

Research

Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons

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∞ See related articles pages 252 and 257

It is hardly news that prisoners constitute a specific population likely to be affected by bloodborne pathogens such as HIV and hepatitis C virus (HCV). Over the last 2 decades, a wide range of government and nongovernment experts have highlighted the importance of taking measures to reduce the risks of HIV transmission in Canadian prisons.¹ And over that time, numerous studies have shown that the prevalence of both HIV and HCV infections is drastically higher among prisoners in Canada than in the general population, results that are consistent with findings from other jurisdictions.² Now, 2 new studies reported in this issue of *CMAJ* provide further proof of the need for action.^{3,4} They come at a time when there is little willingness — and even outright opposition — on the part of correctional systems and their political masters to implement evidence-based measures to address this serious public health crisis.

Calzavara and colleagues³ report that, in Ontario in 2003 and 2004, the prevalence of HIV infection was 11 times higher and HCV infection 22 times higher among inmates in selected provincial remand facilities (jails, detention centres and youth centres) than among people in the general population. They estimate that over 1000 HIV-positive and 9200 HCV-positive adults were admitted to Ontario remand facilities during the study period. Poulin and colleagues⁴ report that the prevalence of HIV infection was almost 19 times higher among inmates in selected Quebec provincial prisons than in the general population in 2003, whereas the prevalence of HCV infection was 23 times higher. They estimate that approximately 800 HIV-positive and 4800 HCV-positive people are admitted yearly to these facilities.

Research over many years and from many jurisdictions has demonstrated not only the higher prevalence of both HIV and HCV infections among prisoners, but also the close relation between such infections and injection drug use — a result of the prevalence of HIV and HCV infections among people who inject drugs in the wider community, the widespread incarceration of people who use drugs and high-risk activities within prisons.⁵⁻⁷ The 2 new studies from Ontario and Quebec confirm these links yet again. In the study by Calzavara and colleagues, 30% of the adult offenders in the remand fa-

ilities who participated in the study reported a history of injection drug use, and the prevalence of both HIV and HCV infections was much higher in this group than in the group who reported no such drug use. In the study by Poulin and colleagues, the prevalence of infection was also much higher among the prisoners who reported a history of injection drug use than among the nonusers. In addition, 63% of the male inmates and 50.0% of the female inmates who reported injection drug use while in prison also reported sharing injection equipment. (The data from Poulin and colleagues also confirm that unsafe tattooing practices pose a similar concern: 37.9% of the male inmates and 4.8% of the female inmates reported receiving a tattoo inside prison, and a substantial proportion of them reported that nonsterile equipment had been used. These figures are in the same range as the 45% of prisoners in federal penitentiaries who reported receiving a tattoo in prison in a national survey conducted almost a decade earlier.⁸)

Neither the high prevalence of HIV and HCV infections among prisoners nor its correlation to these risk activities is a surprise, even to correctional authorities. Nor is it any secret what should be done in light of this evidence. In studies conducted outside prison, access to sterile injection equipment has been shown time and again to be one of the most important HIV prevention interventions among people who inject drugs.⁹ As early as 1994, the Expert Committee on AIDS and Prisons, established by Correctional Service Canada, concluded that making sterile injection equipment available in prisons “will be inevitable,” since only this strategy would make it possible for prisoners in federal correctional facilities to avoid sharing their makeshift drug injection equipment.¹⁰

Since that recommendation more than 13 years ago, numerous studies have confirmed the continued use of drugs and sharing of injection equipment in prisons, numerous jurisdictions (e.g., Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Armenia and Scotland) have introduced needle-exchange programs in a variety of prisons, with over-

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whelmingly positive results, and a number of other jurisdictions (e.g., Iran and Ukraine) have taken steps toward introducing them.⁵ Legal experts have argued that prison systems should implement needle-exchange programs as a matter of respecting and protecting the human rights of prisoners, who retain all rights except those necessarily limited as a consequence of incarceration. Clearly, given the experience outside Canada, denying access to health-protecting measures such as sterile syringe programs is not a necessary incident of imprisonment.⁵ Medical experts have also recommended that Canadian prisons implement needle-exchange programs.¹¹ After an exhaustive review, the Public Health Agency of Canada informed Correctional Service Canada last year of evidence from numerous jurisdictions that prison needle-exchange programs decreased needle-sharing practices among prisoners, did not undermine safety and security, and did not lead to increased drug use among prisoners.² United Nations agencies have stressed that prisons should ensure access to the full range of HIV prevention services available in the outside community, including sterile needles and syringes and sterile tattooing equipment.¹²

Yet policy-makers in every jurisdiction in Canada continue to ignore or reject the evidence. Correctional Service Canada itself has recognized that “[t]he primary means of transmission [of HIV and HCV in federal correctional facilities] is through needle-sharing and unsafe tattooing practices.”¹³ In 2006, even though a draft evaluation indicated that ministry’s pilot project on safer tattooing practices “demonstrated potential to reduce harm,” federal Public Safety Minister Stockwell Day shut the program down even before completing and releasing a final evaluation.^{14–16} As for access to sterile injecting equipment, despite the Public Health Agency of Canada’s findings as to the benefits of such programs, the federal government has refused to implement needle-exchange programs in prisons, instead insisting on more of the same unrealistic “zero tolerance” approach to drug use.¹⁵ Meanwhile, no provincial government has responded to the recommendations, repeated by various expert bodies over the years, for the piloting of such health protection measures in prisons.

It is rare that prisoner welfare and prison conditions attract much attention or concern from politicians or the public. Public comment commonly proceeds on the premise, sometimes stated but often assumed, that conviction removes all rights and that prisoners are entitled to little consideration once incarcerated. In addition to being ethically and legally unsound, such a notion makes for poor public health policy: prisoners’ health is also a matter of public health. Prisoners, prison staff, and their family members all benefit from reducing the prevalence and spread of communicable disease in prisons. Most prisoners eventually leave prison, returning to their communities with whatever health problems they may have acquired while incarcerated. In the study by Poulin and colleagues, the high prevalence of HIV and HCV infections, and of risk behaviours, was reported among people in Quebec provincial prisons serving sentences of less than 2 years. The high prevalence of HIV and HCV infections among inmates in Ontario remand facilities, documented by Calzavara and colleagues, is further cause for public health concern:

Key points

- The prevalence of HIV and HCV infections is much higher in prison populations than in the general population.
- A substantial proportion of inmates are injection drug users, many of whom report sharing injection equipment in prison.
- Needle-exchange programs are a proven, effective measure to reduce sharing of drug injection equipment and the associated risk of HIV and HCV transmission. Such programs have been recommended for use in prisons by medical, legal and community-based experts, as well as United Nations agencies.
- Several countries outside Canada have had years of experience with needle-exchange programs in prisons, with positive results.
- No prison system in Canada currently provides access to sterile injection equipment.
- Correctional Service Canada has documented widespread practices of unsafe tattooing in federal prisons. Despite positive results from initial evaluations of the agency’s safer tattooing pilot project, the federal government cancelled the project in December 2006.
- Given the extensive evidence of known risks and successful responses to harm-reduction strategies, denying prisoners access to sterile injection or tattooing equipment infringes their human rights and raises questions about the legal liability of correctional systems.

this is a particularly transient population of people serving short-term sentences of less than 60 days, or awaiting the outcome of legal proceedings or transfer to other provincial or federal institutions to serve longer-term sentences (where there will be further interaction with other captive populations with known high-risk behaviours and inadequate access to HIV and HCV prevention measures). Correctional Service Canada acknowledged, even after Minister Day discontinued the safer tattooing pilot project, that “[because] most offenders eventually return to the community, [Correctional Service Canada] has an obligation to explore all feasible harm reduction strategies and initiatives to address these realities.”¹³ Taking steps to decrease the risk of HIV and HCV transmission makes prisons safer for those who live and work in them, and for the public more broadly.

Investing in the prevention of bloodborne diseases in prisons is also fiscally responsible. Correctional Service Canada has estimated the annual cost of providing HIV treatment for an inmate at \$29 000, and for hepatitis C treatment at \$26 000.¹⁶ Given that the now-discontinued safer tattooing pilot project cost on average \$100 000 annually for each of the 6 sites, the project would have saved money overall if a site were to prevent as few as 4 infections per year. Correctional Service Canada’s own evaluation of the project found that the cost of the safer tattooing project was “low relative to the potential benefits” and that it was “cost-effective if one of every 38 tattoo sessions were to result in an ‘avoided’ HCV infection, or if one of every 50 tattoo sessions resulted in an avoided HIV infection.”¹⁴

In the face of evidence such as that presented in these 2 most recent studies, this deadly disregard for prisoner

health — and, consequently, public health — becomes increasingly indefensible. Yet the mounting evidence of the problem of HIV and HCV in Canadian prisons, and of what can be done to address it, has failed to move government decision-makers to act. If the political will cannot be mustered to implement evidence-based measures to protect the health of those in the state's custody, it may be time to put the evidence of this ongoing denial of human rights before the courts.

Competing interests: None declared.

REFERENCES

1. Jürgens R. *HIV/AIDS in prisons: final report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society; 1996. Available: www.aidslaw.ca/publications/publicationsdocEN.php?ref=181 (accessed 2007 June 26).
2. Public Health Agency of Canada. *Prison needle exchange: review of the evidence*. Ottawa: The Agency; 2006.
3. Calzavara L, Ramuscak N, Burchell A, et al. Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities. *CMAJ* 2007;177:257-61.
4. Poulin C, Alary M, Lambert G, et al. Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons. *CMAJ* 2007;177:252-6.
5. Lines R, Jürgens R, Betteridge G, et al. *Prison needle exchange: lessons from a comprehensive review of international evidence and experience*. 2nd ed. Toronto: Canadian HIV/AIDS Legal Network; 2006. Available: www.aidslaw.ca/publications/publicationsdocEN.php?ref=184 (accessed 2007 June 26).
6. Correctional Service Canada (CSC). *Infectious diseases prevention and control in Canadian federal penitentiaries 2000-01: a report of the Correctional Service of Canada's Infectious Diseases Surveillance System*. Ottawa: CSC; 2003. Available: www.csc-ccc.gc.ca/text/pblct/infectiousdiseases/en.pdf (accessed 2007 June 26).

7. Skoretz S, Zaniewski G, Goedhuis NJ. Hepatitis C virus transmission in the prison/inmate population. *Can Commun Dis Rep* 2004;30:141-8.
8. Robinson D, Mirabelli L. *Summary of findings of the 1995 CSC national inmate survey*. Ottawa: Correctional Service Canada; 1996. Available: www.csc-ccc.gc.ca/text/rsrch/briefs/b14/toce_e.shtml (accessed 2007 June 26).
9. World Health Organization. *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users* [Evidence for Action technical papers]. Geneva: The Organization; 2004. Available: www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf (accessed 2007 June 26).
10. Correctional Service Canada. *HIV/AIDS in prisons: final report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada; 1994.
11. Ontario Medical Association. *Improving our health: Why is Canada lagging behind in establishing needle exchange programs in prisons?* Toronto: The Association; 2004. Available: www.oma.org/phealth/omanep.pdf (accessed 2007 June 26).
12. United Nations Office on Drugs and Crime; Joint United Nations Programme on HIV/AIDS, World Health Organization. *HIV/AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response*. New York: United Nations; 2006. Available: www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf (accessed 2007 June 26).
13. Correctional Service Canada (CSC). Safer Tattooing Pilot: questions & answers. Ottawa: CSC [obtained by the author in 2006 through an access-to-information request].
14. Correctional Service Canada (CSC). Draft evaluation report: Correctional Service Canada's Safer Tattooing Practices Pilot Initiative. Ottawa: CSC [obtained by the author in 2006 through an access-to-information request].
15. Kondro W. Conservative government scuttles needle exchange. *CMAJ* 2007;176:308.
16. Kondro W. Prison tattoo program wasn't given enough time. *CMAJ* 2007;176:307.
17. *Hepatitis C as a roadmap for integrated communicable disease prevention and control: a strategy for the renewal of the Health Canada/Canadian Institutes of Health Research (CIHR) Research Initiative on Hepatitis C*. Ottawa: Joint Advisory Committee of the Health Canada/CIHR Research Initiative on Hepatitis C; 2005.

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