable HIV prison programmes, integrated into countries' general HIV programmes or at least linked to them, are needed.

At the *international level*, initiatives to support scale-up efforts should include a component specific to prisons and pre-trial detention and ensure that:

- Prison systems (and pre-trial detention facilities) are included in technical assistance missions
- Data about access to HIV prevention, treatment, care and support and coverage in prisons are collected and published
- Best practice models are developed and disseminated
- The public health and human rights implications of inadequate efforts in prisons are brought to the attention of policy makers.

At the *country level*:

- Prison departments (and departments responsible for pre-trial detention facilities) should have a place within the national HIV coordinating committees and the country coordinating mechanisms that develop and submit grant proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria
- Prison issues should be part of the agreed HIV/AIDS action framework and monitoring and evaluation system
- Prison departments (and departments responsible for pre-trial detention facilities) should be involved in all aspects of scale-up of prevention and treatment, care and support, from funding applications (to ensure that funds are specifically earmarked for prisons) to development, implementation, monitoring and evaluation of roll-out plans
- The ministries responsible for health, the prison system and pre-trial detention facilities should collaborate closely, recognising that prison health is public health. Alternatively, governments could assign responsibility for health care in prisons and pre-trial detention facilities to the same ministries, departments and agencies that provide health care to people in the community.

Finally, at the *regional and local levels*, prisons and pre-trial detention facilities should:

- Form partnerships with health clinics, hospitals, universities and NGOs, including organisations of people living with HIV, to provide services for prisoners
- Develop integrated, rather than parallel, care and treatment programmes.

e This can be expressed as 'limited exceptionalism'. Significantly, a number of domestic courts have recognised this principle.

Undertaking broader prison reform

Addressing HIV and HCV in prisons effectively cannot be separated from wider questions of human rights and prison reform. Prison conditions, the way in which prisons are managed and national policy all impact on HIV and HCV transmission in prisons.

Overcrowding, violence, inadequate natural lighting and/or ventilation and lack of protection from extreme climatic conditions are common in many prisons in many regions of the world. When these conditions are combined with insufficient means for personal hygiene, poor nutrition, limited access to clean drinking water and inadequate health services, the vulnerability of prisoners to HIV infection and other infectious diseases is increased, as is related morbidity and mortality. Sub-standard conditions can also complicate or undermine the implementation of effective responses to health issues by prison staff. Therefore, action to prevent the spread of infections in prisons and to provide health services to prisoners living with HIV and HCV is integral to – and enhanced by – broader efforts to improve prison conditions. Efforts to stop the transmission of HIV in prisons must start by making HIV prevention measures available, but should also include reforms aimed at addressing these underlying conditions.

Action to reduce the size of prison populations and prison overcrowding should accompany – and be seen as an integral component of – a comprehensive strategy to prevent HIV and HCV transmission in prisons, to improve prison health care and to improve prison conditions. According to UN agencies, this should include legislative and policy reforms aimed at reducing the criminalisation of non-violent drug offences and significantly reducing the use of incarceration for non-violent users of illicit drugs. Developing alternatives to prison and non-custodial diversions for people convicted of offences related to drug use would significantly reduce the number of people who use drugs who are sent to prison, the overall prison population and levels of prison overcrowding.⁸⁶

Action to reduce the excessive use of pre-trial detention – the arrest and incarceration of people who have not yet been convicted of any crime – is also essential. Pre-trial detainees account for over one-third of all the people in prisons around the world. They are frequently held in overcrowded, substandard conditions without medical treatment or any measures for infection control. Incarceration exposes detainees to a range of health risks, including interruption of critically important medications to treat HIV, TB or drug dependence and exposure to new infections. As in prisons, drug use and sex occur in pre-trial detention centres, while tools to promote protection such as condoms, drug dependence treatment and sterile syringes are largely unavailable – even in jurisdictions where these measures are available in prisons. The health risks associated with pre-trial detention affect not only those detained but also societies at large, as people move between pre-trial detention and the community.⁸⁶

International standards clearly state that pre-trial detention should be an 'exceptional' measure that is used sparingly. For health, human rights and prison reform advocates, it is imperative to advocate for programmes that provide safe alternatives to pre-trial detention for persons accused of low-level crimes, for effective disease prevention and treatment for those who must

remain in pre-trial detention and for better conditions while in pre-trial detention.

Finally, 'in the medium and longer-term, transferring control of prison health to public health authorities could also have a positive impact'.⁸⁷ This recommendation recognises that health care in prisons can be delivered more effectively by public health authorities than by prison management, as long as sufficient resources are provided and freedom of action of the new prison health authorities is guaranteed.

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