

Irish Penal Reform Trust
Iantaobhas Eireannach Teo Um Leasu Pianuil



A Call for Action

*HIV/AIDS and Hepatitis C
in Irish Prisons:*

By Rick Lines, MA, 2002

M Q I
Merchants Quay Ireland

Homeless and Drugs Services

HIV/AIDS AND HEPATITIS C
IN IRISH PRISONS:
A Call for Action

**Irish Penal Reform Trust
& Merchants Quay Ireland**

By Rick Lines, MA
May 2002

ACKNOWLEDGEMENTS

This report would not have been possible without the assistance provided by people working in the HIV/AIDS, harm reduction, and prisoners' rights movements in various parts of Ireland. I would like to thank those who shared their knowledge and experiences with me in the preparation of this document.

I am also indebted to the excellent and extensive research on HIV/AIDS, hepatitis C, drug use, and risk behaviours in Irish prisons that has been published over the last number of years. The findings powerfully demonstrate the need for fundamental reform of prison health service.

There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a

responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities.¹

Joint United Nations Programme on HIV/AIDS

(UNAIDS)

IPRT/MQI Summary Findings

on HIV/AIDS & Hepatitis C in Irish Prisons

- The rate of HIV infection among Irish prisoners is more than ten times higher than that in general Irish population.
- The rate of hepatitis C infection among Irish prisoners is more than 100 times higher than that in general Irish population.
- Rates of hepatitis C infection among women prisoners are as high as 50%.
- High risk behaviours for the sexual and intravenous transmission of HIV and hepatitis C are wide spread in Irish prisons.
- The Irish Prisons Service's provision of HIV and hepatitis C prevention measures falls far short of the best practice models in other European and North American jurisdictions.
- The Irish Prisons Service's provision of health care services results in inconsistent and inadequate access to care for prisoners living with HIV/AIDS and/or hepatitis C.
- In total, the current response of the Irish Prisons Service to the HIV and hepatitis C crisis falls far short of the Service's stated objective, "*[T]o provide primary health care (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to citizens in the general community.*"²
- The current response of the Irish Prisons Service to HIV/AIDS and hepatitis C falls far short of guidelines set out by the World Health Organization and UNAIDS, and is in violation of the spirit of Article 35 of the Charter of Fundamental Rights of the European Union.

IPRT/MQI Summary Recommendations

on HIV/AIDS & Hepatitis C in Irish Prisons

Prisoners' Rights

- Prisoners have the right to protect themselves from HIV and hepatitis C infection.
- Prisoners have the right to informed consent in regards to medical treatments, including the right to refuse treatment.
- Prisoners have a right to confidentiality regarding their HIV and hepatitis C status.
- Prisoners have the right to informed consent in regards to HIV and hepatitis C testing, including the right to refuse testing.
- No prisoner should be segregated based upon HIV or hepatitis C status.
- No one should be allowed to die in prison from HIV/AIDS or hepatitis C.

Recommendations:

- We recommend that the full range of harm reduction materials and initiatives including injecting equipment, sterilising facilities, condoms and sharps bins be made available to all prisoners.
- We recommend that methadone treatment be available to those already on methadone programmes prior to imprisonment, and to those who wish to begin treatment while in prison.
- Comprehensive education and training on drug use, HIV/AIDS, and Hepatitis C should be provided for all staff and prisoners across the country.
- Doctors and other health care staff should be available on a full time basis in larger prisons.
- Prisoners living with HIV/AIDS and/or hepatitis C must have access to proper and sufficient nutrition, including vitamin supplements and supplement drinks.
- Compassionate release provisions for prisoners living with HIV/AIDS and/or hepatitis C should be exercised proactively, and earlier in the course of disease progression.
- All necessary treatments including pain management should be made available in a non-discriminatory and non-stigmatising manner.
- Confidential HIV and hepatitis C testing must be made easily accessible for all prisoners. Pre- and post-test counselling must be a mandatory component of HIV and hepatitis C testing.

BACKGROUND

The Invisible Epidemic

HIV and hepatitis C infection rates in Irish prisons have reached epidemic levels. HIV infection rates amongst incarcerated people are more than ten times higher than in the outside population. Rates of hepatitis C infection, another chronic and potentially fatal

blood-borne disease, are more than 100 times higher.³

Studies have repeatedly shown that high risk behaviours for the transmission of the HIV and hepatitis C viruses not only occur in Irish prisons, they are in fact common. When coupled with the inadequacy of current prison health policies and programmes, this situation creates an environment where prisoners live in conditions of increased vulnerability to HIV and hepatitis C infection, and increased vulnerability to HIV and hepatitis C related health decline. This is not merely an issue of prison health concern. It is an issue with significant public health consequences.

Ireland is not alone in this situation. Many countries are struggling with similar prison health crises. However, while rates of HIV and hepatitis C infection in Irish prisons are the same or higher than those of other western countries, our government's response falls far short of the innovative measures adopted in many other states. In Ireland, effective measures for HIV and hepatitis C prevention are not available to prisoners. Medical services remain inadequate or inconsistently accessible. Irish prison health policy lags far behind current best practice, despite the fact that the measures necessary to address this crisis in a progressive and comprehensive fashion are not only known, they are already running effectively in prisons in other jurisdictions.

Although prison health issues are often invisible to the public at large, the health of prisoners is in fact an important issue of public health concern. *Everyone in the prison environment – whether they are prisoners, prison staff, or family members – benefits from enhancing the health of prisoners, and reducing the incidence of disease.* At the same time, the high degree of mobility between prison and community means that any illnesses or health conditions developed or exacerbated in prison do not stay there. When individuals are released from jail, prison health issues necessarily become community health issues. For these reasons, the issue of HIV/AIDS and hepatitis C in prisons demands immediate action from community and government alike.

The extent of the crisis – HIV and hepatitis C among Irish prisoners.

- A 1997 study of 108 prisoners in Mountjoy found that 9% were known to be HIV positive. This figure was considered a low estimate as half the study participants had never received an HIV test, or were waiting for their results to be processed.⁴
- A 1999 study of 1,200 incarcerated men and women found an overall HIV infection rate of 2% and a hepatitis C infection rate of 37%. This same study found that nearly half of the incarcerated women tested were infected with hepatitis C.⁵
- A 2000 study of 600 committal prisoners found an overall HIV infection rate of 2% and hepatitis C infection rate of nearly 22%.⁶ Among women prisoners, the HIV seroprevalence rate was nearly 10%, and the hepatitis C infection rate was 56%.⁷

Rates of both HIV and of hepatitis C infection in the general Irish population are estimated to be 0.1%⁸ These figures therefore reflect an HIV infection rate among prisoners more than ten times greater than that in the outside population, and a hepatitis C infection rate more than 100 times higher than the outside population.

BACKGROUND

HIV/AIDS & Hepatitis

HIV and hepatitis C are blood borne viruses. Both viruses are transmitted in similar ways, and both can cause chronic illness or death. While drug therapies exist that can help treat people living with HIV or hepatitis C infections, there is currently no cure or vaccine for either.

Human Immunodeficiency Virus (HIV)

The *human immunodeficiency virus*, commonly known as HIV, is the virus linked to AIDS. HIV weakens and eventually destroys the body's immune system – the system enabling the body to fight off disease and infection. When a person's immune system becomes severely compromised, making them vulnerable to *opportunistic infections* that take advantage of the host's weakened defences, they are diagnosed with *acquired immune deficiency syndrome*, or AIDS. These opportunistic infections, many of which are harmless to those with healthy immune systems, have the ability to incapacitate or even kill people living with HIV or AIDS. Most, if not all, people infected with HIV will go on to develop AIDS.⁹

Common HIV related symptoms include chronic fatigue, diarrhoea, fever, mental changes such as memory loss, weight loss, persistent cough, severe recurrent skin rashes, herpes and mouth infections, and swelling of the lymph nodes. Opportunistic infections such as cancers, meningitis, pneumonia and tuberculosis are also common as an individual's immune system weakens.¹⁰

The primary routes of transmission for HIV are through unprotected sexual intercourse (anal or vaginal) with a person living with HIV/AIDS, the sharing of injection equipment or skin piercing equipment contaminated with HIV, and mother to child transmission during pregnancy, labour, and delivery, or as the result of breast-feeding. There is also a risk of transmission via blood transfusion or the use of blood products not screened for the presence of HIV.¹¹

HIV infection can be detected by a blood test. The test detects the presence of HIV antibodies (the reaction of the body's immune system to the presence of the virus) rather than the HIV virus itself. The body typically takes six weeks to three months to produce sufficient antibodies to be detected by the test. For this reason, there is a *window period* in current HIV testing technology between the time a person contracts HIV and when he or she will register a positive test result. During this window period, it is possible that a person infected with HIV may register a false HIV negative test.¹²

While treatment options for people living with HIV/AIDS have improved in recent years, there is still no cure for the disease. New combination therapies, or *drug cocktails*, have been successful in improving the health of many. Combination therapy involves taking three or four different medications at the same time. When effective, combination therapies can strengthen the immune system by suppressing the spread of HIV in the body.¹³ While combination therapy has proven a major breakthrough in HIV/AIDS care, it is not a cure, nor is it effective for everyone.

Drug compliance is a key issue for people taking HIV combination therapies, as missed doses or interruptions in treatment can cause the suppressed HIV to begin spreading again.¹⁴ If many doses are missed, or if medications are taken sporadically, it is possible for the patient to develop resistance to the therapy, thereby negating its future efficacy.¹⁵ Diet can also be important in proper compliance, and some HIV medications are prescribed with specific dietary and mealtimes requirements in order to increase drug absorption, or reduce side effects.¹⁶

Many HIV medications cause significant and unpleasant side effects for the patient, including headaches, nausea, diarrhoea, and changes in body shape.¹⁷ Some HIV therapies are particularly damaging to the liver, which can cause serious concerns for people co-infected with both HIV and hepatitis C, a virus that attacks the liver.

Many people living with HIV/AIDS also suffer from chronic pain. This pain can vary from occasional and mild, to constant and debilitating, depending upon the person, the stage of their disease, and their care setting. It is estimated that 30—80% of people living with HIV/AIDS suffer from pain related to their disease.¹⁸ In some cases, painful conditions can be exacerbated by the side effects of HIV medications. As a result, many people living with HIV/AIDS require pain management medications in addition to HIV therapies, including the use of opioids to treat severe pain. However, access to adequate pain medication can prove problematic. Studies have shown that people reporting moderate to severe pain are more likely to have their pain underestimated by doctors.¹⁹ Studies have also found that a patient's sex, educational level, and history of injection drug use can be a factor in physicians' undertreating of pain in people living with HIV/AIDS.²⁰ Discrimination of this type can create particular barriers for prisoners.

The rate of HIV seroprevalence in Ireland as a whole is estimated at 0.1%.²¹

Hepatitis C Virus

Hepatitis C is a viral infection that affects the liver, and is known to be a major cause of chronic liver disease.

Common symptoms of Hepatitis C infection include chronic fatigue, muscle and joint pain, and headaches. People living with Hepatitis C infection may also suffer nausea, skin rashes, and weight loss.²² Approximately 80% of people infected with hepatitis C will go on to develop chronic infection, which can lead to cirrhosis and liver cancer. Approximately 10—20% of people with chronic hepatitis C infection will develop cirrhosis. Over time, 1—5% of people with chronic infection will develop liver cancer.²³

Like HIV, hepatitis C is a virus that lives in the blood. It is primarily spread via blood to blood contact, particularly through sharing of contaminated injection equipment and skin piercing equipment. In Ireland, sharing syringes is the most common mode of hepatitis C transmission.²⁴ Sexual and perinatal transmission of hepatitis C are also possible, although less frequent. There is also a risk of infection through blood transfusion or use of blood products not screened for hepatitis C.²⁵

While the HIV virus lives for only a short time outside the body, it has been reported that the hepatitis C virus can survive for days, if not longer.²⁶ For this reason, the risks of transmitting hepatitis C through practices such as body piercing and tattooing are high.²⁷ The sharing of personal hygiene implements such as razors, toothbrushes, and nail clippers also presents a risk of hepatitis C transmission.²⁸

Hepatitis C infection can be detected through a blood test. As is the case with HIV, the test for hepatitis C detects the presence of antibodies in the bloodstream, rather than the virus itself. The body typically takes five weeks to three months for hepatitis C antibodies to be produced in sufficient quantity to be detected by the test. For this reason, a window period exists in between the time a person contracts hepatitis C and the time the test will detect their infection.²⁹ During this window period, it is possible that a person infected with hepatitis C may register a false negative test result.

There is no cure for hepatitis C infection. The primary drugs used to treat hepatitis C are interferon and ribavirin, which are either taken alone or in combination. These therapies suppress the virus. They do not eliminate it.³⁰ Treatment with interferon alone is effective in approximately 10—20% of patients. Interferon and ribavirin used in combination is effective in approximately 30—50% of patients.³¹

The rate of hepatitis C seroprevalence in Ireland as a whole is estimated at 0.1%.³²

BACKGROUND

High Risk Behaviours in Prisons

Research in Ireland has consistently demonstrated that high risk behaviours for the transmission of HIV and hepatitis C – unprotected sexual intercourse, or sharing needles for activities such as injection drug use and tattooing – are wide spread among prisoners. Because this high risk behaviour takes place in an environment characterised by disproportionately high levels of HIV and hepatitis C infection, and a near complete lack of effective prevention measures, there exists a significant risk of transmission of these blood-borne diseases.

Injection Drug Use in Irish Prisons

- A 1997 study found that 1 in 3 prisoners had injected while incarcerated, with 84% of this group sharing injection equipment in prison. ***1 in 4 of the injection drug users who had been tested for HIV came back with positive test results,***³³
- A 1999 study found that more than 40% of prisoners reported injecting at least once in their lives. 1 in 5 injection drug users stated that they first injected inside prison. Almost half of injection drug users reported injecting while incarcerated, and nearly three in five reported sharing injecting equipment in prison. ***The study found that 87% of those who had shared injection equipment in prison tested positive for hepatitis C.***³⁴
- A 2000 study found that more than one-quarter of committal prisoners had injected drugs in their lives. Of those identifying themselves as past or current injection drug users, nearly 1 in 5 first injected in prison, and 2 in 5 admitted to sharing injection equipment while incarcerated. ***The study found that 90% of injection drug users who had shared injection equipment in prison tested positive for hepatitis C.***³⁵
- A 2000 study by Merchants Quay Ireland showed that 51% of the clients using their needle exchange programme had been in prison at some point. Of those who had been in prison, more than 2 in 5 reported injecting drugs while incarcerated. ***The study found that 70% of these injection drug user shared injecting equipment while in prison.***³⁶

Sexual Activity in Irish Prisons

- A 1999 study “found evidence of sexual contact between men in prison and an association between both hepatitis b and HIV infection and sex between men.”³⁷ Approximately 2% of the men surveyed admitted to having anal sex with men while incarcerated.³⁸ ***HIV infection rates among this group were found to be greater than 1 in 10.***³⁹ A related study in 2000 found that approximately 1 in 100 male committal prisoners admitted to having anal sex with other men in prison. However, to underscore the conservative nature of this finding, the authors noted that questions on same-sex sexual activity “were the least likely to have been answered truthfully” by the study participants.⁴⁰ We may therefore assume that the true level of sexual activity is higher.

Tattooing in Irish Prisons

- Tattooing is a very popular art form among prisoners, and there are many talented tattoo artists incarcerated in Irish prisons. Tattooing has also been identified as a risk factor for hepatitis C transmission in prisons.⁴¹ In Ireland, a 2000 study found that almost half of the prisoners they surveyed were tattooed, and that a quarter of those (nearly 15% of overall study participants) had received a tattoo while incarcerated.⁴² The researchers concluded “hepatitis C was more common in those with a tattoo than those without a tattoo”. ***They also concluded that those who had been tattooed in prison were more likely to test hepatitis C positive than those who were tattooed outside of prison.***⁴³

Irish research consistently and clearly shows that HIV and hepatitis C infection rates are significantly higher among prisoners than non-prisoners, and that high risk behaviour is commonplace behind bars. The question that must be asked is what steps will the Irish Prison Service take to ensure the health of prisoners, and the public at large?

**HARM
REDUCTION**

*A Framework
for Change*

Traditionally, concerns about disease transmission through injection drug use have been met with calls to further entrench the ethos and practice of “zero tolerance”. Increased penalties for drug use, tightened security measures to reduce the supply of drugs, and heightened surveillance of individual drug users are often put forward as simple ‘law and order’ solutions to complex public health questions. However, such punitive responses alone can never address the issue of HIV and hepatitis C transmission.

While such suggestions may be well intentioned – and are certainly politically expedient – they ignore the larger economic and social realities that drive drug use, drug trafficking, and disease transmission, and in doing so ensure that rates of infection will continue to climb.

In recent years, many countries, including Ireland, have recognised the limitations of a strictly zero-tolerance approach to drug use, and have implemented community health programmes that enable injection drug users to reduce their risk of contracting HIV and hepatitis C while continuing to use illegal drugs. These harm reduction initiatives – such as needle exchange programmes – have been enacted as a pragmatic response to injection drug use, and the attendant risks that HIV and hepatitis C infection pose to the individual and society as a whole.

While harm reduction policies do not condone illegal drug use, they do recognise that reducing the transmission of blood borne diseases in society is a more urgent and achievable goal than is ending drug use. As drug users are often isolated from mainstream health services, harm reduction initiatives such as needle exchanges and methadone maintenance programmes also create important links between health professionals and these marginalized communities, thus enabling drug users to maintain and improve their health.

Ireland’s National Drug Strategy, 2001—2008 endorses the principles of harm reduction in the development of a comprehensive approach to drug use and disease prevention in the community. It states,

Traditionally, the dominant trend in policy has been towards the...ultimate attainment of a drug free society. However, the recognised link between drug misuse and the spread of diseases has resulted in the need to adopt strategies that reduce the risk posed by such behaviour both to the individual misuser and the wider community.⁴⁴

As a result, the National Drug Strategy identifies the expansion of needle exchange and methadone maintenance programmes as key components of its action plan.

While the government has recognised the value of harm reduction programmes, and supported their implementation in the general community, they have made no parallel effort to extend the availability of these programmes to prisoners. Yet drug use and drug trafficking are as much a part of prison life as they are a part of Irish society. The secure environment of the prison does not alter this reality, in Ireland or anywhere else. In fact, studies have shown that the particularities of the prison environment lead many prisoners to use injection drugs for the first time while incarcerated, or to choose injection over other methods of ingestion.⁴⁵

Given these facts, we must ask on what basis can the state continue to delay or deny the implementation of comprehensive harm reduction programmes in prisons? This question is even more resonant given the success of harm reduction initiatives in prisons in other parts of Europe.

Despite their illegality, the penalties for their use, and the significant amounts of money and person hours spent by the Prisons Service to stop their entry, the fact remains that drugs get into prisons, and prisoners use them. Just as in the broader society, drugs get in because there is a market for them, and because there is money to be made by providing them. This simple truth continues to drive drug availability in prisons, and drug availability in Ireland overall. The government must be realistic about this fact, and act pragmatically and effectively to reduce this risk to individual and public health. Rather than focusing solely on the question of “How do we stop drugs getting into prisons?” the government must face up to the bigger question of “How do we minimise the individual and societal health risks resulting from drug use?” The government has taken important steps in this regard in the outside community, and their continued failure to do the same in prison is in clear opposition to the stated objective of the Prison Medical Service, *[T]o provide primary health care (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to citizens in the general community.*⁴⁶

In the words of UNAIDS, “Whether the authorities admit it or not — and however much they try to repress it — drugs are introduced and consumed by inmates in many countries....Denying or ignoring these facts will not help solve the problem of the continuing spread of HIV.”⁴⁷ This is the stark reality that the Irish government must face, and act to address. The experience of health services in many parts of Ireland, as well as in many prison systems internationally, shows us that harm reduction provides the framework for effective action to prevent the transmission of HIV and hepatitis C.

**EXAMPLES OF
INTERNATIONAL
BEST PRACTICE**

*How does
Ireland
compare?*

According to the World Health Organizations' Guidelines on HIV Infection and AIDS in Prisons, "(A)ll prisoners have the right to receive health care, including preventative measures, equivalent to that available in the community without discrimination."⁴⁸ Many countries have taken positive steps to move towards meeting these guidelines by implementing innovative prevention and care programmes. However, the Irish Prison Service lags far behind current best practice in almost every major area of HIV/AIDS and hepatitis C prevention and support. Some of these key areas are summarised below.

Bold initiatives have been undertaken in several European and North American jurisdictions in order to comprehensively address HIV and hepatitis C infection among prisoners. The Irish government must examine these examples of best practice in prison health care, and make similar programmes and services available here.

I. Condoms and Safer Sex materials

Condom use is internationally accepted as the most effective method for reducing the risk of the sexual transmission of HIV⁴⁹. As a result, many prisons across the world provide condoms to prisoners as part of their institutional health policies. As early as 1991, a World Health Organization study found that 23 of 52 prison systems surveyed provided condoms to prisoners.⁵⁰ By August 2001, 18 of the 23 prison systems in the EU were distributing condoms.⁵¹

Condom distribution in prisons as part of a comprehensive HIV prevention programme is supported by the World Health Organization, and is a key recommendation in two major studies of HIV and hepatitis C in Irish prisons produced in 1999 and 2000.

In Ireland...

The Irish Prisons Service remains one of the last jurisdictions in Europe that does not provide condoms to prisoners.

Recommendation:

Condoms, dental dams, and water-based lubricants must be made available to all prisoners. These materials must be available in a discreet and anonymous fashion that does not necessitate making a request to prison staff.

II. Bleach

Full-strength bleach may be used to reduce the risk of HIV transmission via the sharing of used syringes, as it has the potential to kill the virus if used properly. However, bleach is far from an optimum HIV and hepatitis C prevention measure, as it is less than 100% effective in killing HIV, and is of unknown efficacy against hepatitis C. Still, for injection drug using prisoners who cannot access sterile syringes, the provision of bleach does provide a useful harm reduction option, and is available in many prison systems internationally.

According to UNAIDS, the provision of full-strength bleach to prisoners as a harm reduction measure has been successfully adopted in prisons in Europe, Australia, Africa, and Central America. The WHO further reports that concerns that bleach might be used as a weapon have

proved unfounded, and that this “has not happened in any prison where bleach distribution has been tried.”⁵²

By August 2001, bleach was provided in 11 of 23 EU prison systems.⁵³ In Canada, bleach has been available in over twenty prisons in the province of British Columbia since 1992. In 1996, Canada’s federal prison system introduced bleach distribution programmes in all fifty-two institutions under federal jurisdiction.⁵⁴

In April 2000, the Irish Prisons Service introduced disinfectant tablets to the medical unit in Mountjoy. However, this project was stopped following objections from the Prison Officers’ Association.⁵⁵ In September 2001, the Report of the Group to Review the Structure and Organisation of Prison Health Care Services recommended “disinfectant tablets should be introduced in the Irish prison system without further delay.”⁵⁶

In Ireland...

The Irish Prisons Service does not provide bleach to prisoners as a harm reduction measure.

Recommendation:

Access to full-strength bleach must be made available to all prisoners. Bleach must be available in a discreet and anonymous fashion that does not necessitate making a request to prison staff.

III. Needle Exchange

The first prison needle exchange programme was established in the Oberschöngrün maximum security prison for men in Switzerland in 1992/93. In June 1994, a second Swiss programme was initiated at the Hindelbank institution for women.

In the Hindelbank project, sterile syringes were accessed from dispensing machines set up in various parts of the institution. Prisoners were allowed to possess one syringe, provided it was kept in a specially designated cabinet. During the first year of the project, 5,335 syringes were distributed to prisoners.⁵⁷

At the end of the first year the Hindelbank project was evaluated. ***The evaluators found that there were no new cases of HIV or hepatitis C in the institution, there was an overall improvement in prisoners’ health, there was a significant decrease in syringe sharing, there was no increase in drug consumption, and there were no instances of syringes being used as weapons.***⁵⁸

Since that time, needle exchange programmes have been established in a total of nineteen prisons in Switzerland, Germany, and Spain.⁵⁹ A study in Australia has supported the feasibility of prison needle exchange, and a working group established by the Correctional Service of Canada has recommended the implementation of pilot needle exchange programmes in five Canadian prisons.⁶⁰

A 2000 study by Merchants Quay Ireland has demonstrated that needle exchange programmes in the community are effective in reducing syringe sharing among injection drug users.⁶¹ The Irish government’s new National Drugs Strategy, 2001—2008 endorses the importance of needle exchange programmes as part of an HIV and hepatitis C prevention strategy, and identifies the need “[t]o review the existing network of needle-exchange facilities with a view to ensuring access for all injecting drug misusers to sterile injecting equipment.”⁶² Given that a significant number

of injection drug users are incarcerated, the government can only meet this target if they follow international best practice and expand needle exchange programmes into prisons. However, providing needle exchange to prisoners is not part of the Strategy, despite a recommendation in a 1999 study of HIV and hepatitis C in Irish prisons that “a strictly controlled supply of clean needles and syringes should be available for those prisoners who will continue to inject opiates.”⁶³

In Ireland...

The Irish Prisons Service does not provide sterile injecting equipment to prisoners.

Recommendation:

Access to sterile injecting equipment must be made available to all prisoners. This equipment must be available in a discreet and anonymous fashion that does not necessitate making a request to prison staff. The Irish government should investigate the several models of needle exchange programmes currently in operation in various European prisons as a guide.

IV. Methadone Maintenance

Methadone maintenance is used internationally as an effective replacement therapy for opiates, and an important harm reduction option for injection heroin and morphine users. Administered orally, methadone allows injection opiate users an option for ending their reliance on illegal drugs, and to cease injecting practices. As such, methadone forms an important part of harm reduction programmes in many countries, including Ireland.

During the 1990s, methadone programmes were widely introduced in prisons in Europe and Canada. In September 2001, the Correctional Service of Canada (CSC) published an evaluative study on their methadone programme, which concluded that participation in methadone programmes had positive post-release outcomes.⁶⁴ The study found that opiate users accessing methadone maintenance therapy (MMT) during their incarceration were less likely to be readmitted to prison following their release – and were less likely to have committed new offences – than were those not accessing methadone. The study further concluded that

an important implication of these findings is that CSC may spend less money on these offenders in the long term. The cost of the institutional MMT program may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving MMT. In addition, health related costs such as treatment for HIV or Hepatitis C infection would be affected by MMT availability in prisons⁶⁵

In 2000, the Irish Prisons Service introduced methadone into several Dublin prisons. This was an important decision by the Prisons Service, as it recognized the scope of injection drug use within the prison system, and the value of harm reduction programmes.

However, the current system falls far short of the comprehensive response necessary to address the problem of HIV and hepatitis C transmission through injection heroin use. At present, methadone is only available in Dublin prisons, which means that half of Irish prisoners cannot access the treatment by virtue of the region in which they are imprisoned. In addition, only those prisoners who are prescribed methadone prior to incarceration qualify to avail of the programme. Rarely are prisoners authorised to initiate methadone while they are incarcerated, Methadone is thereby eliminated as an option for the majority of opiate-using prisoners. For heroin using

prisoners who are infected with hepatitis C, the inability to initiate methadone therapy while incarcerated can create significant barriers to initiating hepatitis C treatment.

In the words of the Prison Officers' Association – who has been highly critical of the limitations of the current methadone policy – this policy has created “a two-tier prison system and is totally unacceptable.”⁶⁶

In Ireland...

Methadone is provided on a limited basis in Dublin area prisons, and only to those individuals on a methadone programme prior to incarceration. Prisoners are rarely able to initiate methadone therapy while incarcerated.

Recommendation:

The recent decision by the Irish Prisons Service to implement methadone maintenance in Dublin prisons is to be commended. However, methadone maintenance must be expanded to all institutions in all regions, and made accessible to all medically qualifying prisoners. The methadone programme must also be expanded to allow medically qualifying prisoners to initiate methadone therapy while in prison.

V. Care, Treatment, and Support.

HIV/AIDS and hepatitis C are chronic or fatal illnesses for which no cure or vaccine currently exists. Both require ongoing monitoring of disease progression, and access to specialist medical intervention, drug therapies, and pain management. Both require access to proper diet and nutrition as a health promotion strategy.⁶⁷

Providing a proper standard of care, treatment, and support for people living with HIV/AIDS and/or hepatitis C is not simply an issue of service delivery. It is a central component of an holistic and comprehensive health strategy. According to the World Health Organization/ UNAIDS, “[a]ccess to care and support... contributes to the prevention of HIV infection” and “decreases the spread of infectious diseases that are common among HIV-infected people.”⁶⁸ Providing adequate care and support also contributes to enhancing the environment in which people live and in which prevention education initiatives take place. “By caring openly and compassionately for HIV infected people, the care-givers alleviate community’s fear of HIV infection, and alleviate stigma and discrimination.”⁶⁹

In order to provide comprehensive and accessible care and treatment for prisoners living with HIV/AIDS and/or hepatitis C, it is essential that consistent and accessible medical services be available in all institutions, provided by fully trained and certified health care professionals. However, this is not the case in Irish prisons, where primary health care services are provided by GPs contracted on only a part-time basis, and many nursing services are not provided by trained nurses but by medical orderlies – prison officers with only basic first aid training.

To address this inadequacy in the provision of prison medical services, the 2000 General Healthcare Study of the Prisoner Population recommended

*the introduction of an adequately funded comprehensive primary care health service across the prison system.....This would mean that doctors and other health care staff would be available on a full time basis in larger institutions on the same per capita arrangement as a GMS (General Medical Service) list.*⁷⁰

In the case of HIV/AIDS care, existing barriers are exacerbated by disparities in regional health care infrastructure. In Ireland, the majority of physicians specialising in HIV/AIDS are located in Dublin. Therefore, specialised HIV/AIDS care is less available to prisoners incarcerated outside of the Dublin region. While this is not a fault of the Prisons Service, it is an issue the Service must take into account in designing an HIV/AIDS and hepatitis C strategy.

There are currently no “hospital” facilities within Irish prisons, and those prisoners requiring more intensive care are transferred to outside hospitals, typically under security escort.⁷¹ While a “medical unit” does exist in Mountjoy, it has recently been described as “unsuitable for most medical purposes.”⁷² Many prisoners living with HIV/AIDS are housed in this unit in Mountjoy.

The lack of proper hospital facilities and consistent access to specialist care within the Irish prison system is a concern for all prisoners. However, it has particular impact on those with chronic and life-threatening illnesses such as HIV/AIDS and hepatitis C, as the risk of severe health decline requires ongoing medical attention, and can make it difficult or impossible for them to live comfortably within normal prison units.

To address such systemic barriers in providing health services to prisoners, some jurisdictions have opted to remove health care responsibilities from the prison system altogether. According to UNAIDS, “Experience in a range of prison systems has shown that health care in prisons can be delivered more effectively by public health authorities than by prison management.”⁷³ The prison systems in Norway and France have both adopted this model,⁷⁴ as have several prisons in the province of Québec in Canada.

Calls to transfer the responsibility for correctional medical care outside of the Prisons Service have been made here in Ireland. A 1999 study of HIV and hepatitis C in prisons concluded, “it would be better...if ultimate responsibility for the prison health service rested with the Department of Health and Children.”⁷⁵ A related study in 2000 recommended that “[h]ealth services [be] provided by an independent multidisciplinary team.”⁷⁶

In Ireland...

Primary medical services are provided by GPs contracted on a part-time basis. Nursing services are primarily provided by medical orderlies who have no formal medical training or certification. Specialist medical services for prisoners living with HIV/AIDS are concentrated in Mountjoy Prison in Dublin.

Recommendations:

- Access to adequately funded, comprehensive medical services must be consistent across the country and among institutions. Adequately staffed and resourced health units must be developed in all institutions.
- We support the finding of the General Healthcare Study of the Prisoner Population, which recommends “that doctors and other health care staff...be available on a full time basis in larger institutions, on the same per capita arrangement as a GMS (General Medical Service) list.”
- Mentoring relationships should be established between HIV/AIDS and hepatitis C specialist consultants in Dublin and GPs providing primary care services in the various regional institutions in order to support them in providing care to prisoners living with HIV/AIDS and/or hepatitis C.

- The Irish Prisons Service’s commitment to hire professionally qualified nursing staff is to be commended. This process must proceed on schedule, and result in properly qualified nursing staff in all institutions.
- Increased resources must be dedicated, and ongoing training provided, to health care staff in all institutions to enable them to meet the unique and evolving needs of prisoners on HIV and/or hepatitis C therapies.
- Prisoners living with HIV/AIDS and/or hepatitis C must be provided equal and non-discriminatory access to pain management medications.
- Prisoners living with HIV/AIDS and/or hepatitis C must have access to proper and sufficient nutrition, including vitamin supplements and supplement drinks. For those prisoners on medications, diet and mealtimes must be adapted to meet the requirements of the drug therapies.

VI. Confidentiality and Testing

Confidentiality is often the single biggest concern for prisoners living with HIV/AIDS. It is also a concern for those infected with hepatitis C.

Prisoners are entitled to the same confidentiality of their medical information as people in the general community. However, confidentiality is often inadvertently compromised or deliberately breached within the prison environment by staff and prisoners alike.⁷⁷ The fact that prison medical orderlies are themselves prison officers also contributes to a general lack of confidence among prisoners in the security of medical information.

The resulting lack of trust has important implications for an HIV/AIDS and hepatitis C strategy. Because of the significant social stigma attached to HIV and hepatitis C, fears about the confidentiality of medical information affects participation in health services. This lack of confidence acts as a deterrent to testing, to accessing medical care, and even to availing of educational materials and information. For this reason, improving systems and practices for maintaining confidentiality – and building trust in the security of medical information among the prison population – must be a central component of an effective HIV and hepatitis C strategy.

Confidentiality is a particularly crucial element of an effective HIV and hepatitis C testing protocol. Unless prisoners themselves have trust in the privacy of their test results, many will choose not to avail of existing testing services. Pre- and post-test counselling for those being tested is an important element of best practice in this regard. According to the World Health Organization/UNAIDS,

*Testing should be voluntary and confidential, and should be accompanied by counselling. Counselling is important to prepare clients to come to terms with their HIV status: this includes dealing with fear, guilt, stigma, discrimination, care for a chronic condition, the possibility of early death, and to give them an understanding of what they can and should do about HIV infection, should they be HIV-infected. It is also important in helping people devise or strengthen ways of staying HIV negative, if they test HIV negative.*⁷⁸

In several Canadian jurisdictions, “anonymous” HIV testing is available. Anonymous testing has been provided in several prisons in Quebec and Saskatchewan since the mid-1990s. In these institutions, testing is provided by outside community health agencies that come into the prison

on a regular basis to provide the service. The use of outside health workers, rather than prison staff, is done in order to increase trust in the confidentiality of the service among the prison population, and reduce fears that results will be shared with the institution. Pre- and post-test counselling is standard, and the test results are provided only to the prisoners, and not shared with the prison. Based upon the success of these projects, the Canadian federal prison system is currently pilot testing similar programmes in two penitentiaries, with an eye to making anonymous testing available in all federal institutions across the country.

In Ireland...

HIV and hepatitis C testing is provided on request to prisoners. Pre- and post-test counselling is unevenly practiced.

Recommendations:

- Confidential HIV and hepatitis C testing must be made accessible for all prisoners.
- Pre- and post-test counselling must be a mandatory component of HIV and hepatitis C testing practices.
- We welcome plans by the Prisons Service to increase security of prisoner medical information.
- Breaches of confidentiality by employees of the Prisons Service are unprofessional and unacceptable. Ongoing support and education for staff should be provided in an effort to constantly improve institutional confidentiality practices. All breaches of confidentiality by staff should be investigated, and appropriate disciplinary sanctions imposed.

RECOMMENDATIONS

HIV/AIDS & Hepatitis C in Prisons

Based upon these findings, the Irish Penal Reform Trust and Merchants Quay Ireland make the following Recommendations.

Our Recommendations are based upon the following core principles.

- Prisoners have the right to protect themselves from HIV and hepatitis C infection.
- Prisoners have the right to informed consent in regards to medical treatments, including the right to refuse treatment.
- Prisoners have a right to confidentiality regarding their HIV and hepatitis C status.
- Prisoners have the right to informed consent in regards to HIV and hepatitis C testing, including the right to refuse testing.
- No prisoner should be segregated based upon HIV or hepatitis C status.
- No one should be allowed to die in prison from HIV/AIDS or hepatitis C.

Our Recommendations are also based on the belief that reducing the prevalence of disease and illness within prison walls is to the benefit of everyone in the prison community, including prisoners, staff members, friends, and family members.

Prevention and Education.

We recommend that:

1. Condoms, dental dams, and water-based lubricants must be made available to all prisoners.
2. Access to sterile injecting equipment must be made available to all prisoners.
3. Access to full-strength bleach must be made available to all prisoners.
4. The current methadone maintenance programme must be expanded to all institutions in all regions, and made accessible to all medically qualifying prisoners.
5. Personal hygiene items, particularly razors, toothbrushes, and nail clippers, must be individually available to every prisoner.
6. The Prisons Service should investigate strategies to reduce the transmission of HIV and hepatitis C infection via tattooing practices.
7. Comprehensive, accurate, and appropriate HIV/AIDS and hepatitis C prevention education must be made mandatory for all prisoners and prison staff. Funding should be provided so that community-based organisations can increase their role in providing this service, rather than having the responsibility fall to prison staff alone.
8. All prison staff must receive mandatory and ongoing training on the use of universal precautions as a standard part of proper workplace safety and practice.

Care, Treatment, and Support.

We recommend that:

1. Access to adequately funded, comprehensive medical services must be consistent across the country and among institutions. Adequately staffed and resourced health units must be developed in all institutions.
2. We support the finding of the General Healthcare Study of the Prisoner Population, which recommends “*that doctors and other health care staff...be available on a full time basis in larger institutions on the same per capita arrangement as a GMS (General Medical Service) list.*”
3. Mentoring relationships should be established between HIV/AIDS and hepatitis C specialist consultants in Dublin and GPs contracted to provide primary care services in the various regional institutions, in order to assist them in providing care to prisoners living with HIV/AIDS and/or hepatitis C.
4. The Irish Prison Service’s commitment to hire professionally qualified nursing staff is to be commended. This process must proceed on schedule, and result in adequate levels of properly qualified nursing staff in all institutions.
5. Increased resources must be dedicated, and ongoing training must be provided, to health care staff in all institutions to enable them to meet the unique and evolving needs of prisoners living with HIV/AIDS and/or hepatitis C.
6. Prisoners living with HIV/AIDS and/or hepatitis C must be provided equal and non-discriminatory access to pain management medications.
7. Prisoners living with HIV/AIDS and/or hepatitis C must have access to proper and sufficient nutrition, including vitamin supplements and supplement drinks. For those prisoners on medications, diet and mealtimes must be adapted to meet the requirements of the drug therapies.
8. Community-based health organisations must be facilitated in providing HIV/AIDS and hepatitis C support and health promotion to prisoners. Increased financial resources must be made available to community-based organisations for this purpose.
9. Compassionate release provisions for prisoners living with HIV/AIDS and/or hepatitis C should be exercised proactively, and earlier in the course of disease progression.

Confidentiality and Testing.

We recommend that:

1. Confidential HIV and hepatitis C testing must be made easily accessible for all prisoners.
2. Pre- and post-test counselling must be a mandatory component of HIV and hepatitis C testing.
3. We welcome plans by the Prisons Service to increase security of prisoner medical information.
4. Breaches of confidentiality by employees of the Prisons Service are unprofessional and unacceptable. Ongoing support and education for staff should be provided in an effort to constantly improve institutional confidentiality practices. All breaches of confidentiality by staff should be investigated, and appropriate disciplinary sanctions imposed.

CONCLUSION

A Call for Action

Everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practice⁷⁹.

Charter of Fundamental Rights of the European Union
Article 35

HIV/AIDS and hepatitis C are challenging issues for prison systems.

Epidemic rates of infection among prisoners have challenged governments to act. Yet implementing the measures and programmes known to be effective has also challenged the conventional thinking of many prison bureaucracies, prison staff, and the public at large. Prison systems have struggled with the idea that programmes such as condom distribution and needle exchange have a place in the prison environment. In Ireland, these challenges are the same. However, international experience and best practice have demonstrated that these services and others are not only appropriate, they are in fact an essential part of a comprehensive health response to HIV and hepatitis C.

It is an unfortunate truth that negative public attitudes towards prisoners often act as a barrier to objective discussions of prison policy. Yet sound health policy is never based upon prejudice. It is based upon need, and on effective and evaluated models of service delivery. On these criteria, the demand for the implementation of a comprehensive HIV/AIDS and hepatitis C prevention and support strategy in Irish prisons is clear.

While sound health policy is never based upon prejudice, it is often obstructed or delayed by it. Therefore, implementing an effective health policy in Irish prisons demands leadership from government, and the willingness to act in the best interests of public health. Indeed, the government has the responsibility to act. This responsibility is articulated in international guidelines set by the World Health Organization and UNAIDS, and in Article 35 of the Charter of Fundamental Rights of the European Union.

To date, the Irish Prisons Service has been slow to act in the innovative and comprehensive manner of other jurisdictions. While this delay is regrettable, the Prisons Service now has the opportunity to learn from the ground-breaking efforts of other prison systems, and act quickly to implement the types of health services that have been proven effective in other countries.

International experience has shown the advantages when prison staff, community-based HIV/AIDS organisations, medical experts, and prisoners work together to address these often complex health issues. It has also shown the dangers of failing to act in the face of this health crisis.

The Irish Penal Reform Trust and Merchants Quay Ireland look forward to making our contribution to the collective effort to improve health services for prisoners. We invite the Prisons Service to work with us and other community stakeholders to implement a comprehensive and compassionate response to HIV/AIDS and hepatitis C in Irish prisons.

ABOUT THE AUTHOR

Rick Lines has been a prisoners' rights advocate since 1990, and from 1993 has worked specifically in the area of HIV/AIDS programmes and policy. He is the former National Programmes Coordinator for the Prisoners' HIV/AIDS Support Action Network (PASAN) in Toronto, and has represented community-based AIDS organisations on various health committees of the Correctional Service of Canada.

Rick has authored numerous publications on HIV/AIDS and prisons, including Pros & Cons: A Guide to Creating Successful Community-based HIV/AIDS Programmes for Prisoners (Health Canada: 2002), and HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy (co-author, PASAN: 1999). He has spoken on HIV/AIDS and prison issues before many audiences including the Canadian *Parliamentary Subcommittee on AIDS*, the *XI International Conference on AIDS*, and members of the *U.S. Presidential Advisory Council on HIV/AIDS*.

Rick holds a Masters degree in Sociology from York University, Toronto. He is currently working in Ireland in the area of drug policy and programming.

HIV/AIDS & HEPATITIS C IN IRISH PRISONS: *A Call for Action*

Sources Consulted

Allwright, S. Barry, J., Bradley, P., Long, J. & Thornton, L. Hepatitis B, Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk. The Stationery Office, Dublin. 1999.

Armstrong, Todd, Sean Hosein. "HIV/AIDS Treatment: The AIDS Cocktail (combination therapy)." Community AIDS Treatment Information Exchange, Toronto. December 2001. Available online at www.catie.ca/simple.nsf.

----- "HIV/AIDS Treatment: Drug Side Effects." Community AIDS Treatment Information Exchange, Toronto. December 2001. Available online at www.catie.ca/simple.nsf.

----- "HIV/AIDS Treatment: Sticking to Your Treatment (combination therapy)." Community AIDS Treatment Information Exchange, Toronto. December 2001. Available online at www.catie.ca/simple.nsf.

Canadian HIV/AIDS Legal Network. "Info Sheet 3 on HIV/AIDS in Prisons: HIV Transmission in Prisons." Canadian HIV/AIDS Legal Network, Montreal. 2001/2002. Available online at www.aidslaw.ca.

----- "Info Sheet 4 on HIV/AIDS in Prisons: Prevention: Condoms." Canadian HIV/AIDS Legal Network, Montreal. 2001/2002. Available online at www.aidslaw.ca.

----- "Info Sheet 5 on HIV/AIDS in Prisons: Prevention: Bleach." Canadian HIV/AIDS Legal Network, Montreal. 2001/2002. Available online at www.aidslaw.ca.

----- "Info Sheet 6 on HIV/AIDS in Prisons: Prevention: Sterile Needles." Canadian HIV/AIDS Legal Network, Montreal. 2001/2002. Available online at www.aidslaw.ca.

Charter of Fundamental Rights of the European Union.

Consultative Council on Hepatitis C. "Living with Hepatitis C: Information for people with Hepatitis C and their family and friends." Department of Health and Children, Dublin. Undated.

Correctional Service of Canada. Research Report: Institutional Methadone Maintenance Treatment: Impact on Release Outcomes and Institutional Behaviour. Correctional Service of Canada Research Branch, Ottawa. September 2001.

Cox, Gemma and Marie Lawless. Making Contact: An Evaluation of a Syringe Exchange Programme. Merchants Quay Ireland, Dublin. 2000. Available online at www.mqi.ie.

Department of Health and Children. AIDS Strategy 2000. The Stationery Office, Dublin. June 2000.

----- "Understanding Hepatitis C: Information for the General Public" (pamphlet). Department of Health and Children, Dublin.

Department of Justice, Equality and Law Reform. General Healthcare Study of the Prisoner Population. Department of Justice, Equality and Law Reform, Dublin. 2000. Available online at www.hipp-europe.org/resources/intemal/irish-prisons/default.htm.

----- Strategy Statement 1998-2000. The Stationery Office, Dublin. 1998.

Department of Tourism, Sport & Recreation. Building on Experience: National Drugs Strategy 2001 – 2008. The Stationery Office, Dublin. 2001.

Dillon, Lucy. Drug Use Among Prisoners: An Exploratory Study. The Health Research Board, Dublin. 2001.

Dooley, Dr. Enda. Annual Report on Medical and Therapeutic Facilities within Prison Establishments. 1999. July 19,2000.

Eurosurveillance Weekly. “Prevalence of hepatitis C virus infection ten years after the virus was discovered.” Issue 51. (December 16,1999.) Available online at www.eurosurv.org.

Ford, P.M., M. Pearson, P. Sankar-Mistry, T. Stevenson, D. Bell, J. Austin. “HIV, hepatitis C and risk behaviour in a Canadian medium-security federal penitentiary,” QJ Med 2000, 93. (2000.)

Goldberg, David and Avril Taylor. “Preventing transmission of bloodborne virus infections in prisons,” Communicable Disease and Public Health, Volume 3, Number 2. June 2000.)

Group to Review the Structure and Organisation of Prison Health Care Services. Report of the Group to Review the Structure and Organisation of Prison Health Care Services. Ministry of Justice, Equality and Law Reform. September 2001. Available online at www.irishprisons.ie.

Hepatitis C Society of Canada. ‘Hep C – In Depth: How is the HCV spread?’ Available online at www.hepatitiscsociety.com/help/indepthframe.htm.

----- “Hep C – In Depth: What is Hepatitis C?” Available online at www.hepatitiscsociety.com/help/indepthfi-ame.htm.

----- “Hep C — The Basics.” *Available online at www.hepatitiscsociety.com.*

Irish Prisons Service. Report of the Steering Group On Prison Based Drug Treatment Services. July 2000.

----- Irish Prisons Service website. www.irishprisons.ie

----- Press Release “New Report confirms high prevalence of Hepatitis C in Irish Prisons associated with prior use of injected drugs.” Available online at www.irishprisons.ie/publications.html#press

----- Management of Offenders – A Five Year Plan. The Stationery Office, Dublin. 1994.

Joint United Nations Programme on HIV/AIDS (UNAIDS). Statement on HIV/AIDS in Prisons. Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva. April 1996. Available online at www.unaids.org.

----- Prisons and AIDS: UNAIDS technical update. Joint United Nations Programme on HIV/AIDS. Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva. April 1997. Available online at www.unaids.org.

Larue, F., Fontaine, A., Colleau, S. "Underestimation and Undertreatment of Pain in HIV Disease: Multicentre Study," British Medical Journal vol. 314, no. 7073. January 4, 1997.)

Lines, Rick. "The Case Against Segregation in "Specialized" Care Units," Canadian HIV/AIDS Policy and Law Newsletter, Volume 3 Number 4 & Volume 4 Number 1. Canadian HIV/AIDS Legal Network, Montreal. (Winter 1997/98.) Available online at www.aidslaw.ca.

Long, J., Allwright, S. Barry, J., Reaper-Reynolds, S., Thornton, L. & Bradley, F. Hepatitis B, Hepatitis C and HIV in Irish Prisoners. Part II: Prevalence and risk in committal prisoners 1999. The Stationery Office, Dublin. 2000.

Menoyo, C., Zulaica, D., Parras, F. "Needle Exchange Programmes in Prisons in Spain," Canadian HIV/AIDS Policy & Law Review, Volume 5, Number 4. Canadian HIV/AIDS Legal Network, Montreal. 2000. Available online at www.aidslaw.ca.

Moran, R., O'Brien, M., Dillon, L., Farrell, E. A Collection of Papers On Drug Issues in Ireland. The Health Research Board, Dublin. 2001.

National AIDS Trust. "HIV Facts: Basic Facts about HIV and AIDS." National AIDS Trust, London. (2002). Available online at www.nat.org.uk/hiv/index.html.

National Disease Surveillance Centre. HIV and AIDS in Ireland: Statistics for 2000. National Disease Surveillance Centre, Dublin. 2000. Available online at www.ndsc.ie.

Neeles, J., S. Bernasconi, A. Dobler-Mikola, B. Kaufmann. "Provision of Syringes and Prescription of Heroin in Prison," International Journal of Drug Policy. Vol 8, No.1 (1997).

Newman, Christine. "Call for prison drug treatment centre," The Irish Times. Dublin. (July 17, 2000.)

O'Brien, A., Moran, R., O'Brien, M. Annotated Bibliography of Drug Misuse in Ireland. The Health Research Board, Dublin. 2000.

O'Kelly, Barry. "Methadone Move Criticised by POA," The Sunday Business Post. Dublin. (September 17, 2000.)

O'Mahony, Paul. Mountjoy Prisoners: A Sociological and Criminological Profile. The Stationery Office, Dublin. 1997.

Perriens, J., Habiya Mbere, V., Miller, D. Key Elements in HIV/AIDS Care and Support WHO/UNAIDS: A working document. World Health Organization, Geneva. December 2000. Available online at www.who.int/HIV_AIDS/HIV_AIDS_Care/Key_elements_HIV_AIDS_care.htm.

Stöver, H, and Carl von Ossietzky. An overview study: Assistance to drug users in European Union prisons. European Monitoring Centre from Drugs and Drug Addiction, Lisbon. August 2001.

UNAIDS/World Health Organization. Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted infections: 2001 Update. UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, Geneva. 2001. Available online at www.unaids.org.

Watson, Carol. "HIV, Hepatitis B Virus & Hepatitis C Virus Factsheet." Health Promotion Service of Avon. March 2000. Available online at www.hpsa.org.uk/health-L.topics/sexualhealth/hivhepfactsheet.htm.

World Health Organization. "Fact Sheet 1 HIV/AIDS: the infection" World Health Organization, Geneva. Available online at www.who.int/HIV_AIDS/Nursesmidwivesfs/fact-sheet-1/index.html.

----- "Fact Sheet No. 164 – Hepatitis C." World Health Organization, Geneva. October 2000. Available online at www.who.int/inf-fs/en/fact164.html.

-----WHO Guidelines on HIV Infection and AIDS in Prisons. World Health Organization, Geneva. 1993. Available online at www.unaids.org.

World Health Organization/UNAIDS. "Effectiveness of Condoms in Preventing Sexually Transmitted Infections Including HIV." World Health Organization, Geneva. August 15, 2001. Available online at www.who.int/HIV_AIDS/Condoms/effectiveness_of_condoms_in_prev.htm.

¹ Joint United Nations Programme on HIV/AIDS (UNAIDS), Statement on HIV/AIDS in Prisons.

² Department of Justice, The Management of Offenders – A Five Year Plan. (The Stationery Office, Dublin: 1994). p. 51.

³ See figures below.

⁴ Paul O'Mahony, Mountjoy Prisoners: A Sociological and Criminological Profile. (The Stationery Office, Dublin: 1997). p. 106-107.

⁵ Dr. Shane Allwright, *et al.*, Hepatitis B, Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk, (The Stationery Office, Dublin: 1999). p. 10.

⁶ Jean Long, *et al.*, Hepatitis B, Hepatitis C and HIV in Irish Prisoners. Part II: Prevalence and risk in committal prisoners 1999, (The Stationery Office, Dublin: 2000). p. 8.

⁷ Long, *et al.*, p.20.

⁸ While government generated figures on HIV and hepatitis C infection rates are incomplete and/or difficult to access, international health organizations have published recent statistics on seroprevalence rates in Ireland. For HIV, see UNAIDS/World Health Organization, Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted infections: 2001 Update, (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, Geneva: 2001). Available online at www.unaids.org. For hepatitis C, see "Prevalence of hepatitis C virus infection ten years after the virus was discovered," in Eurosurveillance Weekly. Issue 51, (December 16, 1999). Available online at www.eurosurv.org.

⁹ World Health Organization, "Fact Sheet 1 HIV/AIDS: the infection," (World Health Organization: Geneva). Available online at www.who.int/HIV_AIDS/Nursesmidwivesfs/fact-sheet-1/mdex.html.

¹⁰ National AIDS Trust, "HIV Facts: Basic Facts about HIV and AIDS," (National AIDS Trust, London; 2002). Available online at www.nat.org.uk/hiv/index.html.

¹¹ World Health Organization, "Fact Sheet 1 HIV/AIDS: the infection."

¹² Ibid.

¹³ Todd Armstrong and Scan Hosein, "HIV/AIDS Treatment: The AIDS Cocktail (combination therapy)," (Community AIDS Treatment Information Exchange, Toronto: December 2001). Available online at www.catie.ca/simple.nsf.

¹⁴ Ibid.

- ¹⁵ Todd Armstrong and Sean Hosein, “HIV/AIDS Treatment: Sticking to Your Treatment (combination therapy),” (Community AIDS Treatment Information Exchange, Toronto: December 2001). Available online at www.catie.ca/simple.nsf.
- ¹⁶ Dr. Jos Perriens, *et al.*, Key Elements in HIV/AIDS Care and Support WHOAJNAIDS: A working document. (World Health Organization, Geneva: December 2000). Available online at www.who.int/HIV_AIDS/HIV_AIDS_Care/Key_elements_HIV_AIDS_care.htm.
- ¹⁷ Todd Armstrong and Sean Hosein, “HIV/AIDS Treatment: Drug Side Effects,” (Community AIDS Treatment Information Exchange, Toronto: December 2001). Available online at www.catie.ca/simple.nsf.
- ¹⁸ Francois Larue, Alain Fontaine, Sophie M Colleau, “Underestimation and Undertreatment of Pain in HIV Disease: Multicentre Study,” in British Medical Journal (vol. 314, no. 7073, pp. 23-8. January 4, 1997).
- ¹⁹ Ibid.
- ²⁰ Ibid.
- ²¹ UNAIDS/World Health Organization, Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted infections: 2001 Update.
- ²² Consultative Council on Hepatitis C, “Living with Hepatitis C: Information for people with Hepatitis C and their family and friends,” (Department of Health and Children, Dublin: undated), pp.11–12.
- ²³ World Health Organization, “Fact Sheet No. 164 – Hepatitis C,” (World Health Organization, Geneva: October 2000). Available online at www.wrk5.int/inf-fs/en/fact164.html.
- ²⁴ Department of Health and Children, “Understanding Hepatitis C: Information for the General Public,” (Department of Health and Children, Dublin: undated).
- ²⁵ World Health Organization, “Fact Sheet No. 164 – Hepatitis C.”
- ²⁶ Carol Watson, “HIV, Hepatitis B Virus & Hepatitis C Virus Factsheet” (Health Promotion Service of Avon, UK: March 2000). Available online at www.hpsa.org.uk/health_topics/sexualhealth/hivhepfactsheet.htm.
- ²⁷ World Health Organization, “Fact Sheet No. 164 – Hepatitis C.”
- ²⁸ Consultative Council on Hepatitis C, p.5.
- ²⁹ Hepatitis C Society of Canada, “Hep C – In Depth: What is Hepatitis C?” Available online at www.hepatitiscsociety.com/help/indepthframe.htm.
- ³⁰ Hepatitis C Society of Canada. “Hep C – The Basics.” Available online at www.hepatitiscsociety.com.
- ³¹ World Health Organization, “Fact Sheet No. 164 – Hepatitis C.”
- ³² Eurosurveillance Weekly.
- ³³ O’Mahony, p. 106.
- ³⁴ Allwright, *et al.*, pp. 16-19.
- ³⁵ Long, *et al.*, pp. 13-16.
- ³⁶ Gemma Cox and Made Lawless, Making Contact: An Evaluation of a Syringe Exchange Programme. (Merchants Quay Ireland, Dublin: 2000). Available online at www.mqi.ie.
- ³⁷ Allwright, *et al.*, p.30.
- ³⁸ Allwright, *et al.*, p.20.
- ³⁹ Allwright, *et al.*, p.21.
- ⁴⁰ Long, *et al.*, p. 15.
- ⁴¹ Dr. Peter Ford, *et al.*, “HIV, hepatitis C and risk behaviour in a Canadian medium-security federal penitentiary” in QJ Med 2000; 93, p.116.
- ⁴² Long, *et al.*; p. 16.
- ⁴³ Ibid.
- ⁴⁴ Department of Tourism, Sport & Recreation, Building on Experience: National Drugs Strategy 2001 – 2008. (The Stationery Office, Dublin: 2001). p. 104.
- ⁴⁵ Lucy Dillon, Drug Use Among Prisoners: An Exploratory Study. (The Health Research Board, Dublin; 2001). pp.82-83. Also Allwright, *et al.*, pp.16-19, and Long, *et al.*, pp. 13-16.
- ⁴⁶ Department of Justice, p. 51.
- ⁴⁷ Joint United Nations Programme on HIV/AIDS (UNAIDS), Prisons and AIDS: UNAIDS technical update. (Joint United Nations Programme on HIV/AIDS, Geneva: April 1997). p.3. Available online at www.unaids.org.
- ⁴⁸ World Health Organization. WHO Guidelines on HIV Infection and AIDS in Prisons. (World Health Organization, Geneva: 1993). p.4. Available online at www.unaids.org.
- ⁴⁹ World Health Organization/UNAIDS, “Effectiveness of Condoms in Preventing Sexually Transmitted Infections Including HIV,” (World Health Organization, Geneva: August 15, 2001). Available online at www.who.int/HIV_AIDS/Condoms/effectiveness_of_condoms_in_nrev.htm.
- ⁵⁰ Canadian HIV/AIDS Legal Network, “Info Sheet 4 on HIV/AIDS in Prisons: Prevention: Condoms,” (Canadian HIV/AIDS Legal Network, Montreal: 2001/2002). Available online at www.aidslaw.ca.
- ⁵¹ Dr. Heino Stöver, *et al.*, An overview study: Assistance to drug users in European Union prisons. (European Monitoring Centre from Drugs and Drug Addiction, Lisbon: August 2001). p.24.

- ⁵² Joint United Nations Programme on HIV/AIDS (UNAIDS), Prisons and AIDS: UNAIDS technical update, p.6.
- ⁵³ Stöver, *et al.*, p.24.
- ⁵⁴ Canadian HIV/AIDS Legal Network, “Info Sheet 5 on HIV/AIDS in Prisons: Prevention: Bleach,” (Canadian HIV/AIDS Legal Network, Montreal: 2001/2002). Available online at www.aidslaw.ca.
- ⁵⁵ Group to Review the Structure and Organisation of Prison Health Care Services, Report of the Group to Review the Structure and Organisation of Prison Health Care Services, (Ministry of Justice, Equality and Law Reform, Dublin: September 2001). p. 46. Available online at www.irishprisons.ie.
- ⁵⁶ *Ibid.* p.11.
- ⁵⁷ J. Neeles, *et al.*, “Provision of Syringes and Prescription of Heroin in Prison” in International Journal of Drug Policy, (vol 8, no.1, 1997).
- ⁵⁸ Joint United Nations Programme on HIV/AIDS (UNAIDS), Prisons and AIDS: UNAIDS technical update. pp.4, 6.
- ⁵⁹ Stöver, *et al.*, p.26.
- ⁶⁰ Canadian HIV/AIDS Legal Network, “Info Sheet 6 on HIV/AIDS in Prisons: Prevention: Sterile Needles,” (Canadian HIV/AIDS Legal Network, Montreal: 2001/2002). Available online at www.aidslaw.ca.
- ⁶¹ An evaluation of a syringe exchange programme undertaken by Cox and Lawless (2000) illustrated the effectiveness of syringe exchange programme on reducing injecting risk behaviour within the Irish context. For example, 15% of clients who reported lending their injecting equipment at first visit compared with only 9% of clients at follow-up. There was a similar reduction in the number of clients who reported borrowing others used injecting equipment, in that 23% of first visit clients reported such risk behaviour compared with 15% of follow-up clients.
- ⁶² Department of Tourism, Sport & Recreation, p. 118.
- ⁶³ Allwright, *et al.*, p.32.
- ⁶⁴ Correctional Service of Canada, Research Report: Institutional Methadone Maintenance Treatment: Impact on Release Outcomes and Institutional Behaviour, (Correctional Service of Canada Research Branch, Ottawa: September 2001).
- ⁶⁵ *Ibid.*, p. 30—31.
- ⁶⁶ Quoted in Barry O’Kelly, “Methadone Move Criticised by POA” in The Sunday Business Post, (September 17, 2000).
- ⁶⁷ Perriens, *et al.* “As wasting and nutritional deficiencies are important adverse features of HIV infection, it is important to prevent them. This requires nutritional assessment, nutritional counselling and education that includes food safety, and, if possible, the development of a plan of action to prevent weight and muscle mass loss. With some drugs dietary changes are also needed to prevent side effects and specific symptoms. In some cases provision of nutritional supplements may be useful to prevent or treat wasting.”
- ⁶⁸ *Ibid.*
- ⁶⁹ *Ibid.*
- ⁷⁰ Department of Justice, Equality and Law Reform, General Healthcare Study of the Prisoner Population, (Department of Justice, Equality and Law Reform, Dublin: 2000). Available online at www.tupp-europe.org/resources/mtomal/irish-prisons/0090.htm.
- ⁷¹ Group to Review the Structure and Organisation of Prison Health Care Services, p.43.
- ⁷² *Ibid.*
- ⁷³ Joint United Nations Programme on HIV/AIDS (UNAIDS), Prisons and AIDS: UNAIDS technical update. p.7.
- ⁷⁴ *Ibid.*
- ⁷⁵ Allwright, *et al.*, p.34.
- ⁷⁶ Long, *et al.*, p.26.
- ⁷⁷ Confidentiality is cited as a concern in Allwright, *et al.*, pp.30-31; Long, *et al.*, p.25; and by community-based HIV/AIDS service providers consulted in preparation of this report. Improving the security of confidential medical information is recommended in Group to Review the Structure and Organisation of Prison Health Care Services, pp.48-49.
- ⁷⁸ Perriens, *et al.*
- ⁷⁹ Charter of Fundamental Rights of the European Union, Article 35.

€12

ISBN 0-9535531-5-9

Irish Penal Reform Trust

Iantaobhas Eireannach Teo Um Leasu Pianuil

***Mission:** The Irish Penal Reform Trust is a human rights based advocacy organisation which campaigns for the creation of a more rational and humane penal system, and promotes the implementation of Restorative Justice.*

Further information from:

Swanbrook House
Bloomfield Avenue
Morehampton Road
Dublin 4
Ireland

Telephone: 01-6680072

Email: info@penal-reform.ie

www.penal-reform.ie

New members welcome