UNODC
United Nations Office on Drugs and Crime

A handbook for starting and managing needle and syringe programmes in prisons and other closed settings

ADVANCE COPY

CONTENTS

LIST OF ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
BBV	blood-borne virus
EMCDDA	European Monitoring Centre for Drugs & Drug Addiction
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IEC	information, education and communication
ILO	International Labour Organization
NGO	nongovernmental organization
NSP	needle and syringe programme
OST	opioid substitution therapy
PEP	post-exposure prophylaxis (for HIV)
PNSP	prison (or other closed setting) needle and syringe programme
PWID	people who inject drugs
STI	sexually transmitted infection
TB	tuberculosis
UNDP	United Nations Development Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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INTRODUCTION

Every year, 30 million men and women spend time in prisons or closed settings, with 10 million incarcerated at any given point in time. In most prisons around the world the prevalence rates of infectious diseases, including HIV, hepatitis B (HBV), hepatitis C (HCV), syphilis and tuberculosis (TB) are higher than in the general population (1).

People who use drugs (including people who inject drugs) are present in disproportionately high numbers in prison settings. In the absence of access to sterile injecting equipment in prisons, HIV and hepatitis B and C can be transmitted between prisoners who share contaminated needles and syringes. Together with unprotected sexual contact, sharing injection equipment represents the greatest risk of transmission of HIV and hepatitis in prisons (2).

Like all persons, prisoners are entitled to enjoy the highest attainable standard of health. This right is guaranteed under international law. Access to health care should be at least equivalent to that provided in the community, in accordance with the United Nations basic principles for the treatment of prisoners, which recognize that "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (3).

The WHO/UNODC/UNAIDS comprehensive package of evidence-based interventions for HIV prevention and treatment among people who inject drugs (see box below) has been endorsed by high-level political bodies including the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, and the UNAIDS Programme Coordinating Board (4).

Comprehensive package of interventions for HIV prevention and treatment among people who inject drugs

1. Needle and syringe programmes (NSP)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB).

To successfully address HIV and hepatitis where injecting drug use occurs, countries should prioritize implementing NSPs and evidence-based drug dependence treatment (specifically OST), HIV testing and counselling and access to antiretroviral therapy.

Needle and syringe programmes (NSP) provide access to sterile injecting equipment to people who inject illicit drugs to prevent the transmission of HIV and hepatitis B and C through shared injection equipment.

While community-based NSP have been implemented in 82 countries (5), in 2013, only eight countries around the world report having NSP in prisons.[1] The first prison needle and syringe programme (PNSP) was established in Switzerland in 1992. More than 20 years later, despite the evidence of their feasibility, PNSP have been established in only thirteen countries, often on a pilot basis for a limited time and in a limited number of prisons.

The purpose of this guide

This guide aims to provide information and practical guidance to support the implementation of NSP in prisons and other closed settings. It addresses the issues that have sometimes prevented PNSP from being implemented more widely, such as denial of the use of drugs in prisons, the illegality of drug use in a custodial setting, the illicit status of sharp objects in the possession of prisoners and detainees, and concerns about prisoner and staff security. The guide presents models of PNSP that have been tried and evaluated around the world, and provides recommendations and practical advice on advocating, starting, scaling up and monitoring PNSP, based on the lessons learned from these experiences. It shows how a PNSP can be safely and effectively implemented across a range of closed settings to help reduce the spread of HIV, HBV and HCV, how it can bring additional individual and public-health benefits such as a decrease in injecting-related injuries, and how it can contribute to security and good order in the prison.

This guide builds on and complements a series of documents on HIV in prisons produced by United Nations agencies, in particular HIV prevention, treatment and care in prisons: a comprehensive package of interventions (6); HIV prevention, treatment, care and support in prisons: a framework for an effective national response (2); and Interventions to address HIV in prisons: needle and syringe programmes and decontamination strategies (7). More than 40 experts from different regions of the world contributed to its development of this guide, which is based on the requirements of international laws and standards, existing published scientific evidence and best practices.

The intended audience for this guide includes prison governors, administrators and staff, health-care managers and programme coordinators at all levels across all types of custodial institutions, prison administrations, ministries in charge of health in custodial settings, public-health authorities, national AIDS programmes, national drug programmes, police authorities, non-governmental organizations (NGOs) and trade union officials.

This guide focuses on adult prisons, which have been the setting for the majority of PNSP. However, PNSP in adolescent or juvenile detention centres or other institutionalized settings for adolescents deserve specific consideration, and the needs of adolescents who inject drugs should not be ignored.

A note on terminology

Different terms are used across different jurisdictions for places of detention which hold people who are awaiting trial, have been convicted or are subject to other conditions of security. Similarly, different words are used to describe various groups of people who may be in detention. In this publication, the terms “prison” and “closed settings” are used for all places of detention, and the term “prisoner” is used to describe all who are held in such places, including adult and juvenile males and females detained in criminal justice and prison facilities during the investigation of a crime; while awaiting trial; after conviction and before

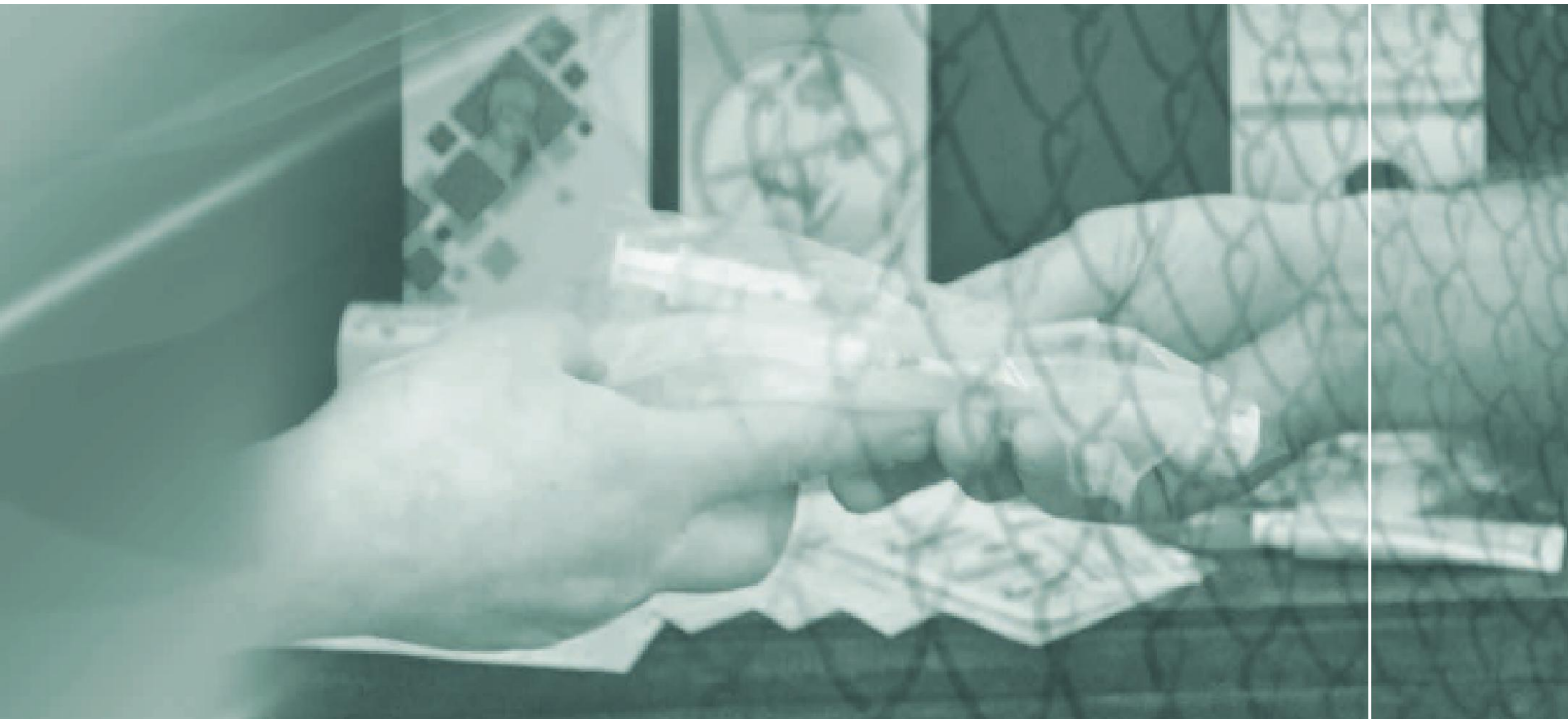
[1] Germany, Kyrgyzstan, Luxembourg, Moldova, Romania, Spain, Switzerland and Tajikistan.

sentencing; and after sentencing. Although the term "prisoner" does not formally cover persons detained for reasons relating to immigration or refugee status, those detained without charge, or those sentenced to compulsory treatment and rehabilitation in centres which exist in some countries, nonetheless most of the considerations in this guide apply to these settings as well.

In this guide, the term "needle and syringe programmes" (NSP) refers to programmes that provide people who inject drugs with access to sterile injecting equipment (needles and syringes, swabs, vials of sterile water) and most often also to health education, referrals, counselling and other services. The term "prison needle and syringe programmes" (PNSP) refers to NSPs in all places of detention referred to above as "prisons".

Harm reduction is part of a broader public health approach that refers to policies, programmes and practices that aim primarily to reduce adverse health, social and economic consequences of drug use such as HIV or hepatitis transmission or overdoses prevention.

For the purposes of this paper, harm reduction services are defined by the interventions included in the comprehensive package of evidence-based interventions to reduce harms associated with injecting drug use (Table 1), as outlined in the WHO, UNAIDS, UNODC technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (4). This package of interventions has been widely endorsed by the United Nations (8, 9, 10, 11, 12) and major international donors including the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief (PEPFAR).



PART 1: Background

PART I: BACKGROUND

A. Prevalence of HIV, other blood-borne infections, drug use and risk behaviours in prisons

On any given day, approximately 10 million people are held in prison around the world, about one-third of whom are in pre-trial detention. In total, about 30 million men and women spend some time in prisons each year. In many countries, drug-related offences are one of the main reasons for imprisonment, and people who inject drugs represent 5-50% of the prison population *(13)*. This rate is extremely high compared to the 0.27% prevalence of injecting drug use in the general population aged 15-64 *(14)*.

Prevalence of HIV and HCV in prison populations is 2 to 10 times higher than in the general population; in some settings it may be up to 50 times higher *(15)*. Outbreaks of both HIV and HCV among prisoners have been documented in a number of prisons and countries *(16, 17)*. Other studies have concluded that a significant percentage of HIV or HCV infections among people who inject drugs were acquired in prison *(18)*. Outside sub-Saharan Africa, the transmission of HIV in prisons is mostly driven by the sharing of contaminated needles, syringes and other equipment used to prepare or inject drugs. Until recently, the spread of HIV within prisons in sub-Saharan countries was mainly linked to sexual contact and unsafe medical practices. However, the emergence of injecting drug use in Ghana, Kenya, Mauritius, Nigeria, Senegal, South Africa and Tanzania, among others, means that sharing injection equipment now constitutes a risk for HIV transmission in prisons in these countries as well.

Although some people who inject drugs before imprisonment either reduce or stop injecting when they enter prison, up to 75% of prisoners with a prior history of injecting drug use continue to use drugs in prison *(19)*. Furthermore, some people are initiated into injecting drugs while in prison: up to 25% of people who inject drugs in prison first did so there *(20, 21)*.

Risk behaviours among prisoners for the transmission of HIV and HCV include the sharing of syringes and unprotected sexual contacts *(1, 22, 23)*.

In the absence of access to safe injecting equipment, people who inject drugs share needles and syringes (often home-made ones) more frequently than in the wider community *(24, 25, 26, 27).* It is more difficult to smuggle needles and syringes into prisons than it is to smuggle drugs into them. Drug traffickers in prisons do not smuggle needles. Therefore in the absence of programmes, needles and syringes are very scarce and a single needle or syringe will often circulate among a large population of prisoners who inject drugs, being shared by 10 or more people. A prisoner who owns a needle or syringe may lend it or rent it to others for a fee, or may keep it for his or her exclusive use and reuse it again and again over a period of months. Sometimes, the injection equipment is home-made, for example, fashioned out of plastic and ballpoint pens, or eye-drops bottles. Such equipment often damages veins and can cause infections.

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

Many countries provide harm reduction services to people who inject drugs in the community. The effectiveness of NSP in preventing transmission of HIV through the sharing of injection equipment has been well documented *(28)*. NSP are listed first in the comprehensive package of evidence-based interventions for HIV prevention, treatment and care for people who inject drugs, endorsed by the United Nations *(4)*.

NSPs are effective not only in the wider community but are also feasible in prison settings. PNSP is one of the 15 recommended components of a comprehensive approach to HIV in prisons *(6)*.

The use of sterile injection equipment for injecting drug use prevents transmission of HIV among people in prisons. As the distribution of clean needles and syringes to people who inject drugs is linked most of the time to a recuperation of used syringes, it decreases the risk that other people in the community will be accidentally exposed to a contaminated needle. In prisons, it also reduces the risk that staff, including security staff, will be exposed to HIV. As most of the people in prisons will eventually return to the community, PNSP is a measure benefiting not only prisoners but the entire community.

PNSP have been successfully implemented in men's and women's prisons of varying sizes, in civilian and military systems, in institutions that house prisoners in individual cells and those that house prisoners in barracks, in institutions of different security levels, and in different forms of custody (remand and sentenced, open and closed). Evaluations have found that they can be successfully implemented in countries with very limited funding and infrastructural supports (e.g., Moldova, Kyrgyzstan, Tajikistan) as well as within jurisdictions that are comparatively well resourced and financed (e.g., Germany, Spain, Switzerland).

A meta-analysis *(29)* of 11 PNSP that were scientifically evaluated to assess the feasibility and efficacy of PNSP addressed the two greatest concerns expressed by some prison officials at the start of the programmes – that they may lead to increases in injection drug use, and that the presence of syringes and needles may create a more dangerous environment for staff and prisoners. The study found that PNSP had the following outcomes:

No increase in drug consumption or injecting: Evaluations of PNSP have consistently found that the availability of sterile needles and syringes does not result in an increased number of people who inject drugs, an increase in overall drug use, nor an increase in the amount of drugs in the institutions.

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 every prison where NSP are in place, drugs remain prohibited. Security staff members are instructed to locate and confiscate all illicit drugs and any needles or syringes that are not part of the programme. On the other hand, the significant level of high-risk injecting drug use (involving the sharing of non-sterile needles and syringes) that currently exists within many prisons that have no PNSP will be of substantial concern to all professionals responsible for the well-being of prisoners under their jurisdiction.

Increased institutional safety for staff and prisoners: The potential for the misuse of needles and syringes as weapons among prisoners or against prison staff remains one of the most controversial issues facing PNSP. However, in no research evaluation of PNSP has such misuse been recorded. There have also been no recorded safety problems with disposal of syringes. Exchange rates within PNSP are very high (almost 1:1): for example, the return rates for two prisons in Lower Saxony, Germany were 98.9% for a dispensing machine in the women's prison in Vechta, and 98.3% in the men's prison in Lingen, Groß Hesepe.

Inmates participating in PNSP are generally required to keep their kit in a pre-determined location within their cells. Because PNSP is an approved programme, there is no need for the offender to conceal the equipment in their cells. This reduces the risks of accidental punctures with used needles for staff and for prisoners. To date, no PNSP-related needle-stick injury to a prison staff member has been reported anywhere in the world.

Trained prison staff accept and support PNSP in a short period of time: Prison staff are usually trained to see abstinence as the only goal of drug-dependence treatment. They might therefore be expected to have difficulty adjusting to a policy of confiscating drugs but not injection equipment. However, as experiences in Germany, Moldova, Spain and Switzerland have demonstrated, staff attitudes have changed as the officers have learned first-hand about PNSP and have participated in its implementation and review.

The authors of the analysis of studies of PNSP *(29)* concluded that PNSP are not only feasible but effective, especially when embedded within a comprehensive prison-based harm reduction and health-promotion strategy.

The evidence from countries where PNSP operate (7, 19) establishes that:

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

Based on a review of the evidences on the feasibility of NSP in prisons *(7)*, WHO, UNODC and UNAIDS recommend:

- Prison authorities in countries experiencing or threatened by an epidemic of HIV infection among prisoners who inject drugs should introduce NSP urgently and expand implementation to scale as soon as possible.

- Prisoners should have easy, confidential access to NSP, and prisoners and staff should receive information and education about the programmes and be involved in their design and implementation.

- Carefully evaluated pilot programmes of prison-based NSP may be important in enabling the introduction of these programmes, but they should not delay the expansion of the programmes.

The availability of sterile needles does not undermine or impede the provision of drug dependence treatment programmes, including OST, but rather offers people who inject drugs assistance to safeguard their health status, and provides a potentially greater interaction with the range of generic health services and drug-dependence treatment services offered in a particular institution. In this way PNSP can provide a bridge to drug dependence treatment and other beneficial health services.

As heroin and other opioids are among the most common causes of overdose and death among people who inject drugs, including in prisons, a comprehensive prison harm reduction approach should include immediate access to the antidote naloxone as an emergency response to any case of suspected overdose.

C. A legal framework for PNSP

The principle of equivalency of care declares that prisoners are entitled, without discrimination, to the same standard of health care that is found in the outside community, including preventive measures. This principle is supported by several international norms and standards.

International law:

- Principle 9 of the United Nations basic principles for the treatment of prisoners states: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation." In the context of HIV and other blood-borne viruses (BBV), equivalence of health services would include providing prisoners the means to protect themselves from exposure to HIV and HCV.

- United Nations standard minimum rules for the treatment of prisoners (30) and United Nations rules for the treatment of women prisoners and non-custodial measures for women offenders (the Bangkok Rules) (31).

- The revised Guideline 6 of the United Nations International guidelines on HIV/AIDS and human rights (2002) states that States should "take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention".

- The World Health Organization (WHO) 1993 Guidelines on HIV infection and AIDS in prisons state: "In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this."

National policies: Prison rules, which generally carry full legal authority within any jurisdiction, forbid the possession by prisoners of sharp (and therefore potentially dangerous) objects. There are instances where authorized exceptions to these particular rules can be granted. Examples include prisoners undertaking training and work that requires specialized tools, such as building work, and prisoners who have a medical condition such as insulin-dependent diabetes or risk of anaphylaxis, which may require them to carry a needle and syringe.

As drug dependence is a health condition *(32)*, countries introducing PNSP have applied this medical exemption to their prison rules. These variations require the agreement of the ministries of justice and health in addition to that of the individual department of corrections.

In view of the great variation in the legal frameworks that govern justice and health across different countries, it is recommended that individual jurisdictions consult their national legal authorities to determine a mechanism by which PNSPs can be introduced. Domestic legislation or regulations may need to be changed to permit the legal availability, distribution and possession of injecting equipment provided under a sanctioned PNSP. This requires a comprehensive legal appraisal. Engaging legal advice is therefore of the utmost importance prior to the introduction of a PNSP.

D. The role of other interventions to prevent HIV transmission through injection equipment

NSP are the most effective intervention to prevent transmission of HIV through shared syringes and should be the priority intervention for this goal. The following two approaches are sometimes proposed as alternatives to NSP in prisons, but they should not be seen as adequate substitutes for the benefits gained through PNSP, for the reasons explained below.

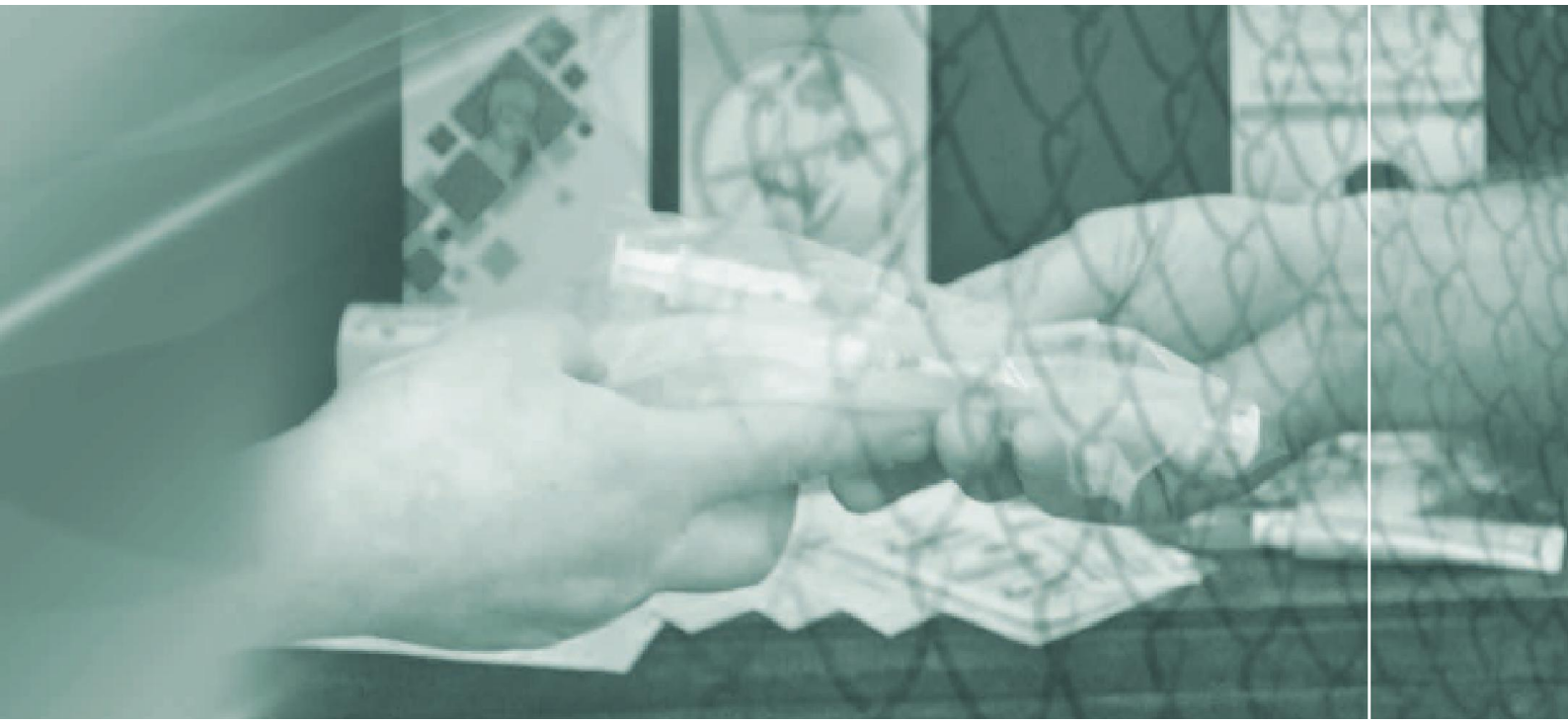
Provision of bleach: In some jurisdictions chlorine (bleach) has been introduced in order to give prisoners who inject drugs a means of disinfecting their injecting equipment. However, bleach is not fully effective in reducing HCV transmission. Experience in Cataluña, Spain has also indicated that bleach is not a reliable and effective means of HIV prevention in prison settings, because prisoners rush the cleaning process for fear of detection by correctional staff. Additionally, the use of homemade needles and syringes leads to a greater likelihood of blood clots in the equipment, which are impossible to disinfect. The provision of bleach might even be detrimental if it gives prisoners a false sense of security. Bleach programmes should therefore only be regarded as a second-line strategy to PNSP*(7)*, and it is unethical to propose bleach when a more efficient means of prevention, such as PNSP, is available and applicable.

Opioid substitution therapy: OST is an essential element of a comprehensive harm reduction strategy, both in the community and in prisons, as it provides an important option for people who inject drugs who wish to stop injecting opioids. Evaluations of OST programmes in prisons have indicated the following positive results *(33, 34)*:

- Lower rates of heroin use
- Reduced injection drug use
- Reduced syringe-sharing among those enrolled in OST compared with prisoners in a control group
- Lower rates of fatal overdose, especially post-release
- Increased adherence to ART
- Lower re-incarceration rates.

The most effective method for reducing HIV and HCV incidence among people who inject drugs is the *combined* provision of NSP and OST *(35, 36, 37)*. OST is the most effective drug-dependence treatment for heroin dependence, but there are several potential circumstances in which prisoners will not access or benefit from OST, explaining why both NSP and OST should be accessible:

- Prisoners who inject heroin may choose not to access OST for various reasons.
- Some prisoners continue to inject illicit drugs, including drugs other than heroin, even when enrolled in well-implemented OST programmes.
- There are often limits on the number of prisoners enrolled in OST at any one time.
- It can take time to process and authorize a request for OST,
- Some people do not use or inject heroin but do inject cocaine or amphetamines (many times a day). These non-opiate users will not benefit from OST, and PNSP is therefore the only suitable harm reduction/prevention option available in the prison setting.



PART 2:
Elements of NSP

PART II: ELEMENTS OF PNSP

A. Models of needle and syringe programmes in prisons

Various delivery models for the distribution of injecting equipment in closed settings have been implemented and evaluated in different countries. These include distribution by prison health staff, by peer educators, by NGO representatives and via dispensing machines.

In 1992, Switzerland was the first country to start a PNSP. The programme was introduced by a medical doctor, who started to exchange syringes in the health clinic of a men's prison. In 1994, in Hindelbank women's prison, syringe-dispensing machines were introduced to allow women who injected drugs to access safe injection equipment with complete anonymity and confidentiality. These two above models have since been used in most countries where PNSP have been introduced, but other models have also been implemented and evaluated. These include:

1. Hand-to-hand by prison health staff (e.g., social worker or nurse). This method is used in several Spanish and Swiss and Romania prisons. The used syringes are either exchanged at the cell door (e.g., Champ-Dollon, Switzerland, and Romania) or in the medical unit (e.g., Luxembourg).

2. Hand-to-hand by trained peers (i.e., prisoners) to ensure confidential contact with prisoners who use drugs and access at almost all times (e.g., Moldova) *(38)*.

3. Hand-to-hand by external personnel or NGOs who also provide other harm reduction services (e.g., Bilbao, Spain)

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

Each method has advantages and challenges in terms of greater or lesser anonymity, confidentiality, supervision, monitoring and costs. These issues are examined below *(39)*.

1. Hand-to-hand distribution by prison nurse and/or doctors	
Advantages	**Disadvantages**
❖ Allows for personal contact with prisoners and an opportunity for counselling ❖ Can facilitate outreach to and contact with drug users ❖ Prison maintains high degree of control over access to syringes ❖ One-for-one exchange or multiple syringe distribution possible.	❖ Limited anonymity and confidentiality may reduce the participation rate ❖ Access more limited, as syringes are available only during the established opening 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

CASE STUDY: PNSP in Spain

The first pilot PNSP in the autonomous region of Cataluña was established in 2003, and in 2010 PNSP were implemented in all but one of the region's prisons. The provision of needles is undertaken by prison health staff. The main features of the PNSP in Cataluña include: one-for-one exchange of retractable syringes; prisoners must carry the syringe with them or keep it with their personal possessions; the syringe must be inside the sealed plastic package (before use) or with the needle retracted (once used); if a prisoner is to be searched by a prison officer, they must inform the officer that they have a syringe with them; prisoners in a methadone programme can also participate in the PNSP.

In 2010, a 10-year review of the PNSP in Ourense (Spain) prison *(40)*, where new syringes were handed out in exchange for used ones, found that a total of 15 962 syringes had been supplied to 429 users, (average 20.2 users/month), and 11 327 (70.9%) returned. The prevalence of HIV infection decreased from 21% in 1999 to 8.5% in 2009, and HCV prevalence from 40% to 26.1%. Most of the inmates and prison staff believed that the programme did not increase intravenous drug use and that it improved hygienic living conditions in prison. Because of the low participation in the programme, the evaluation was complemented by a qualitative evaluation *(41)*, which confirmed that the PNSP increased contacts with current drug users, giving the possibility of providing care, health education and referral to drug dependence treatment, and leading to a decrease in the sharing of homemade syringes. However, the evaluation also found that some prisoners who injected drugs were unwilling to participate in the programme because of lack of confidentiality and fear of loss of their privileges (conditional releases) or of increased control. There was a low understanding of or support for the PNSP among prison officers, some of whom harassed participants or transferred them to other prisons. The evaluation report recommended informing prison staff and managers better about the aim of the PNSP; increasing the confidentiality and anonymity of the programme; increasing accessibility through better coverage and access and by adding peer-based distribution or dispensing machines to distribution by health staff; and linking participation in the PNSP to privileges rather than to loss of privileges.

2. Hand-to-hand provision by trained peer outreach workers (volunteers)

Advantages

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

Disadvantages

- No direct staff control over provision and no formal monitoring system, which can lead to increased fears about workplace safety among staff
- Volunteers might blackmail other prisoners by disclosing information about their participation
- 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 in return)
- High turnover of prisoners and need for continuous training

CASE STUDY: Increasing participation through peer volunteers in Moldova

In Moldova, the first PSNP was introduced in Branesti prison in 1999, initially through medical department staff handing out needles and syringes. Despite the high prevalence of injecting drug use, uptake was low. Due to a lack of anonymity and confidentiality, many prisoners did not trust the programme, and needles were not available after health staff left in the evening. In response, peer-to-peer exchanged was introduced. Peer volunteers are trained to provide harm reduction services in the different sites in the prison, under the supervision of health-care staff. Services are available on a 24-hour basis because the sites are based in living units. With the introduction of the peer model, participation in the programme increased, and after one year, based on the results, programme coordinators were allowed to implement harm reduction projects in other prisons, including needle exchange and condom distribution (38)

2. Hand-to-hand provision by external NGOs or health-care professionals not employed by prison administration

Advantages

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

Disadvantages

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

CASE STUDY: NGO-led PNSP, Bilbao, Spain

In 1995, an NGO working in the Spanish Bilbao prison, which has 250 male prisoners, initiated an NSP. This model was preferred to dispensing machines because the NGO was already working in the prison and offered the possibility of providing health education information. All prisoners and staff received information on the programme, which was established in two discreet locations. The service was available five hours per day. Prisoners received injection kits (similar to the ones available in pharmacies) containing a syringe, distilled water, disinfectant swipe, a condom and a hard container for carrying the used needles. The evaluation indicated that the prisoners trusted the system and no prisoner had lost any privilege due to their participation in the programme. Prison staff did not report any security problems. The programme allowed for referral to drug dependence treatment. While the programme was not run on a one-for-one exchange basis, the planning committee's target was an 80% exchange rate, which was achieved *(42).*

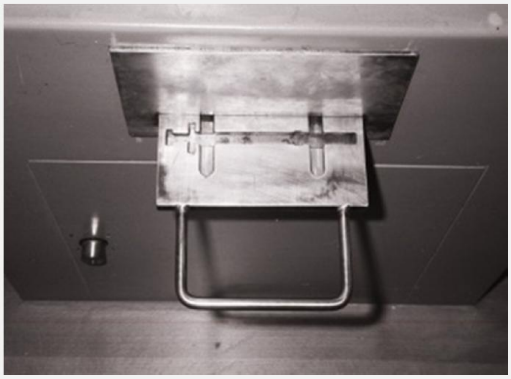
NGO engagement can make the programme more robust and responsive. NGOs experienced in harm reduction can have an important role in the design of the programme and in the training and information, education and communication (IEC) around the programme. They also help to build contacts between prisoners who use drugs and NGOs on the outside, which is helpful when prisoners transition from penitentiary to the community. In Kyrgyzstan, some prisons provide prisoners upon release with a packet consisting of a disposable syringe, disinfectant, multi-vitamin, and a leaflet with the addresses of HIV prevention organizations (43).

2. Automated dispensing machines

Advantages	Disadvantages
• High degree of accessibility (often multiple machines are placed in various locations in the institution, which can be accessed outside the established hours of the medical service) • High degree of anonymity, as there is no involvement with staff • High acceptance by prisoners • Strict one-for-one exchange (which could be seen as a disadvantage as well)	• Machines are vulnerable to vandalism by prisoners or sabotage by staff who are not in favour of the programme • Technical problems with functioning of the dispensing machines can make syringes unavailable for periods of time • Some prisons are architecturally unsuited to the use of dispensing machines (i.e., lack of discreet areas freely accessible to prisoners in which machines may be placed) • Machines must be custom designed and individually constructed, so costs can be prohibitive for some prison systems • Purely technological solution, with no opportunity for advice or counselling • Requires close monitoring to ensure machines have always sufficient supplies

CASE STUDY: Dispensing machines (Switzerland)

In 1994 a pilot needle and syringe programme was launched in Hindelbank women's prison. The programme has two main components: syringe exchange via automated dispensing machines, and IEC and counselling on HIV and harm reduction to prisoners by external NGOs. Six syringe distribution machines were placed in various discreet locations accessible to all inmates (44). All prisoners are offered dummy syringes at the start of the programme, and new prisoners are offered dummy syringes upon entering the prison (45). The dummy syringe or the used syringe is inserted in the machine, which gives a new sterile syringe in exchange .



As with a number of community-based NSP, providing a range of ways for prisoners to access needles and syringes is probably preferable to just one. A combination of a peer-distribution programme with a health-care staff programme and dispensing machines may prove most effective, since some prisoners may prefer one method of accessing a syringe at one time, and a different method at another (46). The prison's health-care team may work in cooperation with a specialist external agency such as an NGO with experience in working with drug-dependent prisoners.

B. Elements of an effective programme

To be effective, a needle and syringe programme needs to be accessible, and equipment and information should be of good quality and respond to the needs of prisoners who inject drugs.

1. **PNSP should be physically accessible:** The PNSP should be established in areas that are easily accessible to the prisoners. It is important to take into account the architecture of the prison and the prisoners' freedom of movement within the prison to determine the best location.

2. **PNSP should be equitable, non-discriminatory and non-stigmatizing:** PNSP are health interventions. There **s**hould be no exclusion criteria except medical ones or a severe breach of the rules that endangers the safety of other prisoners or staff. Programme participants should not lose any privileges, nor be stigmatized because of their participation. Similarly, exclusion from the programme should not be decided as a punishment. Programmes should be available to all prisoners, whether men or women, pre-trial or sentenced.

3. **Need for confidentiality and trust:** Trust and confidentiality are essential elements of a successful programme. Without trust, people will not participate in the programme. It is challenging to gain prisoners' trust, especially if prison staff, including health staff, are directly involved in the distribution of injecting materials. Prisoners will not be willing to register in a programme if they fear it could be used as proof that they continue to use drugs in prisons and therefore lead to a denial of conditional release. It is important to address stigma as part of the PNSP to reduce the risks of discrimination and violence against participants.

CASE STUDY: Portugal

By-law 3/2007 of 16 January and Order 22 144/2007 of the Ministry of Health and Justice authorized a pilot PNSP in Lisbon and Paços de Ferreira in 2008–2009. This was part of a broader strategy to decrease the incidence of HIV, HBV and HCV in prison settings by reducing risk behaviours associated with intravenous drug use, sexual activity, piercings and tattoos and injected use of steroids. The participant, after giving specific information on his pattern of use, received a kit with two syringes, filters, disinfecting towel, clean cup, citric acid, bi-distilled water and a condom. The rules were that the kit should be kept inside its box; if the cell were inspected, the inmate should state that he is in possession of the kit; and the kit should only be taken outside the cell to be exchanged by the health-care unit.

An outcome evaluation showed that reasons for not taking part in the programme included that most prisoners were afraid of being discriminated against, feared negative consequences for their penal situation, feared lack of confidentiality, did not want to declare themselves to be using drugs and were afraid of being identified as such or as participating in the PNSP. No syringes were exchanged in either of the prisons during the 12 months of the PNSP (47).

4. **Materials should be un-rationed:** The needs for syringes for each prisoner who inject drugs vary greatly with factors such as the type of drug injected and its availability in the prison, as well as individual factors. Needs will also depend on access to the service (for example, the opening hours in the case of distribution by health-service staff or NGOs). Supply should be determined by need and not limited by cost or other considerations. NSP with strict limits on the number of syringes provided to each client, or based on a strict exchange of one used syringe for a new syringe, are less successful in preventing HIV than those that do not impose such restrictions.

5. **PNSP should be affordable:** Participation in the programme should be free of charge. When access is lower because of limited supply or because of costs, there is the risk that syringes may be used as a form of currency or be sold. A mixed system of distribution, ensuring good access, reduces the potential risk of syringes to be sold.

6. **PNSP should be part of a comprehensive harm reduction programme:** Just as NSP should not only be about exchanging injection equipment, PNSP should be part of a comprehensive package of HIV interventions. Programmes should also make available information on HIV and hepatitis or overdose; information on access to services in the prisons such as HIV and hepatitis testing and counselling; OST and other drug dependence treatment and antiretroviral treatment for those who are HIV positive. Considering the high risk of overdose in prisons, training on overdose prevention and management together with the provision of naloxone, including at the syringe exchange points, should be considered.

7. **PNSP should be part of a post- release preparation plan:** The immediate post-release phase is a high risk period for people who inject drugs (48). Preparation for release, provision of kits for safe injection equipment and condoms to people released from prisons, as well the involvement of external harm reduction services in the prison programmes, facilitate the re-entry within the community and reduce the risks for overdoses and for sharing injection equipment and other risk behaviours.

C. Materials to be distributed

The materials distributed as part of a PNSP include:

- Needles or syringes of different types, adapted to the needs of prisoners who inject drugs
- Individual plastic box to store injection equipment
- Paraphernalia such as ascorbic acid, disinfectant swabs, tourniquet, sterile water, spoons (cookers), filters
- Condoms
- Information leaflets on HIV, hepatitis, overdoses, HIV, post-exposure prophylaxis (PEP), drug dependence services available in the prison (via external or internal services)
- Rules for participants in the programme
- Naloxone for overdose management

Depending on the model selected for the PNSP, the material that can be distributed will vary. In the case of automated exchange machines, existing programmes have provided syringes only. However, the system could be adapted to provide a full injection kit in exchange for a used or dummy syringe. The range of information material that can be distributed is much larger in peer-to-peer programmes.

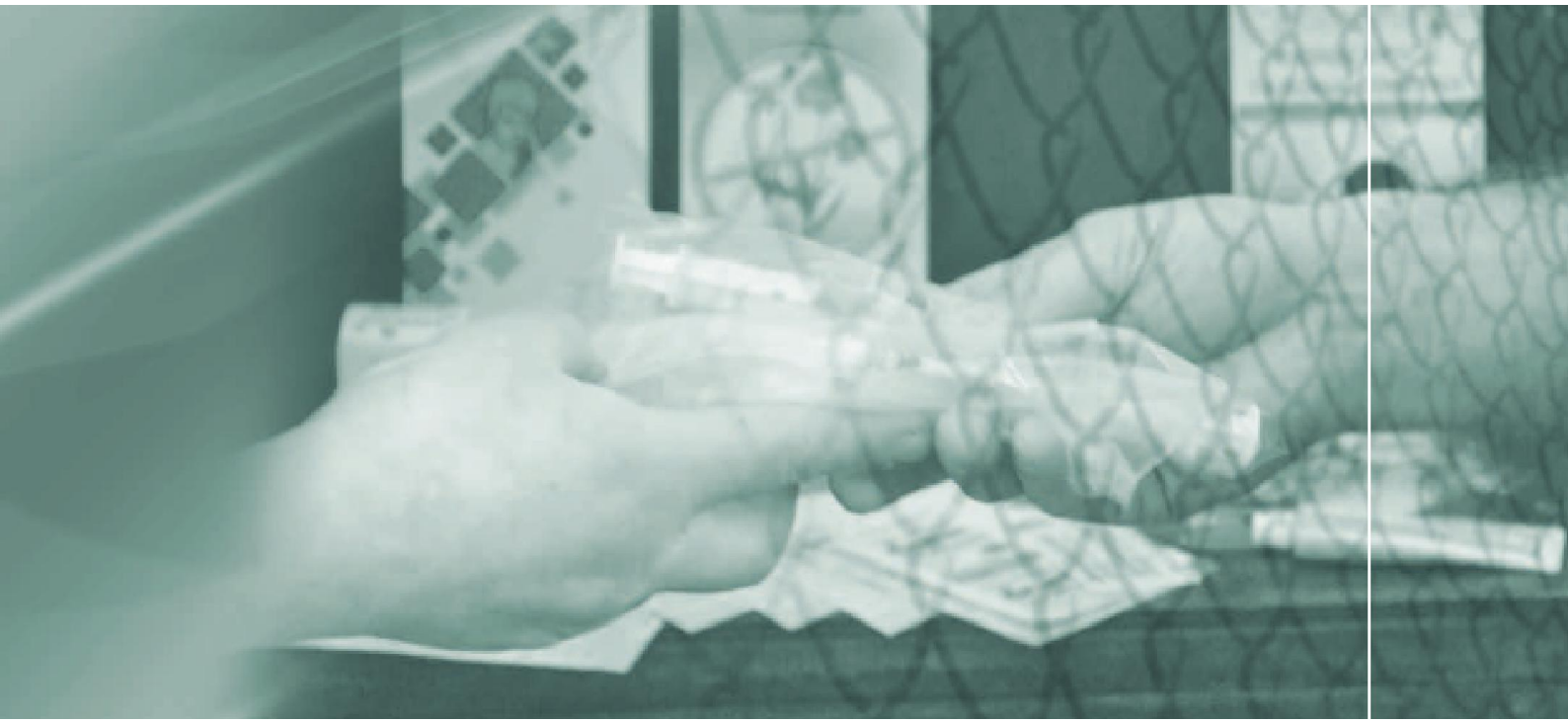
In Switzerland "FLASH kits" are handed out by prison doctors/nurses to prisoners upon request, and used syringes are exchanged for a new one either at the cell door or in the medical unit. FLASH kits comprise:

- 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%
- 2 bags of ascorbic acid 0.5g

For further information on materials see Part IV.

Flash Kit

Plastic container (Rieder et al. 2009)



PART III:
Advocacy Strategy

Part III: ADVOCACY STRATEGY

PNSP remain controversial even in some countries where they are currently operating, but the collective experiences of prison systems that operate them show that after a short period of time, PNSP become viewed as a normal service among the other drug services. Nevertheless, careful advocacy is needed to lay the groundwork for the introduction of a successful and sustainable PNSP.

CASE STUDY: Germany

In the prison at Vechta, when authorities decided to terminated the PNSP, prison staff, who had not been consulted before the decision was taken, protested against the move because they saw that the programme was valuable and effective and supported it.

A. Document HIV, hepatitis, injecting drug use and risk behaviours among prisoners

Information should be gathered from epidemiological studies, prison services, drug dependence treatment and harm reduction services and HIV services both in the community in prisons.

B. Identify and educate key stakeholders

Advocacy for PNSP can be undertaken by anyone from within the security or health system or drug control system, or by NGOs, organizations of people who use drugs, human-rights organizations, ex-prisoners organizations or prisoners' groups. However, the early involvement of prison authorities in lobbying government ministries for changes in policy and legislation is pivotal to ensure the introduction of PNSP is consistent with international guidance.

It is essential to identify the key national officials and experts with the relevant mandate, ability, and expertise. This should include representatives from sectors including the ministry responsible for prisons, the ministry of health, the national HIV/AIDS programme, the national drugs control programme and from NGOs and community experts. It is imperative to identify key stakeholders with the seniority to make decisions and commitments – including commitments regarding funding and budgeting.

One stream of advocacy activity should be dedicated to establishing working relationships between prison authorities, trade unions/staff associations, courts, judges, NGOs, health authorities and the national HIV/AIDS programme. The cooperation of trade unions/staff associations is essential to the introduction of PNSP. The security of prison staff is one the primary issue to address in advocacy.

Identify and support "champions" to lead implementation efforts: A component of identifying key stakeholders should also be the identification and promotion of "champions" within the system. These individuals should be tasked with – and supported in – promoting the initiative internally within the government and externally with the public. These champions should be helped to develop expertise on the issue of HIV/AIDS in prisons and to act as key centres of knowledge and information for the system as a whole.

CASE STUDY: Support from top-level staff in Moldova

"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 programmes 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" (38).

C. Review the national and legal and policy framework

All countries have policies and regulations that could support the introduction of PNSP. It is important to highlight these in the advocacy work. Legislation and policies can be related to the right to health of the population, including those in prison; harm reduction for people who inject drugs; and workplace safety and health.

CASE STUDY: Australia

Numerous advocacy documents from national bodies, medical associations, consumer groups, harm reduction organizations and public-health advocates in many of Australia's jurisdictions have outlined the health reasons for introducing PNSP. In 2011, the NGO Anex investigated the legislative and regulatory considerations underlying the introduction of PNSP in the state of Victoria. 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 PNSP. This duty of care is reinforced by the state's Charter of Human Rights and Responsibilities Act 2006. To establish PNSP in prisons, compliance with the state's Corrections Regulations 2009 will be required and consent must be obtained from the prison governor. Additionally, steps are required to ensure that the PNSP is properly authorised and gazetted pursuant to the Drugs, Poisons and Controlled Substances Act 1981 (39).

D. Raise national awareness of HIV and AIDS and prison issues among decision-makers and politicians

Many of the government officials who need to be involved in developing and implementing the programme may be unfamiliar with issues of HIV and AIDS, drugs or prisons. Other key decision-makers in the areas of prisons, health, drugs, etc. will also need education on the importance of PNSP, on scientific evidence and on international best-practice models. Education and awareness-raising should include providing information on HIV and injecting drug use in prisons, including prevalence rates of both; the public-health impact of prison health; legal and ethical obligations of governments; and examples of international best practice, showing the benefits of PNSP for individual prisoners, for the well-being of the wider prison community and for the entire community.

CASE STUDY: France

The National AIDS Council (Conseil National du Sida) has stated in a position paper that "access to sterile injection material should be guaranteed to intravenous drug users, regardless of their penal situation. National standards of risk reduction, defined by decree #2005-347 of April 14, 2005 (and particularly its chapter III, on distribution of prevention material) apply to the entire population, including detainees[…] The National Council of AIDS calls for a reform of harm reduction in prisons and recommends the establishment of NSP programmes in places of detention. [… The Council] hopes that…syringe exchange programmes can be set up, in a gradual manner but without delay.[…] Imprisonment is a sentence that deprives a criminal of freedom, not health care or prevention. Risk reduction measures should be fully set up in correctional facilities in accordance with the Public Health Code" (49).

During the preparation of the National AIDS/STI Plan 2009–2012, the working group on harm reduction for prisoners made a recommendation on the "priority" need for PNSP. PNSP was included in the AIDS/STI final plan.

Elus Locaux Contre le Sida (ELCS), an organization of elected local officials, based on the work of the National AIDS Council, raised with the Mission Interministérielle de Lutte contre les Drogues et la Toxicomanie (MILDT) its concerns about the degradation of harm reduction policy in France and mentioned the establishment of PNSP as a priority for action (50).

E. Tools and media

Different advocacy approaches are required to obtain the support needed: formal and informal meetings with stakeholders, involvement of programme managers in multisectoral AIDS and drugs committees, and development of relationships with selected representatives from the mass media.

Prepare briefs: Briefing notes should be short, summarizing the different elements needed by decision-makers, politicians, health or human-rights groups, or the media. These elements could include:

(a) review of epidemiologic situation in prisons in the country: short presentation summarizing background information on people who inject drugs in prisons, the consequences of risk behaviour and the necessity for a public-health response using international guidelines. Data on infectious disease incidence inside prisons can strengthen the argument, even more so if the incidence can be related to drug-injecting risk behaviour in prison.

(b) international public health guidance and evidence

(c) the benefits for workplace safety

(d) the benefits for the entire population

(e) international and national human-rights and legal obligations

(f) national policy and legal framework

(g) cost-effectiveness analysis of harm reduction interventions

The note can also have the format of a Q&A, pre-empting questions related to the introduction of PNSP. See for example the Harm Reduction International briefing Advocating for needle and syringe exchange programmes in prisons (52)and the Canadian HIV/AIDS Legal Network policy brief on prison needle and syringe programmes (52). The language in the brief should be accessible to all and should avoid any jargon related to health or legal matters. The brief should be tailored to the specific audience.

Multimedia and social media: All media can potentially be used to advocate and raise awareness on the need for PNSP. Short films disseminated on the Internet through websites, Facebook or other social networks can be more explicit than a document and make it possible to depict practices and to broadcast interviews with authorities responsible for health or existing PNSP.2

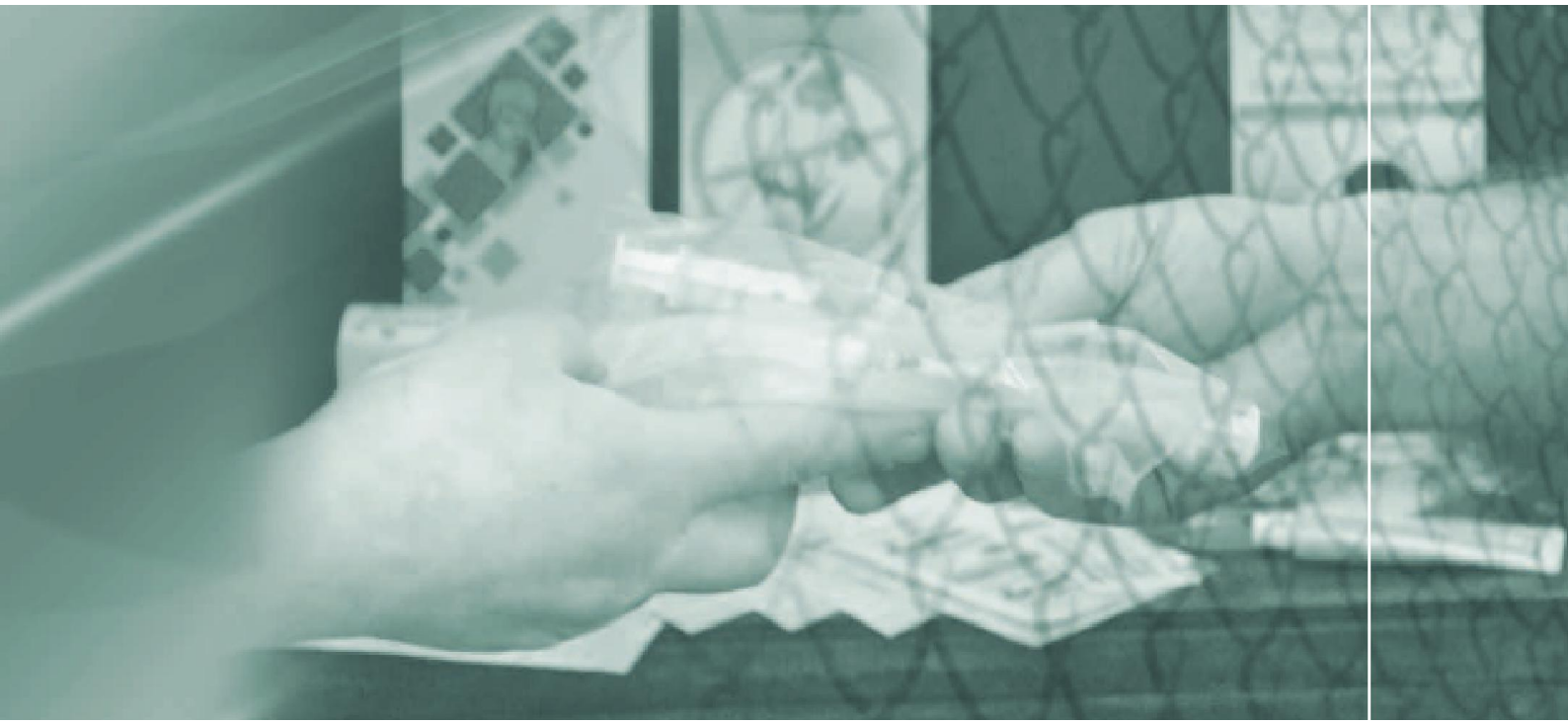
Organize study tours: When considering beginning a PNSP, study visits either by representatives of the ministry of justice or prison administration, prison governors, medical personnel and security staff may be helpful. Concerns can often be best overcome by visiting a prison already operating a PNSP. It is recommended where possible that the type of prison be similar and the intended mode of provision of syringes and needles analogous to the prison where the PNSP is planned.

Lawsuits: The possibility of litigation for PNSP if other avenues have failed should be considered as part of the advocacy.

CASE STUDY: Canada

A Study Group on Needle Exchange Programmes was convened by the Correctional Service of Canada (CSC) to investigate the introduction of NSP into federal prisons. In its final report in 1999, the group issued a consensus recommendation that the CSC obtain ministerial approval in principle for a multi-site PNSP pilot in men and women's federal correctional institutions, including the development and planning of the programme model, and implement and evaluate the pilot programme (19). In 2013 in Canada, following a lawsuit, PNSP were recommended by the Canadian Medical Association, the Canadian Human Rights Commission and the Correctional Investigator (ombudsman for federal prisons). However, the federal government insists on a strategy of "drug free" prisons and has refused to implement PNSP.

2 An example from Canada of advocacy for PNSPs utilizing new media can be found at www.prisonhealthnow.ca



PART IV: Planning and implementing PNSP

PART IV: PLANNING AND IMPLEMENTING PNSP

A PNSP is a multifaceted and interdisciplinary programme, and implementation therefore requires a project management approach.

Core principles

The following principles have been found essential to the implementation and operation of successful PNSP:

- **Support from leadership at the highest level**, e.g., senior officials responsible for prison health-care services, or for prisons generally, and support from the head of the prison in which the PNSP is to be established.
- **A steadfast commitment to public-health objectives**, to a harm reduction approach, and to the right to health of people in prison.
- **Clear policy direction** and oversight of the programme
- **Consistent guidelines and protocols**. However, these should allow some flexibility for individual institutions to take into account variations in population profile and security levels.
- **Participation of staff and prisoners** in the planning and operational process, including training to raise understanding, allay fears of staff and prisoners and encourage prisoner participation. Table 1 is a project outline for the planning and implementation of PNSP into one or more prisons. The tasks are presented sequentially, but some will be undertaken simultaneously. They are described in detail in the following pages.

Table 1. PNSP Project Schedule

1. Establish national steering committee	• Ensure membership from all major stakeholders • Decide which prisons to be included • Define policies
2. Conduct a situation and needs assessment	• Draw on existing data sources • Carry out additional survey if required
3. Preparatory phase	• Establish goals and objectives • Decide on the model to be implemented • Set programme timelines • Pilot sites/scale-up • Implementation study • Determine materials to be provided • Develop an IEC strategy • Set a budget
4. Develop a programmes framework	• Review legal and policy framework • Consult legal authorities • Secure ministerial, correctional agency and prison governor approval • Develop operating procedures and protocols
5. Implement the programme at the prison level	• Establish a local steering group • Make pre-implementation checks • Prepare prison staff for their role in the PNSP • Analyse intermediate results and review programme
6. Monitor, evaluate & conduct quality assurance	• Continue to monitor • Complete process evaluation and adjust service in the light of findings. Embed adjusted services in prison quality assurance processes

1. Establish a national steering committee for PNSP

In countries with no experience with PNSP a national steering committee will be needed to define the programme, lead the establishment of PNSP, coordinate the possible pilot projects and scale up the programme to all relevant prisons in the country.

Composition: All key stakeholders should be involved from the earliest stage in the development of a PNSP. These include prison security and health staff, management and prisoners and CSO. However, discussions and planning should proceed even without the participation of every invited stakeholder, to avoid the possibility of stagnation if some key stakeholders choose to boycott the consultations and planning stages.

The cooperation of trade unions/staff associations is essential to the introduction of PNSP. The security of prison staff is the primary issue to be addressed. Some of the main concerns raised by trade unions regarding PNSP have been the need for training, regulations, protocols, adequate prevention material, and clear guidance in order to keep the consequences of PNSP transparent and understandable to each staff member.

The early involvement of external stakeholders (such as the national AIDS committee, ministry of health and local health-care organizations and community harm reduction services) is also very important, as they often create an environment for internal stakeholders to move issues forward and also bring their knowledge and expertise related to HIV, harm reduction and NSP in the community.

The national steering committee may choose to appoint a project manager to serve as a central contact and coordination point for all procedures and processes and be responsible for all internal or external communication, under the direction of the steering group. Clear communication is essential at the planning stage.

The tasks of the steering committee are to:

- Clearly define the objectives for harm reduction in the specific prison context
- Review situation assessment and select the pilot sites
- Define the main components of the PNSP, including:
  - ✓ Choose the mode(s) of provision of sterile injection equipment
  - ✓ Workplace security
  - ✓ Overdose prevention and management
  - ✓ Training activities
  - ✓ Other HIV or drug-related services
- Develop transparent communication strategy
- Develop a training strategy
- Review the results of the programme
- Pursue advocacy issues
- Monitor the programme
- Development and overview the scale up strategy

2. Conduct a situation and needs assessment

Information generated from the situation and needs assessment will feed in the development process of both the preparatory and scale-up phases. It will also helped to identify prisons where PNSP is needed assist the steering committee in selecting pilot sites.

There are several indicators for the need of a PNSP:

- Number of people who inject drugs
- Likelihood that there is a high proportion of people with a history of injecting drugs.
- Number of drug users reporting injecting and sharing material in prisons
- Number of abscesses and other skin penetrations treated in the medical unit
- HIV prevalence and incidence in prisons
- Hepatitis C prevalence and incidence in prisons
- Drugs that are injected or used needles and syringes found during cell searches.

Some prisons will lack data on injection practices in prisons. However, this should not inhibit careful consideration for needle and syringe programmes .

There may be resilient data available from qualitative studies, focus groups, mandatory or voluntary drug testing programmes and surveys of risk behaviour which can provide a deeper knowledge of the prevalence of drug use, risk behaviours and infectious diseases. Prison staff, health-care workers (doctors, nurses) and governors may also have a good overview of risk behaviours in prisons with respect to sharing of needles and equipment, tattooing and piercing. This knowledge may be sufficient to plan and initiate a PNSP.

If more evidence for risk behaviour and intravenous drug use is needed, the prison administration can commission a rapid assessment in the prisons envisaged for the PNSP. This generally takes a few weeks. The ultimate goal of a rapid assessment is the development of a harm reduction response to injecting drugs use, rather than the simple collection of data *(54)*. (see also UNODC/EMCDDA: HIV/TB in prisons situation and needs assessment toolkit *(55)*). Prison healthcare departments may have conducted a general needs assessment which can contribute to the analysis.

3. Preparatory phase

A. Establish goals and objectives

The steering committee must first determine the goals and objectives of the PNSP. These will generally include a reduction in sharing of contaminated injecting equipment, reduction in transmission of blood-borne viral infections and abscesses, reduction in accidental punctures, and improvement in the overall health of prisoners who inject drugs, and improved security.

CASE STUDY: Objectives of PNSP, 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 programmes into health and social services offered by the prison.
- Promote safety in the workplace by avoiding needle-stick injuries.

Specific objectives

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

Complementary objectives

- Facilitate communication between people who use drugs and health-care professionals to foster referral to drug dependence treatment programmes.
- Determine the characteristics and needs of people who used drugs so that appropriate counselling and health education interventions can be designed and prioritized.
- Motivate and increase the awareness of prison workers about the benefits of PNSP.B Decide on the model to be implemented

B. Decide on the model to be implemented

Using the data collected through the implementation study and the assessment, and based on international best practices and respective advantages and disadvantage of the possible models, the steering group must decide which model (or models) of distribution will be used in the pilot and in the scale-up phase of the PNSP. Varying models have been implemented in different types of prison (e.g., high, medium and low security; large and small institutions). Every prison system must find its own most appropriate method for provision. The main goal is to ensure the best possible access, guaranteeing confidentiality and taking into account any concerns of security staff. This can be achieved if:

- There is no stigmatization of people using the service.
- Anonymity is respected as far as possible in a prison environment.
- The service is available every day.

(See Part II, Section A for more information.)

Considering the respective advantages and disadvantages of the different modes of distribution, in order to ensure the best access to safe injection equipment and information to people who inject drugs in prisons, authorities should adopt mixed model with at least two modes of distribution: one being peer-based and/or dispensing machine and an alternative model possibly through health services and/or NGOs.

There is a growing consensus that a service based on distribution is preferable to an NSP that only exchanges syringes on a strict one-for-one basis, although safe return of the used syringes should remain a fundamental aim. Compared with community services, PNSP generally bring a high return of used needles and syringes, which gives the staff reassurance of sustained interest in their safety and security.

Additional considerations for peer-based programmes

If a peer-to-peer approach is chosen, the following steps are recommended in view of the high responsibility borne by peer volunteers and their consequent vulnerability to intimidation or corruption:

1. An identified member of prison staff (a senior member of either the health-care or security staff) is responsible for the continued safe running of the peer-to-peer service.
2. Peer volunteers are carefully selected on the basis of demonstrable histories of good conduct during their prison sentence, and of high motivation.
3. Peer volunteers are trained thoroughly. Their training includes vectors and risks of disease transmission, hygienic infection control, and emergency procedures for HIV post-exposure prophylaxis (PEP)[3] and for the reversal of opioid overdose via naloxone.
4. Peer volunteers have a full supply of latex gloves, bleach and sharps bins.
5. Peer volunteers receive reward/remuneration commensurate with their contribution to the PNSP.
6. Peer volunteers are provided with highly structured supervision, with regular confidential meetings with NGO or clinic staff.
7. Regular confidential surveys of both prisoners and staff are conducted to identify as early as possible any potential instances of corruption of the service.
8. Where malpractice by a peer volunteer is suspected, the volunteer is relieved of his/her duties and a contingency arrangement is put in place.

The steering committee must also consider how the PNSP will accommodate the risk presented by prisoners with extreme behavioural problems or active, serious mental-health problems. It should also ensure the service has the scope to meet the needs of particular prisoner groups, such as:

- **Women:** In general, women in prison tend to have a proportionately higher level of injecting drug use than male prisoners *(56)*, making the need for PNSP in women's prisons more pressing than in any other type of secure setting. As a consequence of distress caused by abusive pasts and separation from their children, women also have a far higher tendency to self-harm (for example, 14 times greater in England) *(57)*. This disregard for personal safety makes women particularly vulnerable to high-risk injecting drug use. Another crucial risk factor is the risk of mother-to-baby transmission of BBVs: one third of women surveyed in prison have children under the age of five *(58)*.

[3] Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a partner with HIV infection..

- **Ethnic-minority groups:** Drug use is highly taboo in many minority ethnic communities. Prisoners from these communities who inject drugs are therefore often extremely fearful of accessing PNSP that have a poor record of maintaining confidentiality. Language and cultural barriers must also be addressed.

C. Set programme timelines

The initial project plan should have two phases, each with a clear timeline:

1. Pilot phase (6–12 months): The pilot programme is used to assess the best method of providing the fullest access to clean needles and syringes in prisons, taking into account the constraints of the environment.

Experience shows that pilot projects can be undertaken quickly and do not have to delay broader implementation of PNSP. For example, in Kyrgyzstan a pilot PNSP began in October 2002 and in early 2003 approval was given to expand the programme. By September 2003 programmes were operating in six prisons and by April 2004 in all 11 prisons.

It is essential that monitoring and evaluation of the pilot is designed as part of the work plan, Indicators must be developed that relate to the objectives of the PNSP, and systems established to collect data on these indicators. See Part IV, Section 9 for further information.

2. Scale-up phase (e.g., 12–24 months): During this phase the goal is to ensure effective coverage of the entire target population by the PNSP.

D. Select pilot sites

In countries or regions introducing PNSP for the first time, two or three sites should be selected to pilot the project. The objective of the pilot is to test and assess implementation modalities and to adjust the model and procedures to ensure the best access to needles and syringes given the local context and structures of the prison system. Pilots should be short and lead to a rapid scale-up based on the acquired experience. Criteria that have been used for the selection of pilot sites include:

- Prison has a relatively high number of prisoners who inject drugs
- Prison has a high prevalence of HIV and/or hepatitis
- Prison has a significant prevalence of high-risk behaviour

CASE STUDY: Objectives of PNSP, Spain

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. The facility was chosen because it housed the largest number of prisoners in the country known to be living with HIV, had the largest number of people incarcerated for drug-related offenses, had the lowest average age of prisoners (mid-20s), and a significant majority of prisoners 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 (38).

Implementation study: Once the sites have been selected, a study should be conducted to determine the exact needs in the prisons and be best way to design the programme. This study includes collection of information on the needs and preferences of both prisoners and prison security staff for PNSP.

The extent to which prisoners will use the new service depends greatly on the degree to which they feel their access to syringes is confidential and anonymous (38). Prisoners' voices should therefore be heard before starting the project. The essential questions to be discussed with them are the following:

- What are the specific risks and risk behaviours?
- What is the frequency of injection and number of syringes needed per day?
- What are the conditions for prisoners to trust the needle and syringe programme?
- How can they easily and anonymously access needles, syringes, and paraphernalia?
- What type(s) of syringes and other injecting equipment such as swabs and sterile water do they need?
- How could a service be tailored to these needs?
- Estimate number participants ?

Similarly the security of prison staff is a primary issue to be addressed. Staff should be consulted about their needs in terms of:

- Prevention of accidental exposure (safety boxes, protective gloves, eyewear, access to PEP)
- Training on HIV, hepatitis, universal precautions and overdose management
- Guidance documents and regulations for the PNSP
- How a PNSP would be tailored to their needs.

E. Determine materials to be provided

The injection equipment provided through a PNSP should correspond to what is provided through NSP in the community. An effective PNSP should supply prisoners with:

- Puncture-proof case (to store injection equipment)
- Sterile needles and syringes
- Sterile water
- Disinfectant swabs
- Filters
- Ascorbic or citric acid
- Spoons
- Puncture-proof containers for the disposal of used needle and syringe (sharps box).

Different kinds of needles/syringes should be made available depending on the patterns of injecting drug use among prisoners in the specific country/prison. To prevent HIV, HBV or HCV and risk of other infections through abscesses and other sceptic problems, materials should not be limited to needles or syringes. Spoons, sterile water, filters and tourniquets are important to prevent HCV

transmission. Ascorbic acid or citric acid is needed to prepare the injection. (In the absence of ascorbic acid, the person who injects drugs use other available acidic substances such as lemons or vinegar, which can be responsible for severe infections, including endocarditis). To encourage prisoners to change from injecting to smoking drugs, providing aluminium foil to users who request it may also be considered.

The number of kits to be supplied during each contact with the programme depends on the frequency of the needle exchange and the user's consumption habits: the quantity should be sufficient to cover the prisoner's needs so that he or she does not have to reuse a syringe before the time of the next exchange.

The PNSP should also provide information on HIV, HBV and HCV transmission and prevention, and on how to reduce the risks of injecting, including overdose prevention. Condoms may also be distributed to prisoners through the PNSP.

Harm Reduction Kit: Soto de Real Prison, Madrid (Rick Lines,2004)

F. Develop an information, education and communication (IEC)strategy

Before starting a PNSP, educational and informational events should be conducted for prison staff and prisoners to communicate the importance and goals of the programme. Prisoners and prison staff should be fully informed of the plan to implement the service via multiple communication channels (general meeting of prison staff, written information, prison newspaper, personal interviews, etc.).

Prison staff members usually have two fundamental questions that must be addressed:

- "Will PNSP increase the risks of a syringe being used against me as a weapon, or of staff receiving needle-stick injuries due to the presence of more injection equipment?" The clear answer from the numerous PNSP evaluated across many jurisdictions is that PNSP do not increase the risks of either assault or accidental needle-stick injury.
- "Why do we allow PNSP if drug use and trafficking are illegal?" The perceived paradox is very similar to the situation of harm reduction programmes in the community. The answer to this question should cover public-health issues such as the protection of the health of prisoners and the health of prison staff, and human-rights elements, particularly the principle of equivalence of health care.

IEC material should be developed for staff. Particular attention should be given to get the participation of staff in the development and design of the material in order to ensure that it:

- Addresses their questions and needs
- Is linguistically and culturally appropriate and accessible

- Covers general information on HIV, hepatitis, drug dependence, overdoses and other consequences
- Covers workplace safety.

Prisoners may have similar questions, and others related to the consequences of the PNSP for themselves. When the programme is ready to start, inmates should be informed as to:

- The programme's design and rules (storage of needles, method of transport, sanctions, etc.)
- Where and when the first needle and syringes/paraphernalia (kits) can be obtained
- The confidential nature of the service
- Any potential disadvantage to their current sentence when participating in the programme (in cases where confidentiality is compromised), such as more frequent cell searches or urine drug controls.

New prisoners entering the institution should immediately be informed of the programme's procedures and rules.

Prisoners may support the implementation of the project by advertising it in the prison-based magazine, newspaper or broadcast.

IEC is not sustainable as a stand-alone strategy and should be directly linked to other harm reduction services in order to change the risk behaviours that relate to the transmission of BBVs and overdose (7, 61, 62). Prisoners should be informed of the general services for health care, HIV testing and counselling, hepatitis, and drug-dependence treatment, counselling and support available in the prison. In addition:

1. Written materials about the PNSP should be available in prisoners' own languages. They should be appropriate to their level of education and literacy, prioritizing pictures over text, using drug terminology common in the prison, and including interactive elements such as a quiz. Prisoners should be involved in the development and the design of these educational materials.
2. Peer education programmes are the most effective ways to deliver targeted education on risk behaviours and should be a part of the harm reduction approach where possible.
3. Where relevant and accessible, new media (e.g., the Internet) should also be used to transmit messages about harm reduction and transmission risks *(63)*.
4. In order to avoid stigma and discrimination by other inmates against people who inject drugs and prisoners with HIV, the necessity for prevention of infection and the nature of dependence should be communicated to all prisoners.

G. Set a budget

PNSP are inexpensive and most cost-effective if designed and implemented well (59). The budget will depend on the mode of provision of sterile syringes and needles, and should include direct and indirect costs.

Syringes, needles and paraphernalia: Direct costs are relatively easy to calculate. Although costs will vary between countries, syringes and needles are generally inexpensive and can be obtained quite cheaply in bulk through the prison's medical unit. This also applies to additional injection paraphernalia, cases and safe sharps boxes for disposal of used needles.

Dispensing machines: If the exchange is to be done via automated dispensers, the budget should include the cost of these machines. For example the approximate unit cost of each of the one-for-one exchange machines used in Switzerland is US $6,500, plus the costs of maintenance.

Personnel costs: Demand for personnel will depend on the design of the programme, the size of the target population, and whether the programme is implemented partly or entirely by an external agency or by peers. For example, in a women's prison in Hindelbank, Switzerland, one health-care worker (half-time, approx. 20hrs per week) is employed by the municipality's health agency to conduct the PNSP. Activities to be taken into account are:

- Liaising with staff
- Counselling prisoners
- Stock management
- Training staff and prisoners
- Overseeing, coordinating and monitoring the programme.

The costs for staff training programmes vary considerably and can best be calculated at the local level. In Moldova the service is provided by an external NGO and is peer-based. In 2008 the overall budget for the NGO's activities in seven penitentiaries was approximately US $37,500 annually, of which $12,700 went towards staff salaries; $9,200 for condoms, syringes and other harm reduction supplies; $2,200 in administrative expenses; and $13,400 for "other expenses", including $2,200 as remuneration for peer volunteers.

Some indirect costs will relate to prison staff . These costs will be higher in the initial phase, and may include working hours for:

- Doctors/nurses/other health staff
- Interdisciplinary and multiprofessional staff in working group
- Advocacy (hosting visits by politicians, media, judges, other professionals)
- Monitoring and evaluation.

4. Develop a programme framework

The implementation of a PNSP requires formal authorization and regulation by the ministry or ministries in charge of prisons, since needles are sharp devices and forbidden in most jurisdictions. Official authorization and regulation make clear to all concerned that the PNSP is supported by the authority in charge. Points to be covered by the regulations include:

- The institution/unit/persons in charge and responsibilities
- The mode(s) of provision of syringes and needles
- Methods of disposal of used needles
- Method of storing needles and syringes in the cell and in transit
- Consequences for prisoners violating these rules
- Duties and rights of peers and health workers enrolled in the PNSP
- Information for security staff on how to respond to finding used needles and syringes
- Formal procedures for monitoring and evaluation
- A formal note that drugs are still illegal and will be taken away as usual
- If a pilot programme has been set up, the duration of the pilot and the steps to be taken if the programme results are either positive or negative.
- Procedure for accessing PEP for prisoners, peer health workers and staff

- Procedure for accessing naloxone to prevent lethal overdoses.

Policies and procedures are important in all phases of PNSP – planning, initiation, operation and scaling-up of services. Policies are overarching guidelines that describe the programme activities, modes of operation and rules, whereas procedures are detailed steps (protocols) for undertaking each task. Examples of good practices in the development of policies and procedures can be found all over the world, as are standards of care and protocols for dealing with issues that arise in PNSP (e.g., Canton of Geneva, Switzerland).

CASE STUDY: Starting PNSP through a Memorandum of Understanding (MoU) between ministries, Spain

In Spain the implementation of the first PNSP pilots was undertaken on the basis of a MoU between the Ministry of Health and Consumer Affairs and the Ministry of Interior (2000), entitled "Key Issues for implementation of needle exchange programmes in prison" (2000). After a few years the experiences gained in operating and piloting PNSP were condensed into a framework document to support prisons in designing their own specific programmes. This enabled prison managers and staff to benefit from previous experience and achieve the best possible results from the outset (60). Working within the framework, each prison designed its own PNSP, which required approval by the Board of Directors of Prison. The concrete procedures for PNSP are laid down in additional documents. (See also Annex A.)

5. Implement the programme at the prison level

A. Establish a local steering group

As with the national steering committee, the prison steering group should include all stakeholders including the prison director, director of the prison health services and other members of the health staff, security staff, staff union delegate, prisoners and external NGOs. It should also include a member of the national steering committee.

CASE STUDY: PNSP working group, Germany

In the women's prison of Vechta, a working group was formed with staff of all relevant prison wards and departments. The group met regularly to discuss, plan and assess the progress of introducing the PNSP. Meeting minutes were made available internally so that all other staff members could see the current status of the programme. This transparency helped build staff trust in the programme. The working group asked staff and prisoners where the five syringe dispensing machines should be installed in order to guarantee discreet and confidential access. The introduction of PNSP was kept as a standing topic for the general meetings of all staff members, to advise them of its progress and evaluation.

Under the guidance provided by the national steering committee, the local steering group is responsible for implementing the following activities:

- Present and explain PNSP concept and goals of the PNSP to all people working and living in the prison
- Conduct the implementation study (see part IV. 3. D.)
- Ensure implementation of measures for safety in the workplace (protection of staff, provision of gloves, etc.)
- Decide on the location, frequency and hours for exchange of syringes

- Establish rules and regulations regarding transportation, distribution, storage and disposal of syringes and associated injecting equipment
- Establish formal links between the PNSP and local NGOs and other authorities in the community (e.g., linkages with the local community HIV and AIDS services services for people who use drugs)
- Organize training for prisoners and staff (by integrating NGOs)
- Establish a mechanism for complaints and respond to any complaints about the programme from prisoners or staff
- Collect baseline indicators for the evaluation (see Part IV, Section 9 on monitoring and evaluation)
- Develop monitoring systems that focus on the accessibility, availability and utilization of the PNSP
- Solve technical or organizational problems that may arise
- Document and summarize interim results of the programme.

B. Make pre-implementation checks

Prior to implementation, ensure all the scheduled milestones on the project plan have been reached. The following checklist gives some examples of elements that need to be in place

Sample pre-implementation checklist

Activity	Already done	Planned date for intro-duction	Date to be reviewed	Project member Respon-sible
Clear protocols developed e.g., how many syringes a prisoner may possess, where he/she must keep them, what is considered abuse or misuse of programme, what sanctions can be imposed for misuse, etc.				
Clear protocols developed for peer health workers or secondary exchange				
Participants are informed about the PNSP, its objectives and rules				
Participants are informed about the full range of HIV and drug dependence treatment services in the prison				
Participants are advised on safer injection practices, HIV and hepatitis				
Define the number of syringes and needles a participant can receive each day in exchange for used ones				
Participants in the programme are given a small container to store needles				
Cleaning materials (e.g., bleach) for paraphernalia are provided if it is not possible to provide sterile equipment (spoons, tourniquets, etc.)				
Sharps boxes are available to all participants for the safe disposal of used needles, syringes and paraphernalia				
Consultations on HIV and drug use will be offered at regular intervals (e.g., every 6 months) to the entire prison population				
Easy access to voluntary HIV, HCV and HBV testing will be provided and prisoners will be advised of the advantages of having regular tests (i.e., at least once a year)				
Hepatitis A and B vaccinations will be offered to prisoners and staff				
Universal emergency access to naloxone to treat overdose				

C. Prepare prison staff for their role in the PNSP

Understand and embracing the goals of the PNSP: Prison staff and management embrace infectious disease prevention when they see that infections in prisons are a threat to everybody. They can be helped to understand their crucial role in making the programme successful. Any concerns they may have will decrease substantially as they learn first-hand about the PNSP and its harm reduction goals, and as they participate in the planning and implementation. Attitudes and opinions can change if staff see that their concerns are dealt with seriously. Providing information passively, e.g. through leaflets, is not enough: other means such as information provided in person by dedicated staff should complement written information.

Statement of principles: Before the PNSP begins, all prison staff should be fully informed of the objectives and purposes of the programme. The project plan should include a statement of core principles and values, which should be developed, agreed upon and signed by everyone included in the project. The statement will help ensure a non-discriminatory approach, contribute to the quality of the PNSP and facilitate its implementation by staff members. It can also serve as a platform for training prison staff and management.

Training of staff: It is essential to train prison staff in order to motivate them and increase their awareness of the benefits of harm reduction programmes, and in particular of PNSP. Training and education should take place on a regular basis to accommodate staff turnover. Training on PNSP (and other measures to prevent HIV and other BBV infections) should be part of any formal training of new prison staff. Key goals of staff training include:

- Helping staff identify with the objectives of the PNSP
- Giving them basic knowledge about drugs, drug use, infectious diseases and other health problems related to drug use
- Discussing and agreeing upon individual and collective needs for safety (64).

It is crucial that prison staff obtain basic knowledge on health protection in the workplace, including:

- Prevention of HIV infections
- Universal precautions
- Responding correctly to cases of overdose
- Responding correctly to needle-stick injuries
- Access to PEP
- Receiving adequate treatment for any wounds
- Hepatitis A and B vaccinations.

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

Workplace safety procedures: A series of measures for protection and prevention should always be taken to eliminate or reduce risks of accidental infection, including:

- Needles or other sharp instruments should be handled with adequate precaution when they are collected or handled for any reason.
- If the needles are not contained in their rigid case, they should not be recapped or handled in any other way.

- Piercing or cutting objects should never be discarded in plastic bags of conventional disposal bins, but only in rigid puncture-resistant containers.
- In the event of needle-stick injury, the incident should be reported immediately to the appropriate occupational health unit, which will specify the measures to be taken in each case (60).

It should be explained to prison staff that the risk 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 needle-stick exposure with an infected needle is approximately 0.3%, the risk of HBV transmission is 6–30%, and the risk of HCV transmission is approximately 1.8% (65). In the event of occupational exposure to a potential source of HIV (including needle-stick injury), staff should be managed in accordance with the local occupational health protocol. It is recommended that this protocol is reviewed to ensure that it is consistent with the joint WHO/ILO (2007) guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection (66).

Safety in the workplace- Spain

The fears of prison staff usually relate to the potential for the programme to malfunction, e.g., that more syringes and needles will be lying around, that the workplace safety of staff will be compromised, that needles could be used as weapons, and that more drug use will occur in the prison. When investigating the safety of prison personnel in the context of a PNSP, the Spanish Directorate General for Labour Inspection stated: "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 Needle Exchange Programmes creates a safer situation for prison officers. This argument arises from a comparison of the situation before and after introduction of the NEPs... Implementation of a needle exchange programme 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."

Hygiene:

- Universal precautions (always take precautions as if a person or an object is infected with HIV, HCV or HBV) should 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.)
- Any cut, other skin break or open wound should be covered by a waterproof dressing.
- For situations where infection risks are high (accidents, fights, cell searches, etc.) the prison will have, or should develop, protocols for the safe cleansing and decontamination of the sites of these incidents. These can be developed with the infection control contact within the prison's health-care department.

D. Analyse intermediate results and review programme implementation

The programme design used should be reviewed and adjusted based on results and on any problems encountered. One of the simplest and most sensitive indicators of programme effectiveness is the participation rate and/or the number of syringes distributed and exchanged each month. Low participation rates can have several causes. These are discussed below.

Opposition from staff: PNSP are a controversial political issue because they may be taken to symbolise failure to keep prisons "drug free". Prison personnel at all levels are nearly always opposed to PNSP at first. However, experience shows that shortly after implementation begins this opposition vanishes, and PNSP becomes routine procedure.

CASE STUDY: Responding to fears and mistrust of the prison staff, Germany

In a men's prison in Germany, all staff members were asked to fill in a card anonymously with their fears regarding the implementation of PNSP. The cards were collected, grouped by theme, and displayed for discussion, to try to give answers to allay these fears. Naturally in such a process there will be some questions that can only be satisfactorily answered during the process of programme implementation (67).

Lack of trust in the programme's confidentiality: When PNSP was first provided in prisons in Moldova, needles were handed to the prisoners by the prison health staff, but the uptake was very low. Many prisoners were reluctant to access the service because they did not believe the programme was truly anonymous and confidential. Another obstacle was that medical personnel were not always available when prisoners needed them: access was limited or non-existent in the evenings and at weekends. In order to improve the degree of trust and confidentiality, and the accessibility of the programme, it was decided to train prisoners as outreach volunteers to provide the services to fellow prisoners (38).

Prisoners' voices should be heard when reviewing the pilot project. The essential questions to be discussed are the following:

- Do prisoners have trust in the needle and syringe programme?
- Can they access needles and syringes without fearing any negative consequences?
- Can they easily and anonymously access needles, syringes, and paraphernalia (vials of sterile water, swabs, filters etc.)?
- Is the service tailored to their needs?
- Do prisoners have access to different types of syringes and to other injecting equipment such as swabs and sterile water?
- Can prisoners obtain sterile injecting equipment without having to identify themselves as drug users to the prison security authorities?
- Is access to paraphernalia ensured in a confidential mode, or in a way that indicates to prison authorities where drugs might be hidden?
- Can they get more than one syringe at one time? (16).

CASE STUDY: Evaluating poor uptake of a PNSP, Luxembourg

In Luxembourg, health staff in charge of the PNSP estimated that only about 20% of the target group were participating, while other prisoners continued to use illegal means to obtain syringes. The main reason reported by the prisoners was their lack of trust in the anonymity and fairness of the service:

- In order to reach the healthcare unit prisoners had to pass several guards, and so they feared disclosure of their status.
- Some guards who were not in favour of the PNSP openly stated that they searched the cells of those prisoners who participated in the programme, and some even ordered urine tests.
- Nurses were not obliged to exchange syringes, and requests by prisoners were sometimes rejected or only dealt with several days later.
- The following lessons were learned from this programme:
- All prison personnel (security as well as health) must understand and support the programme.
- Clear instruction from top management is needed in order to have a standardized and consistent procedure. Staff should always provide clean equipment upon request according to the rules of the programme.
- The exchange location should be organized discretely to guarantee the maximum possible degree of anonymity.
- The monthly rate of cell searches should not vary from the rate before the introduction of PNSP, otherwise it will deter prisoners from participating in the programme.

High turnover of prison staff and of prisoners: Prisons with a high number of remand (un-sentenced) prisoners will be less suitable for a peer-to-peer model of delivery, as volunteers may need to be replaced at an unfeasibly quick rate. As a remedy to a high turnover of staff, prisons that have a PNSP provided by an internal department (i.e., health care or security) can make three particular adjustments to their approach:

- Ongoing training and direct involvement in PNSP of a large number of staff members
- Embedding PNSP into the daily duties of the lead service
- Clear, simple and unambiguous protocols, prominently displayed in staff areas.

6. Monitor, evaluate and conduct quality assurance

Monitoring, evaluation and quality assurance are essential to the successful implementation of a PNSP. They enable evidence-based adjustments and improvements to the programme; they help the programme react to the changing needs of programme participants and prison staff; they help achieve the highest attainable level of transparency; and they provide reliable data that can be used for further advocacy for PNSP with prison authorities, the government and the public.

- Programme monitoring assesses whether the programme is consistent with its design by measuring its performance relative to agreed targets and milestones.
- Evaluation may be divided into two types: process and outcome.

- A process evaluation measures how well the programme (and especially the pilot phase) has been designed and implemented. It incorporates data (e.g., number of participants, number of syringes exchanged) as well as the experiences, opinions and perspectives of key personnel (including prisoners and prison staff). An outcome evaluation measures the results of the project, including changes in injecting behaviour and rates of blood-borne virus infections.
- An outcome evaluation measures the longer-term effectiveness of the programme. Outcome evaluations generally take longer to complete and are more expensive than process evaluations. While not essential to an individual project, an outcome evaluation is extremely valuable for securing the long-term acceptance and support of decision-makers for scaling up the PNSP.
- Quality assurance is a system of ongoing process that provide feedback on how the programme is perceived by participants and prison staff, and on ways to make it more effective.

Monitoring, evaluation and quality assurance should be rights-based, following standards of informed consent, confidentiality and non-discrimination.

A. Monitoring

Continuous monitoring of the PNSP is pivotal. Under the national PNSP in Spain, a computer software package is used in each prison to record the number of programme participants, number of syringes supplied and returned, enrolments/withdrawals from the programme, and reasons for withdrawals. The health status of service users is also included. Diseases associated with intravenous drug use (HIV, HCV, HBV) are also monitored using the computer program. To maintain the confidentiality of the programme participants, a randomly generated number or pseudonym is used to identify each participant.

Checklist of monitoring indicators

- Number of syringes/kits, equipment distributed
- Estimate number of participants in the programme
- Incidence of HIV, HBV and HCV
- Number of abscesses
- 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 (needle-sticks)
- Number of overdoses (as relevant)

On the long term, change in the apparent performance of the programme might not be related to the quality of the programme itself, but a change in the profile of the prison population and a diminution of the demand. It is important to reassess the needs of the prison population after a few years in case a programme is less used.

CASE STUDY: Hindelbank, Canton of Berne, Switzerland (1992 – 2012)

A low participation rate might have other reasons than the effectiveness of the programme. In the prison, where PNSPs started in 1992/3, the exchange has been provided for 20 years by a health prevention worker employed in the community. The entire procedure of PNSP has not changed over this time. However, for the last 10 years only 30-100 needles are exchanged annually. The reasons for this decline are to be found in the change modes of drug use (from injecting to smoking), and an overall reduction of the number of drug users in the prison population.

B. Evaluation

An evaluation should be conducted at the end of the pilot phase, and then regularly thereafter, but not necessarily every year. If there are signs that the programme is no longer working properly, it is essential to conduct an evaluation to identify problems and remedies.

In addition to the monitoring data described above, it is necessary to know the impact of the programme on risk practices and the views of prisoners participating in the exchange and other prisoners on the programme, as well as the opinions of security staff and the team implementing the programme (68). This involves comparing baseline and post-implementation data on the changes in the frequency of sharing injection equipment among prisoners, as well as changes in prisoners' attitudes and opinions about the PNSP. Similarly, prison staff should be surveyed at the start of the PNSP and at later points about their attitudes, knowledge and opinions about the PNSP.

Programme effectiveness: baseline indicators

The effectiveness of PNSP in reducing risk behaviours that lead to HIV infections and other harms may be measured via rates of the following indicators prior to and during the project:

- Reusing injection equipment
- Sharing needles and drug paraphernalia with others
- Number of abscesses
- New cases of HIV/HBV/HCV

Secondary benefits associated with the implementation of PNSP should also be evaluated, such as:

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

Apart from data recorded through the PNSP's own monitoring systems, quantitative information for evaluation purposes can be collected through questionnaires administered to a sample group of inmates and another sample group of prison staff. Qualitative information can be obtained through focus group discussions with prisoners and with staff members.

The following aspects of the programme may be discussed (see also questionnaires in Annexes B and C):

- Convenience and confidentiality of access to injecting equipment
- Accessibility of the programme
- Friendliness of staff
- Functioning of devices (dispensing machine etc.)
- Quality of injection equipment and paraphernalia
- Involvement of prisoners who inject drugs in PNSP activities
- Response of management and staff to complaints and to changes in behaviour and the environment
- Range of injecting equipment and services provided by the PNSP
- Referral processes used.

The Spanish Ministry of Interior provided forms for recording the opinions and attitudes of prisoners and prison staff to obtain a minimum set of common data for evaluation (see Annexes B and C). The information in the questionnaires was collected on an anonymous basis and included:

a) Attitudes and opinions (prisoners and prison staff)

- Level of information on the PNSP
- Level of acceptance of the PNSP
- Level of satisfaction with the functioning of the PNSP (hours, personnel, rules, etc.)
- Impact of the PNSP on prison security
- Impact on relations between prisoners and staff.

b) Behaviours (prisoners)

- Percentage of inmates who have consumed heroin in the last 30 days
- Percentage of inmates who have consumed heroin intravenously in the last 30 days
- Percentage of inmates who have consumed stimulants in the last 30 days
- Percentage of inmates who have consumed cocaine intravenously in the last 30 days
- Percentage of prisoners who inject drugs who have used syringes previously used by others in the last 30 days
- Percentage of prisoners who inject drugs who have lent their used syringes in the last 30 days
- Percentage of prisoners who inject drugs who have shared other injection instruments (spoons, filters, water, containers for dissolving drug) in the last 30 days
- Percentage of inmates who have used a condom in their most recent sexual intercourse.

For detailed guidance on monitoring and evaluation processes, see also *National AIDS Programmes: A Guide to Monitoring and Evaluation (69)* and other on-line free-access toolkits.[4]

Programme coverage: In the absence of any key indicators to assess coverage of PNSP, the following community-oriented indicators have been transferred to custodial settings and may serve as very basic indicators and indicative targets for the prison setting *(4)*:

> **Percentage of prisoners who inject drugs regularly reached by PNSP**
> *Data source:* Programme data
> *Numerator:* Number of prisoners who inject drugs who accessed a PNSP once a month or more within the previous 12 months
> *Denominator:* Estimated number of prisoners who inject drugs
> *Targets:* Low: <20%; Medium: 20–60%; High: >60%

Note: WHO/UNODC/UNAIDS *(4)* recommends (p.19) 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 people who inject drugs in New York, USA. Since there is no data on thresholds for prisons, these coverage indicators must be used with caution. In addition, in prisons, depending on the model chosen, it may prove difficult to calculate the exact number of programme participants. Considering that confidentiality and trust are key for successes of a PNSP, this should not be a priority.

4 http://www.evaluationtoolbox.net.au/

Syringes distributed per person who injects drugs per year
Data source: Programme data
Numerator: Number of syringes distributed in the past 12 months
Denominator: Number of prisoners who inject drugs
Targets: Low: <100 per prisoner who injects drugs per year; Medium: 100–200; High: >200

Note: WHO/UNODC/UNAIDS (4) states (p.19) that these levels are based upon community studies in developed-country settings investigating the levels of syringe distribution and impact on HIV transmission. The levels required for the prevention of HCV are likely to be far higher than those presented here.

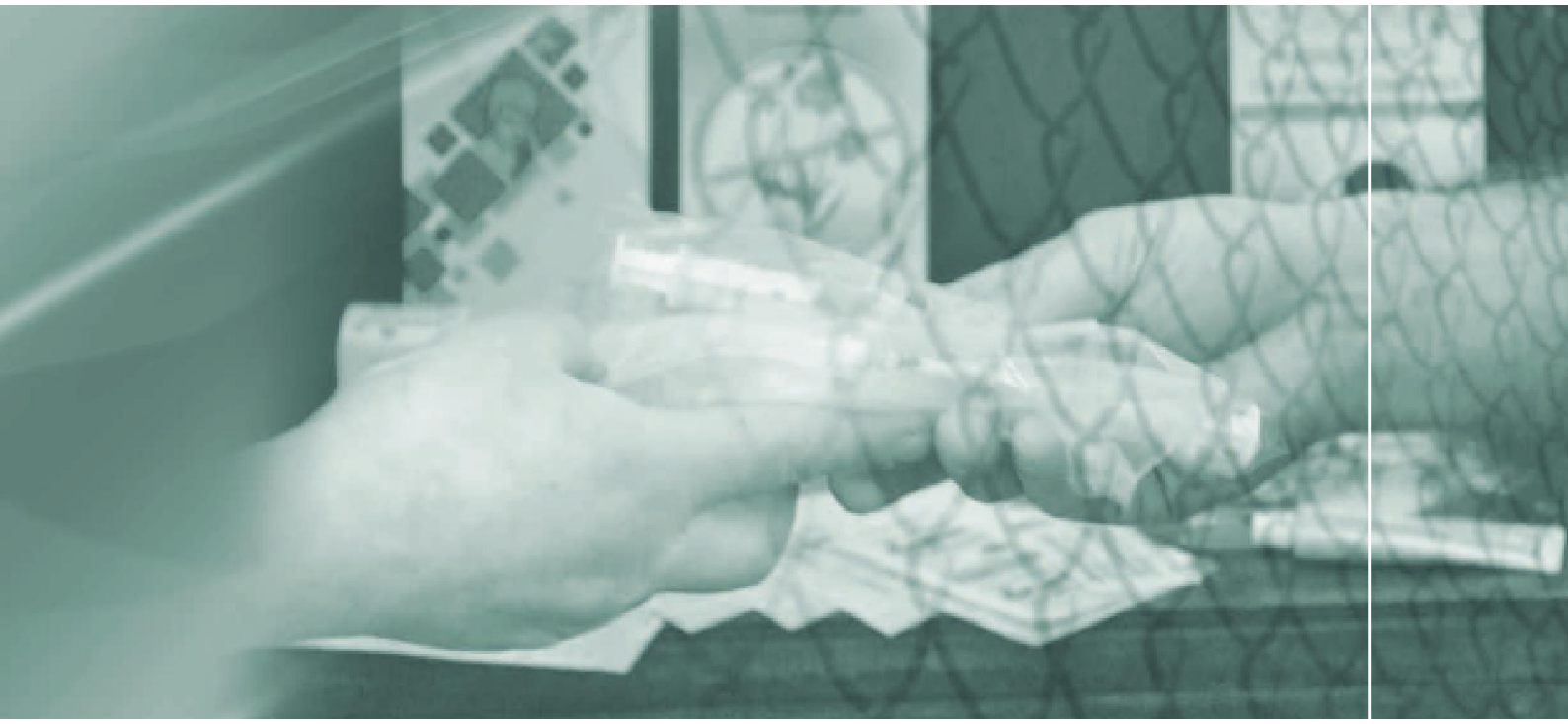
C. Quality assurance

It is important to establish measures to optimise the effectiveness of the programme. Some elements contributing to the quality include:

- Training curriculum and material for both staff and prisoners;
- Establishment of clear guidelines for services providers; for prison staff
- Involvement of external harm reduction services
- Quality check and regular update of all information distributed to the participants

In addition:

1. Hold regular team meetings during which PNSP workers and prison staff identify problems with services or changes in the behaviour of injectors that require improved or different services.
2. Form an advisory group that meets regularly to appraise the PNSP's services, informed by the recommendations of prisoners who inject drugs.
3. Establish and publicize a clear, anonymous complaints procedure for all stakeholders. Forms should be made readily available.
4. Conduct process evaluations as described above *(7)*.



PART V: Useful websites, publications and networks

PART V: USEFUL WEBSITES, PUBLICATIONS AND NETWORKS

A. UNODC, WHO, UNAIDS websites and publications

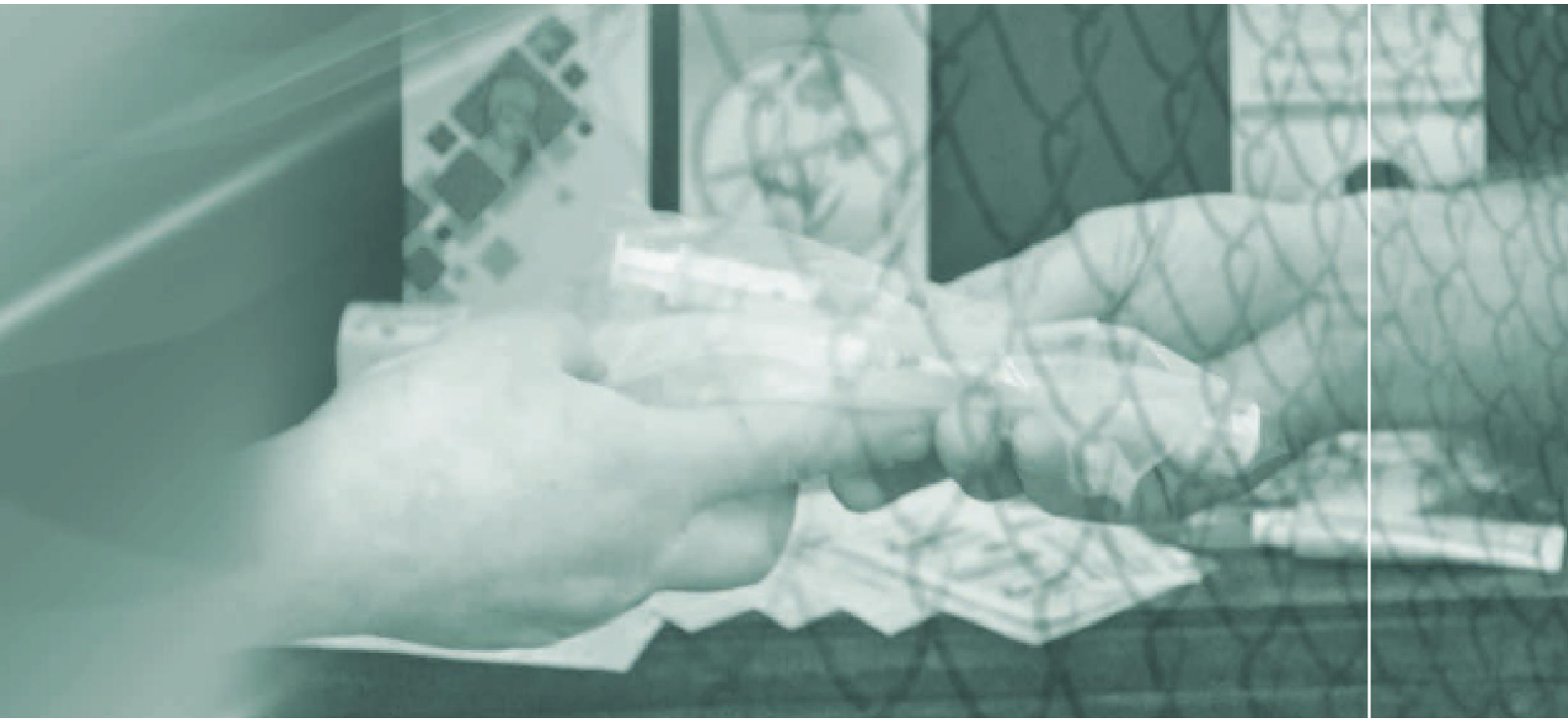
- **United Nations Office on Drugs and Crime** http://www.unodc.org/unodc/en/hiv-aids/new/publications_prisons.html
- **WHO Health in Prisons Programme** http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp
- **UNAIDS, the Joint United Nations Programme on HIV/AIDS:** www.unaids.org/
- **European Monitoring Centre for Drugs & Drug Addiction:** http://www.emcdda.europa.eu/topics/prison

B. Websites on prisons and PNSP

- **Australia**: http://www.atoda.org.au/policy/nsp/
- http://www.afao.org.au/library/hiv-australia/volume-10/vol.-10-number-2/trial-of-needle-syringe-and-programme-announced-for-act-prison)
- **Canada**: www.prisonhealthnow.ca
- **Kyrgyzstan**: http://www.opensocietyfoundations.org/reports/pointing-way-harm-reduction-kyrgyz-republic
- **Moldova**: http://www.unhcr.org/refworld/country,,OSI,,MDA,,4cc57dc72,0.html
- **Switzerland:** Controlling infectious diseases in prisons BIG (official website of FOPH) http://www.bag.admin.ch/hiv_aids/05464/05484/05488/index.html?lang=en

C. Networks

- **African HIV in Prisons Partnership Network** http://www.ahppn.com/home.asp
- **Canadian HIV/AIDS Legal Network** http://www.aidslaw.ca/EN/issues/prisons.htm
- **Eurasian Harm Reduction Network** http://www.harm-reduction.org/
- **Harm Reduction Coalition** http://www.harmreduction.org/article.php?id=418
- **Harm Reduction International** http://www.ihra.net/
- **Observatorio VIH Carceles Latin America Caribbean** http://observatoriovihycarceles.org/en/



ANNEXES

ANNEXES

Annex A. Ministry of the Interior of Spain, Directorate General for Prisons: Memorandum on needle exchange programmes

I 5/2001 SP

Subject: Needle exchange programmes

Scope: HEALTH

Descriptors: HEALTHCARE/ DRUGS/ AIDS

One of the duties of the Prison System is to endeavour to preserve the life, integrity and health of persons deprived of freedom. Therefore, the Prison System must use the utmost efforts to deploy such measures for prevention and health care as may enable it to meet this legal duty.

To that end, the health policy of the Prison System includes strategies recognized as effective in the fields of disease prevention and health promotion and protection. Active drug users are widespread in the prison population; many of them are injecting drug users. Injecting use of toxic substances continues to be the most prevalent variable in HIV infection.

Strategies on drug users in prisons under the authority of the Directorate General for Prisons are implemented through programmes for prevention (information, motivation, health education, etc.), health care (detoxification, recovery in a drug-free module or through outpatient care, with or without pharmacological support) and social reintegration.

The System also implements the methadone maintenance programme, which is now firmly established within the set of strategies known as harm reduction. These programmes aim to minimize the direct pathogenic effect of using toxic substances by introducing variables that are controllable by technical means; the goal is not to change the addictive habit but to preserve the user's life.

In programmes using opiate substitutes, both the substance and the method of administration are under control. Programmes are also initiated to encourage the use of less aggressive methods of administration and to control the devices used. Among the latter, needle exchange programmes are widespread throughout Spain and regarded as very effective in reducing the risk of infection and re-infection with blood-transmitted viruses, such as hepatitis viruses (HBV and HCV) and human immunodeficiency virus (HIV). The strategy is one among others aiming to protect individual and collective health. Its introduction into prisons is a necessity arising from its preventive utility and flowing from the principle of providing healthcare equivalent to that available outside prison.

The actual viability of needle exchange programmes has been tried and tested through pilot initiatives carried out in nine prisons. The earliest such programme has been in operation for four years. Hence it is imperative to extend the strategy so as to ensure uniform availability of healthcare and benefits in all prisons under the authority of this Directorate General.

The programme will be extended gradually, in line with the plan drawn up by the Subdirectorate General for Prison Health, which Unit will notify each prison of the time at which it must initiate the programme. As from that time, in order to facilitate implementation, internal rules will be changed so that it is expressly permitted to possess needles under the terms provided by the official programme, without prejudice to any other extant rules. In addition, the Prison Court is to be advised of the relevant resolutions of the Board of Directors.

Madrid, 7 June 2001: Ángel Yuste Castillejo, Director General for Prisons

Annex B. Anonymous evaluation questionnaire for prisoners

(Source: Spain, Ministry of Interior)

Attitudes and opinions on the PNSP and risk practices for HIV and HCV

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

Name of prison _____ Date completed _____

Q1 Do you know that this prison has a Needle Exchange Programme for people who inject drugs?
- ☐ Yes
- ☐ No

Q2. Have you received enough information about the Programme?
- ☐ No, I haven't received any
- ☐ I have received a little
- ☐ I have received a fair amount
- ☐ Yes, I am well informed

Q3. Do you think consumption of injected drugs has increased with the Programme?
- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q4. Do you think that the number of personal or cell searches has increased with the Programme?
- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q5. Do you think that your cell is being searched more rigorously with the Programme?
- ☐ Same as before
- ☐ A little more
- ☐ Quite a lot more
- ☐ A lot more

Q6. Do you think that prison officers have more control of people who inject with the Programme?
- ☐ Yes, they have more control
- ☐ No, they have the same control
- ☐ No, they have less control

Q7. Do you think that the number of drug use reports has increased with the Programme?
- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

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

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

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

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q10. Do you think that conflictive situations between inmates and health personnel have increased with the Programme?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

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

☐ Yes
☐ No
Why? _____
What do you suggest? _____

Q12. Do you think that the places for needle exchange are the most appropriate?

☐ Yes
☐ No
Why? _____
What do you suggest?_____

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

☐ Yes
☐ No
Why? _____
What do you suggest?_____

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

☐ Unsatisfactorily
☐ Not very satisfactorily
☐ Quite satisfactorily
☐ Very satisfactorily

Q15. What the positive aspects of the programme for you?

_____

Q16. And the negative aspects?

_____

Q17. Do you think it is worthwhile to go ahead with this Programme?

☐ No
☐ Yes
☐ Yes, but making changes
What would you change? _____

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

☐ Yes
☐ No

Q19. What route did you use?

☐ Injected
☐ Smoked
☐ Snorted
☐ Other _____

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

☐ Yes
☐ No

Q21. What route did you use?

☐ Injected
☐ Smoked
☐ Snorted
☐ Other _____

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

☐ I never use it more than once
☐ I sometimes reuse it
☐ Usually 2-3 times
☐ Usually more than 4 times
☐ More than 10 times

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

☐ Never
☐ Occasionally
☐ Often
☐ Always

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

☐ Never
☐ Occasionally
☐ Often
☐ Always

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

☐ Never
☐ Occasionally
☐ Often
☐ Always

Q26. Do you participate in the Needle Exchange Programme?

- ☐ No, I've never used it
- ☐ I've used it very little
- ☐ I use it quite often
- ☐ I use it a lot

Q27. If you are an injecting drug user and do not use the Needle Exchange Programme regularly, what are your reasons for using it? _____

Q28. Some people inject but do not use the Programme. Why do you think they don't use it?
_____

Q29. What do you think could be done so they would use it?
_____

Q30. Did you use a condom in your last sexual relations?

- ☐ Yes
- ☐ No

Q31. SEX

- ☐ Male
- ☐ Female

Q32. AGE (in years)

- ☐ Under 21
- ☐ 21 to 25
- ☐ 26 to 30
- ☐ 31 to 35
- ☐ Over 35

Q33. What is your status in prison?

- ☐ Awaiting trial
- ☐ Convicted

Q34 Is this your first time in prison?

- ☐ Yes
- ☐ No, I've been in prison 2 to 4 times
- ☐ No, I've been in prison more than 4 times

PLEASE MAKE ANY OBSERVATIONS OR COMMENTS BELOW

THANK YOU VERY MUCH FOR YOUR COOPERATION
(This survey is completely anonymous. We are not interested in your name or any other information that could identify you; we are only interested in knowing you opinion about certain aspects related to the programme.)

Annex C. Anonymous evaluation questionnaire for prison staff

(Source: Spain, Ministry of Interior)

Attitudes and opinions on the PNSP and risk perception for HIV and HCV.

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

Name of prison _____ Date completed _____

Q1. Are you concerned that some prisoners may become infected by HIV and/or hepatitis from sharing syringes?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q2. Do you think that drug use has increased in the prison with the Programme?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

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

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q4. Do you think that implementation of the Programme has placed more emphasis on searches?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q5. Do you think that the Needle Exchange Programme has caused demotivation when controlling drugs inside the prison?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q6. In general, do you think that conflictive situations between inmates and prison warders have increased with the Programme?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q7. Do you think that conflictive situations between inmates and health personnel have increased with the Programme?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q8. Do you think the number of accidents during searches has increased with the Programme?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q9. How much do you think the Needle Exchange Programme has changed safety conditions in the prison?

☐ It made them much worse
☐ It made them a little worse
☐ It has made them a little better
☐ It has made them much better
☐ It has not changed them

Q10. Do you consider yourself to be informed about the Needle Exchange Programme currently in use in the prison?

☐ Not at all
☐ A little
☐ Quite a lot
☐ A lot

Q11. Do you think the operating rules of this Programme are appropriate?

☐ Not at all
☐ A little
☐ Quite appropriate
☐ Very appropriate
☐ Not known

Q12. Do you think the current hours for needle exchange the most appropriate for inmates to go when they want?

☐ Yes
☐ No
Why?_____
What do you suggest?_____

Q13. Do you think that the places for needle exchange are the most appropriate for inmates?

☐ Yes
☐ No
Why?_____
What do you suggest?_____

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

☐ Yes
☐ No
Why?_____
What do you suggest?_____

Q15. Do you think that inmates are complying with Programme rules?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q16. From your point of view, do you think that the Programme is running satisfactorily in this prison?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q17. What are the positive aspects for you? _____

P18. And the negative aspects?_____
How would you change the Programme? _____

Q19. SEX

- ☐ Male
- ☐ Female

Q20. AGE (in years)

- ☐ Under 30
- ☐ 30 to 45
- ☐ 46 or older

Q21. What body or group do you belong to?

- ☐ Security
- ☐ Treatment
- ☐ Offices and services
- ☐ Volunteer group

Q22. How long have you been working in prisons?

- ☐ Less than 4 years
- ☐ 4 to 10 years
- ☐ More than 10 years

PLEASE MAKE ANY OBSERVATIONS OR COMMENTS BELOW

THANK YOU VERY MUCH FOR YOUR COOPERATION

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

REFERENCES

REFERENCES

1. Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. Lancet Infectious Diseases. 2009;9:57-66.
2. UNODC, WHO, UNAIDS. HIV/AIDS prevention, care, treatment and support in prison settings. A framework for an effective national response. New York: UNODC; 2006 (www.unodc.org/documents/hiv-aids/HIV-AIDS_prisons_Oct06.pdf, accessed 13 July 2014).
3. Principle 9 of the Basic principles for the treatment of prisoners, United Nations General Assembly. A/RES/45/111, 1990 (http://www.ohchr.org/Documents/ProfessionalInterest/basicprinciples.pdf, accessed 13 July 2014).
4. WHO, UNODC, UNAIDS. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1, accessed 13 July 2014).
5. Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, et al. HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and national coverage. The Lancet. 2010;375(9719):1014-1028.
6. UNODC, ILO, UNDP, WHO, UNAIDS. Policy brief: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna: UNODC; 2013(https://www.unodc.org/unodc/en/hiv-aids/publications.html, accessed 13 July 2014).
7. WHO/UNODC/UNAIDS (2007): Interventions to address HIV in prisons: needle and syringe programmes and decontamination strategies. Evidence for action technical papers. Geneva: World Health Organization. http://www.who.int/hiv/pub/idu/prisons_needle/en/index.html
8. UNAIDS. Global AIDS response progress reporting 2012: guidelines construction of core indicators for monitoring the 2011 Political Declaration on HIV/AIDS. Geneva: UNAIDS; 2011.
9. United Nations General Assembly. General Assembly Resolution 65/277 - Political declaration on HIV/AIDS: intensifying our efforts to eliminate HIV/AIDS. New York: United Nations; 2011.
10. United Nations Economic and Social Council. United Nations Economic and Social Council Resolution E/2009/L.23: Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS); *Adopted 24 July 2009.* New York, United Nations, 2009.
11. Resolution 53/9: Achieving universal access to prevention, treatment, care and support for drug users and people living with or affected by HIV. Vienna, Commission on Narcotic Drugs, 2010.
12. *4th Meeting of the UNAIDS Programme Coordinating Board Geneva, Switzerland 22-24 June 2009: Decisions, recommendations and conclusions.* Geneva, Joint United Nations Programme on HIV/AIDS, 2009.
13. Dolan K, Kite B, Black E, Aceijas C, Stimson G. HIV in prison in low-income and middle-income countries. Lancet Infect Dis. 2007;7:32–41.
14. UNODC. World Drug Report 2014. New York (NY): UNODC; 2014.
15. UNODC/UNAIDS/World Bank. HIV and prisons in sub-Saharan Africa. Opportunities for Action. Vienna: UNODC; 2013 (http://www.unodc.org/documents/hiv-aids/publications/UNODC_UNAIDS_WB_2007_HIV_and_prisons_in_Africa-EN.pdf, accessed 13 July 2014).
16. UNODC/WHO/UNAIDS. HIV in detention: a toolkit for policy makers, prison managers, prison officers and health staff. Vienna: UNODC; 2008.
17. Vescio MF, Longo B, Babduieri S, Starnini G, Carbonara S, Rezza G, et al. Correlates of hepatitis C virus seropositivity in prison inmates: a meta-analysis. J Epidemiol Community Health 2008;62:305–313.
18. Allwright S, Bradley F, Long J, Barry J, Thornton L, Parry JV. Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross sectional survey. BMJ. 2000;321(7253):78–82.

19. Lines R, Jürgens R, Betteridge G, Laticevschi D, Nelles J, Stöver, H. Prison needle exchange: lessons from a comprehensive review of international evidence and experience. Canadian HIV/AIDS Legal Network; 2nd edition; 2006.

20. Boys A, Farrell M, Bebbington P, Brugha T, Coid J, Jenkins R, et al. Drug use and initiation in prison: results from a national prison survey in England and Wales. Addiction. 2002;97(12):1551–60.

21. Bird AG, Gore SM, Hutchinson SJ, Lewis SC, Cameron S, Burns S. Harm reduction measures and injecting inside prison versus mandatory drugs testing: results of a cross sectional anonymous questionnaire survey. BMJ 1997; 315 doi: http://dx.doi.org/10.1136/bmj.315.7099.21.

22. Stöver H et al. Harm reduction in Iranian prisons: integral part of a comprehensive health care approach. Geneva: UNAIDS; 2008.

23. Shewan D, Stöver H, Dolan K. Injecting in prisons. In: Pates R, McBride A, Arnold K (editors). Injecting illicit drugs. Oxford (UK): Blackwell; 2005, pp.69–81.

24. Dolan K, Wodak A, Hall W. HIV risk behaviour and prevention in prison: a bleach programme for inmates in NSW. Drug and Alcohol Review. 1999; 18(2):139–143 HALL

25. Keene J. Drug misuse in prison: views from inside: a qualitative study of prison staff and inmates. The Howard J. 1997; 36(1):28–41.

26. Power KG, Markova I, Rowlands A, McKee AJ, Anslow PJ, Kilfedder C. Intravenous drug use and HIV transmission amongst inmates in Scottish prisons. Br J Addict 1992;87:35-45.

27. Shewan D, Gemmell M, Davies JB. Prison as a modifier of drug using behaviour. Addiction Research 1994;2:203-15.

28. WHO/UNODC/UNAIDS. Evidence for Action series of technical papers and policy briefs (2004–2008) (http://www.who.int/hiv/pub/idu/evidence_for_action/en/index.html, accessed 13 July 2014).

29. Stöver H, Nelles J. Ten years of experience with needle and syringe exchange programmes in European Prisons. Int J Drug Policy. 2003;14(5-6): 437–444.

30. United Nations High Commissioner for Human Rights (1955): Standard Minimum Rules for the Treatment of Prisoners. Adopted by the First United Nations Congress on the Prevention of Crime and Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July and 2076 (LXII) of 13 May 1977.

31. UN standards for the treatment of women prisoners and non-custodial measures for women offenders (2010).

32. WHO. International Statistical Classification of Diseases and Related Health Problems 10th Revision. Geneva: WHO; 2010 (http://apps.who.int/classifications/icd10/browse/2010/en, accessed 13 July 2014).

33. Hedrich D, Alves P, Farrell, M, Stöver H, Möller L, Mayet, S.The effectiveness of opioid maintenance treatment in prison settings: a systematic review. Addiction. 2012;107(3):501–17.

34. WHO, UNODC, UNAIDS. Interventions to address HIV in prisons: drug dependence treatments. Evidence for Action Technical Papers, p.13. Geneva: WHO; 2013 (www.unodc.org/unodc/en/hiv-aids/publications.html, accessed 13 July 2014).

35. Hagan H, Pouget ER, Des Jarlais DC. A systematic review and meta-analysis of interventions to prevent hepatitis C virus infection in people who inject drugs. J Infect Dis. 2011;204(1):74–83. doi: 10.1093/infdis/jir196.

36. Turner K, Hutchinson S, Vickerman P, Hope V, Craine N, Palmateer N, et al.The impact of needle and syringe provision and opiate substitution therapy on the incidence of Hepatitis C virus in injecting drug users: pooling UK evidence. Addiction. 2011;106(11): 1978–1988.

37. Van Den Berg C, Smit C, Van Brussel G, Coutinho R, Prins M. Full participation in harm reduction programmes is associated with decreased risk for human immunodeficiency virus and hepatitis C virus: evidence from the Amsterdam Cohort Studies among drug users. Addiction. 2007;102:454–62.

38. Hoover J, Jürgens R. Harm reduction in prison: the Moldova model. OSI Public Health Programme, 2009.

39. Anex. Inside Information: Prison Needle and Syringe Programme. Melbourne, Australia Protocols, 2009 (http://www.anex.org.au/wp-content/uploads/2011/07/Inside-Information-Prison-Needle-and-Syringe-Program-Protocols.pdf accessed 13 July 2014).

40. Ferrer-Castro V, Crespo-Leiro MR, García-Marcos LS, Pérez-Rivas M, Alonso-Conde A, García-Fernández I, et al. Evaluation of needle exchange program at Pereiro de Aguiar prison (Ourense, Spain): ten years of experience. Rev Esp Sanid Penit. 2012;14(1):3–11 (http://scielo.isciii.es/pdf/sanipe/v14n1/en_02_original1.pdf, accessed 13 July 2014).

41. Crespo R, Codern N, Major XR, Guerrero R, Ayneto X, Muñoz Y, et al. Qualitative evaluation of needle exchange programs in Catalan prisons. Barcelona, Spain: Universitat Autonoma de Barcelona; 2010 (http://hemerotecadrogues.cat/docs/evaluation_pix_cp.pdf, accessed 13 July 2014).

42. Menoyo C, Zulaica D, Parra F. Needle exchange programme at Bilbao Prison, Spain: two years of experience (1992-1999). AIDS conference, Durban, 2000.

43. Wolfe, D. Pointing the way: harm reduction in Kyrgyz Republic. Report commissioned by the Harm Reduction Association of Kyrgyzstan ("Partners' Network", Batma Estebesova, President) with the support of the International Harm Reduction Development Programme OSI NY and Soros Foundation Kyrgyzstan; 2005.

44. Nelles J, Fuhrer A. Prévention du VIH et de la toxicomanie dans les établissements de Hindelbank :rapport succinct des résultats de l'évaluation. Office Fédéral de la Santé Publique, Berne, Suisse ; 1995 (http://mediatheque.lecrips.net/index.php?lvl=notice_display&id=10422, accessed 13 July 2014).

45. Nelles J, Fuhrer A, Hirsbrunner HP, Harding TW. Provision of syringes: the cutting edge of harm reduction in prison? BMJ. 1998;317(7153):270–273.

46. Ryan J. Personal communication; 2013.

47. Ministério da Saúde/IDT Serviços Centrais. Drug-related health policies and services in prison (Portugal). Lisbon; 2012.

48. WHO. Prevention of acute drug-related mortality in prison populations during the immediate post-release period. Geneva: WHO; 2010 (http://www.euro.who.int/__data/assets/pdf_file/0020/114914/E93993.pdf?ua=1, accessed 13 July 2014).

49. Conseil National du Sida. Opinion on Syringe Exchange Programmes in Correctional Facilities. Paris, CNS; 2009 (http://www.cns.sante.fr/spip.php?article310&lang=en, accessed 13 July 2014).

50. ELCS (Elus locaux contre le sida). Lettre ouverte du Président d'ELCS à la MILDT. La réduction des risques ne fait ... plus partie des priorités d'actions [de la Mildt] ; 2009 (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, accessed 13 July 2014).

51. Harm Reduction International. Evidence and Advocacy Briefings Series 01. Advocating for needle and syringe exchange programmes in prisons. London: HRI; 2012 (http://www.ihra.net/contents/1205, accessed 13 July 2013).

52. http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1976

53. WHO. Evidence for Action: Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Geneva: WHO (http://www.unodc.org/documents/hiv-aids/EFA%20effectiveness%20sterile%20needle.pdf, accessed 13 July 2014).

54. Stimson GV, Donoghoe MC, Fitch C, Rhodes TJ, Ball A, Weiler G. Rapid assessment and response technical guide. Geneva: WHO; 2003 (www.who.int/docstore/hiv/Core/Contents.html, accessed 13 July 2014).

55. UNODC, EMCDDA. HIV in prisons: situation and needs assessment toolkit. Vienna: UNODC; 2010 (http://www.unodc.org/documents/hiv-aids/publications/HIV_in_prisons_situation_and_needs_assessment_document.pdf, accessed 13 July 2014).

56. Palmer J. Detoxification in prison. Nurse to Nurse journal; 2003;3(2): 22–23.

57. Palmer J, Wright N. Addressing the health needs of women prisoners. In: Wright N, Marteau D, Palmer J (editors). The offender and drug treatment. Leeds (UK): Wright Publishing; 2009.

58. Ash B. Working with women offenders. London: HM Prison Service; 2002.

59. National Institute for Health and Clinical Excellence, Centre for Public Health Excellence. Review of the public health guidance (PH18): Optimal provision of needle and syringe programmes (NSPs). London: NICE; 2012 (http://www.nice.org.uk/nicemedia/live/12130/59170/59170.pdf, accessed 13 July 2014).

60. Ministerio del Interior/Ministerio de Sanidad y Consumo. Needle Exchange in Prison. Framwork Programme. Madrid: Ministerio del Interior; 2002.

61. Aggleton P, Jenkins P, Malcolm A.HIV/AIDS and injecting drug use: information, education and communication. Int J Drug Policy. 2005;16 (Suppl. 1):S21–S30.

62. Ball A, Weiler G, Beg M, Doupe A. WHO Evidence for action for HIV prevention, treatment and care among injecting drug users. Int J Drug Policy. 2005;16(Suppl. 1):S1–S6.

63. Stöver H, Trautmann F (Editors). Risk reduction for drug users in prisons. 'Encouraging health promotion for drug users within the criminal justice system'. Utrecht (Netherlands): Trimbos; 2001.

64. Ryan J, Voon D, Kirwan A, Levy M, Sutton. Prisons, needles and OHS. J Health Safety and Environment; 2010:26:63–72.

65. Beltrami EM, Williams IT, Shapiro CN, Chamberland ME. Risk and management of blood-borne infections in health care workers.Clin Microbiol Rev. 2000;13(3):385–407.

66. WHO/ILO. Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. Geneva: WHO; 2007 (www.who.int/hiv/pub/guidelines/PEP/en/, accessed 13 July 2014)>

67. Jacob J, Stöver H. The transfer of harm-reduction strategies into prisons: needle exchange programmes in two German prisons. Int J Drug Policy. 2000;11:325–335.

68. Ministry of the Interior; Directorate General for Prisons. Instruction 101/2002 on Criteria of Action in Connection with the Implementation in a Number of Prisons of the Needle Exchange Programme (NEP) for Injecting Drug users (IDUs). Madrid: Ministry of the Interior; 23 August 2002.

69. UNAIDS, WHO. National AIDS programmes: a guide to monitoring and evaluation. Geneva: UNAIDS; 2000 (http://data.unaids.org/Publications/IRC-pub05/jc427-mon_ev-full_en.pdf, accessed 13 July 2014)

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