

Guide to starting and managing needle and syringe programmes in prisons and other closed settings

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I. INTRODUCTION – PURPOSE OF THE GUIDE

In many prisons around the world there is a much higher prevalence of HIV, HBV, HCV, syphilis and tuberculosis than there is in society outside. It has to be recognized that problematic drug users (injecting drugs) are overrepresented in prison settings. This is associated with certain risk factors and forms of risk behaviour in prisons. A fact primarily related to injecting drug use and to unsafe injection practices, both in the community and in prisons, and also to unprotected sexual contacts in prisons (Matic et al., 2008; UNODC, WHO & UNAIDS, 2006).

In the last 30 years, needle and syringe programmes (NSP) have become an indispensable tool and a paramount component of an integral and pragmatic public health response to the risk of HIV and hepatitis transmission among people who inject drugs and, ultimately, to the general public. It is the first intervention of WHO/UNODC/UNAIDS comprehensive package for HIV for people who inject drugs (WHO/UNAIDS/UNODC 2007 - 2012). Extensive studies on the effectiveness of these programs have been carried out, providing scientific evidence that the provision of sterile injection equipment is an appropriate and important preventive health measure (WHO/UNODC/UNAIDS 2007). NSPs in the community has been implemented in 82 countries. Regional and national coverage varied substantially (Mathers et al. 2010).

The availability of harm-reduction measures in prisons lies far behind the availability of these interventions in the general community. Illustrating this gap most vividly is the provision – or lack-there- of needle and syringe programmes. The Commission of the European Communities for instance found that although 24 of the 27 EU Member States have needle and syringe programmes in the community, only 3 of those have implemented them in prisons. This disparity lead the Commission to conclude that, ‘harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equivalence adopted by UN General Assembly, WHO and UNODC, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services.’ (Commission of the European Communities, 2007).

This is also reflected or underlined in many documents of international bodies, e.g. in the Comprehensive Package of “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions (UNODC, ILO, UNDP 2012).

The experiences of health services in many countries, as well as in many prison systems internationally, demonstrate that harm reduction provides the framework for an effective action to prevent the transmission of HIV and HCV in prisons (UNODC, WHO, UNAIDS 2006). It has also been shown that the goal of reducing HIV and hepatitis B/C transmission is best accomplished when prison-based needle exchange is one component of a broader, comprehensive harm reduction and health care package.

A Comprehensive Package developed by UNODC, ILO, UNDP, WHO and UNAIDS (2012) consists of 15 interventions that are essential for effective HIV prevention and treatment in closed settings:

1. Information, education and communication
2. HIV testing and counselling
3. Treatment, care and support
4. Prevention, diagnosis and treatment of tuberculosis
5. Prevention of mother-to-child transmission of HIV
6. Condom programmes
7. Prevention and treatment of sexually transmitted infections
8. Prevention of sexual violence
9. Drug dependence treatment including OST
10. Needle and syringe programmes
11. Vaccination, diagnosis and treatment of viral hepatitis
12. Post-exposure prophylaxis
13. Prevention of transmission through medical or dental services

14. Prevention of transmission through tattooing, piercing and other forms of skin penetration
15. Protecting staff from occupational hazards

However, in a 2008 WHO report monitoring State progress in achieving the Dublin Declaration goals found that, of the 53 signatory countries, condoms were available in prisons in only eighteen, syringe exchange programmes in six and substitution treatment in seventeen (WHO, 2008). A review by the International Harm Reduction Association in 2009 found the situation only marginally improved, with nine countries in Europe and Central Asia having syringe exchange in prisons and twenty-eight substitution treatment (Cook, 2009).

Although there is an urgent need to improve coverage of harm reduction services in prisons, prison-based needle and syringe programs (PNSP) and other harm reduction interventions are still missing in most countries. One reason for that might be the lack of information on how to practically introduce and implement harm reduction measures in prisons and especially PNSPs.

In April 2011, UNODC organised a consultation with professionals involved in needle and syringe programmes in prisons in Beirut/Lebanon. The purpose of the consultation was to identify factors of success and barriers to the implementation and scaling-up of these programmes in prisons. Participants of the meeting recommended (i) to develop guidance documents on the different models of implementation; (ii) to develop advocacy materials; (iii) to develop networking opportunities for professionals implementing prison needle and syringe programmes.

The discrepancy concerning the success of PNSPs in prisons on the one hand and its low acceptance and spread on the other hand is striking. Guidances on how to implement PNSPs in prison are therefore given in this guide to assist a more objective discussion. The purpose of this guide is to provide countries, organisations and professionals with a tool to support their efforts to advocate for, implement, scale-up and monitor needle and syringe programmes (PNSPs) in prisons.

This guidance document is built on UNODC, WHO and UNAIDS guidelines on HIV in prisons and closed settings, especially the WHO/UNODC/UNAIDS “Evidence for Action Technical Paper on Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies”, and on recent reports on experiences and reviews of literature on the subject. It will also build on international needle and syringe programme guidance documents for the community.

The document will cover advocacy, step-by-step implementation of different models of needle and syringe programmes in prisons, and monitoring and evaluation. Examples will be provided from existing documented programmes.

The target audience of this guide are prison governors and prison staff of all levels in all kind of custodial institutions, prison administration, ministries in charge of health in custodial settings, police representatives, NGOs.

II. THE BACKGROUND

A. Prevalence of HIV, other infectious diseases, drug use, and risk behaviour in prisons

High prevalence rates of HIV and HCV infections and risk behaviours for the transmission of HIV and HCV, including the sharing of syringes and unprotected sexual contacts are well documented in prisons. (Jürgens, Ball & Verster 2009; Stöver et al., 2008; WHO 2008; Shewan et al. 2005;).

Globally, HIV and HCV prevalence rates are higher in prisons compared to the community. Outbreaks of both HIV and hepatitis C among prisoners have been documented in a number of prisons in a number of countries (Jürgens 2003, p. 4), and other studies have concluded that a significant percentage of cases of HIV infection among people who inject drugs were acquired in prison (Allwright et al., 2000; Hagan, 2003).

Outside sub-Saharan Africa, the transmission of HIV in prisons is mostly driven by intravenous drug use with unsterile needles, syringes and drug using equipment.

The prevalence rates of psychotropic substance use and dependence were found to be up to ten times higher among prisoners than in the general population, ranging from 10% to 48% in male inmates and 30% to 60% in female prisoners (Fazel et al., 2006). In some countries problem opioid drug use in prison settings is even up to 100 times higher than in the community. Many people who inject before imprisonment reduce or stop injecting when they enter prison, but many resume injecting upon release, some continue and some even start in prisons.

Though some studies indicated less frequent IDU in prison than in the community, risk behaviour might even be higher (Dolan et al., 1996; Keene, 1997; Shewan et al., 1995), prisoners are sharing injecting equipment with a population of fellow prisoners that often has a high rate of HIV and HCV infections. Experts estimated that up to 75% of the prisoners with a history of IDU continue drug use in prison (Hellard et al., 2004; Lines et al., 2005; Lines et al., 2006; Stark et al., 2006; Stöver, 2002), and up to 25% of people who inject drugs (PWID) started injecting while in prison (Gore et al., 1995).

This situation was the motivating factor for some jurisdictions to consider and finally implement PNSPs. Catalonia for instance was experiencing an extremely high prevalence of HIV in prisons in the 1980s (40.7% of all prisoners, 67.8% of PWID); most people living with HIV/AIDS were people who inject drugs (87.7%). Half of the PWID with HIV have been in prison in the beginning of the nineties (Roca).

Most prisoners return to the community. National strategies to address HIV and HCV are also affected by the fact that intravenous drug use is continuing in prisons and by the level of access to HIV prevention, treatment, care and support services.

Prisons are a coercive environment. They are settings where prisoners encounter new, unanticipated risks that they may not have faced in the community (drug use with no access to clean needles and syringes, clandestine sexual contacts, rape or other non-consensual sex practices, tattooing with contaminated needles). To be effective, programmes addressing BBV prevention must take into account these conditions. Community-based strategies cannot simply be transferred into the prison setting without acknowledging the particularities of the risk environments and the limitations on behavioural change. If prevention messages are to be understandable and relevant, specific living conditions and risk factors must be identified and prevention strategies tailored to them. For instance, people who inject drugs (PWID) in prisons are far from being an homogeneous population, but one that comprises various subgroups that can benefit from targeted interventions (see Shewan/Stöver/Dolan 2005):

- those who inject outside but not in prisons;
- those with no previous history of injecting (approximately 5–10% of all PWID start injecting while in prison);
- those who smoked drugs like heroin in the community but inject in prison, mostly for reasons of economy and efficiency;
- those who have a history of injecting in prison but no longer do so, (similar to the first group);
- occasional injectors, for whom the behaviour may be opportunistic, recreational or impulsive;
- independent injectors, who are disciplined about risk reduction and have their own injecting equipment that they will not share or lend;
- closed-circle injectors, who share equipment only within their own group, whether to reduce risk or to avoid detection by prison officers;
- renters, who rent injecting equipment from others for money, drugs or favours; and
- hirers, who own injecting equipment and rent it out for a fee or service.

There are obvious risk differences among these groups, especially for infection through contaminated equipment; for example, the renters are clearly at higher risk than the independent injectors. Moreover, all these groups will be composed of both HIV-positive and HIV-negative people, whose needs will often be different. Harm reduction and prevention programmes in prisons need to be adjusted their accordingly (see Stöver & Lines 2006, p. 75).

271 B. Scientific evidence: PNSP as an effective harm-reduction intervention

272 Prison needle exchange programs have been successfully implemented in both men's and women's
 273 prisons, in institutions of varying sizes, in both civilian and military systems, in institutions that house
 274 prisoners in individual cells and those that house prisoners in barracks, in institutions with different
 275 security ratings, and in different forms of custody (remand and sentenced, open and closed). Needle
 276 exchanges were typically implemented initially on a pilot basis, and later expanded based on the
 277 information learned during the pilot phase. Several different methods of syringe distribution are
 278 employed, based on the specific needs and the environment of the given institution. These methods
 279 include automatic dispensing machines; hand-to-hand distribution by prison physicians/health-care
 280 staff or by external community health workers; and programs using prisoners trained as peer outreach
 281 workers (WHO/UNODC/UNAIDS 2007; Lines et al. 2006).

282
 283 In a meta-analysis of 11 prisons, which have been scientifically evaluated to assess feasibility and
 284 efficacy, results did not support fears that commonly arise in the start-up of implementation of PNSPs
 285 (Stöver & Nelles 2003). Syringe distribution was not followed by an increase in drug use or injection
 286 drug use. Syringes were not misused, and disposal of used syringes was uncomplicated. Sharing of
 287 syringes among drug users reduced. Based on these experiences, the authors concluded that in these
 288 settings harm reduction measures, including syringe exchange, were not only feasible but efficient.
 289 One important lesson to be learned out of this meta-analysis is that PNSPs are part of a broader health
 290 goal and should therefore be embedded in a global comprehensive prison-based drug and health
 291 promotion strategy. This process was part of the success of PNSP's.

292
 293 The evidence from the countries where prison needle exchange programmes exist clearly demonstrates
 294 that PNSPs:

- 295
- 296 • are feasible and affordable in a wide range of prison settings
- 297 • have been effective in decreasing syringe sharing among people injecting drugs in prison,
- 298 thereby reducing the risk of disease transmission (HIV, HCV) among both prisoners and
- 299 prison staff.
- 300 • have not been associated with increased attacks on prison staff or other prisoners,
- 301 • have not led to an increased initiation of drug consumption or injection.
- 302 • Have contributed to workplace safety too; when prisoners are not forced to conceal injection
- 303 equipment and a prisoner is permitted to have a sterile syringe for personal use, guards
- 304 conducting searches of prisoners or cells are less likely to be pricked with a contaminated
- 305 needle.
- 306 • can lead to reduced overdose risks and a decrease in abscesses, and facilitate referral to and
- 307 utilization of drug dependence treatment programmes (where available).
- 308 • can employ any of several different methods of needle distribution successfully in
- 309 response to staff and inmate needs; and
- 310 • can successfully coexist with other drug prevention and treatment programmes (Lines et
- 311 al. 2006).
- 312
- 313

314 For PNSPs to be successful in prisons, prisoners need to have easy, confidential access to syringes,
 315 and both prisoners and staff should be involved in the design and implementation of the PNSP.
 316 Successful PNSPs also feature a rigorous mechanism for safe disposal of syringes and good
 317 monitoring, evaluation and quality control.

318
 319 The history of PNSPs demonstrates that needle and syringe programme s can be successfully
 320 implemented in jurisdictions that are relatively well resourced and financed (Switzerland, Germany,
 321 Spain), as well as in countries in economic transition that operate with significantly less funding and
 322 infrastructural supports (Moldova, Kyrgyzstan, Tajikistan). Successful programmes took into account
 323 not only institutional size, security level, or structure of the particular prison in which a program was

started, but also the needs of the prisoner population. Once transmission risks have been recognized as a severe threat to the health of prisoners, staff, families, and partners by the representatives of the penitentiary system, prison authorities have shown flexibility and creativity by designing and implementing a PNSP adapted to the needs of the particular population and institutional set-up in an institution.

C. Bleach instead of PNSP?

In some jurisdictions chlorine or bleach had been introduced in order to give people who inject drugs a tool to disinfect their injecting equipment. Experiences in Catalunya/Spain for example, have shown that bleach is not reliable for HIV prevention in the prison setting (Roca). As drug use is a clandestine behaviour and syringes are contraband it is unlikely that the needed time to clean the equipment effectively is being taken by the prisoner, especially when more than one prisoner is going to inject (sharing of drugs is very likely). 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.

Bleach is not fully effective in reducing HCV transmission. So this could lead to a feeling of false security in passing on used and not properly cleaned needles and syringes to other prisoners. Mostly there is no instruction of how to use bleach properly attached. Many injection drug users are not educated and informed of how to properly disinfect needles and syringes using bleach. The provision of bleach alone is clearly an inadequate response. Bleach programmes should therefore only be regarded as a second-line strategy to PNSPs (WHO UNODC UNAIDS 2007, p. 8).

While needle exchange programs have also improved staff safety by reducing or eliminating the risk to prison staff of accidental needle-stick injuries from concealed syringes during cell and personal searches, the provision of bleach does not offer this benefit to prison staff. Needles are still considered as contraband within the institutions and are therefore hidden rather than stored safely in visible areas.

Finally it is unethical to propose bleach, when more efficient means of prevention are available and basically applicable. In medicine, the safest possible treatment approach has to be used. To propose a less efficient way is both risky and unethical.

D. Opioid Substitution Therapy instead or complementary to PNSP?

Opioid Substitution Treatment is a crucial element of a comprehensive harm-reduction strategy, both in the community and in prisons, as it provides an important option for injection-drug-using prisoners who wish to stop injecting opioids. Evaluations of OST programs in prisons have indicated positive results:

- lower rates of heroin use,
- lower rate of injection drug use, and
- lower syringe sharing among those enrolled in OST compared with prisoners in a control group.
- Lower rate of overdose, especially post release
- Increased adherence to ART
- Lower re-incarceration (Hedrich et al. 2012; WHO/UNAIDS/UNODC 2009; WHO/UNODC/UNAIDS 2007c, p. 13f)

Despite its value, there are several reasons why providing OST in the absence of PNSP is an insufficient response to the risk of HIV and HCV transmission in prisons via injection drug use. OST is the most effective drug dependence treatment for heroin dependence. But there are several potential circumstances in which prisoners will not access OST:

- prisoners who inject heroin may choose not to access OST (for what reason ever).

- prisoners may continue to inject illicit drugs, including drugs other than heroin, even during OST treatment.
- often there are limits on the number of prisoners enrolled in OST at any one time, based on the capacity to administer the program within each institution.
- it takes time to process an application for OST and to initiate OST once a prisoner is accepted into the program.
- under accepted guidelines, OST is only for drug users who are physically dependent upon opiates according to standard criteria (DSM IV, or ICD-10) and not occasional users
- Some people do not inject heroin (a few times per day) but do inject cocaine/amphetamines (many more times during a day).

Thus OST is an essential element of a harm-reduction strategy; alone it is not a sufficient response to the risk of disease transmission via injecting drug use in prisons.

E. Legal framework

Like all persons, prisoners are entitled to enjoy the highest attainable standard of health, as guaranteed under international law. Key international instruments reveal a general consensus that the standard of health care provided to prisoners must be equivalent to that available in the general community. Principle 9 of the Basic Principles for the Treatment of Prisoners of the UN General Assembly (1990) states: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation." In the Standard Minimum Rules for the Treatment of Prisoners, issued in 1955 (p. 3) it is said that "the medical services should be organized in close relationship to the general health administration in the community or nation." In the context of HIV/AIDS, and other BBV infections equivalence of health services would include providing prisoners the means to protect themselves from exposure to HIV and HCV. Already in 1993 the World Health Organization (WHO) responded to the growing evidence of HIV/AIDS in prisons and issued "Guidelines on HIV Infection and AIDS in Prisons". With regard to health care and prevention of HIV, the guidelines emphasize 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" (WHO 1993). In paragraph 23 it is said: "In countries where clean syringes and needles are made available to people who inject drugs in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this."

The United Nations Commission on Human Rights consequently stated in 1996 that "by 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."

According to the Declaration of Commitment on HIV/AIDS made in June 2001 by the United Nations General Assembly Special Session on HIV/AIDS (the UNGASS Declaration), "The vulnerable must be given priority in the response [to HIV/AIDS]" (2). This statement has particular relevance in addressing the issue of HIV/AIDS and other BBVs in prisons.

III. WHAT DO WE KNOW ABOUT PNSPs?

In the following PNSPs are described, the scientific evidence and practical experiences with operating PNSPs are presented.

A. History of PNSP

Starting from the first needle and syringe programme in prison in Switzerland in 1992 the introduction of this effective measure in prisons is very slow.

Only nine countries worldwide have implemented PNSPs in prison settings yet, and even in most of these countries the coverage is quite poor and patchy:

- Switzerland: First program 1992
 - Today – PNSP in 11 out of 113 prisons
- Germany: Pilots in 1996
 - Today – PNSP in 1 prison out of 185
- Spain: Pilot in 1997
 - Today – PNSP approved for all 82 prisons, and programs operating in over 30 prisons out of 82
- Moldova: Pilot in 1999
 - Today – PNSP in 9 prisons out of 17
- Kyrgyzstan: Pilot in 2002
 - Today – PNSP in 9 colonies and 1 detention centre (out of 16 colonies and detention centres)
- Romania: Pilot projects since 2008
 - Today – PNSP in 2 prisons out of 44
- Luxembourg, since 2005
 - Today – PNSP in 1 prison out of 1
- Islamic Republic of Iran: Pilot in 2006-2011
 - Today – PNSP has been stopped in 2011
- Tajikistan, pilot in 1 prisons started in 2010
 - Today – PNSP in 1 prison out of 13.

In at least 65 prisons worldwide PNSPs have been implemented. However, often these PNSPs have either been set up on a pilot basis or on a small scale. In some countries pilot projects or projects that have been implemented for a considerable time (e.g. 6 prisons in Germany and 3 in Iran) have been stopped.

B. Global overview

In the following a brief overview of the PNSP models is given in chronological order of its implementation (for further information, please see Lines et al. 2006).

1. Switzerland

Switzerland was the first country to start syringe exchange in prisons in 1992, initially by a doctor in the men's prison in Oberschöngrün (hand-to-hand-provision), followed in 1994 in the women's prison of Hindelbank (via dispensing machines). The decision was taken due to the high prevalence of drug use, injecting and high-risk behaviours for HIV and hepatitis transmission in prisons (Nelles, Fuhrer, et al., 1999). The dispensing machines, in which a used syringe has to be inserted in order to get a new one, was a new approach and has since then being copied in several countries (e.g. Germany). Currently PNSP is provided in eleven prisons out of 113.

Currently, there are two main operational protocols used in the Swiss PNSPs:

a) distribution through medical services; syringes or FLASH boxes are handed out by the nurse or the medical doctor to prisoners upon request; and used syringes, placed in specific container, are exchanged for a new one either at the cell door or in the medical unit (Nelles et al., 1997).

2 sterile syringes 1 ml with filter, 2 sterile needles (available in two different sizes,) 2 alcohol swaps 2 dry swaps, 2 vials of 1,5 ml of NaCl 0,9% and 2 bags of ascorbic acid 0,5g



a) b)
Injection kit box: a) Contents and b) plastic container (Rieder et al. 2009)

b) through dispensing machines:

Other prisons use dispensing machines, placed in discrete areas of the prison to facilitate anonymity. For example, in Hindelbank prison near Berne, six syringe distribution machines were placed in various locations accessible to all inmates (Nelles, Fuhrer, Hirsbrunner, & Harding, 1998). In projects where dispensing machines were used, all prisoners were offered dummy syringes at the start of the programme and new prisoners are offered dummy syringes on prison entry.

Overall, Switzerland has taken significant strides towards providing its prisoners with effective and efficient PNSP programs. PNSPs are available in several prisons of various types and sizes: remand and closed, women and men's prison.

In 1997 the Swiss Federal Ministry for Justice issued an official statement which confirmed the 'legality and necessity' of distributing syringes within Swiss prisons. The Canton of Berne was the first Swiss State to require all prisons to distribute syringes in 1998. However, passive resistance has hindered operation in most of these prisons.

In 2000, the Geneva State Council Decree was implemented, which required the organization of correctional health care of Geneva, to follow the Council of Europe's recommendations in regards to prison health care. The decree also included an entire chapter on detainees' entitlement to preventative health care measures; these are intended to provide access to materials needed to prevent transmission of infectious diseases (e.g. condoms, injection devices, needle and syringe exchange). For the Canton of Geneva, this decree provides the legal basis to uphold standards of prison health and consequently, helps to ensure that detainees receive the health care services to which they are entitled.

Evaluations revealed that after the introduction of the needle exchange program, the incidence of needle sharing virtually disappeared (Stöver & Nelles 2003). As did the incidence of new infections.

2. Germany

Out of 7 prisons that originally started a PNSP, it is currently available in only one out of 185 prisons in Germany.

In 1996 the first PNSPs started in a women's prison (Vechta) and in a men's prison (Lingen). Both prisons had a high number of drug users. The spread of infectious diseases in prisons and the use of self-made injection devices had been observed for several years, prompting discussions on syringe exchange programmes within the prison setting. The Ministry of Justice of the State of Lower-Saxony established an expert committee and followed its recommendations to implement a pilot prison syringe project. Prison staff, directors, prison officers, health staff, social workers, and inmates were included in the planning process. The goals of the two pilots were to assess the feasibility, acceptance, efficacy and changes in attitudes and behaviour. Each prison chose different set-ups for their programme.

Following the Swiss model, the women's prison installed five dispensing machines in accessible and discrete areas of the prison. The men's prison distributed syringes through drug counselling staff at a 'contact café'. Prisoners could enter the PNSP by asking the prison doctor or the counselling staff. In 1997 the third syringe exchange programme started in an open prison in Hamburg. Initially syringes were distributed by dispensing machines. But rapidly the slot machines were replaced by external drug counsellors who handed out the first syringe. Later, this modality was expanded to two other prisons in Hamburg, one with a larger number of prisoners (550) and to a smaller women's prison (Stöver, 2001). In 1998 two projects were initiated in Berlin, one in a men's prisons and one in a women's prison. These PNSPs were running successfully for many years. However, for political reasons the PNSP in the men's prison was been stopped in 2001, whereas the one in the women's prison is still operating in 2013.

All but one PNSP in German prisons were discontinued due to political changes in the governments of the Länder and not because of incidences or threatening scenarios between prisoners or towards staff. The officially stated reasons for the discontinuation of 6 out of 7 PNSPs were an alleged lack of acceptance of the program by the staff and the orientation towards a drug-free prison, which doesn't need PNSP. The decisions to terminate effective needle exchange programs in all of the above described programs were taken without consulting prison staff, and without an opportunity to prepare prisoners for the interruption of access to the programs and despite encouraging and positive scientific evaluations (Lines et al. 2006)



Needle exchange slot machine in women's prison in Lichtenberg Berlin/Germany (photograph by Rick Lines)

3. Spain

The beginning

In June 2001, an order of the General Director of the Correctional System of Spain decreed that in all of the 68 Spanish prisons, drug users were to be given free access to sterile needles and syringes. Currently 34 (out of 79, date: 2008) prisons followed this order. All prisons have the technical and legal conditions to establish PNSPs (Sanz, 2003). An agreement by the management to implement such programmes is obligatory for all prisons (Ministerio del Interior/Ministerio de Sanidad y Consumo (2002).

The first pilot programme started in the prison of Basauri/Bilbao in 1997 (Carrón, 2000), based upon a proposition of the Basque parliament. The second PNSP was introduced in Pamplona prison in 1998 (Villanueva, 2002), based upon an order of the judges of the provincial audience. After the positive evaluation of these two pilot programmes, comparable programmes were implemented in 25 other

prisons. Prisoners receive an exchange kit (transparent box with syringe and needle, disinfectant swap and distilled water). New syringes are handed out in exchange for used ones. The number of syringes exchanged in the prison increased substantially.



Harm Reduction Kit in Soto de Real Prison, Madrid/Spain (photographs by Rick Lines)

Development of PNSPs in Spain (Torre et al. 2009)

The graphic gives an overview of the 12 years from 1997 to 2008. The decrease in the exchange rate from 2006 is following the decrease in the preferred mode of use of drugs (Torre et al. 2009).

“It is easier to find drugs in prison than syringes” (Xavier M. Roca)

A pilot needle exchange program has also been established in one of the 9 prisons (Tarragona 2003, second prison: Lleida 2004) under the autonomous jurisdiction of the government of Catalunya in 2003. Now in all but one prisons (La Modelo-Barcelona) needle exchange programmes have been implemented. An ongoing annual evaluation and assessment of the programs within the jurisdiction of the Spanish Ministry of the Interior is conducted on a national basis.

The provision of needles is done by prison health staff (Roca)

- 1x1 exchange.
- The inmates carry the syringe with them or keep it with his/her as personal staff.
- It has to be inside the sealed plastic bag (before use) or with the needle retracted (once used).
- If an inmate is going to be searched by a prison officer, they have to inform the officer that they have a syringe with them

- Prisoners in a methadone programme can also participate.

Results from an evaluation (N=100, 13 ever in PNSP) of the first prison with PNSP reveal after 12 months:

- Last 30 days: 12 had used heroin (43 % injected) and 10 cocaine (20% injected)
- The information about the PNSP has not been good enough (66%)
- Prisoners think that searches have increased (38%) (more than 30%)
- There is more control of prison officers (65%)
- There has been a decrease of prison benefits (32%)

The *lessons learned* in Catalunya with PNSPs show:

- Syringes have never been used as a weapon, No increase on drug consumption
- Increased contact with current drug users whereby there is the possibility to provide care and health education and referral to drug dependence treatment
- There are still PWID not willing to participate (fear of loss of their privileges, increased control): couriers, rented – still the coverage is low
- Boycott by prisons officers: Searches, transfer to other prisons
- Because of the strong opposition: The PNSP has become too strict (high control, low flexibility, admission is slow process)
- Decrease sharing of home made syringes but they still exist.
- Lack of commitment of prison directors and other prison staff

The evaluation comes to the conclusion that the programme is feasible but it has to be improved. Therefore it is recommended the following points:

- Leadership by prison administration (top-down) and at the same time support from prison staff (bottom-up) is needed
- Involvement of all stakeholders: prison officers, inmates, health staff, and safety on the workplace
- Confidentiality
- Accessibility (coverage)
- The independence of the health staff from prison director and prison treatment
- Education is better than punishment: To reduce prisoners expelled from the PNSP or the PNSP becoming too rigid
- Give freedom to every prison to chose the system: By health staff, by external NGO, by peers, using slot machines,
- Couriers are not a desirable system but better than nothing so all inmates should be accepted in PNSP
- Retractable syringes can be used at the beginning to overcome fears.

Again in this evaluation process important lessons can be learned for future designing and quality assurance of PNSPs.



4. Moldova

The beginning

In December 1999, the Ministry of Justice allowed PNSPs to be implemented because of the high prevalence of HIV infections in Moldova prisons. The first pilot project was implemented in the men's prison of Branesti. The project was sponsored by the Open Society Institute International Harm Reduction Development and supported by a local NGO "Innovative Projects in Prisons" in close co-operation with the medical department of the prison.

Although legal permission was given, practical implementation turned out to be complicated. It was initially decided to hand out needles and syringes through the medical department. As a consequence, the needles were not available after 5 PM when health staff has left the prison. In addition many inmates did not trust the programme. Thus, only few prisoners initially used the programme. It was then decided to develop a peers-to-peers needle and syringe programme. Prisoners, who are accepted by other prisoners, hand out information leaflets, syringes and condoms. The project participation in the programme increased (Laticevski & Leorda, 2001). Subsequently, the project was expanded in 2002 to another prison started to in 2002 (personal communication: Laticevscu, 2003), and a to a third one in 2003 (Soltan, 2003).

The *lesson learned* was that harm reduction is a practice that works well in prisons and that can protect staff as well as inmates from HIV infection (Lines et al. 213). One significant barrier to acceptance and success of the program was that initially prison guards continued to consider syringes as contraband, and to search for and confiscate them from prisoners. It was a long process to explain to the staff that drug possession and distribution remain illegal in the prison, but that the syringes project would be 'legal' and that syringes distributed through the project should not be confiscated." The change in the mode of provision towards integrating prisoners as volunteers for needle exchange provision has had significant positive results in others areas, including decreasing stigmatization and increasing the self-esteem of prisoners living with HIV/AIDS, increasing awareness of HIV transmission among the prison population, and enhancing the credibility of the health services by creating a more humane image.

While using prisoners increases trust in and anonymity of the program, there is the potential for the quality of the information disseminated to be lower than that provided directly by experienced health-care staff. Therefore there must be a commitment to ongoing training and support for the peer volunteers.

The Moldovan projects do not adhere to a strict one-for-one exchange policy. Unlike the programs in Western Europe, there is also no safety boxes to store the used syringes, nor are there regulations about where they may be stored. Initially, the decision against providing plastic cases was made on economic grounds. Later, it became clear that the programs were working well and safely without such storage cases and it was therefore decided they were unnecessary. The Moldovan projects have experienced no instances of syringes being used as weapons, and no problems with dirty needles.

“It took two years to break the ice of mistrust. We had to learn a lot, say strange things, and act oddly in front of a [sceptical] majority. But harm reduction became normal. And with the head of the prison administration in favour of harm reduction, as well as the minister of justice now, we can look forward confidently“
(Dr Bodrug, physician in the prison where PNSP was piloted, quoted in Lines et al. 2006)

Current situation

In 2011, needles and syringe programmes are available in 9 prisons (out of 17) hosting more than 60% of the prison population in Moldova. In 2010 it was estimated that the programme had 1020 beneficiaries, including 112 prisoners living with HIV. In the Rusca prison for example the peer volunteers provide harm reduction services in four different sites within the prison living units (barracks-style accommodations, with 70 or more men living and sleeping in the same large room at that time). Two peer volunteers are assigned to each site, where they distribute all relevant supplies from a designated cabinet or closet near their living space. The service is accessible 24 hours a day, seven days a week because clients and direct service providers live near each other. Interviews with the peer volunteers showed that most prisoners access the project during the day and evening. Volunteers do not register names or last names; they collect no information other than writing down the number of syringes and condoms distributed. This basic data is then given to the medical unit staff supervisor. The activities are carried out in cooperation with the prison physician. The role of the physician is to act as project supervisor and as a link between the peer volunteers, prison staff, and the NGO staff. The PNSP programme was evaluated in 2008¹.



¹ OSI



Models of needle and syringe provision through peer workers (Moldova) Photographs by Elena Vovc

5. Kyrgyzstan

The beginning

Kyrgyzstan initiated a pilot prison needle exchange project in October 2002. In early 2003 approval was given to expand needle exchange into all Kyrgyz prisons. Needle exchanges are now operating in all prisons.

In October 2002 a pilot needle exchange project was introduced in Prison IK-47, a maximum-security institution. It was decided that exchanges should take place in a location where prisoners cannot be seen by guards: the medical wards. Syringe exchange is provided in the narcological unit of the central prison hospital, and all prisoners have an opportunity to avail themselves of the program. A prisoner asks to come to the medical unit to receive medical service and while there, he exchanges his syringe. The pilot also provides secondary exchange using prisoners as peer volunteers, as in the Moldovan model. The project coordinators found that both options for syringe exchange were needed.

At the start of the pilot, everyone was given one syringe. Exchange was made on a one-for-one basis. Only the prisoners involved in the pilot were allowed to access the exchange. Records were maintained on exchanges, and education is provided for staff. In early 2003 an order was issued approving the provision of sterile needles in all Kyrgyz prisons.

In all but one of the 9 institutions, needle exchange is done by trained nurses, partly assisted by prisoners trained as peer outreach workers (exception prison No. 3, see below). The NGO "Inter-Demilge" is in charge of syringe exchange and training of peers in the penal system. This model was adopted following concerns that emerged when the medical unit was the sole point of exchange. Because needles could only be accessed from the medical unit during the day, and most drug trafficking took place in the evening, some non-drug using prisoners were accessing sterile needles during the day that they would later sell at night to prisoners who injected drugs. This problem was rectified by the implementation of the peer outreach worker model. Since the outreach workers live in the prison units, they are available to distribute sterile needles 24 hours a day, and the profit market for needles was effectively eliminated.

In April 2004, with programs established in all Kyrgyz prisons, the number of participants in the programme was approximately 1,000. Drug users are provided with one syringe and three extra needle tips. This allows prisoners who inject drugs to inject more – up to three times a day without having to reuse a needle. This also reduces the cost of the syringe exchange program, since tips cost less than complete syringes with needles.

The prison No.3 is the prison administration's core institution for the needle and syringe exchange programme. The programme has been in operation since 2002. The exchange is handled by the chief of the medical unit, who is assisted by a nurse. Syringes are exchanged here at a 1:1 ratio by the

nurses. No exchange through volunteers among prisoners is allowed in this institution. In 2005 the programme had 124 steady clients with 9,200 syringes exchanged in that year. Clients' preferences are limited to 5ml syringes and this is the type of syringes being provided. Along with syringes clients receive needles, condoms, bleach and tissue. On average between 45-75 prisoners visit the exchange programme every day.

New clients are registered using a special form and assigned a code that consists of the first letter of his or her first name, mother's last name and mother's first name. Each new client also receives information about drug-related harms. Most inmates feel free to participate in the exchange programme. It has been in operation since 2002 and no repressions against its clients have been initiated. Used syringes are placed into a paper box to be destroyed by security officers on a daily basis.

In another prison (Penitentiary Institution No.1) it has been reported that MSM do not even enter medical facilities, according to the informal rules established by criminal gangs in prisons. As a result, medical staff either arrange exchange services for drug injecting MSMs outside the infirmary or exchange syringes through the informal leader of MSM group. Before getting services, clients are asked to show track marks and are informed about drug-related harm.

In the Penitentiary Institution No.2 syringe/needle exchange is also managed by trained nurses and the chief of the medical unit, but a volunteer among prisoners is supporting them during the weekends and nights. The volunteer receives 10-15 syringes to be exchanged during and there is strict control over returning the used syringes. Both 2 and 5 ml syringes are given out through the services and these types of syringes meet the preferences among clients.

On a monthly basis, the service generates reports that reflect the number of clients, the number of syringes given out and the number of syringes returned. At least once a month used syringes are destroyed in the presence of prison officials.

Those released from some prisons in Kyrgyzstan receive links to ongoing HIV prevention: an individual packet consisting of a disposable syringe, disinfectant, multi-vitamin, and a leaflet with the addresses of HIV prevention organizations (Hoover & Jürgens 2009)

Lessons learned

Needle/Syringe Exchange Programmes in penitentiary institutions in Kyrgyzstan have proven to be an effective method of HIV prevention as there are no reported new cases of HIV infection among their clients. In some prisons there is an inadequate supply of HIV prevention materials including needles and syringes, bleach, alcohol swaps, as well as condoms. There have been no instances of syringes being used as weapons, and prison medical staff have identified a reduction in injection-related health problems such as abscesses (Zelichenko).

Results of a rapid assessment revealed that security officers express their understanding and support for the exchange and encourage inmates to use the services. Prisoners avoiding direct contact with the exchange are gang leaders who tend to send their subordinates to exchange syringes.

Current situation

Syringe exchange programs are currently operating in 9 colonies and 1 detention centre. ²

6. Romania

In Romania 2 out of 44 prisons are currently providing PNSP, both of them located in the capital of Bucharest. Both are prisons for adult male prisoners (Jilava: half open with 1,700 prisoners and Rahova prison a remand prison with 1,300 prisoners).

The programmes have been implemented by the National Administration of Penitentiaries with support of UNODC and local teams from the prison staff. Preliminary evaluations of these two pilot programmes indicate:

² Source?

- these interventions are useful and can be adapted to specific detention conditions in the Romanian prison system;
- PNSPs can change behaviour and lead to a reduction in harms related to drug use;
- PNSPs facilitates the access of inmates to drug dependence treatment programmes;
- there was no increase of drug use inside prison;
- there was no incidents related to syringes;
- The programme has to be flexible and adapted to specific conditions inside prisons (Hoover/Jürgens 2009).

The Syringe Exchange Programme started in Jilava Penitentiary in June 2008. Generally prisoners can participate in PNSP without any discrimination. By making a request for joining this program they will receive 3 syringes/day. The prisoners have to declare the need for injecting equipment and i.v. drug use (IDU) at the medical unit, where participants will be registered and receive a personal code to register the amount of delivered and collected (used) equipment. They will also be informed about the rules of PNSP and related penalties when rules are not followed.

In case of breaching the rule, the project team decides if a prisoner has to be excluded from PNSP and will communicate this decision to the prisoner. The project team can accept the excluded client to rejoin PNSP, if he/she asks for readmission. There will be no disciplinary sanctions resulting from the exclusion.

A detailed procedure manual³ has been developed by the National Administration of Penitentiary in Romania for the successful implementation of preventive programmes addressed to fight HIV, hepatitis B and C infections for IDU among the prison population. This manual states amongst others:

- The syringe exchange is done at the door of the detention room (see photo below) and is performed by a person from the medical staff (at the beginning of this program, a peer educator, prisoner, was involved).
- Used syringes are returned in special plastic container or in empty juice plastic bottle.
- The project team receives and uses protective gloves, sterile syringes and alcohol pads, plastic boxes for contaminated medical waste, disinfectants and also condoms for inmates.
- If peer educators are involved in PNSP, medical staff will train them about universal cautions and how avoid incidences related to syringe exchange.
- If a search procedure is started in a detention room, syringes must be placed in a visible place.
- Syringes that do not belong to the PNSP are forbidden objects.

PNSPs are part of broader harm reduction services for drug using prisoners in Romanian prisons, which consist of:

- Information activities with inmates related to risks associated to drug use;
- Trainings for peer educators (prisoners);
- Voluntary counselling and testing for HIV, HVB and HVC;
- Condom distribution;
- Opioid (Methadone) substitution treatment;
- Syringe Exchange Programmes;
- Therapeutic communities for inmates in 3 prisons (Rahova, Jilava and Târgșor).

The recommendation after the first evaluation of the syringe exchange programme was to expand these programmes and to integrate it in a broader comprehensive medical and psycho-social programmes, together with health education, psychological therapy and counselling for inmates who used drugs, opioid substitution treatment, detoxification and rehabilitation. After an analysis of the efficiency, impact and costs of the pilot syringe exchange programme, it has been decided to make

³ Procedure Manual For Medical and Psycho-Social Syringe Exchange Pprogramme (SEP) in the Romanian Penitentiary System

these interventions available in all prisons in Romania, for all inmates who wish to join in. Legally PNSPs have been made possible by a number of laws and regulations to fight HIV and drugs .



or in Jilava Penitentiary:

7. Luxembourg

The beginning

Due to the high percentage of people who inject drugs within the prisons system, the programme was established in 2005 as an explicit harm reduction measure part of a comprehensive approach. . First, there was an expressed need for improving working conditions and workplace safety. Second, in order to comply with European recommendations, it was necessary to implement harm reduction measures comparable to the quality of community services.

The programme is being operated by the medical unit with medical confidentiality. The first syringe is handed out by the physician after a written demand by the prisoner. The prisoner will then be informed about the rules and has to confirm by signature that he has been given a kit (see annex X).

Anonymous statistics are computed once a month, the number – not the names - of participants is communicated to the director of the prison.

In 2010, 34 beneficiaries exchanges 328 syringes. This figure corresponds to a 60% increase compare to 2009.

Lessons learned

The communication on policy with both prisoners and prison personnel is key.

Security staff as well as some medical staff do not support the PNSP. The resistance of the security staff translates in ordering urine tests or conducting cell searches, or creating obstacles for the medical staff to respond to a prisoner's request for a sterile syringe. In addition, participation of nurses in the PNSP is entirely voluntary. The director instructions need to be very clear and precise.

The physical access to the medical ward, where the exchange takes place, needs to be prepared to safeguard anonymity. If a prisoner is observed by security staff and/or psycho-social professionals while attending PNSP, mistrust and fears are produced.

Current situation

At the moment improvements of the PNSP in order to increase the access of participants are discussed with prisoners and prison staff.

8. Islamic Republic of Iran

The background

Iran has a long history of widespread incarceration of drug offenders (see for the following Farhoudi 2012). About 45% of the prison population is incarcerated for drug-related offences (Islamic Republic of Iran 2010). Previous research indicated that prisoners in Iran were at risk of drug-related harm, including blood-borne infections. A study showed a third of all drug users continued their drug use in prison (Bolhari et al. 2001). Several studies reported the risk of HIV transmission in association with shared drug injection in Iranian prisons (Farhoudi et al. 2003; Zamani et al. 2006). Furthermore several HIV outbreaks seemed having occurred inside prisons in Iran in the mid-1990s (UNAIDS 2006). It was stated that a history of imprisonment and injection inside prison was the most important risk factor for HIV infection in Iran. (Burrows & Wodak 2005).

Triangular clinics

Triangular clinics were established separately from regular health centres in prisons to provide specialized care, namely health education; risk reduction information; risk reduction counselling and harm reduction services to drug users; screening, diagnosis and treatment of sexually transmitted infections; and organizing care and support services for HIV-positive inmates. In response to the clear connection between tuberculosis and HIV/AIDS, the triangular clinics provide screening, diagnosis and treatment facilities for tuberculosis. With assistance from the Ministry of Health and Medical Education, the clinics offer ART for selected individuals. (World Health Organization/Regional Office for the Eastern Mediterranean XX).

The beginning

In early 2005, the Head of the Judiciary Organization issued a circular to all courts in support of harm reduction programmes for drug users. (see box ###) The circular stated that judges at all courts and prosecutors' offices must consider the issue of public health in the implementation of interventions by the Ministry of Health and Medical Education (such as provision of sterile injecting equipment, as well as methadone maintenance programmes for opiate dependent people). The letter also asked judicial authorities not to impede the implementation of these much-needed and successful programmes. There are some anecdotal evidences that distribution of needle and syringes was started unofficially in a very limited scale by some prison physicians and health stuffs in 2003-2004. Between 2005- 2006 some prisoner authorities tried to develop a national protocol for implementing NSP programs in Iran prisons, which never started, because of some concerns about PNSP adverse effects and worry of the opposition of people, relatives of prisoners and prison officials.

Current situation

In 2008-2009 a pilot project was implemented in 3 prisons. All the volunteers were those prisoners with a history of IDU. Participants in the pilote PNSP were not participating in the OST programme. The pilot program was conducted in three major prisons in Iran, including Tehran, Isfahan and Hamadan. The prisoners were given sterile needles and syringes weekly, and the used ones were also collected regularly. Data including the number of syringes shared or used by each person were collected at the beginning of the program and then once a week. Information regarding blood-borne diseases was also given to the enrolled prisoners continuously. Among 341 volunteer IDU prisoners enrolled in this project, an average of 3.7 syringes was exchanged per week. At the end of the program, the prevalence of using shared syringes among volunteers declined to zero.

The managers of the project concluded that despite the access to other harm reduction interventions, (except for Opioid substitution therapy) the need and desire to inject drugs will not disappear and if the prisoners are not given sterile syringes and needles, they will share them. Syringe distribution among these prisoners can help to reduce the problem. They recommended the programme to be extended to the rest of the Iranian prisons in case the results are satisfactory and there are minor complications (Shahbazi et al. 2010).
An evaluation of the pilot project was conducted and concluded that NSP was not effective. However, some problems of methodology of the evaluation remained.

9. Tajikistan

In January 2010, the Department of Correction Affairs signed a decree on piloting PNSP in prisons of the Republic of Tajikistan. The first step included training on PNSP implementation for staff and prisoners in the prison. Two two-day trainings on HIV/AIDS prevention focusing on harm reduction for 20 staff members in the pilot facility were organized (UNDP 2010).

PNSP in Tajikistan started with the financial support of the UNDP GFATM on 15 March 2010. In accordance with the order signed by the Head of Department of Correctional Affairs, PNSP was initiated in the prison 3 / 4. The cumulative number of PWID in the programme is 30 and currently 17 PWID are in the needle and syringe programme.

The initial plan was to start PNSP in one prison and later in a second one, based on the assessment of the effectiveness and achieved results. Despite positives result it has not been started in the second prison yet. UNDP is planning to support the implementation process (Vohidova 2012).



10. Recent developments in other countries

In addition to the developments in the above countries advocacy is going on in several other countries. In some countries it is controversially debated.

In **Portugal** by Law 3/2007 of 16 January and Order 22 144/2007 of the Ministry of Health and Justice a pilot project of PNSP has been carried out in Lisbon and Paços de Ferreira in 2008-2009. This was part of a broader strategy to decrease infectious diseases incidences, namely HIV/AIDS, hepatitis B and C, through diminishing risk behaviour associated to intravenous drug use, sexual intercourse, piercings and tattoos and use of steroids in prison settings. The volunteers after giving specific information on his pattern of use received a kit composed of 2 syringes, filters, disinfecting towel, clean cup, citric acid, bi-distilled water, and condom. The rules to use the kit were quite simple:

the kit should be kept inside its box; when the cell is inspected, the inmate should refer that he is in possession of the kit; the kit should be kept in accordance with the Prison regulation for the PETS; the kit should not be taken outside the prisons premises and only be taken outside the cell when to be exchanged by the Health care unit.

The outcome evaluation indicated results in behaviours, attitudes and perceptions of all prisoners and attitudes and perceptions of the prison staff. Specifically the reasons for not taking part in the programme were of interest: Most prisoners pointed out the fear of being discriminated, to fear consequences on their penal situation, the non respect of confidentiality, not wanting to assume to be a drug injector, to be afraid of being identified as drug user and finally to be afraid of being identified as participant.

However, the pilot program was evaluated as an important step on the health education, associating resources for health promotion, prevention of drug use, risk prevention and drug treatment (Ministério da Saúde)...\\.\Prisons (Portugal_january 2012).pdf” Even if no syringes were exchanged in neither of the prisons during the 12 months of the PETS, the pilot program was evaluated as an important step on the health education, associating resources for health promotion, prevention of drug use, risk prevention and drug treatment”.

In **France** the National council on AIDS (Conseil National du Sida – CNS 2009) has published a position paper in which is it stated that “The Council hopes that (...) syringe exchange programs can be set up, in a gradual manner but without delay”.

In the national AIDS/STI plan 2009-2012 the working group in charge of elaborating recommendations on harm reduction for inmates presented a precise recommendation about the need for needle exchange programmes in prison. PNSP is presented as a “priority” to the authorities, and has been included in the AIDS/STI final plan. Furthermore an organization gathering elected members involved in the fight against AIDS; Elus locaux contre le sida (ELCS) alerted about the degradation of the harm reduction policy in France. The setting up of NEP in prison is mentioned as a priority of action (ELCS 2009).

In **Australia** the NGO Anex was funded to investigate the legislative and/or regulatory considerations underlying the introduction of Needle and Syringe Programs (NSPs) in prisons in Victoria, Australia; and to develop model protocols for their successful operation in these settings.

The project found that legislation relating to workplace health and safety, and the provision of reasonable medical treatment and care to prisoners establish the duty of care underlying the provision of prison-based NSPs. This duty of care is reinforced by the *Charter of Human Rights and Responsibilities Act 2006* (Vic). To establish NSPs in prisons, compliance with the *Corrections Regulations 2009* (Vic) will be required and consent must be obtained from the Governor of the prison. Additionally, steps are required to ensure that the NSP is properly authorised and Gazetted pursuant to the *Drugs, Poisons and Controlled Substances Act 1981* (Anex 2011, p. 1)

C. Lessons learned

1. 20 years of experiences and encouraging scientific evidence

Prison-based needle exchange is a pragmatic and necessary health response to the challenges of HIV, HCV, and injection drug use. It has been proven to be effective and safe in prison also. Needle exchange has been available in some prisons for as long as 20 years and it is an approach that has been rigorously evaluated almost everywhere it has been enacted. Different and mostly encouraging experiences have been made with different modes of provision in different levels of prison security and different sizes of prisoner population in several countries. The results are encouraging prison systems and governments to improve the health of prisoners by providing PNSP.

The experiences and evidence from the presented eight countries where prison needle exchange programs currently exist (in approx. 65 prisons, see chapter XX), demonstrate that such programmes:

- 1027 • do not endanger staff or prisoner safety, and in fact, make prisons safer places to live and
- 1028 work;
- 1029 • do not increase drug consumption or injecting;
- 1030 • reduce risk behaviours and BB diseases (including HIV and HCV) transmission;
- 1031 • have additional positive outcomes for the health of prisoners (e.g. referral to other drug or
- 1032 health related services);
- 1033 • have been effective in a wide range of different prison systems
- 1034 • have successfully employed different methods of needle/syringe provision to meet the
- 1035 different needs of the institution and prisoners.
- 1036

1037 2. PNSP and harm reduction remain controversial issues

1038 No matter how effective they are in practice, prison harm-reduction initiatives, like PNSP, remain
1039 controversial, even in countries where they have been successfully implemented for almost 20 years.
1040 This is the main reason for not scaling-up these harm-reduction services (e.g. Switzerland). Despite
1041 existing evidence of the success of PNSP the opposition still remains and blocks the introduction.

1042 The five principal objections towards the implementation of prison needle exchange are: PNSPs

- 1043
- 1044 • would contradict with prison rules
- 1045 • might lead to increased violence and the use of syringes as weapons against prisoners and
- 1046 staff.
- 1047 • would lead to an increased consumption of drugs, and/or an increased use of injection drugs
- 1048 among those who were previously not injecting.
- 1049 • would undermine abstinence-based messages and programs by condoning drug use.
- 1050 • local evidences about effectiveness cannot be generalised because evaluations of existing
- 1051 programs reflect specific and unique institutional environments (Lines et al 2006).
- 1052

1053 These fears are widespread and have lead to a fundamental opposition to implementation of PNSP in
1054 prisons in most parts of the world. However, there is no scientific evidence that these scenarios have
1055 ever come true. On the opposite, PNSP has been identified as an evidence-based intervention
1056 worldwide.(WHO/UNODC/UNAIDS 2007a).

1057 3. Increased institutional safety

1058 One of the most important lessons to emerge from international experience is that implementing prison
1059 needle exchange programmes does not necessitate a trade-off between health and security. In fact, in
1060 no case had needles and syringes been used as weapons either against personnel or other inmates. This
1061 was and is one of the controversial issues facing PNSP. Syringes were not misused and disposal of
1062 syringes did not exhibit any problems. For reasons of safety in the working place, it is interesting to
1063 note that exchange rates within PNSPs are high (almost 1:1): e.g. the return rate for two prisons in
1064 Lower Saxony were 98.9% for the dispensing machine in the women's prison in Vechta, and 98.3% in
1065 the men's prison in Lingen, Gross-Hesepe. (see also Champ-Dollon it is not as high, but this can mean
1066 that prisoners left with their material, broke it in the toilet, gave it-new-to someone else). Therefore the
1067 risk of needle stick injuries by syringes not properly disposed is very low.

1068

1069 Usually inmates participating in the needle exchange programme are required to keep their kit in a pre-
1070 determined location in their cells. This is expressed in most of the regulations to operate PNSP. This
1071 measure assists the staff when they enter the cell to conduct cell searches. Because PNSP is an
1072 approved program, there is no need for the offender to conceal them in their cells. To date, no needle
1073 stick injury inflicted accidentally on staff by a needle obtained through the PNSP has been reported
1074 worldwide.

1075

Providing prisoners with access to the means necessary to protect them from contracting HIV and HCV is in fact compatible with the interests of workplace safety and of the maintenance of safety and order in the institutions (Anex 2010 for Australia).

All the international evidence indicates that there are already needles present within the prisons of many countries. A “needle-free” environment is to a wide extent a myth. Harm reduction means to acknowledge this situation and to respond with well-managed prison-based needle exchange programs, in which the number of syringes in circulation is known, the prisoners who have them are (in almost all models) known, and the needles are sterile, or at least used only once and by one person only. From a workplace health and safety perspective, this scenario is the most promising, because in the long term, reduction of parentally transmitted diseases will make prisons a healthier and less risky environment⁴.

4. No increase in drug consumption or injecting

The belief that needle exchange programmes promote injection drug use has historically been a central barrier to the implementation of this effective harm-reduction measure in both the community and in prison. However, within prisons this argument is complicated by the fact that many prisoners are incarcerated as a result of drugs or of drug-related offences. Consequently, providing bleach or sterile needles to prisoners is seen to be condoning or promoting behaviour that the prison should be seeking to eradicate as part of the individual’s rehabilitation. Acknowledging the reality of drug use in prisons may be perceived as an admission of the failure of such systems and their personnel to provide effective drug treatment and counselling programmes and to maintain institutional control and security.

In the case of prison syringe exchange, evaluations (Stöver/Nelles 2003) have consistently found that the availability of sterile needles and syringes does not result in an increased number of drug injectors, an increase in overall drug use, or an increase in the amount of drugs in the institutions.

There is evidence in a number of countries that a considerable number of prisoners inject drugs for the first time while in prison (5-25%). The argument that a needle exchange program would lead to prisoners begin using injection drugs is therefore undermined by the fact that this behaviour is already existing in many countries, again without prison needle exchange programs. In these jurisdictions individuals are forced to share or reuse needles, creating a high risk of HIV and HCV transmission. While making sterile needles and syringes available to incarcerated drug users has not led to an increase in drug use, it has led to a decrease in the number of prisoners sharing injection equipment and thus contracting HIV, HCV, and other infections.

5. PNSP as part of a comprehensive package of a broader health approach

The provision of sterile needles and syringes has not meant condoning the use of illegal injectable drugs in prisons. The provision of sterile needles in prisons has not resulted in prison officials condoning or otherwise permitting the use, possession, or sale of drugs. In all cases, drugs remain prohibited within institutions where needles exchange is in place, and security staff is instructed to locate and confiscate all such contraband (including needles and syringes that are not part of the exchange program). In this sense, the policy and practice is not different than in jurisdictions that do not have needle exchange programs. PNSP signify that prison authorities take seriously their legal obligation to protect the health of prisoners under their care and control.

PNSP is one of the 9 interventions recommended by WHO/UNODC and UNAIDS to address HIV among injecting drug users. (http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf):

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling (T&C)

⁴ See also the Spanish Ministry of the Interior and the Ministry of Health and Consumer Affairs, in their 2002 guidelines on the implementation of prison needle exchange programs

4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for PWID and their sexual partners
7. Targeted information, education and communication (IEC) for PWID and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB).

Ideally, needle and syringe exchange programs should be one component of a comprehensive package of drug services within prisons that includes abstinence-based programs, drug dependence treatment, and counselling, drug-free units, opioid substitution therapy, and harm-reduction measures. PNSP is only one part of a harm reduction approach – a paramount module within a comprehensive package of complementary drug services, which finally is part of a health promotion strategy

From this perspective, the availability of sterile needles does not undermine or impede the provision of other programs, but rather offers drug users more options for improving their health status, and a potentially greater interaction with the range of health and drug treatment options offered in a particular institution. The interrelations of services should be made clear!

PNSPs can serve as valuable points of contact and referral for a difficult-to-reach drug-using population to other drug addiction treatment programmes in prison and the community. Especially the latter is of utmost importance, links to harm reduction and HIV prevention programmes upon release and during breaks need to be organised. In some jurisdictions those released from prison receive an individual package consisting of a disposable syringe, disinfectant, ascorbic acid, and a leaflet with the addresses of HIV prevention organizations (e.g. Moldova).

The Moldova experiment reports about prisoner empowerment, when the project had helped to motivate prisoners to focus on and take greater care of their own health. One reason was that prisoners were more inclined to believe that the administration was willing and able to support and help them (Hoover & Jürgens 2009).

Finally PNSP is also one of the 15 components of comprehensive approach to HIV in prisons (see UNODC, ILO, UNDP 2012)

6. Models of provision of needles and syringes – advantages and disadvantages

There is no general recipe applicable for the method of needle exchange programmes for all prison needs - different methods of needle provision have been effective in different prison types (high, middle low security, big and small prisons as well). Every prison system has to find its own way of provision. The different modes are related to the goal the prison is pursuing: whether the prison is interested in getting more contact to formerly unknown drug users or if the contact is already satisfactory, whether the prison relies on its own personnel, or if the personnel from outside (either NGOs or health worker of the municipality) is providing the harm reduction materials. The different methods used by the countries studied for needle provision were:

- via personal contact (hand-to-hand provision by prison personnel (either social worker and/or health care staff (nurse), e.g. several Spanish and Swiss projects). The used syringes are either exchanged at the cell door (by nurses e.g. Champ-Dollon/Switzerland) or in the medical unit (e.g. Luxembourg)
- via external personnel, who is doing the preventive and harm reduction work: informing prisoners handing out and exchanging harm reduction equipment e.g. women's prison in Hindelbank/Switzerland,
- via NGOs who are delivering harm-reduction materials (Jacob, Keppler, Stöver 2001)
- via peers who are chosen to get a confidential contact to drug using prisoners (peer leaders, e.g. prisons in Moldova; Hoover & Jürgens (2009).
- via slot machines e.g. prisons in Germany and Switzerland (1:1 exchange, starting with a dummy as first device).

The modes of provision do not necessarily exclude each other. Sometimes in one and the same country or even prison different modes of provision are applied (e.g. Kyrgyzstan). All these methods do have unique opportunities and challenges in terms of more or less anonymity, confidentiality, supervision, documentation, one-to-one-exchange, costs, preparatory work etc., which will be discussed in the following:

1. Hand-to-hand distribution by prison nurse and/or physician

Advantages:

- Allows for personal contact with prisoners and an opportunity for counselling
- Can facilitate outreach to and contact with previously unknown drug users
- Prison maintains high degree of control over access to syringes
- One-for-one exchange or multiple syringe distribution possible (as necessary, and as reflects individual prison policy and individual needs)

Disadvantages:

- No anonymity and confidentiality, which may reduce the participation rate
- 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 provision by peer outreach workers (volunteers)

Advantages:

- High acceptance by prisoners
- High degree of anonymity and trust, without 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 in charge of the PNSP can also do peer information and prevention

Disadvantages:

- No direct staff control over provision, no formal monitoring system, which can lead to increased fears of workplace safety among staff
- One-for-one exchange more difficult to ensure
- Volunteers might blackmail other prisoners by disclosing information of participation in the programme
- Volunteers might sell syringes and injection equipment to other prisoners
- Selected prisoners might not provide reliable services to fellow prisoners (e.g. by demanding other goods or services)
- Bias in identified in trainings and on the ground of their interest and length of sentence the eligible persons.

3. Hand-to-hand provision by external non-governmental organizations or health care professionals (not paid by prison administration; e.g. Hindelbank/Switzerland)

Advantages:

- Provides personal contact with prisoners and an opportunity for counselling
- Facilitates outreach to and contact with previously unknown drug users Prison has opportunity to maintain high degree of control over access to syringes
- One-for-one exchange or multiple syringe provision possible (as necessary, and as reflects individual prison policy)
- Provides a higher degree of anonymity and confidentiality, as there is no interaction with prison staff

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 on participation to the prison
- There can be mistrust by prison staff of the external services providing syringes
- External workers may experience more barriers in dealing with the prison bureaucracy than internal prison health staff
- Turnover in staff of non-governmental organization 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 in various places 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

Disadvantages

- Machines are vulnerable to vandalism and damage by prisoners and staff who are not in favour of this program
- Technical problems with functioning of the dispensing machines can mean syringes are unavailable for periods of time, which can decrease prisoner confidence in the program
- Some prisons are not architecturally suited for the use of dispensing machines (i.e., lack of discreet areas freely accessible to prisoners in which machines may be placed)
- Because the machines must be custom designed and individually constructed, the expense of providing them in sufficient numbers in multiple prisons can be prohibitive for some prison systems.

A general remark: In many prisons the provision of needles and syringes is done by prison nurses and/or physicians, by non-governmental organizations, or health professionals who come to the prison for this purpose. This may lead to the fact that PNSP is not accessible once clean needles are needed, because often very limited opening hours. In this case it should be allowed to store more than one syringe in order to be prepared for the case that drugs come into the institution and the PNSP is closed or the one needle is already no longer sharp. Moreover peer-led provision has probably the advantage that provision through peers has led to much greater access. “For example, in Moldova only a small number of prisoners accessed the programme when it was located within the health-care section of the prison. It was only when prisoners could obtain injecting equipment from fellow prisoners trained to provide harm-reduction services that the number of injecting equipment distributed increased significantly”. (Hoover/Jürgens 2009)

Box X: Overview of advantages and disadvantages of different syringe provision models

Needle exchange slot machines, discreetly located in different wards to allow anonymous access

Advantages:

- Easier access
- High degree of discretion
- Better acceptance by inmates
- Better control of syringe disposal (1:1 exchange = one used for one new syringe)

Disadvantages:

- Less controlling of those inmates using drugs (inmates might use the syringe of program participants and get their own syringe)
- Machines can be damaged by inmates or staff not in favor with this program

1291 Lots of technical problems with functioning/dis-functioning of the slot machines (e.g. sharing
1292 of syringes may inadvertently occur if a machine does not suspend a new syringe when the used one is
1293 disposed)

1294 **Hand-to-hand provision by staff of the medical unit and/or the prison doctor**

1295 Advantages

- 1296 - Can serve as an opportunity for counseling and therapy
- 1297 - Facilitates making contact with formerly unknown drug users
- 1298 - High control over access
- 1299 - 1:1 exchange.

1300 Disadvantages:

- 1301 - Low degree of anonymity and confidentiality, possibly resulting in a decreased acceptance of
1302 the program
- 1303 - Probability of 'informal participation' by inmates who send others instead of attending
1304 themselves

1305 **Hand-to-hand provision by NGOs or external health care professionals**

1306 Advantages:

- 1307 - Can serve as an opportunity for counseling and therapy
- 1308 - Facilitates making contact with formerly unknown drug users
- 1309 - High control over access
- 1310 - Can offer some degree of anonymity and confidentiality

1311 Disadvantages:

- 1312 -Syringes are only available at limited times during the week
- 1313 -Anonymity and confidentiality might be limited as the involved community services might have to
1314 provide information on participation rate to prison management
- 1315 -Mistrust by prison staff of the 'intruding' community services staff providing syringes

1316 **Distribution via peer leaders (e.g. Moldova)**

1317 Advantages

- 1318 -High acceptance by inmates
- 1319 - Anonymity and confidentiality is given
- 1320 - Distribution of needles can be connects with the provision of other harm reduction material

1321 Disadvantages

- 1322 - No control over distribution
- 1323 - Syringes may still serve as goods in the hierarchy of prison subculture.
- 1324 - Safety of the work place for personnel is not guaranteed.

1325 The provision of the first needle and syringe is according to these above described models, either via

- 1326 • Doctor after medical examination and/or test of drug dependence (a dummy for using the slot
1327 machine the first time), or
- 1328 • NGO or external health worker (via expressing the need).

1329 Also in all models safe individual containers and large sharp boxes for used needles are necessary.

1330 In addition to maximizing confidentiality, providing adequate and tailored access to the needle
1331 exchange program and paraphernalia (sterile water, disinfectant swabs, filter, ascorbic acid) is a key
1332 factor. Different kinds of needles should be made available based on the habits of IDU in the specific
1333 country/prison: distribute multiple varieties of needles and syringes. Flexible hours of opening of the
1334 PNSP may be needed to approach the majority of drug users, whose use is not timed around usual
1335 working hours.

1336 A difficult area is also the programme entry. If there is a delay in accessing the programme this may
1337 then lead to risk behaviour again.

What material should be used in PNSPs?

Ideally the PNSP kit should contain not only the sterile syringe but some additional paraphernalia. In Spain the following items are recommended (Ministerio...12):

- Syringe and needle in a transparent or translucent rigid case
- Disinfectant swabs
- Distilled water

Several of the most preferred sizes of needles should be provided (e.g. American (0.33 x 12.7) or Spanish (0.5 x 16). Injection of cocaine requires the larger gauge needle, while the smaller gauge is sufficient for heroin injection. Supplying a filter and a sterile cup (e.g. stericup) for injection preparation may also be considered. In order to encourage a change of route, providing aluminium foil to users who request it may also be considered. The number of kits to be supplied depends on the frequency of exchange and the user's consumption habits: it should be sufficient to cover the inmate's needs so that he does not have to reuse the syringe before the next day of exchange.

Recently the development of new syringes has been improved to prevent needle stick injuries. So-called 'safety' or 'bio-safety' products (devices without needles, needle-protection devices, needles that retract automatically) have been invented. In some prisons their use is already in place or even mandatory.

Exchange versus distribution (kits), paraphernalia

No matter which of the above mentioned models of provision is applied, after the first needles/syringes or kit are provided, the rule should be exchange. Only a high rate of returned needles and syringes gives the staff the feeling that their interests are maintained and that as less syringes and needles are hidden and not returned in the institution. Before a new needle/syringe (kit) is handed out (by hand-to-hand or slot machine) the used one has to be returned.

7. Trained prison staff accept and support PNSP in a short period of time

Prison staff trained in an ethos of abstinence as main and only goal of drug dependence treatment have had to come to terms with confiscating drugs but not injection equipment. However, as the experiences in Switzerland, Spain, Germany and Moldova have demonstrated, staff attitudes have changed as the staff has learned first-hand about the needle exchange programs and the harm-reduction philosophy, and as they have participated in the implementation and review of needle exchange programmes. This is the same process that has been observed in the community, where police attitudes have evolved to accommodate needle exchange programs. Police forces in countries with community needle exchange programs have integrated the broader harm-reduction philosophy into their work without undermining their mandate to protect and safeguard the populations they serve. In fact, a harm-reduction approach is consistent with the ultimate aim of protecting and preserving life. Prison staff accepts and supports PNSP and considers harm reduction offers as an integral part of drug treatment and counselling, but this requires a very sound base of teaching, communication and implication of the programme. This effort is necessary to achieve acceptance of staff. Without it, resistance to the program can remain for many years. And on the contrary, with training, staff can be made familiar to the program in a few months..

D. Guiding principles for implementing and managing PNSPs successfully

1. Prison health is public health! Close connections between health care in the community and in prisons

In order to better implement PNSPs and to create the precondition harm reduction in prison should become an integral part of national drug and HIV/AIDS policy that means harm reduction in prisons should be considered in the relevant national or regional programmes and action plans.

2. The principle of equivalence

Key international instruments on human rights standards and international health guidelines provide clear indications that standard of health care provided to prisoners must be equivalent to that available in the general community. The principle of equivalence is the essential guiding strategy of prison health.

The statement of the principles articulated in Article 12 of the Covenant on Economic, Social and Cultural Rights that “[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Basic Principles for the Treatment of Prisoners, principle 9 (UN 1990) states that “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”

It has subsequently been reflected in numerous other international instruments, as well as in national prison policy and legislation in many countries. In the context of HIV/AIDS, hepatitis, tuberculosis, equivalence of “health services” would include providing prisoners with means to protect themselves from exposure to Blood borne virus infections.

This principle of equivalence of prison health care has been applied to the issue of HIV/AIDS by the WHO, UNODC and other international organizations.

With regard to services for drug users in prisons the WHO guidelines on HIV infection and AIDS in prisons stated already in 1993: “Preventive measures for HIV/AIDS in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among people who inject drugs and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release”. (p. 4)

Recently, the Council of Europe has outlined several recommendations to improve and guide prisoner health. Recommendation No. R (98)7, addresses the ethical and organizational aspects of health care in prisons and mandates that prisoners receive medical, psychiatric, and dental treatment that is equal to the services available to the general public

The right of people in prison to access adequate standards of HIV/AIDS prevention and care is also supported by UNAIDS. At the United Nations Commission on Human Rights, UNAIDS stated that “...with regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community.” This would again support the contention that where sterile syringes are provided to people who inject drugs in the community, these same programs must be implemented in prisons. Furthermore, Guideline 4 of the International Guidelines on HIV/AIDS and Human Rights specifically states that prison authorities should provide prisoners with means of HIV prevention, including “clean injection equipment.” These Guidelines are intended to promote and protect respect for human rights in the context of HIV/AIDS, to benefit governments by “outlin[ing] clearly how human rights standards apply in the area of HIV/AIDS and indicate concrete, specific measures, both in terms of legislation and practice, that should be undertaken” to fulfil state obligations in relation to public health within their specific contexts.

3. Political leadership and professional support

PNSPs cannot be introduced without support and the explicit will from government officials, policy makers and other relevant national stakeholders. Government officials, senior prison authorities, the judiciary, senior health officials, and other informed individuals and groups, including health professional associations, civil society organisations, people living with HIV/AIDS, HCV, prisoners/former prisoners, and prison managers and prison staff, have a crucial role to play in mobilising political support for prison-based HIV/AIDS interventions such as PNSP, and in supporting government actions necessary to effectively combat HIV/AIDS and other infectious diseases in custodial settings.

The need for leadership from elected officials, prison authorities and professionals on the issue of prison needle exchange programs is pivotal and not only needed in the phase of introduction, but moreover during the whole starting and operating process. Leadership is also required from individual prison staff (both correctional staff and health service staff) and from outside physicians who work in prisons. In the context of needle exchange programs in prisons, leadership implies a number of attributes. First, leadership implies an understanding of the legal obligations of prison systems to respect, protect, and fulfil prisoners' right to health. Second, leadership implies knowledge of the experience of and evidence from existing prison needle exchange programs. Third, leadership implies a willingness and commitment to make prison needle exchange programs responsive to the needs of prisoners and prison staff (both health care and correctional). This means involving prisoners and prison staff in the design and implementation of programs.

Three lessons emerge from a review of the Spanish experience.

First, those responsible for the administration of the needle exchange programs have maintained a steadfast commitment to the health objectives and benefits of the program, a harm-reduction philosophy, and the right to health of people in prison. As a result, the Spanish prison system has been able to develop very progressive, pragmatic, and flexible approaches to challenging issues that arise in the programs. Their solutions to controversial issues such as strict one-for-one syringe exchange, access to needle exchange for prisoners who are supposedly "drug free" (i.e., those on methadone maintenance or living in drug-free units), and access to syringes for violent or psychotic prisoners are all underpinned by the fundamental principle that people in prison have a right to protect themselves against HIV and HCV infection, that harm-reduction responses must be adapted to meet individual and unique needs, and that it is always preferable to find a way to provide prisoners who inject drugs with a sterile needle than force them into a position where they will share. This is a valuable lesson for other jurisdictions.

Second, the Spanish example demonstrates the value of providing **clear guidelines** and protocols for prison syringe exchange programs, yet allowing some flexibility in how each individual institution implements those guidelines. This is particularly important given that a one-size-fits-all policy would have been difficult to impose on a system of 82 different prisons of different sizes, regions, security levels, etc. However, providing clear guidelines and principles on implementation, and clear political instruction that these programs were to be implemented by a deadline, has allowed institutions to make such programs available within their own unique institutional environments.

Third, prison needle exchange programs can be quickly scaled-up where political will is combined with a solid implementation plan. At the end of 2001, needle exchange programs were in operation in XX prisons. In 2003 the legislative and policy infrastructure was in place for implementation in all 82 Spanish prisons, with needle exchange programs running in XX of them.

It is crucial to have supportive leaders at the highest level to successfully create and implement prison needle exchange programs. Practically, this may mean leadership by key senior officials responsible for prison health-care services, or prisons generally, and support by the head of the prison in which the needle exchange is being established. The support of prison staff has also been shown to be an integral part of successful programs. In all PNSP models described in this document, educational workshops

and consultations with prison staff have been a key aspect in the development of prison needle exchange. In several cases, as is evidenced in the evaluations, staff members were reluctant at the start, yet grew to support the program over time as its benefits were experienced first-hand. The initial reluctance of staff makes the need for committed, informed, inclusive leaders supporting the implementation of prison needle exchange programs all the more important. While bottom-up processes that include the involvement and cooperation of staff have been shown to be successful, there is mixed evidence on the success of top-down approaches, where the implementation of prison needle exchanges is directed by government. Switzerland has experienced problems when a strictly top-down approach has been followed. On the other hand, the experience in Spain has shown that it is possible for government, including parliament, to take a leading role in setting the agenda for the implementation of needle exchange programs as long as practicality and flexibility at the prison level are encouraged.

Box X: Support from the top-level staff, e.g. Moldova experiences

“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 is 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.” (Hoover/Jürgens, 2009, 12)

4. Participation of staff and prisoners in the planning and operation process

In the discussion about introducing a PNSP and furthermore in developing concept notes and guidance documents on the provision of needle and syringe, all relevant actors in prisons should be participating: prison security and medical staff, management as well as prisoners. In designing the conceptual framework of a PNSP all relevant perspectives should be integrated in order to make a PNSP target-group specific. Especially the prisoners’ views and needs should be integrated. For instance at the start of the program, drug users could be asked to indicate what type of needles are most useful, and where in the prison and under which formal circumstances they would access such a programme.

Combining all the different views and perspectives is usually being done by implementing a steady interdisciplinary and multi-professional working group, which is guiding and supervising the process of preparation and implementation, including monitoring and evaluation.

5. Involvement of NGOs and Civil Society

In many countries NGOs have been providing prisoners with HIV/AIDS and hepatitis education, information, psychological support, counselling. NGOs often employ former drug users so that their specific knowledge can be utilised. The advantages of integrating NGOs in prison harm reduction services are threefold: NGOs

- are usually independent from the ministry in charge and therefore prisoners tend to trust them more than prison staff.

1543 • do have a high understanding of the needs of people living with HIV/AIDS and/or hepatitis
1544 and have a long experience in operating and providing a wide range of harm reduction
1545 services, distribution of clean injection equipment and condoms.

1546 • link prisoners after release from prison to community harm reduction services, so that a
1547 continuity of services and care is guaranteed.

1548 The involvement of NGOs, drug users and people with HIV/AIDS play an important part in
1549 establishing prison-based syringe and needle exchange program,

1550
1551 6. Training of staff and prisoners

1552 Before a PNSP is introduced educational and informational activities have to be conducted for prison
1553 staff and prisoners to discuss the importance and goals of starting the programme. The more the policy
1554 of participation is applied, the less the objection to the programme will happen.

1555
1556 Hostility and non-understanding of harm reduction policies was widespread in the community in the
1557 past and still is even more in the prison setting. Training that has preceded and accompanied operating
1558 a PNSP can raise awareness about the transmission risks and nature of HIV, hepatitis and risk
1559 behaviours and thus leads to a deeper understanding of the necessity of harm reduction interventions.
1560 The awareness helps reducing HIV/AIDS-related discrimination and stigma both among personnel and
1561 prisoners, thereby improving the lives of prisoners living with HIV/AIDS and/or hepatitis.

1562
1563 The experiences demonstrate that both NGOs, prisoner and prison staff stress the importance of
1564 training and education on a regular basis, not only when a project begins. That is because turnover of
1565 prisoners and also personnel is high in all prisons. Personnel's safety concerns with regard to
1566 HIV/AIDS and other blood borne-virus infections need to be addressed by providing extensive
1567 information about transmission and protection. One essential goal of PNSP is also to increase the
1568 workplace safety for staff.

1569 All in all distrust and fears among staff and prisoner can only be reduced by extensive training efforts.
1570 NGOs should participate in these training activities.

1571

1572 7. Monitoring and evaluation

1573 Monitoring and evaluation are indispensable strategies within health promoting interventions, like
1574 PNSP. These tools help to control and adjust the program, the results give an overview over
1575 programme characteristics and dynamics, and deliver information to prison management, prison staff,
1576 stakeholders, politicians, professional and general public. Only if the programme is monitored
1577 regularly and thoroughly, adjustments and improvements can be made, if necessary, to make it
1578 respond better to the needs of prisoners and of staff. Monitoring and evaluation significantly
1579 contribute to transparency of the programme which is also necessary for donors and supporter.

1580 It might be useful to plan an evaluation after 6-12 months of starting the program. This will reassure
1581 staff, that further changes are possible and can lower resistance to start.

1582 IV. ADVOCACY OF PNSPs

1583 Advocacy for PNSP can be done by different actors, from the prison system or from external
1584 organizations, involved in the initiation of a PNSP. I

1585 One stream of advocacy activities should be dedicated to establishing stable working relationships
1586 between the prison authorities, , trade unions, courts, judges, , NGOs health authorities, and the
1587 National HIV/AIDS Program. Many of these actor perceived prisons as drug-free zones.. With the
1588 spread of HIV/AIDS and other blood-borne infections, many studies revealed that in most prisons
1589 drug use and risk behaviour are widespread. Focusing solely on abstinence might exclude many
1590 prisoners from the support they need. For the above mentioned authorities it might pose a problem to

understand the purpose of a PNSP, which is the promotion of public health and social well-being and not the promotion of injection drug use.

Stakeholders need to be briefed on the experiences of PNSPs worldwide with an emphasis on the benefits of these programmes for prisoners, their co-inmates, their friends, colleagues, and partners etc. It is essential to mention human rights obligations, public health implications including the benefit for staff workplace security.

The most effective way to develop the working relationships between the authorities mentioned is to identify influential senior officials who are (or can be persuaded to be) sympathetic to the PNSP's work and who are able to ensure that the PNSP can operate without interference. These seniors or identified key persons should be invited to the prison to discuss the envisaged PNSP, or if implemented already to see how it is being operated.

Visits could be organised on an individual basis as prison visits or on a collective basis by organising events, in which the envisaged PNSP is being discussed (WHO/UNAIDS/UNODC 2007, p. 18ff).

PNSP remain controversial – even in some of the countries, where they are implemented. It is pivotal to get these programs started, because the experiences show that after a short period of time, PNSP become a 'normal' service within the other drug services. Thus the most critical step is to start. The controversy cannot be solved by talking endless about pros and cons.

Careful thought and substantial work has to be devoted to overcoming community fears and government concerns about the programmes.

To obtain the support different modes of advocacy strategies have to be applied: formal and informal meetings with stakeholders, involvement by program managers in multi-sector AIDS and drugs committees and, in most cases, building relationships with selected representatives from mass media. A short presentation summarizing the background of intravenous drug users in prisons, the extension of risk behaviour and the necessity to respond in a way public health responds successfully to this challenge on the outside is useful!

The advocacy phase takes resources that cannot be underestimated: Prison visits, discussions, events around these issues are time and resources consuming including for prison authorities.

Starting up: Establishment of an advocacy group, consisting of representatives from penitentiary, health, HIV, scientific sectors including NGOs.

Collecting the evidence: Why is such a programme needed? What is the evidence of intravenous drug use among prisoners?

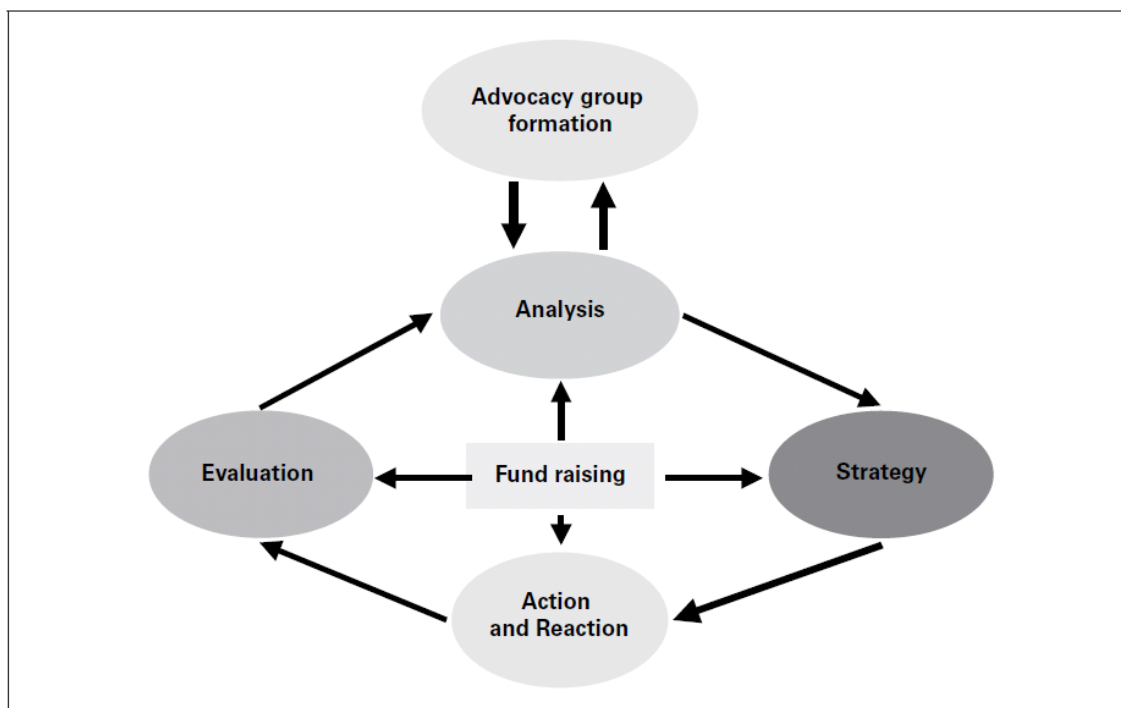
Analysis: The group systematically analyses the identified elements of the problem including key stakeholders, existing norms and policies, the organizations involved in putting those policies into practice, and the channels of access to influential people and decision-makers. Ideally the gap between international 'soft law' (recommendations, guidelines, common statements) and the prison health care practice is ideal for carrying out this analysis.

Strategy: Based on the results of the analysis, a strategy with specific objectives and goals need to be developed to focus the advocacy efforts. The strategy will also identify how the goals will be reached and by whom.

Action and reaction: An advocacy action plan is formulated, and support is built for changes to policies and practices (e.g. by prison doctors, governors, representatives from prison administration or even Member of Parliaments). Implementation of the campaign may prompt various reactions by influential groups. Addressing the reactions of critics helps to keep attention and concern on the advocacy issue.

Evaluation: A team needs to review regularly what has been accomplished and what more remains to be done. The concrete impact of advocacy may be difficult to evaluate in the short term, so one may need to measure the progress made in the process of advocacy.

The advocacy process



Some PNSP projects were developed from the ‘bottom-up’ (e.g. the prison itself elaborated a concept) and others were developed ‘top down’ (e.g. the Ministry of Justice or Interior was proactive). Both ways reflect the political and professional conditions of the prison and the community or state. Successful models of a particular prison in a particular country cannot necessarily be transferred to another prison or country. The specific circumstances and needs of the prison as a consequence of a top-down process from political authorities have to be taken into account first when planning a PNSP. Based on various experiences, both approaches have been successful.

Checklist X: Advocacy of PNSPs

1. What groups or stakeholders need to support the decision for PNSP?
 - What could be the basis of their support? What are the obstacles?
 - Can prison management, security staff and/or health care staff be involved in advocacy?
 - Can persons and capacities of the Ministry of Health, NAC or drug service institutions being used?
2. What groups or stakeholders oppose the decision for PNSP (e.g. trade unions)?
 - What could be the basis for their opposition?
 - How can the trade unions be approached?
 - How can political parties be approached?
3. Which NGOs can be approached to support and advocate for the decision for PNSP?
 - Can prison management and NGO act together in the public?

4. How can the professional public be consulted and informed?
 - Are they aware of the necessity of PNSP?
5. How could the media portray and characterize such a PNSP program?
 - How did they report until now, what are the main obstacles in favour of prisoner's health?
 - How can the media (local newspaper, TV, radio stations) be approached?

BOX: Basque Parliament

V. PLANNING AND IMPLEMENTING of PNSPs

A. Before initiation of the program

1. Definition of the programme, objectives and target groups

It is important to define the goals of the PNSP right in advance. PNSP as is primarily a harm reduction intervention to prevent the transmission of blood borne diseases among people who inject drugs who share needles, syringes and/or injection equipment. This is the main objective of the program. All practical and technical issues should be centred on this objective. As in the community PNSP does have other positive side effects, which might be an increased contact with hard to reach groups, a bridging function into other health programmes, notably drug dependence treatment and counselling or voluntary HIV testing. However, prevention of HIV and hepatitis for both prisoners and prison staff is the main objective and has to be achieved independently from other objectives. Finally PNSPs should reduce the risk of accidental punctures of prison staff and other prisoners with infected needles.

Box X: Objectives of PNSP – the example of Spain

General objectives

- Prevent infections by HIV, HBV, HCV and other pathogenic agents associated with injecting drug use in the prison population.
- Integrate harm reduction programs into health and social services offered by the prison.
- Safety at the working place by avoiding needle sticks injuries.

Specific objectives

- Reduce the frequency of shared use of needles and syringes for drug injection through the distribution of sterile injection material.
- Improve conditions of hygiene for self-injection through health information and education, and encourage modification of other risk behaviors to prevent sexual transmission of these diseases.

Complementary objectives

- Facilitate communication between PWID and health care professionals to foster referral to drug dependence treatment programs.
- Determine the characteristics and needs of the IDU population so that appropriate counseling and health education interventions can be designed and prioritized.
- Motivate and increase the awareness of prison workers about the benefits of PNSPs

Who is the target population for PNSP? Basically the target group consists of all people who inject drugs in a custodial institution.. Often opioid substitution programme (OST) is seen as an exclusion criteria from PNSP on the basis that there is a perceived contradiction with OST (oral substitution

medication should prevent injecting drug use). However, drug dependence is a relapsing disease and relapses do occur. In addition OST is not a treatment for cocaine and amphetamine PWID. Furthermore exclusion criteria often contribute to a disclosure of health data and to a loss of anonymity. PNSP should be organised independently from other health and drug services, so that the access to PNSP is organised on a low-threshold basis.

Box X: Special situations

-Psychotic or psychiatrically impaired inmates.

The requests of inmates suffering of severe psychiatric diseases to participate in the PNSP should be assessed individually by the physician responsible for his care

- Inmates included in drug dependence treatment programs.

Inmates included in these programs (methadone, naltrexone, drug-free programs) should have access to needle exchange whenever they want it. Inmates in methadone maintenance programs who request syringes generally use them to inject cocaine, but the inmate should be asked what type of drug he consumes, since continued use of heroin usually indicates that the methadone dose is inadequate. Request by an inmate in a drug-free program should be approached from a therapeutic point of view, and appropriate therapeutic measures taken to help him to overcome the relapse, but access to sterile injection material should never be denied.

- Especially dangerous inmates.

From a health perspective, all inmates should be given the same opportunities to access sterile injection material. Prison authorities should regulate the means of access for especially dangerous inmates, bearing in mind that it is always preferable to adopt special security rules with these inmates than to deny access to sterile syringes (see Ministerio 2002, 10).

2. Organisational procedures and responsibilities

It has to be made clear who is responsible for the implementation of the PNSP. In most cases it will be implemented by the health care team of the prison, probably in cooperation with support by external agencies (NGOs), who are possibly already working with drug dependent prisoners. All members of the prison health care team may participate in operating the program, including physicians, nurses and nurse assistants. In this case each health team will decide which persons will be in charge of exchange and other daily duties associated with the program, as well as the location, frequency and hours when exchange is to take place, monitoring, based on available resources and taking into account that:

- The location and hours chosen should ensure access to the program and its confidentiality.

- A higher frequency of distribution, in addition to improving accessibility, reduces the time during which the inmate has a contaminated syringe, and therefore the probability of it being reused by him or by other inmates (Ministerio...2002).

3. Information, education, communication strategy

Before starting a PNSP both inmates and prison staff should be fully informed about the plans to implement a PNSP, using the communication procedures which are most often used to announce innovative strategies (general assembly of prison staff, written information, prisons newspaper, personal interviews etc.).

Inmates should be informed already in the admission stage of how:

- concretely the programme is designed (storage of needles, transport modalities, sanctions etc.)

-where and when the first needle and syringes/paraphernalia (kits) can be obtained,
- the confidentiality can be guaranteed, and if there are any disadvantages for their current sentence when participating in the programme.

New prisoners entering the institution should immediately be informed about the concrete procedure and rules of the programme. Flyer, leaflets in several languages and written in the style of the prisoners should be handed out.

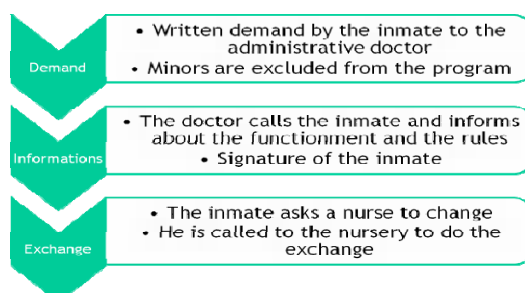
Prisoners should also be informed about the general health care and drug dependence treatment, counselling and support infrastructure in the prison. As harm reduction should always be embedded in a wider range of services possible bridging options should be made clear. For opiate dependent prisoners, the most effective treatment is Opioid Substitution Therapy (OST). It needs to be offered, because there are evidence of the effectiveness especially in conjunction with NSP. If OST is not available or is not chosen by the prisoner or not indicated (prisoners dependent to cocaine or amphetamine) cognitive-behavioural treatment (CBT) should be offered. In addition access to VCT, ARVs, to hepatitis A/B – vaccination, hepatitis C testing, condom provision is needed. The information about treatment and support options need to be made clear in a non-obstructing way.

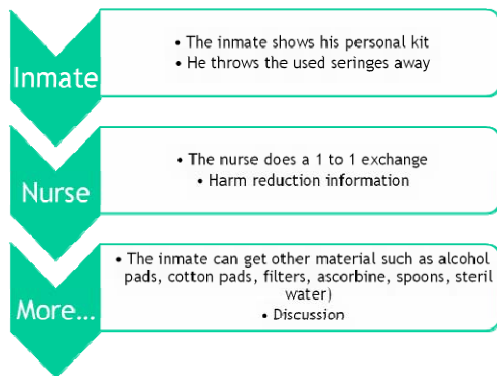
4. Access to the PNSP, rules, continuation, sanctions and interruptions of exchange

The access to PNSP is organised differently in the prisons operating such a programme. According to the different modes of provision of sterile injecting equipment, either physicians or nurses are giving out the starter kit. with the first syringe or dummy. Usually the first syringe is handed out by an appointed person (doctor, nurse, social worker, all integrated into medical confidentiality) after written demand by the prisoner, then the prisoner will be informed about the rules and has to confirm he/she has been given a kit. The inmates declares :

- To change used syringes
- To have a kit only for personal use
- To have only one kit
- Not to give the kit to another person
- To give the kit back to the nursery on release

In Luxembourg PNSP is done via the nursery - the procedure of access to PNSP is the following (Hoffmann 2012). One of the key problems in this model in Luxembourg is that the nurses are not obliged to do the needle and syringe exchange, they can do it on a voluntary basis (see attachment I). This leads to disorientation among prisoners and the remaining staff. According to the prison officials the PNSP is not being accepted as it should be, so that the medical department interviewed prisoners and prison staff how to change the provision. The registration method might also contribute to the barriers to access the clean needles.





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Plastic tube handed out in the prison of Luxembourg. It consists of:

- Two 1ml insuline syringes
- Ascorbin
- Alcohol pads
- Cotton pads
- Filters
- Spoons

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The etui is made of transparent plastic and has with an adhesive etiquette the name of the owner on it. This is seen as important part once the guards find an etui and can then better allocate the plastic tube to the owner. The etiquette with the name of the owner is also important for the personnel exchanging the needles. If the plastic container does not have etiquette on, it will be confiscated and an exchange will no longer be possible. The confiscated etui will be returned to the medical unit. The owner of the plastic container has to write a new request to the physician and will be invited by him.

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It is seen as important that the etui is of transparent material, because the prison personnel might see at once the contents without opening the container and thus avoiding any possible contact with the injecting equipment.

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The participant in the programme has to have the container with him/her or depose it in the cupboard, where he could protect it from being seen at once by covering it with cloths. The prisoner is not allowed to hide the container, e.g. under the mattresses.

1849 The discovery of syringe and needles not stored in the cupboard or plastic container will be punished
1850 by the director of the prison. This has been done in order to increase the safety for the staff working in
1851 prisons. A prisoner who has only one syringe in his / her container is only able to exchange one
1852 syringe. An empty etui will be taken away from a prisoner and he /she has to demand a new one at the
1853 prison doctor.

1854 Furthermore the prisoners are given dry swabs and alcohol swabs, sterile water in small bottles, filter
1855 and ascorbin acid. These items are to be found in the nursery unit, where the exchange is taking place.
1856 The guiding principle is that the prisoner should have the same advantages as a drug user in the
1857 community. The different parts are of the same quality as the material handed out in the community by
1858 a drug service.
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1861
1862 In Luxembourg the following sanctions have been foreseen:
1863

- Syringes in the kit (maximum 2) will not be punished
- Syringes found outside the kit will be taken away and given to the nursery
- Disciplinary punishment by the administration, information to the doctor
- Consumption, possession and dealing drugs will be punished and will get a penal pursuit
- Illicit drugs will be given to the police.

1869
1870 Just to illustrate the programme, in 2011 30 Kits have been demanded and 440 needles have been
1871 exchanged.
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1873 The PNSP in Luxembourg is covered by medical confidentiality. Only a list with the numbers of
1874 needles exchanged is passed to the director on a monthly basis.
1875

1876 The prisoner has to state if he or she is going to stop the participation in the exchange project.
1877 However, there are several situations where problems may arise:
1878

1879 In the event of release from prison, the prisoner has to deliver his or her syringes and needles to the
1880 providing service, usually the health care service. According to experiences prison releases often occur
1881 on short term basis, unexpectedly, or before the week-end, where health care services may not or no
1882 longer be around, and/or the prisoner will not see the health care service personnel anymore. For this
1883 problem a clear protocol needs to be in place to avoid thrown away needles. This protocol could also
1884 include links to the community NSP.
1885

1886 Guidelines should make provisions to ensure that in case of transfer to another prison, where there is
1887 no PNSP, beneficiary from the programme continues to have access to clean injection equipment.
1888 SOPs should describe the procedure.
1889

1890 If the prisoner is on furlough and will have no access to exchange through the resources available
1891 outside of prison he or she has to be provided with the necessary equipment needed during the leave.
1892

Inclusion in a medication assisted program, such as a substitution programme, or other drug dependence treatment programs should not be incompatible with needle exchange. Access to syringes should not be refused except under very exceptional circumstances (assault with a syringe, flagrant repeated failure to comply with program rules resulting in a hazard to other persons). In this regard, it should be remembered that the main objective of this program is to prevent the transmission of diseases and therefore to ensure the availability of sterile injection material (Ministerio...2002, 12).

Finally it should be taken into account that is unadvisable to establish a large number of rules, since an excessive number of rules dilute the importance of the basic rules. It is easier to ensure compliance with a minimum number of basic rules that have real impact on maintaining the safety of the program than to implement a program with many accessory rules may cause effective preventive measures to be neglected (Ministerio.....2002, 16f)

5. Safer use education and information

Participating prisoners should be informed about the risks regarding injecting drug use and how to prevent damages (e.g. abscesses by informing about safe injection techniques). It is of upmost importance to make sure that prisoners understand that HIV and hepatitis C & B can be transmitted not only through sharing needles and syringes, but also filters, spoons, tourniquet or containers where the drug is dissolved.

Additional information should be provided on VCT, ARV and on the risks of transmission of HIV and of hepatitis C & B including tattooing, piercing and sharing individual hygiene equipment such as scissors, toothbrush or razors.

Prisoners should receive information on HIV, including testing and treatment, and on how to reduce the risks. Peer-to-peer projects have shown to be particularly effective.

6. How to create anonymity confidentiality and trust

Anonymity and confidentiality are difficult to be kept in institutions such as prisons. Privacy is limited in overcrowded dormitories or cells with several prisoners. Even prisoners in single cells are object to observations as soon as they leave their cell. Rumours are spreading fast. Inside any prison, absolute confidentiality of prisoners' personal information may be impossible. However, in the context of prison needle exchange programs, it is crucial to preserve the confidentiality of prisoners who use drugs and access sterile needles to the greatest extent possible.

The acceptance of the provision of sterile syringes depends very much on how 'safe' prisoners feel about the programme.



Questions prisoners ask themselves

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- Is the doctor telling anybody about my participation in the program.
- Is the governor allowed to see the list of program participants?
- Does the nurse telling anything to the guards, because he/she does also security duties
- Those who monitor the programme, do they inform the governor about the frequency of usage of PNSP, which indicates frequency of drug use on a specific ward?
- What does the guard tell to others, when he/she sees my needle/syringe stored in the cupboard?
- Will anybody tell my partner or family whether I am in the programme?
- Will the judge be informed that I am continuing using drugs in prisons, because I am in the PNSP programme now?



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Questions medical staff considers

- How to manage confidentiality, privacy and true consent of the patient in the prison environment?
- How to obtain trust of the prisoners?
- How to balance professional relationships with prisoners and custodial staff?
- How to deal with pressures and expectations from prisoners and from the prison administrations?
- How to keep up complete professional independence while being employed and salaried by the prison administration?
- How to react when prisoner are using needles despite their participation in a drug dependence treatment (e.g. OST).



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Questions prison staff considers

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- Are medical confidentiality, patient's consent and the doctor's professional independence compatible with safety and security in prison?
- Why shouldn't the prison doctor give us the list of participants on PNSP?
-

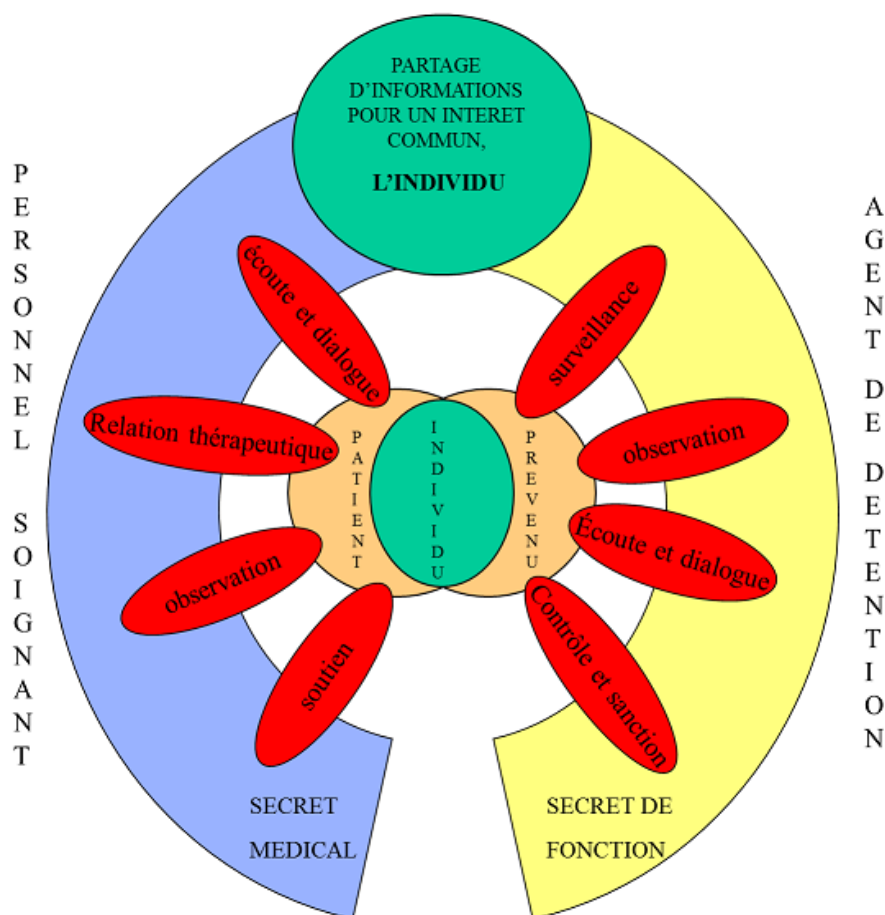
The different views clearly illustrate that different perspectives need to be brought together in a functioning prison-based needle and syringe exchange programme. The key to achieve anonymity and confidentiality related to participation in a PNSP is transparency of the procedures in the working group and communication during trainings or preparatory meetings prior to implementing such a PNSP. Both prison staff and prisoners need to understand that disclosing information about participation may lead to an unsatisfying participation in the programme.

Experiences from countries show that especially the initial phase is essential for trust building and for testing the limits of the programme. When 1:1-slot machines have been installed in the German prison in Vechta, female prisoners started to draw much more needles out of the automat than needed, just to test the programme. In a men's prison drug using prisoners didn't show up at the return point and sent other prisoner instead, just to hide their status as drug user. It took several years before it was clear to prisoners that their participation did not lead to negative consequences for their current sentence.

To summarize, prisoners often mistrust the institution's offers even those which look at the first sight as completely lying in their interest, e.g. harm reduction and PNSP. The rules and structures for safe-guarding anonymity and confidentiality need to be communicated in every detail. Therefore it is pivotal to involve the prisoners already in the process of planning and designing of the PNSP right from the beginning is pivotal.

In some prisons, syringe-dispensing machines located in areas where prisoners are housed have proved the best mechanism for confidential needle distribution. In those institutions where a person-to-person method of exchange is in place, it has been shown that identifying a discreet area of the prison in which to conduct the service is a factor in its success. The importance of confidentiality was demonstrated quite vividly in the Moldovan experience, where the needle exchange pilot in Prison Colony 18 saw a significant increase in uptake when the physician decided to use peer outreach workers rather than the medical unit as a point of contact with prisoners who inject drugs. The experience in the Spanish pilot program in Bilbao, where the evaluations found that prisoners preferred the program to be administered by an external non-governmental organization rather than prison staff, is also an indication of the importance of confidentiality to the program's users. Similarly, the evaluation of the two German pilots found that the program that used a hand-to-hand distribution method through health-care staff enjoyed less trust from prisoners than did the one using anonymous dispensing machines. That said, the Bilbao project also indicated that absolute anonymity is perhaps less important to the people who inject drugs than is trust in the person(s) or agency running the program and the quality of the service provided. The Bilbao evaluation found that the prisoners valued the personal interaction with workers from an external non-governmental organization who conducted the exchanges, and in fact identified this as a preferable distribution method than anonymous dispensing machines.

How to build trust (Peigné 2012): In ENGLISH!



7. Study visits and study groups

When considering the initiation PNSP site visits either by representatives of the Ministry of Justice or prison administration or prison governors, medical personnel and security staff might be helpful. Fears and doubts can often be overcome when visiting a prison operating a PNSP. It is recommended that the type of the prison should be similar and the mode of provision of syringes and needles be analogue. Several stable prison relationships have been developed on this ground, because they offer the possibility to exchange experiences and to probably develop common projects (publications, scientific evaluations etc.).

Helpful for a decision making process when considering PNSP is to set up a study group on PNSP.

Box X: Study group results

The 1999 Final Report of the Study Group on Needle Exchange Programs was prepared by the Study Group on Needle Exchange Programs, convened by CSC. The Study Group was specifically convened to investigate the issue of introducing needle exchanges into Canadian federal prisons. The Study Group included Dr Peter Ford, an internal medicine specialist in infectious disease, physician contracted to CSC to provide care to HIV-positive prisoners in several institutions in Ontario, and co-author of four epidemiological studies on HIV and HCV prevalence in Canadian prisons. Other members of the Study Group included CSC staff (security, health services, and women-offenders representatives), health and community organizations, Health Canada, prisoners, and the public. The project included a CSC task force of health service and security representatives that visited three Swiss prisons to learn more about harm-reduction strategies, and more specifically needle exchange programs. In the Final Report of the Study Group on Needle Exchange Programs, the Study Group recognized that a needle exchange project:

- would advance the government's promise of building safer communities and reinforce the Solicitor General's commitment to public safety and protection

- can reach offenders who are at relatively high risk for HIV and HCV infection and act as a gateway that links them to other appropriate health-care services, drug treatment programs, and counselling and social services, encouraging reintegration of offenders back into the community

- is not and cannot be a stand-alone program, and must be offered as part of comprehensive prevention and treatment programs such as methadone maintenance, substance abuse and addictions programs, and counselling.

The Study Group issued a consensus recommendation that the CSC do the following: To obtain ministerial approval in principle for a multi-site NEP [needle exchange program] pilot program in men and women's federal correctional institutions, including the development and planning of the program model; and the implementation and evaluation of the pilot program (Lines et al. 2006, 59).

Checklist #: To be considered before initiation of the program

- Establishment of an interdisciplinary, multiprofessional working group from all prison departments, initiated with the support of the governor and ministry in charge
 - Development of an internal communication strategy to make the process as transparent as possible
 - Development of an advocacy strategy to inform all agencies who are involved in prison health policy (the ministries, NGOs, courts, judges, lawyers, representatives of drug and HIV/AIDS programmes in the country/region) in order to make the initiation and need of a PNSP as transparent as possible
 - Estimating total number of PWID in prison,
 - Define who is in charge for the programme: medical and/or security staff, NGOs?
 - Needle and syringes must be accessible
 - Discuss and define the mode of provision of sterile syringes
 - PNSP continuity should be guaranteed,
 - Participants' identification should be confidential,
 - Training of staff
 - Targeted HIV and other BBVs information and education should be provided
- Designing and establishing the program in smaller prisons and plan for scaling up to all relevant prisons after maximum 12 months of piloting.
- Evidence based drug dependence programme should be provided (e.g. OST and CBT), but
 - Voluntary HIV/HCV testing and access to ARV should be provided

Checklist #: Process of PNSP: What should be considered before starting?

- Before providing needle and syringes, participants should be informed about the programme, objectives and rules
- Participants are informed about the full range of drug dependence treatment options and HIV services in the prison
- Participants to be informed on safe injection practices, HIV, hepatitis
- Define the number of syringes and needles a participant can get each day (e.g. two), in exchange of used ones
- Participants in the programme are given a small container to store needles.
- Needles should always be kept in the container easy to identify by the security staff.
- Cleaning materials (e.g. bleach) should also be provided in order to clean paraphernalia if needed in case it is not possible to provide sterile equipment (spoons, tourniquets etc.)

- 2091 • The distributed syringes should be marked in some way to able the the
- 2092 identification of used syringe that can be traced back, to safeguard that the PNSP
- 2093 material is used
- 2094 • For used needles sharp boxes, where needles can be thrown into need to be
- 2095 available
- 2096 • Consultation about HIV and drug use should be offered in regular intervals (e.g.
- 2097 each 6 months)
- 2098 • HIV, HCV and HBV voluntary testing should pro-actively be offered each 6
- 2099 months.

2100 B. Needs assessment

2101 Intravenous drug use is widespread in prisons (see chapter XXX), but if the number of i.v. drug users
 2102 seems to be low, should it be implemented as well? Does that mean that every prison needs a PNSP?
 2103 As drug dependence is a chronically relapsing disease relapses of injecting drug use may occur in a
 2104 range of different frequencies. Thus, to avoid transmission in case of relapse, prison doctors and/or
 2105 nurses should establish models of provision of clean syringes in every prison where intravenous drug
 2106 use may occur even in single cases.

2107
 2108 Is PNSP necessary in every custodial setting? Here are some points to define the necessity of starting
 2109 PNSP.

2110 There are several indicators for the need of a PNSP:

- 2111 • the number of drug users,
- 2112 • drug users report injecting and sharing material in prisons
- 2113 • number of abscesses and other skin penetrations treated in the medical unit
- 2114 • seroconversion of HCV or HIV during incarceration
- 2115 • discovery of injectable drugs, used needles and syringes during cell searches.

2116 Furthermore there might also be resilient data from case studies, focus groups, monitoring of risk
 2117 behaviour and surveys carried out to have a better knowledge of the prevalence of drug use, of risk
 2118 behaviours and infectious diseases. Surveys might have been conducted. However, prison staff, health
 2119 care workers (doctors, nurses), governors can also have a good overview of risk behaviours in prisons
 2120 with regard to sharing of needles and equipment, tattooing and piercing. This knowledge might be
 2121 already sufficient to plan and initiate a PNSP, this depends very much of the culture and specific
 2122 circumstances in the respective country.

2123 If more evidence for risk behaviour and intravenous drug use is needed prison administration can
 2124 commission a rapid assessment in the envisaged prisons to collect this information. A rapid
 2125 assessment in the penitentiary system does take a few weeks. Intervention and response development -
 2126 rather than the simple collection of data - is the ultimate goal of a rapid assessment (Stimson et al.
 2127 2003; see also UNODC/EMCDDA HIV/TB in prisons situation and needs assessment toolkit).

2128 In some countries people who inject drugsput into custody by the police are given clean sterile
 2129 syringes when they are released from the police station. When a detainee arrives in custody with
 2130 either a used or unused needle(s) either loose or in a pack, then the police will dispose of them
 2131 in the sharps container provided and kept solely for this purpose.

2132 Box xx Procedure for the replacement of injecting equipment in custody (elaborated by the police of
 2133 Kent) – see “Protocol for the replacement of injecting equipment in police station”

**PROCEDURE FOR THE REPLACEMENT
OF INJECTING EQUIPMENT IN CUSTODY**

PERSON ARRESTED

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I

DETAINEE ADVISED OF EXISTENCE OF
SCHEME PRIOR TO SEARCH

I
I

DETAINEE IN POSSESSION OF
NEEDLES/SYRINGES?

I
I

YES - CONFISCATE AND PLACE IN
BIN PROVIDED

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I

EXPLAIN REASON FOR DISPOSAL AND INFORM DETAINEE
THAT REPLACEMENT PACK WILL BE PROVIDED
ON RELEASE IF DESIRED

I
I

PUT NEEDLE EXCHANGE PACK IN PRISONERS PROPERTY.
ENDORSE CUSTODY RECORD AND COMPLETE
"NEEDLE LOG SHEET"

I
I

OFFER DETAINEE THE OPPORTUNITY TO
SEE A CUSTODY NURSE.

I
I

ON RELEASE HAND REPLACEMENT PACK TO DETAINEE
ALONG WITH PRISONERS PROPERTY.
IF REMANDED OR TRANSFERRED,
PACK TO REMAIN WITH PRISONERS PROPERTY

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C. Legal regulations, policies and procedures

Policies are general guidelines that describe the programme activities, modes of operation and rules, whereas procedures are detailed steps (protocols) for doing each task. This becomes important in all phases of PNSP: initiation, operation and scaling-up of services.

In many ways clear guidelines and protocols are the result of professionals dealing with health challenges as they guide successful practice and deliver a systematic response towards health threats like the transmission of BBVs. Examples of good practices in the development of guidelines are to be found all over the world as are standards of care and protocols for dealing with issues that arise (e.g. Switzerland, canton of Geneva).

Clear protocols and standards are necessary to ensure the health needs and human rights of prisoners are addressed and also to allow detainees to share their concerns.

The implementation of PNSP needs formal authorisation and regulation by the ministry in charge of prisons, because needles are sharp devices, which in most jurisdictions are forbidden, need separate regulation. Official regulation (usually “Standard Operating Orders (SOPs)” make clear to everyone that PNSP is supported by the authority in charge.

This regulation needs to include:

- the institution/unit/persons in charge
- the mode(s) of provision of syringes and needles
- practice of discarding used needles
- the mode of storing needles and syringes on the cell and on transport
- the consequences for prisoners violating these rules
- information for security staff how to behave in cases of finding used and probably filled needles
- the formal procedures of monitoring and evaluation
- the formal note that drugs are still illegal and will be taken away as usual
- procedures for re-designing and adjusting the conceptual framework within the pilot phase.
- if a pilot has been set up, the period for the pilot and the consequences if the project results are either positive or negative

Box X Getting PNSP started by a Memorandum of Understanding (MoU) between ministries

In Spain the implementation of the first PNSP pilots has been done on the basis of a MoU between the Ministry of health and Consumer Affairs and the Ministry of Interior (2000), called “Key Issues for implementation of needle exchange programs in prison”. This was a basic document to get the PNSP started. After a few years the experiences accumulated in operating and piloting PNSP have been condensed in a framework document with the objective to support prisons to design their own specific program within a common framework, which enables them to benefit from previous experiences and to achieve the best results from the start (Ministerio del Interior 2002). Each prison designs its own PNSP, which needs approval by the Board of Directors of Prison. The concrete procedure is laid down in additional documents (example in Annex).

At a later stage a clarifying and supporting statement respective an instruction of the Director General for Prisons in Spain has been issued to expand programmes (7 June 2011)

D. Selecting the most suitable prisons for the pilot

Criteria for implementing an initial harm reduction project would be a relatively large number of prisoners who are supposed to use injectable drugs, where blood-borne-virus infections are known or

supposed to be widespread and where incidence data on risk behaviour are available (see chapter needs assessment).

Historically it is not a coincidence that the first needle exchange programmes have been implemented in women's prisons (Hindelsbank/Switzerland and Vechta/Germany). Traditionally health topics are differently discussed and handled in women's and men's prisons and in the wider society. Thus prevention tools, harm reduction could be more easily introduced in custodial settings for females. Therefore women prisons who traditionally host a large number of drug users, are for a pilot project of PNSP. If this is done, already in the planning phase it should be negotiated to how to transfer (positive) results to men's prisons.

However the only rationale for a pilot study is to evaluate the effectiveness of the implementation modality. By definition, the aim of the pilot study is to establish the basis for scaling up the service and cover all the population in needs. Therefore, when authorities planned for such a pilot it must have a clearly defined period, of maximum one year. Evaluation criteria and tools should be clearly developed from the beginning, and be monitored to allow for adjustments. As soon as the pilot period is completed and implementation modalities well established the programme can be scaled up to ensure an effective coverage of the PWID in prison. The major challenge in implementing a PNSP is to ensure the access to the service.

Box X: Criteria for Site Selection – The example of Moldova

NGO and penitentiary officials agreed to implement an initial harm reduction project at Branesti prison, a medium and maximum-security prison with a population at that time of approximately 1,000 men. They chose that facility because it housed the largest number of prisoners known to be HIV-positive, had the largest number of people incarcerated for drug-related offenses, was the prison with the lowest average age (mid-20s) and where a significant majority were imprisoned for the first time. 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 youth and "newness" of the prisoners meant they were less hardened than those elsewhere (Hoover & Jürgens 2009, 14).

E. Coordination and Communication: Implementing a working group

The implementation of a PNSP project is a challenging work for ministries in charge of prisons, in charge of health in prisons, prison authorities, and prison staff. Whether at the ministerial or at prison level, before initiating a PNSP all prison staff members and prisoners should be informed about the project through clear memos at least or by issuing changes in law and/or regulations, and by requesting active involvement of staff and prisoners. This best can be done without putting the needle exchange too much in the foreground but instead by making clear that the drug strategy is being improved and new options have been developed which add to the existing offers.

A working group should be established with all key stakeholders. The task of the steering committee are to design, initiate and finally manage and evaluate the project. This is because PNSP affects many professional procedures not only for security staff and medical professions (doctors and nurses), but also for management.

This group also serves as central contact and coordination point for all procedures and processes and is responsible for all internal or external communication:

- To discuss the concept of the PNSP with all people working and living in prison
- To choose the mode(s) of provision of sterile injection equipment in all details
- To ensure safety in the workplace (protection of staff, gloves etc.)
- To establish rules and regulations re storage and transport (e.g. of used syringes)
- producing information and education material in the respective languages

- 2240 • linking the PNSP to NGOs and other authorities in the community
- 2241 • organising training for prisoner and staff (by integrating NGOs)
- 2242 • responding to complaints of prisoner and staff
- 2243 • solving arising problems (either technical or organisational)
- 2244 • to produce transparency regarding the operation of the project
- 2245 • to summarize interim results and experiences
- 2246 • following advocacy issues
- 2247 • To document the project.

2248

2249 This group also might do the first assessment and ongoing planning of the process. It ensures the
 2250 realisation of policy, where the functioning of the program is described. Information regarding the
 2251 functioning should be communicated regularly with prison administrators and NGOs involved.
 2252 Working relationships in order to align prison health interventions with community NSPs are crucial
 2253 (Annex 2010, 10).

2254 The amount of work will be high when initiating the project and will then decrease once it is operating
 2255 successfully. A spokesman/spokeswoman needs to be chosen for communicating with the governor,
 2256 NGOs, and/or ministry.

2257 Dealing with fears and mistrust of the personnel will be a central task of the working group and/or the
 2258 governor. It is quite understandable that staff, who were confiscating needle and syringes as an
 2259 indicator for drug use during their whole professional life do have difficulties in switching the harm
 2260 reduction model. All fears have to be treated seriously, in order to respond to them adequately. This
 2261 can be done in several ways, but what is needed is transparency regarding the plans of implementing a
 2262 PNSP, the goals and the modus of operation (see Box X).

2263

2264 To what extent harm-reduction programmes, including the provision of sterile syringes, are accepted
 2265 by the prisoners greatly depends on the degree to which they feel their access to syringes is
 2266 confidential and anonymous (Hoover/Jürgens 2009). Therefore prisoners' voices should be heard
 2267 when starting the project, because their view is quintessential for the acceptance of the project. The
 2268 forum to listen to prisoners is the meeting of the working group. Topics like where in the prison access
 2269 would be most discreet, which modes would they use without fearing any negative consequences,
 2270 which types of needles and syringes and paraphernalia should be provided, which language would be
 2271 needed in the information leaflets and brochures, which kind of training would best be understood,
 2272 which additional paraphernalia, which regulations to transport them in the pocket and to store them in
 2273 the cell etc.

2274 Mistrust of prisoners against even harm reduction services is often widespread. Even PNSP might
 2275 raise fears in them in the way that they feel controlled and that participating in these services might
 2276 lead to intensified supervision and cell searches by security staff.

2277

2278 The essential questions to be discussed with them are the following:

- 2279 • Do prisoners have trust in the needle and syringe programme?
- 2280 • Can they easily and anonymously access needles, syringes, and paraphernalia?
- 2281 • Is the service adjusted to their needs?
- 2282 • Have prisoners access to different types of syringes and to other injecting equipment such as
- 2283 swabs and sterile water?
- 2284 • Can prisoners obtain sterile injecting equipment without having to self identify as drug users
- 2285 to prison authorities?

- 2286 • Is the access to paraphernalia ensured in a confidential mode or a way to indicate where drug
- 2287 might be hidden?
- 2288 • Can they get more than one syringe in a preventive way (when drugs are in the institution, but
- 2289 the PNSP is closed?) (see also UNODC 2008, p. 85: Checklist 10. Needle and syringe
- 2290 programmes).

2291 Also prisoner could support the implementation of the project by advertising it in the prison-based
 2292 magazine, newspaper, or broadcast.

2293

2294 **Box X: Coordination and Communication: working group**

2295 In the women's prison of Vechta/Germany a working group has been formed by integrating staff of all
 2296 relevant prison wards and departments. The group met regularly to discuss, plan and assess the
 2297 progress of the introduction of the needle exchange project. The protocols of the meeting were prison
 2298 internally available, so that all other staff member could have a look at the current state of affairs. This
 2299 transparency was intended to serve as a trust building measure for all other staff. Staff as well as
 2300 prisoners were being asked by the coordination group where the 5 syringe dispensing machines should
 2301 be installed in order to guarantee a discreet and confidential access to the automats.

2302 The introduction of PNSP has always been a topic on the general meeting of all staff members in order
 2303 to inform them about the progress and evaluation.

2304

2305

2306 F. Information, education and communication (IEC) for prison staff and prisoners

2307 1. Prisoners

2308 With the implementation of PNSP questions of risks for the transmission of infectious
 2309 diseases will become a central point in discussions for both prisoners and prison staff. The
 2310 intensive discussion of BBV infection risks inside the institution raises awareness, interest,
 2311 and fears: How big is the problem, what exactly are the infection risks regarding e.g. HIV,
 2312 different types of hepatitis, how likely is the transmission in an everyday contact etc.

2313 Institutions have to be prepared that PNSP inevitably raises these questions. Therefore IEC
 2314 programmes for both prisoners and staff are essential prerequisites for operating PNSP
 2315 successfully. Educational workshops and consultations with prison staff and prisoners have
 2316 been a key aspect in the development of PNSP.

2317 Staff and prisoners alike should receive ongoing trainings on issues including overdose
 2318 prevention, transmission of HIV and hepatitis, STIs and safer sex education. Prisoners and
 2319 prison staff design harm reduction tools themselves that are put through focus groups and
 2320 produced for distribution throughout the prison system.

2321
 2322 As IEC as a stand alone is not a sustainable strategy it is supposed to be more effective when
 2323 directly linked with harm reduction services in order to change risk behaviours regarding the
 2324 transmission of BBVs and overdose (WHO, UNODC, UNAIDS 2007; Aggleton et al. 2005;
 2325 Ball et al. 2005).

2326

2327 1. Written materials should be appropriate for the educational level in the population in
 2328 custodial settings. These should be available in the different languages needed. Prisoners
 2329 should be involved in the development of these educational materials. The material should
 2330 have an interactive character (e.g. quiz etc.)

2331 2. Peer education programmes are the most effective ways to deliver target-oriented
 2332 education on risk behaviours

- 2333 3. Where relevant and accessible, new media (e.g. internet) should be used in order get the
2334 messages of harm reduction and transmission risks adequately transported
2335 (Stöver/Trautmann 2001).
2336 4. In order to avoid stigma and discrimination of PWID and PWHIV by other inmates it is
2337 necessary to communicate the necessity of infectious prophylaxis and in a broader sense
2338 issues of dependence to all prisoners.
2339

2340 2. Prison staff

2341 Prison staff should be fully informed about the objectives and purposes of the program before
2342 it is started. It is advisable to conduct courses to train, motivate and increase awareness on the
2343 benefits of harm reduction programs, and in particular of PNSPs. It is of utmost importance to
2344 achieve and maintain trust and confidentiality. Furthermore the rules established for its
2345 operation should also be explained and made transparent.

2346
2347 Rejecting staff attitudes have changed as prison staff has learned first-hand about the prison-based
2348 needle exchange programs and the harm-reduction goals, and as they have participated in the
2349 implementation, planning process, and when staff is noticing that their fears are dealt with seriously.
2350 Attitudes and opinions can change. This change can result from knowledge and information gained
2351 through first-hand or through workplace education programs.
2352

2353 Especially important issues for training seminars for prison staff include:

- 2354
2355 - Seminars that help prison staff to identify themselves with and support the objective of
2356 PNSPs
2357 - Seminars in which prison staff acquires basic knowledge about drugs, drug use, infectious
2358 diseases and other drug use related health risks
2359 - Seminars in which individual and collective needs for safety are discussed and agreed upon
2360

2361 Again the focus of these seminars cannot only be on knowledge but should also focus on:

- 2362 - Skills, e.g. in the field of counselling;
2363 - Raising awareness about the staff's attitude towards drug use, sexual behaviour, etc.
2364

2365 The training seminars should focus on adequate behaviour patterns as part of measures
2366 initiated to prevent the spread of infections in prison. A single training on behaviour change,
2367 however, will not be efficient without accompanying structural changes in the prison setting.
2368

2369 ***Identification the goals of PNSPs***

2370 Prison staff and management appropriate themselves the infectious diseases prevention
2371 objectives of preventing infections if there is an understanding that infections in prisons are a
2372 threat for everybody, both in and outside prisons. They need to understand that they have a
2373 crucial role in making the programme successful. Information on leaflets is not enough. These
2374 are only suited to complement other measures such as personal counselling by informed and
2375 committed staff but they cannot replace such measures. Implementation of preventive
2376 measures is frequently jeopardized by individual attitudes and prejudice of prison staff
2377 ("Inmates know exactly what they are doing; they are grown-ups and they are responsible for
2378 themselves"). Moreover, prison staff often considers drug consumption a weakness of
2379 character ("Addiction can be overcome if the will is strong enough ("Quitting is the only
2380 solution!") or religious reasons are given for why earthly means are hardly suitable for
2381 combating risks of infection ("AIDS is the well-deserved punishment imposed by a higher
2382 power!"). Such attitudes and beliefs are deeply rooted in people. They cannot be changed
2383 easily. Hence training offered to prison staff should aim at familiarizing them cautiously with

new attitudes and at sensitising staff towards the situation of drug-using inmates and of course, allaying the fears of colleagues.

Special attention needs to be paid to confidentiality: All prison medical staff and officials are trained in the importance of safeguarding confidentiality for HIV positive prisoners, who may face violence and discrimination if their HIV status is known.

Acquiring basic medical knowledge

The use of illegal drugs and the use of medical services and medication are often related to each other. However, frequently, drug-using inmates are reluctant to seek help concerning their use of illegal drugs directly from medical services. The situation is getting more complicated by the taboo under which drug use (in prison) operates. Therefore it is crucial that prison staff members learn basics knowledge in order to:

- Avoid infections, especially viral infections often associated with drug use,
- Allow prevention and early treatment of transmission of HIV or Hepatitis,
- react adequately in case of overdoses,
- react adequately in case of needle stick injuries.

Accepting and meeting individual and collective needs for safety

This is an important issue when training prison staff, as it has been shown that fears, feeling of insecurity have a negative effect on the atmosphere in the prison and on relations between staff and inmates. These will also affect the success of harm reduction activities, such as discussing safer behaviour for example. A closer relationship between staff and inmates can only be established if the prison staff's needs for safety are met. Seminars should focus on supporting prison staff, helping them to feel more secure in handling drug-related problems. Besides extending their knowledge on drug and drug use related issues, seminars should also answer questions related to the risk to prison staff of getting infected, and inform participants on interventions like Post-Exposure-Prophylaxis (PEP) after a needle stick injury, first aid in drug-related emergencies, adequate treatment of wounds and the availability of hepatitis B vaccinations.

Taking up the staff's needs and fears as an initial point of departure for training is crucial. Guidelines and protocols for avoiding risk exposure and adequate safety behaviour (such as wearing gloves when searching cells etc.) are needed. Problems in transferring these guidelines into practice can be discussed in trainings.

G. Addressing health and safety concerns of prison staff

The importance of occupational health and workplace safety for all prison staff members should be put into the focus of any PNSP. Correctional institutions have a duty of care to protect the health and safety of prison employees. The controlled provision of needles and syringes might contribute to make the workplace safer, because it would reduce the number of used and potentially contaminated needles in circulation and help prevent BBV infections. (Annex 2010).

Box X: Safety at the work place

The fears of prison staff are mainly related to a malfunctioning of the programme. Concretely prison personnel fears that more syringes and needles are lying around, that their workplace safety is concerned and that more drug use would occur in prisons, that needles could be used as weapon. The opposite is the case as has been pointed out by the Spanish Directorate General for Labour Inspection who stated when inspecting the safety of prison personnel: "On

a first review of the issue under discussion, we find that we face two legal rights that are to be protected: inmates' right to health protection and workers' right to effective protection of their health and safety. A more detailed examination, however, leads us to say that the introduction of NEPs creates a safer situation for prison officers. This argument arises from a comparison of the situation before and after introduction of the NEPs." (Directorate General for Labor Inspection ...2002, 3).

According to the Spanish experiences the results in prisons, where the program is already operating, have not confirmed these fears. In this regard and with reference to the potential increased risk for prison workers when a NEP is implemented, the Directorate General for Labour Inspection and Social Security in its directive 101/2002 considers that "implementation of a NEP does not pose serious risks for the performance of prison officer activities, but rather reduces them and minimizes the risks derived from the clandestine syringe use".

However, a series of measures for protection and prevention should be taken to eliminate or reduce the risks, including among others:

- Needles or other sharp instruments should be handled with adequate precaution when they are collected or manipulated for any reason.
- If the needles are not contained in their rigid case, they should not be recapped or manipulated in any other way.
- Piercing or cutting objects should never be discarded into the plastic bags of conventional disposal bins; but rather into the rigid puncture-resistant containers available in all prisons.
- In the event of needle stick injury the incident should be reported as soon as possible to the appropriate occupational health unit, which will specify the measures to be taken in each case (see Ministerio ...2002, 16).

With respect to the risk of occupational accidents, prison workers should know that the risk to health care personnel of acquiring HIV infection from a needle-stick injury is very low: Prospective studies of health care workers have estimated that the average risk for HIV transmission after a percutaneous exposure is approximately 0.3%, the risk of HBV transmission is 6 to 30%, and the risk of HCV transmission is approximately 1.8% (Beltrami et al. 2000).

- "First of all, illicit syringes, which are usually hidden and unprotected, are replaced by program syringes equipped with a rigid protective case. Prisoners participating in the programmes do not need to hide their used syringes under mattresses etc. which reduces the risk for accidental puncture during the searches of the cells or prisoners
- Secondly, in the event of an accident, it is less likely that the syringe has been used because the inmate can and should exchange it for a new one at the first opportunity after use.
- Thirdly, in the event that the syringe has been used, it is less likely that it has been shared by various inmates, thus reducing the probability of it being infected and enabling the user to be identified with greater certainty, which allows preventive actions to be taken if necessary.
- Finally, in the long term, reduction of parentally transmitted diseases will make prisons a healthier and less risky environment.

Although the risk of accidental needle stick injury in a prison is very low and much less likely than in a health care centre, it is important to adopt the required measures to offer the maximum protection to workers. A key element for this is to ensure that the syringe is always kept in its case. A syringe in a closed case is not dangerous even if it is hidden, while an accident is always possible with an exposed needle, even if it is visible. Therefore, program rules should stress particularly that it is compulsory to keep the syringe in its case." (Ministerio...2002, 16f).

Box X: A comparison of the situation before and after introduction of the PNEPs
(Ministry of the Interior, Directorate General for Prisons)

.
Before the PNSPs:

- Clandestine needles used by inmates are without a hard protective casing. They are also a prohibited object, and therefore always hidden.
- Needles are used repeatedly, as inmates are unable to procure new ones. Thus the likelihood increases that a needle has been used by more than one inmate, which in turn exacerbates the risk that it is infected, and that it may cause contagion through accidentally piercing skin.
- In the event of a needle accidentally piercing skin, the fact that it is not known who has used it hinders the use of preventive measures against possible contagion.

After the PNSPs, however:

- Needles have a hard casing that precludes accidental piercing or punctures, as set down by the program rules; needles are not prohibited, and thus need not be hidden.
- An inmate can, and is told that he must, exchange used needles for new as soon as possible. Hence needles will be cleaner or unused. As all inmates using needles, under the established restrictions, have access to new needles, shared use – and thus the risk of contagion – is drastically reduced, as is the risk of accidental punctures.
- In the event of accidental piercing, identification of the needle-user by the health service allows for preventive treatment against any possible contagion with AIDS or hepatitis, wherever such is deemed medically advisable. This reasoning, in the event of accidental piercing (during searches, etc.), supports the argument here advanced – that NEPs make for lower risk. In addition, it can be reasonably held that the use of needles as a weapon of intimidation is unusual and in some senses falls outside the sphere of work; and, though possible, such use is not at present linked to corroborating data that might be addressed with rules of control that would repress such punishable offences, or with the deployment of a different NEP methodology with new resources or different organisational measures determined by the prison authorities.

In Spain the Directorate General for Prisons of the Ministry of the Interior (2002) gave out specific instructions for the protection of staff and for accidental needle stick injuries:

a) Risk assessment

The prison shall carry out a risk assessment for prison officers with a view to the new work conditions arising from introduction of NEP programs, especially for officers, who in their function of guarding and keeping custody of prisoners, frequently search inmates and their cells, in order to determine the risks, accidental or otherwise, to which they are exposed through use of needles under the program.

The risk of transmission of HIV from an infected patient through a needlestick where the skin is punctured by a sharp is less than 1% (for HCV approx. 1,8%). The risk for transmission from exposure to infected fluids or tissues is believed to be lower than for exposure to infected blood.

b) Healthcare and health-monitoring measures

Where applicable, it may be advisable that prison officers and workers (since prisoners are given rules for the use of needles and health education guidelines by the unit in charge of implementing the PNSP) adopt the following preventive measures:

- Introduction of safety products into the program, such as those indicated in chapter X, so as to prevent accidental punctures for prison officers.
- Vaccination against hepatitis B is a universal precaution measure for prison staff and prisoners.

- To develop clear protocols for staff working in prisons on what to do in the event of any puncture.
- training on Universal precautions
- access to Post Exposure Prophylaxis (see comprehensive package, p. X)
- Provision of protective equipment.

c) Handling and disposal of needles and waste materials

All prison workers must handle with extreme care the needles and cutting instruments they may pick-up or handle for any reason (officers in charge of custody and surveillance, cleaners, personal services workers, etc.). Precautions shall be taken in handling, in cleaning work and in disposal. In addition, the following shall be taken into account:

- Once a needle has been used, if it is not contained within its hard casing and thus not under control, it shall not be re-encased with the protection cone or handled in any way.
- For disposal, needles and other cutting or piercing instruments shall be placed in puncture-proof containers located in the areas to be used most often, such as in the places used for needle exchange and any other relevant locations based on assessment conducted by the working group, which coordinates and monitors the programme and the medical departments shall set down,
- Cutting or piercing objects shall never be left on a surface, as there is a risk that other officers or workers may be hurt.
- Containers shall never be entirely filled, as needles protruding from containers constitute a significant risk to people handling them.
- Especial care shall be taken to ensure that no cutting or piercing objects are contained in clothing for laundry, as they may cause accidents to workers handling the clothing.
- Cutting or piercing objects shall never be disposed in plastic bags in conventional refuse bins, for the same reason.
- Waste and discarded objects contaminated with blood with a potential risk of infection shall be deemed hazardous and shall be incinerated (if possible) or disposed of in accordance with the prison rules on infectious waste and public health rules , taking into account a range of preventive measures: colour coding, impermeable vessels, labelling, or a combination of such measures.

d) Personal hygiene

- The concept of universal precautions (take always precautions as if a person or an object is HIV or HCV/HBVcontaminated) needs to be explained and implemented
- .- Established personal-hygiene measures shall be adhered to (hand-washing when hands may have come into contact during work activities with potentially contaminated materials such as blood, etc.).
- In many situations infection risks are high (accidents, fights, cell revision etc.) - prison officers and workers shall:
 - Put on waterproof gloves.
 - Pour 10% solution bleach (one part domestic bleach to nine parts water) onto the contaminated surface.
 - Clean the area with dispensable towels.

- Take off their gloves and wash their hands.

e) Measures to be taken in the event of accident

The WHO recommends the following management of occupational exposure to HIV:

- First AID should be given immediately after the injury: wounds and skin sites exposed to blood or body fluids should be washed with soap and water, and mucous membranes flushed with water.
- The exposure should be evaluated for potential to transmit HIV infection (based on body substance and severity of exposure).
- The exposure source should be evaluated for HIV infection. Testing of source persons should only occur after obtaining informed consent, and should include appropriate counselling and care referral. Confidentiality must be maintained.
- Clinical evaluation and baseline testing of the exposed health care worker should proceed only after informed consent.
- Exposure risk reduction education should occur with counsellors reviewing the sequence of events that preceded the exposure in a sensitive and non-judgmental way (WHO information about PEP for HIV prevention)

More detailed information from the Spanish PNSP experiences suggest the following precautions:

- In the event of cuts or puncture wounds with potentially hazardous materials, such wound shall be covered with impermeable dressings and, providing as much information as possible about the wound, medical care shall be sought.
 - Specifically, in the event of skin-piercing accidents (punctures, cuts, etc.) the following action shall be taken:
 - Withdraw the object causing the puncture or cut.
 - Clean the wound with tap water, without rubbing, allowing blood to flow freely for 2 to 3 minutes under the tap water. Induce bleeding if necessary.
 - Disinfect the wound with povidone-iodine, chlorhexidine gluconate or another disinfectant. Several options are provided in the INSHT Biological Agents Guide (biocides).
 - Cover the wound with an impermeable dressing.
 - In the event of spattering with blood or fluids on skin or mucous membranes:
 - Wash with abundant water and soap .
 - All accidents shall be notified as soon as possible to the Medical Department or Unit in charge of recording them. The prison's established protocol for post exposure prophylaxis shall apply.
 - Staff accidentally exposed to equipment contaminated by blood and not yet vaccinated against to hepatitis B shall be offered hepatitis B vaccination. In addition post-exposure prophylaxis should be provided. –
- (For memory: The risk of AIDS contagion, after an accident involving biological risk through piercing or cutting and involving HIV-positive persons, is 0.3%, plus the risk corresponding to hepatitis B or C, if applicable – such as may occur, for example, in a search without due precautions having been taken – see point “Risk assessment” in this chapter)

Prison officers and workers shall be protected against the risk of accidental injury by piercing or cutting objects by means of personal protection equipment (essentially gloves and jackets) during work thus defined by assessment of the risk involved, and specifically in searches and similar tasks.

Given that in the introduction of the PNSP sensitive issues have been raised in respect of adoption of the proposed healthcare policies, the participation of the affected officers and workers is to be encouraged through meetings between the latter and the Prison System authority in order to discuss the problems detected and to provide effective solutions.

During the initial stages of introduction of the PNSP in each prison, prison officers and workers in connection with operation of the program shall be informed and trained with regard to their motivation, in order that they are aware of the advantages and drawbacks of such introduction, the potential general and specific risks relating to their job position, and the protection and prevention activities that can be adopted to eliminate or reduce the risks discussed above.

In any event, there shall be carried out all legally required regular monitoring of workers' health (see WGO/ILO 2007).

Prisons should develop clear guidelines and communicate them to staff: what to do in case of accidental punctures or exposures to blood; who to contact; (PEP should start within 72 hours).

H. Difficulties and problems in starting and operating PNSP

1. Opposition by staff

Syringe exchange schemes are still a controversial political issue because they are supposed to symbolise the failure of keeping prisons 'drug free'. Furthermore PNSPs are still subject to political decisions and strategies (e.g. German experiences, see chapter XX). Prison personnel at all levels are nearly always opposed to PNSP projects at first. Experiences show that already after already a short period of time after implementation this has vanished and has become routine procedure. There are several examples of how to deal with fears and the attitude of prison staff. In Hamburg/Germany for instance prison staff was asked to vote for or against the introduction of PNSP. The vote was clearly against it (85% opposed the initial introduction of the needle exchange program in 1998). However, PNSP has been introduced despite this voting (reference.). Another example of dealing with fears is presented in the following.

Box X: Responding to fears and mistrust of the prison staff

In a men's prison in Germany a similar group has been formed to introduce the pilot needle exchange project. Here during an assembly all staff members were being asked to fill in a card anonymously with their fears regarding the project. The cards have been collected and grouped on the board in order to try to give answers to these fears mentioned. Of course, some of the answers could only be given during the process of implementation.

In Moldova PNSPs have been introduced and fears of prison staff have been tackled in a dual strategy of "command and education." (see Hoover/Jürgens 2009). The command part is the

top-down element as many other instructions and orders: An order to start the project is issued to heads of individual prisons and their medical departments' supervisors. They have had no choice but to act on the department's order and allow the project to operate in their facilities. However, it has been emphasized that such a command must be accompanied by a clear and immediate commitment to education and trainings focusing on raising awareness about BBVs and other relevant drug-related health issues for all prison staff, from directors to guards. PNSP has been explained both in concept as well as in execution. Guards need to know exactly how to act and respond in particular situations.

Both prison staff and prisoners must be aware of and understand the specific legal issues and contexts as well. It should be made clear that there is both a disciplinary and a health promoting element. Both is important for the guards to understand, because it helps them to act professionally on a legal basis with sanctions when the PNSP rules are not obeyed and it helps them to understand and accept the harm reduction project.

Furthermore it contributes to the work place safety, when specific and very basic health information are given, e.g. to explain to staff that the best prevention is to treat every prisoner as if he or she is HIV- or hepatitis C positive.

That does not mean to discriminate them, but to deliver a simple message to wear gloves when touching bodily fluids or during cell searches.

Training needs to be provided on an ongoing and regular basis, not just prior to the project's initiation in a specific facility. Training has to be continued regularly because there are always new prisoners coming into institutions, both new prisoners and new guards.

NGO's could play a major role in these trainings because of their competence and long standing expertise in dealing with PLWH.

2. Opposition by general public and media

In trying to understand professional and political resistances to harm reduction, it is necessary to go back and examine the underlying attitudes towards health care for prisoners generally – and drug use in prisons specifically – among both prison workers as well as general society, as each plays a role in influencing the context in which decisions on prison health services are made. These attitudes can range from ingrained societal prejudices, such as the widespread perception of prisons as being '5 star hotels' (Hassim, 2006) to ignorance of scientific evidence supporting harm reduction interventions or a belief that poor health care is a legitimate aspect of legitimate punishment.

Despite an extensive body of international human rights law and guidelines outlining adequate standards of health care in prisons (Lines, 2008), these attitudes and prejudices remain powerful factors in determining prison health policy and especially PNSPs. Despite commitments of most countries in the world, political obstacles and cultural resentments hinder or altogether block the implementation of harm reduction measures, resulting in an overall prison health system that was very poor.

Health care in prisons is an ideal field for 'symbolic policy', where officials or the public can demonstrate 'toughness' and 'law and order' by approaching health services as an issue of crime and punishment rather than one of public health, let alone human rights. This often can make prison health and harm reduction programmes vulnerable to narrow political interests and political campaigns.

For example, between 2001 and 2004, well established and successful syringe exchange programmes being operated in six German prisons were terminated following elections in the respective federal states ('Bundesländer'). Despite scientific evidence of their value the termination of these programmes was politically and ideologically motivated, and the decisions ignored six years of evidence and good experiences of the successful prison needle exchange implementation in Germany. The decisions were made without consulting prison staff (many of whom supported the programmes), and were driven by the political objective of abolishing harm-reduction measures and establish drug-free prisons as the main policy objective. (Lines et al., 2006; Stover & Nelles, 2003; Jacob & Stover 2000).

Generally the quality, the availability of and access to those health care measures applied successfully in the community is dependent on several factors. Despite the fact that there is a lack of evidence for the effectiveness of imprisonment (Gendreau, Goggin & Cullen, 1999; Tonry, 2004), and that there is little relationship between imprisonment and crime rates (Kovandzic & Vieraitis, 2006; Reiner, 2000), countries use imprisonment to the level of pain that they are willing to inflict on their citizens (Christie, 1982; Stevens et al. 2009). The quality of health care is part of this policy and depends on several factors:

- Transparency of health care practice and living conditions in prisons in general: if there is a close relationship between community and prison health care system (like Spain, France, England & Wales, some cantons of Switzerland), or if prison health care is even performed by the community health care services itself, the likelihood of adequate services is much higher (see recent changes in England; Marteau & Stöver 2009).

- Strength of media, professional, and general public in tackling prison topics respectively living conditions of prisoners: if NGOs and, for example, human rights agencies are watching and monitoring the effects of imprisonment, and are informed and engaged to make prison (health care) issues a topic in mass media and to scandalise circumstances and practices the likelihood of adequate services is higher.

- Perception of loss of freedom itself as major punishment without additional sub-punishment structures (like bad food, poor hygiene, or lack of proper health care services): if there is a consensus that the loss of freedom is the only punishment, the principle of equivalence of health care is more likely to be accepted.

3. Low participation rate

Participation rate means the number of people actually benefiting from the programme related to the number of those who theoretically could benefit from this offer or are supposed to be in need of this offer. The participation rate can only be a rough indicator as though too many questions remain unsolved: we do not need the total number of people who inject drugs in prisons, and we do not know much about consumption patterns (frequency of injecting etc.) Insofar there are some structural limitations in that calculation. Anonymity is key to have a successful PNSP in prisons and should be maintained. However, rough calculations show if a PNSP is not used when the rate of syringes taken compared to the (potential) number of people who inject drugs seems too high.

Problems might arise when it becomes clear that there is a low participation rate in the PNSP. This might have several reasons:

- prisoners have fears of disclosure of data and suspect negative consequences for their current sentence

- confidentiality is lacking in high threshold provision of syringes. The programme is not trusted

2782 - the mode of provision of clean needles and syringes might not be adequate

2783 - the wrong needles, syringes and/or drug paraphernalia are being provided (e.g. single-use, self

2784 destroying needles),

2785 - the programme is not made publicly known to all prisoners,

2786 - the rules remain unclear,

2787 - the mode of drug use has changed towards smoking of drugs

2788 - people who inject drugsthemselves do not use the programme but non-drug using inmates. Here a

2789 hidden or secondary exchange system might exist.

2790 - most of PWID are under OST and the number of people injecting in prisons is reduced.

2791

2792 In all these cases the programme needs readjustment for either of the problems mentioned. On the one

2793 hand the basic and underlying fears and mistrusts of many prisoners have to be taken into account. On

2794 the other hand the design of the programme might not be appropriate.

2795

2796 An example for a successful project revision is delivered by the Moldovan PNSP (see Hoover &

2797 Jürgens 2009). In Moldovan prisons, at the beginning of the project, when needles were handed to the

2798 prisoners by the prison health staff, the uptake was low. In the five first months of the implementation

2799 phase less than 50 syringes were exchanged and fewer than a third of the prisoners known to inject

2800 drugs were accessing the project. Many prisoners were reluctant to access the services because they

2801 did not believe the program was truly anonymous and confidential. Another obstacle was that medical

2802 personnel were not always available when prisoners needed them. The project's services were usually

2803 available only when the majority of medical staff were present—perhaps eight hours during the day,

2804 from Monday through Friday. That meant access was nonexistent or limited in the evenings and on the

2805 weekends.

2806 In order to improve the degree of trust and confidentiality and the accessibility, it was then decided to

2807 select prisoners to be trained as outreach volunteers to provide services to fellow prisoners.

2808 Another example comes from Luxembourg. The persons in charge do believe that only approx. 20%

2809 of the target group are participating in the programme, while the others still use illegal ways to get

2810 hold o f a syringe. The main objective brought forward by the prisoners is their lack of trust in the

2811 anonymity of the service, because of several reasons:

- 2812 • In order to reach the nursery unit they have to pass several guards, and fear disclosure of their
- 2813 status.
- 2814 • According to prisoners, staff from psycho-social services in the prison, who help the prisoners
- 2815 in reintegrating, shouldn't know that they are exchanging drug usage equipment.
- 2816 • Furthermore some guards, who are not in favour of the PNSP openly express that they search
- 2817 the cells of those prisoners, who are participating in the programme. Some even order urine
- 2818 controls and finally
- 2819 • Nurses are not obliged to exchange, which leads to the fact that a request by the prisoner is
- 2820 either rejected for that day or is being dealt with days later. Prisoners who have heir request
- 2821 rejected once or twice tend not to ask again.

2822

2823 The lessons learned for this programme:

- 2824 • The entire prison personnel (security as well as health) has to understand and to support the
- 2825 project
- 2826 • A clear instruction from the top management is needed in order to have a standardised and
- 2827 consistent procedure

- 2828 • The exchange location should be organised discretely so that the maximum of anonymity is
2829 guaranteed
- 2830 • The monthly rate of cell searches should not be different from the situation before introduction
2831 of PNSP. Otherwise it will counteract the goal of PNSP
- 2832 • Once a PNSP is decided, all nurses should always provide clean equipment, otherwise it might
2833 become arbitrary, who gets sterile syringe and when.

2834

2835 Following these observations, nurses and physicians discussed with both prisoners and staff on how to
2836 improve the situation. The rules and procedures are being revisited.

2837 A low participant's rate might also have other reasons. In the prison where PNSPs started in 1992/3
2838 (Hindelbank in the canton of Berne/Switzerland) the exchange is done since 20 years by a health
2839 prevention worker employed in the community. The entire procedure of PNSP has not changed for 20
2840 years. However, for the last 10 years only 30-100 needles are being exchanged annually. The reasons
2841 are to be found in the reduction in the number of drug users, change modes of drug use (smoking),
2842 reduction of the number of drug users consequence of mixing drug users with non-drug users within
2843 the prison population.

2844 I. Budget

2845 The budget for PNSP depends very much on the mode of provision of sterile syringes and
2846 needles. There are direct and indirect costs in such projects.

- 2847 • Syringes, needles and paraphernalia:

2848 The direct costs are quite easy to calculate. The syringes and needles are not that expensive
2849 and can be obtained quite cheaply in bulk through the medical unit of the prison. This
2850 accounts also for additional injection paraphernalia. The price depends on the specific
2851 country prices.

2852

- 2853 • Dispensing machines:

2854 If the exchange is done via slot machines budget should include the costs for the machine.
2855 For example the approximate cost of the Swiss 1 : 1 exchange machines is 6,500\$ plus the
2856 costs of maintenance.

2857

- 2858 • Personnel costs:

- 2859 ○ To operate the programme

2860 Needs in personnel will depend on the design of the programme, the size of target population,
2861 whether the programme is implemented partly or entirely by an external agency. For example,
2862 in a women's prison in Hindelbank/Switzerland one health care worker (half time, approx.
2863 20h per week) is being employed by the external health agency from the municipality to
2864 conduct the project in the prison.

2865 The activities to be taken into account:

- 2866 a) counselling staff
- 2867 b) in case of using a dispensing machine: time to ensure the machine is always
2868 properly stocked
- 2869 c) stock management
- 2870 d) training of staff and prisoners
- 2871 e) overseeing, coordinating and monitoring the programme

2872

2873 For example in Moldova where the service is provided by an external agency, the overall
2874 budget (2008) for the NGO's activities in seven penitentiaries was US\$37,541 annually, from
2875 which \$12,650 went to staff salaries; \$9,240 to condoms, syringes, and other harm reduction

supplies; \$2,244 to administrative expenses; and \$13,407 to “other expenses” of the project, of which \$2,200 were for rewards to volunteers.

The indirect costs are related to prison staff for operating PNSP in prison. These costs are allocated to staff, because of the time dedicated to develop, implement and monitor the programme. There is necessarily a higher amount in the initial phase but some costs will remain during operating the project. These costs might include working hours for (and again depend on the mode of provision):

- physicians/nurses

for initial examination of the suitability of the prisoner (diagnose of drug dependency with mode of intravenous drug user) – if this mode of first syringe and needle provision has been chosen

- interdisciplinary and multi-professional staff in working group (see chapter V. F)

- permanent advocacy (visits of politicians, media, judges, other professionals)

- monitoring and evaluation purposes (see chapter VI).

However, in some jurisdictions prisoners just ask for injection equipment and are allowed to participant. In this way no extra costs arise.

J. From pilot to regular services and scaling up of PNSP services

It is most important to plan for scaling-up from the beginning of the pilot program. The initial workplan should have two phases with a clear timeline: (1) a pilot phase for a limited period of time (6 maximum 12 months) and (2) a scaling-up phase to ensure an effective coverage of the entire target population (for example 2 years). The pilot phase is needed to assess the implementation modalities and to make adjustments to ensure the best access to the programme. Failing to develop such a workplan often results in a very low coverage even in countries where PNSP has been accepted for many years.

The effectiveness of needles and syringe programmes has been amply documented⁵. Similarly evidences on the feasibility in prisons has been documented⁶. The aim of the pilot is not to measure this effectiveness. The aim of the pilot programme is to define the optimal implementation modality to provide the best access to clean needles and syringes in prisons, taking into account the constraints of the environment.

In some countries a single pilot has been used, while others such as Germany implemented two pilots running in parallel (men’s and women’s prison). The outcomes of the pilot program evaluations have then been used to guide future planning. In some instances (Switzerland, Germany, Spain) the prisons selected for the initial pilot programs were relatively small institutions and/or open or half-open institutions with lower security levels. In these cases, programs were tested and evaluated in these prison environments before expanding the programs into larger, closed prisons with higher security levels. In Moldova for instance the pilot needle exchange was done in a medium/maximum-security prison with a population of approximately 1,000 Prisoners (Hoover/Jürgens 2009).

Experiences demonstrate that pilot projects can be undertaken quickly and do not have to delay broader implementation of PNSPs. For example, in Kyrgyzstan a pilot needle exchange was opened in

⁵ WHO (YEAR) Evidence for Action: Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users (WHO) (pdf) <http://www.unodc.org/documents/hiv-aids/EFA%20effectiveness%20sterile%20needle.pdf>

⁶ WHO/UNODC/UNAIDS (200XYEAR) Evidence for Action Technical Papers - Intervention to address HIV in prisons. Needle and Syringe Programmes and Decontamination Strategies (pdf) <http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20PNSP.pdf>

October 2002, in early 2003 approval was given to expand the program, as of September 2003 programs were operating in six of 11 prisons, and by April 2004 programs were operating in all 11 prisons. Nor do evaluations have to be fully completed before programs are expanded to other prisons. For example, in Belarus a program was piloted in one prison beginning in April 2003, scheduled to run until January of 2004. Although the term of the pilot was extended to June of 2004, it was also extended to two other prisons, and the Ministry of Internal Affairs signalled its willingness to expand needle exchange to prisons throughout the country. It is important to note that in the prison systems presented in this report, pilot projects have not been relied on as a tactic to delay the broader implementation of needle exchange programs.

Not only are evaluations important in the expansion of needle exchange programs within a jurisdiction, but they are also of great use to the broader international community. Rigorous evaluations of pilot needle exchange programs (and expanded programs) contribute important information to the international literature regarding prison needle exchange programs.

The findings of evaluations provide the evidence for other jurisdictions. With such evidence, more jurisdictions can demonstrate leadership and generate consensus surrounding the need for, and implementation of, prison needle exchange programs.

For example in Spain (... timeline)

However, the processes of implementing PNSP remain slow. In Switzerland for instance only 11 out of 113 (ICPS 2012) provide PNSPs. The Federal Office of Public Health (FOPH) asked for juridical expertise to clarify the situation in the country with regard to PNSP. Although it was the first country worldwide (see Lines et al. 2006) to start PNSP in 1993 and to scale-up in xx prisons, no additional PNSP has been implemented since the year 2000 (Achermann & Künzli 2006). Only 2 out of 26 cantons (Berne and Geneva) have regulations allowing PNSPs.

Despite encouraging scientific results (reduction of needle/equipment sharing, reduction of new infections with HIV and hepatitis, reduction in overdoses and abscesses, no threatening incidences; see Läubli & Weber 2000) several cantons are objecting PNSPs until now (Achermann & Künzli 2006).

In 2008 the FOPH has supported a project with the aim of a common standard in health care in Switzerland (Enggist & Klaue 2010). On this basis, a consensus conference and an expert commission was established to elaborate concrete guidelines in order to develop equal health care services in the whole country, including PNSPs. The guidelines are now to be implemented in the whole of Switzerland (BIG 2012).

VI. MONITORING, EVALUATION, QUALITY ASSURANCE

Monitoring, evaluation and quality assurance are important strategies to have the highest attainable transparency, to be able to adjust and improve the programme, to react to the needs of the programme users and prison staff, and to present solid data to the (professional) public. Furthermore the general and professional public are interested in developments and dynamics of the PNSP. Sound data material delivers the basis for advocacy strategies in order to increase or maintain acceptance and transparency.

A. Monitoring

In Spain prison needle exchange has been expanded nationally, guidelines for ongoing monitoring and evaluation have been developed as part of the Framework Program. A computer software package called SANIT is used in each prison to record the number of users of the program, number of syringes supplied and returned, enrolments/withdrawals from the program, and reasons for withdrawals. The health status is also included. Diseases associated with intravenous drug use (HIV, HCV, HBV) will

also be monitored by the computer programme (SANIT, Notifiable Diseases). It is recommendable to collect information on both incidents and penalties related to the PNSPs.

To maintain the confidentiality of the program users, a randomly generated number or pseudonym is used to identify each participant.

Checklist #: Indicators to monitor

- ✓ Number of participants of the program
- ✓ Number of syringes/kits, equipment distributed
- ✓ Incidence of HIV, HBV and HCV
- ✓ Number of incidents of violent behaviour using a needle obtained through the programme
- ✓ Percentage of returned syringes and needles
- ✓ Number of incidents of accidental punctures
- ✓

While some indicators are specific to the closed setting environments, it is also important to align as far as possible the indicators with the ones used for NSP in the community and to link the two monitoring systems. Especially when in the community standardised indicators to measure coverage and quality are used.

The information available depends on the type of delivery. For example: the number of paraphernalia handed out and returned, drug used, users (regular, irregular, under OST).

Program effectiveness: early indicators

The effects of syringe exchange programs in reducing risk behaviours that lead to HIV infections and other harms, are clearly measurable. Avoidance of negative effects:

- Reusing injection equipment at the start of the project,
- sharing needles and drug paraphernalia with others.
- Number of abscesses
- New cases of HIV/HBV/HCV

But also secondary benefits associated with the implementation of PNSP are worth mentioning, the indicators would be:

- Relationships between prisoner and staff
- Increased awareness of infection transmission and risk behaviours
- Reduction in the number of accidental punctures (staff and prisoners)

In absence of any key indicators to assess coverage of PNSP the following community oriented indicators have been transferred to custodial settings and serve as very basic indicators and indicative targets for the prison setting (see WHO, UNODC, UNAIDS 2009)

Coverage:

a). Percentage of PWID regularly reached by PNSP

Data source: Programme data

Numerator: Number of PWID who accessed a PNSP once per month or more in the past 12 months (as baseline the data of those prisoners receiving an original dummy or being registered to the programme might serve)

Denominator: Estimated number of PWID

Targets: Low: <20%

Medium: >20– <60%

High: >60%

WHO/UNAIDS/UNODC (p. 19) recommend that the numerator should count individual clients and not the number of contacts or occasions of service recorded by NSP services. The high target level is based on a retrospective analysis of the coverage required to reverse the HIV/AIDS epidemic among PWID in New York

b). Syringes distributed per IDU per year

Data source: Programme data

Numerator: Number of syringes distributed in the past 12 months

Denominator: Number of PWID

Targets: Low: <100 per IDU per year

Medium: >100–<200

High: >200

WHO/UNAIDS/UNODC (p. 19) recommend that these levels are based upon studies in developed country settings investigating the levels of syringe distribution and impact on HIV transmission. It has to be noted that the levels required for the prevention of HCV are likely to be much higher than those presented here.

B. Evaluation

As mentioned above, there is plenty of evidence of the effectiveness of needle and syringe programmes in preventing HIV transmission. There is no need to further evaluate this.

However, the effectiveness of a programme will depend very much on its implementation modality and the related access of the target population, namely people who inject drugs in prisons, to the programme. The evaluation will inform programme managers on the quality of the implementation of the programme.

In addition to quantitative data, the evaluation also includes qualitative feedback from prisoners and staff. Due to the high turn over rate in many countries it is suggested that evaluations be done on at least an annual basis, if not more regularly (i.e., three-, six-, and 12-month intervals). As a result, ongoing evaluation and assessment of the programs will be available annually on a national basis.

In addition to the monitoring data elaborated above, it is necessary to know the impact of the program on risk practices and the opinions of prisoners participating in the exchange and other prisoners on the program, as well as those of security staff and the team implementing the program (see Ministry of Interior 2002). In the case of prisoners, it is useful to collect information on the changes in the frequency of sharing injection equipment, as well as their attitudes and opinions about the PNSP. In the case of prison staff, a survey of their attitudes and opinions about the PNSP should be conducted.

It is important to conduct this evaluation during the second half of the period of the pilot or in case changes are happening either in terms of population profile, number of syringes exchange or policies. Quantitative information can be collected through questionnaires. The simplest way to do so is by selecting a sample of inmates and another sample of prison staff. To complement the information collected through questionnaires, focus group discussions can be organised with prisoners and with staff members.

If resources permit, an evaluation of the quality of the PNSP may be done of these and other aspects of the programme the following items may be used (see also questionnaire in the ANNEX XX):

- Convenience and confidentiality of access to injecting equipment;
- Accessibility of the program

- 3074 • Friendliness of staff;
- 3075 • Functioning of devices (dispensing machine etc.);
- 3076 • Quality of injection equipment and paraphernalia;
- 3077 • Involvement of injection drug users in PNSP activities;
- 3078 • Response of management and staff to complaints and to changes in behaviour and the
- 3079 environment;
- 3080 • Range of injecting equipment and services provided at the NSP; and
- 3081 • Referral processes used.

3082
 3083 The quality of the methodology for evaluating is critical. The evaluation has to be linked to the
 3084 objectives of the programme. It is therefore most important to clearly define these objectives, agree
 3085 upon them as well as on the indicators from the very beginning of the programme. If the methodology
 3086 used to evaluate the programme is weak or inappropriate, the results will be biased and not reflecting
 3087 the reality. Weak results could lead to wrong decisions that can be most damageable to the
 3088 programme.

3089
 3090 The Spanish Ministry of Interior provided forms for recording the opinions, attitudes, etc. of prisoners
 3091 and prison staff, respectively, in order to obtain a minimum set of common data for evaluation (see
 3092 Annexes). The information in the questionnaires will be collected on an anonymous basis. The data
 3093 collected will allow the following indicators to be obtained:

- 3094
- 3095 a) Attitudes and opinions (prisoners and prison staff)
 - 3096 - Level of information on the PNSP
 - 3097 - Level of acceptance of the PNSP
 - 3098 - Level of satisfaction with the functioning of the PNSP (hours, personnel, rules...)
 - 3099 - Impact of the PNSP on prison security
 - 3100 - Impact on relations between inmates and prison workers
 - 3101 b) Behaviours (prisoners)
 - 3102 - Percentage of inmates who have consumed heroin in the last 30 days
 - 3103 - Percentage of inmates who have consumed IV heroin in the last 30 days
 - 3104 - Percentage of inmates who have consumed stimulants (cocaine/amphetamines) in the last 30 days
 - 3105 - Percentage of inmates who have consumed IV cocaine in the last 30 days
 - 3106 - Percentage of PWID who have borrowed syringes previously used by others in the last 30 days
 - 3107 - Percentage of PWID who have lent their used syringes in the last 30 days
 - 3108 - Percentage of PWID who have shared other injection instruments (spoons, filters, water, containers
 - 3109 for dissolving drug...) in the last 30 days
 - 3110 - Percentage of inmates who have used a condom in their most recent sex relation.

3112
 3113 A report on the PNSP based on the monitoring and/or evaluation data should be made at least on a
 3114 yearly basis that includes information on the incidence of associated diseases, program activities, as
 3115 well as any new needs or problems that may have been detected or any other pertinent information.

3116
 3117 The thorough evaluation of pilot projects is of upmost importance for evidenced-based decision-
 3118 making in scaling-up the project to ensure the optimum implementation modalities are used
 3119 considering the context (see V.J).

3120 3121 C. Quality Assurance

3122 Monitoring and evaluation are of upmost importance in order to assure and improve quality of PNSPs.
 3123 To ensure that an PNSP is effective, continued monitoring is required to assess the quality of the
 3124 services and products provided (see WHO/UNODC/UNAIDS 2009). Five?? processes are
 3125 recommended to monitor the environment and services and act on the findings in terms of quality
 3126 assurance (see also WHO/UNODC/UNAIDS 2007):

- 3127 1. meetings of the interdisciplinary and multi-professional steering committee described above
3128 (see chapter XX). Here PNSP workers will identify problems with services or products
3129 provided, and changes in the behaviour of injectors that require improved or different services
3130 and commodities (e.g. low participants rate needs reflections towards the mode of provision,
3131 the venue of exchange, anonymity). These changes are written down in order to follow the
3132 development precisely, which then leads to improvements and further monitoring and
3133 changes, as required
3134
- 3135 2. the steering committee plays a key role in quality assurance, especially if this group is
3136 informed by the recommendations of injecting prisoners and prison staff brought together on a
3137 regular basis to discuss the PNSP's services
3138
- 3139 3. it is recommended that for ? all those contributing to the services is established and publicized
3140 a clear, anonymous complaints procedure. Forms should be made discretely available together
3141 with a box in which the forms can be placed anonymously
3142
- 3143 4. complaints should be discussed in the above mentioned steady working group and should be
3144 investigated thoroughly
3145 5. guidelines
3146 6. training

3147 VII. USEFUL WEB SITES; PUBLICATIONS AND NETWORKS
3148

3149 A. UNODC, WHO, UNAIDS web sites and publications

3150 B. Other web sites and publications

3151 WHO HIPP

3152 C. Networks

3153 Harm Reduction Coalition

3154 <http://www.harmreduction.org/article.php?id=418>

3155

3156 Harm reduction international

3157 AHPPN

3158 Observatorio VIH Carceles Latin America Caribbean

3159

3160 VIII. ANNEXES

3161 A. Ministry of the Interior of Spain / Directorate General for Prisons: Needle exchange programs

3162

3163 I 5/2001 SP

3164 Subject: Needle exchange programs

3165 Scope: HEALTH

3166 Descriptors: HEALTHCARE/ DRUGS/ AIDS

3167 One of the duties of the Prison System is to endeavour to preserve the life, integrity and health
3168 of persons deprived of freedom. Therefore, the Prison System must use the utmost efforts to

3169 deploy such measures for prevention and healthcare as may enable it to meet this legal duty.

3170 To that end, the health policy of the Prison System includes strategies recognised as effective

3171 in the fields of disease prevention and health promotion and protection. Active drug users are

3172 widespread in the prison population; many of them are injecting drug users. Injecting use of

3173 toxic substances continues to be the most prevalent variable in HIV infection.

3174 Strategies on drug users in prisons under the authority of the Directorate General for Prisons

3175 are implemented through programs for prevention (information, motivation, Health

3176 Education, etc.), healthcare (detoxification, de-habitation in a drug-free module or through

3177 outpatient care, with or without pharmacological support) and social reintegration.

3178 The System also implements the methadone maintenance program, which is now firmly

3179 established within the set of strategies known as Harm Reduction. These programs aim to

3180 minimise the direct pathogenic effect of using toxic substances by introducing variables that

3181 are controllable by technical means; the goal is not to change the addictive habit but to

3182 preserve the user's life.

3183 In programs using opiate surrogates, both the substance and the method of administration are

3184 under control. Programs are also initiated to encourage the use of less aggressive methods of

3185 administration and to control the devices used. Among the latter, needle exchange programs

3186 are widespread throughout Spain and regarded as very effective in reducing the risk of

3187 infection and re-infection with blood-transmitted viruses, such as hepatitis viruses (HBV and

3188 HCV) and human immune-deficiency virus (HIV). The strategy is one among others aiming

3189 to protect individual and collective

3190 health. Its introduction into prisons is a necessity arising from its preventive utility and

3191 flowing from the principle of providing healthcare equivalent to that available outside prison.

3192

3193 The actual viability of needle exchange programs has been tried and tested through pilot

3194 initiatives carried out in nine prisons. The earliest such program has been in operation for four

3195 years. Hence it is imperative to extend the strategy so as to ensure uniform availability of

3196 healthcare and benefits in all prisons under the authority of this Directorate General.

3197 The program will be extended gradually, in line with the plan drawn up by the Subdirectorate

3198 General for Prison Health, which Unit will notify each prison of the time at which it must

3199 initiate the program. As from that time, in order to facilitate implementation, internal rules

3200 will be changed so that it is expressly permitted to possess needles under the terms provided

3201 by the official program, without prejudice to any other extant rules. In addition, the Prison

3202 Court is to be advised of the relevant resolutions of the Board of Directors.

3203 **Madrid, 7 June 2001**

3204 THE DIRECTOR GENERAL FOR PRISONS

3205 Ángel Yuste Castillejo

3206

3207 B. Evaluation Questionnaire for Prisoners

3208

3209 Attitudes and opinions on the NEP and risk practices for HIV.

3210

3211 This survey is completely anonymous. We are not interested in knowing your name or any other
3212 information that could identify you; we are only interested in knowing your opinion about certain
3213 aspects related to the program that could help us to improve it. Please mark only one box for
3214 each question.

3215

3216 **Name of prison**_____ **Date completed**_____

3217

3218 **Q1** Do you know that this prison has a Needle Exchange Program for people who inject drugs?

3219 Yes

3220 No

3221

3222 **Q2.** Have you received enough information about the Program?

3223 No, I haven't received any

3224 I have received a little

3225 I have received a fair amount

3226 Yes, I am well informed

3227

3228 **Q3.** Do you think consumption of injected drugs has increased with the Program?

3229 Not at all

3230 A little

3231 Quite a lot

3232 A lot

3233

3234 **Q4.** Do you think that the number of searches has increased with the Program?

3235 Not at all

3236 A little

3237 Quite a lot

3238 A lot

3239

3240 **Q5.** Do you think that your cell is being searched more rigorously with the Program?

3241 Same as before

3242 A little more

3243 Quite a lot more

3244 A lot more

3245

3246 **Q6.** Do you think that prison officers have more control of people who inject with the Program?

3247 Yes, they have more control

3248 No, they have the same control

3249 No, they have less control

3250

3251 **Q7.** Do you think that the number of drug use reports has increased with the Program?

3252 Not at all

3253 A little

3254 Quite a lot

3255 A lot

3256

3257 **Q8.** Do you think that the number of prison leaves has been reduced with the Program?

3258 Not at all

3259 A little

3260 Quite a lot

3261 A lot

3262

3263 **Q9.** In general, do you think that conflictive situations between inmates and prison staff have
3264 increased with the Program?

3265 Not at all
3266 A little
3267 Quite a lot
3268 A lot

3269

3270 **Q10.** Do you think that conflictive situations between inmates and health personnel have increased
3271 with the Program?

3272 Not at all
3273 A little
3274 Quite a lot
3275 A lot

3276

3277 **Q11.** Do you think that the current hours for needle exchange are the most appropriate for
3278 persons to go when they want to?

3279 Yes
3280 No
3281 Why? _____

3282 _____
3283 What do you suggest? _____

3284 _____

3285

3286

3287 **Q12.** Do you think that the places for needle exchange are the most appropriate for persons to
3288 go when they want to?

3289 Yes
3290 No
3291 Why? _____

3292 _____

3293 What do you suggest? _____

3294 _____

3295

3296 **Q13.** Do you think the persons in charge of dispensing the syringes deserve your trust?

3297 Yes
3298 No
3299 Why? _____

3300 _____

3301 What do you suggest? _____

3302 _____

3303

3304 **Q14.** From your point of view, do you think that the Program is running satisfactorily in this
3305 prison?

3306 Unsatisfactorily
3307 Not very satisfactorily
3308 Quite satisfactorily
3309 Very satisfactorily

3310

3311 **Q15.** What the positive aspects of the program for you?

3312 _____

3313 _____

3314 **Q16.** And the negative aspects?

3315 _____

3316 _____

3317

3318 **Q17.** Do you think it is worthwhile to go ahead with this Program?

3319 No
3320 Yes

3321 Yes, but making changes
3322 What would you change? _____
3323 _____
3324

3325 **Q18.** Have you consumed heroin in the last 30 days?

3326 Yes

3327 No

3328

3329 **Q19.** What route did you use?

3330 Injected

3331 Smoked

3332 Snorted

3333 Other

3334

3335 **Q20.** Have you consumed stimulantes (cocaine/amphetamines) in the last 30 days?

3336 Yes

3337 No

3338

3339 **Q21.**What route did you use?

3340 Injected

3341 Smoked

3342 Snorted

3343 Other

3344

3345 **Q22.** If you are an injecting drug user, how many times do you usually reuse the same needle or
3346 syringe?

3347 I never use it more than once

3348 I sometimes reuse it

3349 Usually 2-3 times

3350 Usually more than 5 times

3351 More than 10 times

3352

3353 **Q23.** If you are an injecting drug user, how often in the last 30 days have you used needles or syringes
3354 previously used by other inmates?

3355 Never

3356 Occasionally

3357 Often

3358 Always

3359

3360 **Q24.** If you are an injecting drug user, how often in the last 30 days have you lent your
3361 previously used needles or syringes to other inmates?

3362 Never

3363 Occasionally

3364 Often

3365 Always

3366

3367 **Q25.** If you are an injecting drug user, have you shared other items for injection such as spoons,
3368 filters, containers for dissolving the drug, etc.?

3369 Never

3370 Occasionally

3371 Often

3372 Always

3373

3374 **Q26.** Do you use the Needle Exchange Program?

3375 No, I've never used it

3376 I've used it very little

3377 I use it quite often
 3378 I use it a lot
 3379
 3380 **Q27.** If you are an injecting drug user and do not use the Needle Exchange Program regularly, what
 3381 are your reasons for using it?
 3382 _____
 3383 _____
 3384
 3385 **Q28.** Some people inject but do not use the Program. Why do you think they don't use it?
 3386 _____
 3387 _____
 3388
 3389 **Q29.** What do you think could be done so they would use it?
 3390 _____
 3391 _____
 3392
 3393 **Q30.** Did you use a condom in your last sexual relations?
 3394 Yes
 3395 No
 3396
 3397 **Q31.** SEX Male Female
 3398
 3399 **Q32.** AGE (in years)
 3400 Less than 21
 3401 22 to 25
 3402 26 to 30
 3403 31 to 35
 3404 Over 35
 3405
 3406 **Q33.** What is your status in prison?
 3407 Awaiting trial
 3408 Convicted
 3409
 3410 **Q34** Is this your first time in prison?
 3411 Yes
 3412 No, I've been in prison 2 to 4 times
 3413 No, I've been in prison over 4 times
 3414
 3415 **PLEASE MAKE ANY OBSERVATIONS OR COMMENTS BELOW**
 3416
 3417 THANK YOU VERY MUCH FOR YOUR COOPERATION
 3418
 3419 (This survey is completely anonymous. We are not interested in your name or any other
 3420 information that could identify you; we are only interested in knowing your opinion about certain
 3421 aspects related to the program)
 3422
 3423

3424 C. Evaluation Questionnaire for Prison Officers

3425 3426 Attitudes on the NEP.

3427
 3428 This survey is completely anonymous. We are not interested in knowing your name or any other
 3429 information that could identify you; we are only interested in knowing your opinion about certain
 3430 aspects related to the program that could help us to improve it. Please mark only one box for
 3431 each question.
 3432

3433 **Name of prison** _____ **Date completed** _____

3434

3435 **Q1.** Are you concerned that some inmates may become infected by HIV and/or hepatitis from

3436 sharing syringes?

3437 Not at all

3438 A little

3439 Quite a lot

3440 A lot

3441

3442 **Q2.** Do you think that drug use has increased in the prison with the Program?

3443 Not at all

3444 A little

3445 Quite a lot

3446 A lot

3447

3448 **Q3.** Do you think that the number of drug use reports has increased with the Program?

3449 Not at all

3450 A little

3451 Quite a lot

3452 A lot

3453

3454 **Q4.** Do you think that implementation of the Program has placed more emphasis on

3455 searches?

3456 Not at all

3457 A little

3458 Quite a lot

3459 A lot

3460

3461 **Q5.** Do you think that the Needle Exchange Program has caused demotivation when

3462 controlling drugs inside the prison?

3463 Not at all

3464 A little

3465 Quite a lot

3466 A lot

3467

3468 **Q6.** In general, do you think that conflictive situations between inmates and prison warders

3469 have increased with the Program?

3470 Not at all

3471 A little

3472 Quite a lot

3473 A lot

3474

3475 **Q7.** Do you think that conflictive situations between inmates and health personnel have

3476 increased with the Program?

3477 Not at all

3478 A little

3479 Quite a lot

3480 A lot

3481

3482 **Q8.** Do you think the number of accidents during searches has increased with the Program?

3483 Not at all

3484 A little
3485 Quite a lot
3486 A lot

3487
3488 **Q9.** How much do you think the Needle Exchange Program has changed safety conditions in
3489 the prison?

3490 It made them much worse
3491 It made them a little worse
3492 It has made them a little better
3493 It has made them much better
3494 It has not changed them
3495

3496 **Q10.** Do you consider yourself to be informed about the Needle Exchange Program currently
3497 in use in the prison?

3498 Not at all
3499 A little
3500 Quite a lot
3501 A lot
3502

3503 **Q11.** Do you think the operating rules of this Program are appropriate?

3504 Not at all
3505 A little
3506 Quite a lot
3507 A lot
3508 Not known
3509

3510 **Q12.** Do you think the current hours for needle exchange the most appropriate so inmates can
3511 go when they want?

3512 Yes
3513 No
3514 Why? _____
3515 _____
3516 What do you suggest? _____
3517 _____
3518

3519 **Q13.** Do you think that the places for needle exchange are the most appropriate so inmates
3520 who want to can go to them?

3521 Yes
3522 No
3523 Why _____
3524 _____
3525 What do you suggest? _____
3526 _____
3527

3528 **Q14** Do you think that the staff in charge of dispensing the syringes is appropriate?

3529 Yes
3530 No
3531 Why _____
3532 _____
3533 What do you suggest? _____
3534 _____
3535

3536 **Q15.** Do you think that inmates are complying with program rules?

3537 Not at all

3538 A little

3539 Quite a lot

3540 A lot

3541
3542 **Q16.** From your point of view, do you think that the Program is running satisfactorily in this
3543 prison?

3544 Not at all

3545 A little

3546 Quite a lot

3547 A lot

3548
3549 **Q17.** What are the positive aspects for you?

3550 _____

3551 _____

3552
3553 **P18.** And the negative aspects?

3554 _____

3555 _____

3556 How would you change the Program? _____

3557 _____

3558
3559 **Q19.** SEX

3560 Male

3561 Female

3562
3563 **Q20.** AGE (in years)

3564 Less than 30

3565 31 to 45

3566 46 or older

3567
3568 **Q21.** What body or group do you belong to?

3569 Surveillance

3570 Treatment

3571 Offices and services

3572 Volunteer group

3573
3574 **Q22.** How long have you been working in prisons?

3575 Less than 4 years

3576 4 to 10 years

3577 More than 10 years

3578
3579 **PLEASE MAKE ANY OBSERVATIONS OR COMMENTS BELOW**

3580
3581 THANK YOU VERY MUCH FOR YOUR COOPERATION

3582
3583 (This survey is completely anonymous. We are not interested in your name or any other
3584 information that could identify you; we are only interested in knowing your opinion about certain
3585 aspects related to the program)

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MINISTÈRE DE LA JUSTICE
Administration pénitentiaire
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La participation au programme d'échange de seringues est volontaire pour le personnel infirmier.

Echange de seringues

Accès des détenus au programme :

Demande à faire par le détenu au médecin-fonctionnaire qui le convoque et décide de la participation du détenu
Remise par le médecin-fonctionnaire d'un kit (tube en plastique étiqueté avec 2 seringues ainsi que du désinfectant et de l'acide ascorbique)

Echange des seringues utilisées :

Demande par le détenu le matin de voir l'infirmier
Convocation à l'infirmerie (lors des traitements ou de la visite médicale)
Les seringues doivent être amenées dans le tube en plastique
Le détenu jette lui-même les seringues dans le bac
L'infirmier lui remet les nouvelles seringues et note le nombre de seringues données sur la feuille de statistique accrochée dans la cuisineAB et la pharmacieNB
L'échange des seringues se fait 1 contre 1 avec un maximum de 2 seringues
Il est interdit qu'un détenu procède à l'échange pour un autre détenu !
En cas de perte du kit ou des seringues, une nouvelle demande doit être introduite auprès du médecin-fonctionnaire

Le nombre total de seringues données est communiqué à la fin du mois au médecin-fonctionnaire.

Schons Marc
Infirmier dirigeant

28.11.07

3633

3634 E. Confirmation of participation in the PNSP – to be signed by prisoner - Luxembourg

3635

3636 **Dr Jos SCHLINK**

3637 médecin - chef de division à l'Administration Pénitentiaire

3638 Boîte postale 35

3639 L-5201 Sandweiler

3640 TEL: + (352) 35 96 21 - 892 / FAX : + (352) 35 96 21 - 875

3641 jos.schlink@apsch.etat.lu

3642 *Schrassig, le (date)*

3643

Déclaration de (nom du détenu), lorsqu'il a reçu un étui avec deux seringues
--

3644 ❖ Le soussigné déclare avoir reçu un étui avec deux seringues et qu'il doit remettre les deux
3645 seringues pour en avoir de nouvelles.

3646 ❖ Il s'engage à les utiliser seulement pour lui-même et ne pas les donner à quelqu'un d'autre

3647 ❖ Il déclare ne posséder qu'un seul étui.

3648 ❖ Il déclare qu'il ne remettra pas l'étui à une autre personne.

3649 ❖ Il dit qu'il va remettre l'étui à un gardien le jour où il sortira de la prison

3650 ❖ Signature :

3651

IX. NOTES AND REFERENCES

- Achermann, A.; Künzli, J. (2006): GESUNDHEIT UND HAFT. Gesundheitsrelevante Rechte inhaftierter Personen insbesondere im Bereich des Schutzes vor Infektionskrankheiten und Kompetenzen des Bundes zu ihrer Durchsetzung. Studie zuhanden des Bundesamtes für Gesundheit
- Aggleton P, Jenkins P, Malcolm A. HIV/AIDS and injecting drug use: information, education and communication. *International Journal of Drug Policy*, 2005, 16:S21–S30
- Anex (2010): With conviction: the case for controlled needle and syringe programs in Australian Prisons. Anex, Melbourne, Australia
- Anex (2011): Inside Information: Prison Needle and Syringe Program. Melbourne, Australia Protocols
- Ball A, Weiler G, Beg M, Doupe A. WHO Evidence for action for HIV prevention, treatment and care among injecting drug users. *International Journal of Drug Policy*, 2005, 16(Suppl. 1):S1–S6.
- Beltrami, E.M., Williams, I.T., Shapiro, C.N., Chamberland, M.E. (2000): Risk and Management of Blood-Borne Infections in Health Care Workers. In: *Clin Microbiol Rev.* 2000 July; 13(3): 385–407.
- BIG (2012): Bekämpfung von Infektionskrankheiten im Gefängnis (BIG). Bundesamt für Gesundheit (accessed 9.3.2012)
- http://www.bag.admin.ch/hiv_aids/05464/05484/05488/index.html?lang=de
- Bolhari J, Alvandi M, Afshar P, Bayanzadeh A, Rezaii M, Rahimi Movaghar A (2002): Assessment of Drug Abuse in Iranian Prisons. United Nations Drug Control Programme (UNDCP) Iran, Drug Control Headquarters (DCHQ) (not published in Farsi)
- Burrows, D.; Wodak, A. (2005): Harm Reduction in Iran; Issues in national scale-up. 2005, WHO
- CONSEIL NATIONAL DU SIDA (CNS; 2009): Opinion on Syringe Exchange Programs in Correctional Facilities. Paris, 10.9.2009
- ECDC/European Centre for Disease Prevention and Control and EMCDDA/European Monitoring Centre for Drugs and Drug Addiction. Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC, 2011. Stockholm, October 2011
- ELCS (Elus locaux contre le sida; 2009). Lettre ouverte du Président d'ELCS à la MILDT " La réduction des risques ne fait ... plus partie des priorités d'actions [de la Milldt]
http://www.elcs.fr/Lettre-ouverte-du-President-d-ELCS-a-la-MILDT-La-reduction-des-risques-ne-fait-plus-partie-des-priorites-d-actions-de-la_a286.html
- Elger, S. (2008): Towards Equivalent Health Care of Prisoners: European Soft Law and Public Health Policy in Geneva. *Journal of Public Health Policy* 2008; 00: 1-15
- Enggist, S.; Klaue, K. (2010): Bekämpfung von Infektionskrankheiten im Gefängnis (BIG). Bundesamt für Gesundheit. Presentation 19.11.2010 workshop DBDD Berlin/Germany, "Drogen und Haft"
- European convention for the prevention of torture and inhuman or degrading treatment or punishment. 2002.
- Farhoudi, B. (2012): Personal Communication
- Farhoudi B, Motevalian A, Motamedi Heravi M, Motevali Khameneh M, Mohraz M, Rassolinejad R, Jafari S, Afshar P, Esmaili I, Mohseni L (2003): Human immunodeficiency virus and HIV – associated tuberculosis infection and their risk factors in people who inject drugs in a prison in Iran. Report to the WHO/EMRO
- Hedrich, D., Alves, P., Farrell, M., Stöver, H., Möller, L., Mayet, S. (2012): The effectiveness of opioid maintenance treatment in prison settings: a systematic review. In: *Addiction* (in press)
- <http://www.ncbi.nlm.nih.gov/pubmed/21955033>
- Hoffmann, P. (2012): PNSP. Presentation 20.6.2011. Luxembourg
- Hoover, J.; Jürgens, R. (2009): Harm Reduction in Prison: The Moldova Model. OSI Public Health Program
- Jacob, J.; Keppler, K.; Stöver, H. (ed.): LebHaft: Gesundheitsförderung für Drogen Gebrauchende im Strafvollzug. AIDS-Forum, Deutsche AIDS-Hilfe, Berlin
- ICPS (2012): World Prison Brief. (Accessed 9 March 2012)

- 3706 • <http://www.prisonstudies.org/info/worldbrief/wpbcountry.php?country=167>
- 3707 • Islamic Republic of Iran. Iran National AIDS Committee, Technical Committee of Monitoring and
- 3708 Evaluation (2010): HIV Situation and Response Analysis in the. March 2010
- 3709 • Jürgens, R. (2003): HIV/AIDS Prevention for Drug Dependent Persons Within the Criminal
- 3710 Justice System. Presented at the Commission on Narcotic Drug Ministerial Segment. Ancillary
- 3711 Meeting on HIV/AIDS and Drug Abuse. Vienna 16 April 2003
- 3712 • Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting
- 3713 drug use in prison. *Lancet Infectious Diseases* 2009; 9: 57-66;
- 3714 • Läubli, M; Weber, M. (200=): Swiss Federal Office of Public Health, Evaluation Services,
- 3715 Prevention and Harm Reduction Measures within the Swiss Prison Context: Summary of
- 3716 Evaluation and Research Findings - 1993-1999. Bern 2000.
- 3717 • Lines, R.; Jürgens, R.; Betteridge, G.; Laticevschi, D.; Nelles, J.; Stöver, H. (2006); Prison Needle
- 3718 Exchange: Lessons from a Comprehensive Review of international Evidence and Experience.
- 3719 Canadian HIV/AIDS Legal Network; 2nd edition 2006
- 3720 • Mathers B et al. (2010) HIV prevention, treatment and care for people who inject drugs: A
- 3721 systematic review of global, regional and national coverage. *The Lancet*. 375 (9719): 101 4-1028.
- 3722 • Meyenberg, R.; Stöver, H.; Jacob, J.; Pospeschill, M.: Infektionsprophylaxe im Niedersächsischen
- 3723 Justizvollzug – Abschlußbericht. Bd. 3 der Schriftenreihe "Gesundheitsförderung im
- 3724 Justizvollzug". Oldenburg: BIS-Verlag, 1999, 508 S.
- 3725 • See: http://oops.uni-oldenburg.de/frontdoor.php?source_opus=716 - accessed 19th of January
- 3726 2012
- 3727 • Michel, L.; Jauffret-Roustide, M. ; Blanche, J.; Maguet, O. ; Calderon, Chr. ; Cohen, J. and
- 3728 Carrieri, P.M. (2011): Limited access to HIV prevention in French prisons (ANRS PRI2DE):
- 3729 implications for public health and drug policy. In: *BMC Public Health* 2011, 11:400
- 3730 • Ministerio del Interior/Ministerio de Sanidad y Consumo (2002): Needle Exchange in Prison.
- 3731 Framework Program. Madrid, October 2002
- 3732 • Ministério da Saúde Serviços Centrais: Ministério da Saúde Serviços Centrais: Drug-related health
- 3733 policies and services in prison (Portugal). Lisbon
- 3734 • Ministry of the Interior; Directorate General for Prisons (2002): Instruction 101/2002 on Criteria
- 3735 of Action in Connection with the Implementation in a Number of Prisons of the Needle Exchange
- 3736 Program (NEP) for People who inject drugs(PWID). Madrid, 23 August 2002
- 3737 • Peigné, N. (2012): Programme d' échange de seringues. Presentation 6th European Conference
- 3738 « Health in Custody » in Geneva 1-3 February 2012 Unité médicale à la Prison de Champ-Dollon,
- 3739 Genève, Suisse
- 3740 • Rieder, J.-P.; Broers, B. ; Pinault F.; Ritter, C.; Wolff, H. (2009): Programme d'échange de
- 3741 seringues pour usagers de drogues par voie intra-veineuse dans une prison préventive à Genève
- 3742 • Roca, X.M. (without year): Trying to overcome inequity and discrimination in prison health: the
- 3743 Syringe Exchange Experience in Catalonia and Spain. Presentation
- 3744 • Shahbazi M, Farnia M, Keramati MR and Alasvand R. Advocacy and piloting the first
- 3745 needle and syringe exchange program in Iranian prisons. *Retrovirology* 2010, 7(Suppl
- 3746 1):P81 doi:10.1186/1742-4690-7-S1-P81. Accessed
- 3747 at:<http://www.retrovirology.com/content/7/S1/P81>
- 3748 • Shewan, D., Stöver, H.; Dolan, K.: Injecting in Prisons. In: Pates, R.; McBride, A.;
- 3749 Arnold, K. (ed.): *Injecting Illicit Drugs*. Blackwell: Oxford, 2005, pp.69-81
- 3750 • Stimson, G. V., Donoghoe, M. C., Fitch, C. and Rhodes, T. J. with A. Ball and G. Weiler (2003)
- 3751 Rapid Assessment and Response Technical Guide, World Health Organization (Department of
- 3752 Child and Adolescent Health and Development, and Department of HIV/AIDS) Geneva. Available
- 3753 at www.who.int/docstore/hiv/Core/Contents.html
- 3754 • Stöver, H.; Trautmann, F. (ed. 2001): Risk Reduction for Drug Users in Prisons. 'Encouraging
- 3755 Health Promotion for Drug Users within the Criminal Justice System'. Utrecht: Trimbos
- 3756 • Stöver, H.; Nelles, J. (2003): Ten years of experience with needle and syringe exchange
- 3757 programmes in European Prisons. In: *International Journal of Drug Policy* Dec./2003, volume 14,
- 3758 Issues 5-6), pp 437-444

- 3759 • Stöver, H. (2003): 10 years of syringe provision to intravenous drug users in prisons – an end to
3760 the projects in Germany. Newsletter **XX**
- 3761 • Stöver, H.; Lines, R.: Silence Still = Death. 25 years of HIV/AIDS in Prisons. World Health
3762 Organisation/WHO – Regional Office for Europe (ed.): 25-Years of HIV/AIDS in Europe, S. 67-
3763 85, 2006
- 3764 • Torre, R. de la; Acín, E.; Sanz, J.; Arroyo, J.M. (2009): Le Programme D' Échange de Seringues
3765 en Milieu Pénitentiaire en Espagne. Présentation: Journée nationale Prison. Représentations,
3766 pertinence et faisabilité dans le contexte des prisons françaises. Maire du 10ème, Paris, 25 juin
3767 2009. Division Santé de la Direction Générale Pénitentiaire - Ministère de l'Intérieur - Espagne
- 3768 • UNAIDS (2006): Report on the Global AIDS Epidemic, May 2006, p. 114. At
3769 www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.
- 3770 • UN General Assembly. Basic principles for the treatment of prisoners. UN General Assembly
3771 Resolution. Geneva; 1990.
- 3772 • WHO/UNAIDS/UNODC (2007): Guide to starting and managing needle and syringe programmes.
3773 World Health Organisation, Department of HIV/AIDS
- 3774 • WHO/UNODC/UNAIDS (2007): Interventions to address HIV in prisons: needle and syringe
3775 programmes and decontamination strategies. Evidence for action technical papers. Geneva
3776 • http://www.who.int/hiv/pub/idu/prisons_needle/en/index.html (accessed on 23.11.11)
- 3777 • World Health Organization. Regional Office for the Eastern Mediterranean **0**: HIV prevention and
3778 care among people who inject drugs in the Islamic Republic of Iran: A Review of Best Practice
- 3779 • WHO, UNODC, UNAIDS (2007c). Interventions to Address HIV in Prisons: Drug Dependence
3780 Treatments. Evidence for Action Technical Papers.
- 3781 • www.unodc.org/unodc/en/hiv-aids/publications.html
- 3782 • WHO/UNODC/UNAIDS (2007): Interventions to address HIV in prisons: needle and syringe
3783 programmes and decontamination strategies / Ralf Jürgens. (Evidence for Action Technical Papers). Geneva
- 3784 • UNAIDS (2006): Islamic Republic of Iran Country Report on Monitoring of the United Nations
3785 General Assembly Special Session on HIV and AIDS Declaration of Commitment. Office of the
3786 Under-secretary for Health, Ministry of Health and Medical Education, Centre for Diseases
3787 Management. [Accessed at:
3788 http://data.unaids.org/pub/Report/2006/2006_country_progress_report_iran_en.pdf?preview=true
- 3789 • UNDP (2010): Bulletin, Issue # 11, February 2010
- 3790 • United Nations Commission on Human Rights. HIV/AIDS in Prisons -- Statement by the Joint
3791 United Nations Programme on HIV/AIDS (UNAIDS). Presented at the 52nd session; item 8 of the
3792 agenda. Geneva; 1996.
- 3793 • UNODC, WHO, UNAIDS (2006): HIV/AIDS Prevention, Care, Treatment and Support in Prison
3794 Settings. A Framework for an Effective National Response. http://www.unodc.org/documents/hiv-aids/HIV-AIDS_prisons_Oct06.pdf (accessed on 23.11.11)
- 3795 • United Nations High Commissioner for Human Rights (1955): Standard Minimum Rules for the
3796 Treatment of Prisoners. Adopted by the First United Nations Congress on the Prevention of Crime
3797 and Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social
3798 Council by its resolutions 663 C (XXIV) of 31 July and 2076 (LXII) of 13 May 1977
- 3799 • United Nations General Assembly (1990): Basic Principles for the Treatment of Prisoners. 14
3800 December 1990
- 3801 • UNODC, ILO, UNDP (2012): HIV prevention, treatment and care in prisons and other closed
3802 settings: a comprehensive package of interventions. A Policy Brief
- 3803 • Vohidova, M. Personal Communication. National Project Officer Tajikistan Project Office
3804 UNODC/ROCA
- 3805 • WHO (1993): WHO guidelines on HIV infection and AIDS in prisons. First printed 1993,
3806 WHO/GPA/DIR/93.3; UNAIDS/99.47/E (English original, September 1999),
- 3807 • WHO, UNODC, UNAIDS (2007): Guide to starting and managing needle and syringe
3808 programmes. Geneva
- 3809 • WHO, UNODC, UNAIDS. Interventions to address HIV in prisons. Evidence for action technical
3810 papers. Geneva, WHO, 2007a, at 59-64
- 3811 • http://www.who.int/hiv/pub/prisons/e4a_prisons/en/index.html.
- 3812

- 3813 • WHO, UNODC, UNAIDS. Effectiveness of interventions to address HIV in prisons. Evidence for
3814 action technical papers. Geneva, WHO, 2007b,
- 3815 • WHO/UNAIDS (ed.; 2008): Progress on implementing the Dublin Declaration on
3816 Partnership to Fight HIV/AIDS in Europe and Central Asia progress on implementing the
3817 Dublin. Copenhagen: WHO/UNAIDS, S. 223-231, 2008
- 3818 • WHO, UNODC, UNAIDS (2009). Technical Guide for countries to set targets for universal access
3819 to HIV prevention, treatment and care for injecting drug users.
3820 <http://www.who.int/hiv/pub/idu/targetsetting/en/index.html>. (accessed on 23.11.11)
- 3821 • WHO/ILO (2007): Post-exposure prophylaxis to prevent HIV infection. Joint WHO/ILO
3822 guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection
3823 • <http://www.who.int/hiv/pub/guidelines/PEP/en/> (accessed 22 January 2013)
- 3824 • WHO, UNODC, UNAIDS (2009): Technical guide for countries to set targets for universal access
3825 to HIV prevention, treatment and care for injecting drug users. Geneva
- 3826 • [https://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/idu_target_se](https://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/idu_target_setting_guide_en.pdf)
3827 [tting_guide_en.pdf](https://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/idu_target_setting_guide_en.pdf) (accessed 15 September 2012)
- 3828 • Wolfe, D. (2005): Pointing the Way: Harm Reduction in Kyrgyz Republic. Report commissioned
3829 by the Harm Reduction Association of Kyrgyzstan (“Partners’ Network”, Batma Estebesova,
3830 President) with the support of the International Harm Reduction Development Program OSI NY
3831 and Soros Foundation Kyrgyzstan
- 3832 • Zelichenko A. (without year): Rapid Assessment in Prisons