

## CHAPTER 2

# POLICY OPTIONS

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The issue of HIV/AIDS in prisons has become an important topic world-wide, both in countries where HIV prevalence is minimal as well as where the impact of HIV is much more severe. In March 1993, the World Health Organisation (WHO) distributed guidelines on HIV infection and AIDS in prison. The guidelines covered HIV testing, preventive measures, management and care of HIV-infected prisoners, confidentiality, tuberculosis, and early release policies. The general principle advocated by the WHO is that of the 'equivalence principle':

All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality. The general principles adopted by a national AIDS programme should apply equally to prisoners and to the community.<sup>134</sup>

The WHO guidelines were publicly supported and endorsed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in a statement issued in April 1996. The UNAIDS statement explained that ignorance and lack of government support in addressing HIV/AIDS in prison has led to denial, ineffective policies, violence and discrimination.<sup>135</sup> Many different policy options have been explored in response to HIV/AIDS in prison with varying results in different countries and contexts. However, an international consensus confirmed by the WHO and UNAIDS has declared that some of the more popular policies are not only ineffective but unnecessary and unjustified. The policies which have been condemned by international bodies include mandatory testing, and segregation. Other policies employed in various prison systems include education, condoms, disinfectant and sterilised needles, and general penal reform.

### **Mandatory testing**

The primary goal of most policies regarding prisoners with HIV is to prevent transmission either to inmates or prison staff. The most severe policy com-

bines mandatory mass testing and isolation of HIV positive inmates. Testing for HIV is not entirely straightforward, and complicates the effectiveness of this policy. There is no such thing as an AIDS test, rather a person is tested for the antibodies which the body develops in response to HIV.

The most commonly used test in South Africa is the enzyme-linked immunosorbent assay (ELISA) test. The immunofluorescent antibody test, IFA or Western Blot, is also used although it is usually more expensive and less sensitive. No single test is 100% accurate. Researchers at the Medical Research Council use a combination of three ELISA tests, each with a varying degree of sensitivity, to weed out false positives and guarantee more accurate results. Further complicating the matter is the fact that sometimes the body does not develop enough HIV antibodies to be detected by a test for up to three months after infection. The result is that if all prisoners are tested upon admission to the prison, they must be tested again three months later to be assured of the reliability of the results.

Assuming the resources were available for multiple testing, both upon entrance and three months later, the concept of involuntary testing runs into many legal and ethical roadblocks. The WHO stresses that a prerequisite for any medical intervention is the informed consent of the patient. This doctrine of informed consent does not apply in circumstances where the general health of society are at stake. This is the case with a mass immunisation programme intended to contain a contagious disease, such as small pox, or standard testing in health facilities for highly contagious diseases, such as TB.

The notable difference between HIV and either small pox or TB is that HIV is not a contagious condition with the potential to infect unprotected citizens. HIV is not transmitted through casual contact, or by a person simply functioning in the community. In fact, not one study has found a case in which AIDS was transmitted, "through ordinary nonsexual contact in a family, work, or social setting."<sup>136</sup> Furthermore, the effects of mandatory testing can have far-reaching impacts on the lives of prisoners after release, as they can potentially suffer from insurance or employment discrimination. For these reasons, HIV cannot be compared to TB or other curable medical conditions when discussing the ethics versus necessity of mandatory HIV testing.

Detecting HIV as early as possible is the most cost-beneficial means of providing treatment in prisons. The premise behind this argument is that it is cheaper to prevent HIV from developing into AIDS than it is to care for prisoners with full-blown AIDS.<sup>137</sup> However, this argument only holds if prisoners

who test positive for HIV will receive treatment that can delay the onset of AIDS. Treatment of opportunistic infections does not delay the progression of HIV. Rather, ARV therapy and a high-protein diet can accomplish this feat for many HIV positive patients. Unless a standard of care can be provided to prisoners that will delay the development of AIDS, one cannot use the argument for early detection in support of a mandatory testing policy.

Proponents of mandatory mass testing argue that determining exactly how many prisoners, and specifically which ones, are HIV positive will enable correctional services to improve care, target education programmes, gather information on transmission, provide special supervision, and plan and budget effectively for HIV-related programmes and policies.<sup>138</sup>

A further argument employed to support mandatory testing is that voluntary testing will be ineffective, as a good portion of inmates will not agree to participate. A survey conducted in the US revealed that 85% of inmates would consent to a voluntary HIV test, and 66% would voluntarily attend counselling or education programmes.<sup>139</sup> This argument does not take into account the effectiveness of statistical sampling techniques to determine HIV prevalence of a specific population. Academic studies to determine HIV prevalence frequently rely on randomly selected voluntary participation, often with a sample size which consists of only 10% of the prisoners at a given correctional facility. Assuming that the prison administration legitimately wishes and is able to provide additional services and care for HIV positive prisoners, a sample size which covers 85% of the population would be more than adequate to make projections for budget and programme planning purposes.

## Segregation

Whether testing is mandatory or voluntary, the issue of confidentiality is important. In some instances, a prisoner's HIV status is disclosed discreetly to prison officials on a 'need to know' basis, and in more extreme situations, prisoner cells or files are clearly marked so that anyone who cared to know would be aware of their HIV status. Maintaining confidentiality of a prisoner's HIV status is important because of the social stigma associated with the disease. In an independent report issued on the British prison system, the importance of confidentiality was underlined, with the understanding that, "HIV prisoners must not and need not become the pariahs of the prison system".<sup>140</sup>

Issues of confidentiality are usually not considered by those proponents of mandatory testing who also argue for the isolation or segregation of HIV positive prisoners. The intention is that by identifying and separating HIV positive prisoners, the prison will be able to provide increased health monitoring, additional surveillance of high risk behaviour, elimination of transmission within prison, and protection from discrimination or violence from other inmates.<sup>141</sup> There is a very real concern that not segregating HIV positive inmates will lead to increased prison violence, in that HIV prisoners will threaten cell mates with infection and other prisoners will target HIV inmates for abuse. In this respect, segregation is for the seropositive inmate's protection as much as it is for the protection of the general prison population.

Some countries report considerable success with HIV segregation programmes. In Poland, prisoners with HIV were held on a separate, less crowded floor and allowed access to more facilities, such as additional health care staff and recreational activities. The general atmosphere was one of support and specialised care, as opposed to the discrimination and insults endured in the rest of the prison. In Polish institutions where segregation was not initiated, prisoners refused to share eating or toilet facilities, or even shake hands with HIV positive prisoners. In some cases, medical doctors would refuse assistance and encourage protest from the staff against the non-segregation policy.<sup>142</sup>

The risk for abuse in a segregated system is great, as it is conceivable that HIV positive inmates held in a separate facility would be denied access to the same health, training, and educational services that are available to the rest of the prisoners. For this reason, proponents of segregation have cautioned that segregation, "not be used a method of punishment or as a means of reduction of care for inmates."<sup>143</sup> Rather, the idea is that appropriately implemented segregation can have beneficial effects for all prisoners, whether HIV positive or not. The argument is that "it is the negative implementation of these programmes, not the concept of segregation itself, that has prevented the success of segregation."<sup>144</sup> On the other hand, the lessons of history have shown us that regardless of the noblest intentions of any segregation policy, the reality is that 'separate but equal' simply does not exist.

Segregation of HIV positive prisoners is a declining practice in most countries. WHO guidelines explain that:

Since segregation, isolation, and restrictions on occupational activities, sports, and recreation are not considered useful or relevant in the

case of HIV negative infected people in the community, the same attitude should be adopted towards HIV-infected prisoners.<sup>145</sup>

Segregation is no longer accepted as a sensible strategy because it contributes to the stigmatisation of HIV positive people and presents numerous logistical problems.<sup>146</sup> Opponents of segregation point out that even assuming equal treatment was maintained, the result is a costly duplication of services which is neither medically necessary nor reliably effective.

Although the philosophical arguments against segregation of HIV positive prisoners are sound, the most convincing argument is based on medical facts. As discussed previously, the 'window period' means that when a person first becomes infected with HIV, he or she may test negative for HIV for approximately three months. The duration of this window period varies by person and is impossible to predict. To accommodate this reality, prisoners would have to be tested upon entrance and those who test negative would then have to be isolated in an 'undetermined status' section for the first three months of their incarceration. They would then have to be tested again after three months, and moved to either the 'HIV' or 'non-HIV' sections of the prison according to their status. This means that recently-infected and non-HIV infected prisoners could be confined together in the 'undetermined status' section for the first three months.

The counter argument is that the number of recently-infected prisoners who were in the window period upon entering the prison would be much less than the number of prisoners who were already HIV positive and so the policy would still substantially reduce the risk of transmission. The rationale is that it is better to only have a few who were recently infected held in common with others for a little while, than to have all the HIV positive prisoners intermixed with all the other prisoners for the duration of incarceration.

This does not take into account that research has determined that the viral load of an HIV positive person peaks in the first few weeks after transmission, when the virus is still undetectable because the body has not yet produced the antibodies which are detected by an HIV test.<sup>147</sup> Once the body begins to fight the virus by producing sufficient antibodies, the viral load declines dramatically and then only slowly creeps upwards over the next several years. It is at this point that a person tests positive for HIV because the test is able to detect the presence of HIV antibodies in the person's blood, urine, or saliva.

The probability of HIV transmission is related to a number of factors, including viral load. If a person has a high viral load, the probability of that person

transmitting HIV is also high.<sup>148</sup> Thus, during the window period when viral load is very high, a recently infected HIV positive prisoner has a much greater probability of transmitting the virus. Add on to this the fact that many prisoners in the 'undetermined status' will have a false sense of security owing to the fact that all of them have tested negative upon entry to the prison and the known positives have already been segregated. The result is the potential that every single HIV negative prisoner could be confined for three months with HIV positive prisoners who have a higher probability of transmitting the virus than a good portion of those who have already tested positive for HIV. Clearly, this would negate the intended benefits of this policy and could possibly be counter-productive.

## Education

Both sides of the debate on segregation agree that education is one of the most important ingredients of an effective HIV/AIDS in prison policy. However, HIV/AIDS education in the prison environment presents specific challenges which are unlike those for the general population. The personality profile of many prisoners often includes a deep-seated suspicion of anything 'official' or government related, which can negate the efforts of programmes which enjoyed significant success in the general community.<sup>149</sup>

In addition, mass education programmes have not proven effective at changing behaviour because they are not presented in the context of specific lifestyles. The prisoners perceive them as irrelevant and will not relate the information to their own lives.<sup>150</sup> Scare tactics have also proven ineffective, and may possibly be counterproductive to the extent that they elicit a denial response.<sup>151</sup> Also, prisoners in South Africa are normally members of the lower socio-economic strata, and have had very little formal education.<sup>152</sup> Education materials must cater to the wide diversity of languages spoken in prisons, and need also take into account the low literacy rate of the prison population.

The unfortunate truth is that an increase in HIV/AIDS related knowledge is not always translated into altering or reducing high risk behaviour.<sup>153</sup> HIV/AIDS information needs to be specifically targeted, and take into account the common characteristics or lifestyles that put prisoners at risk for HIV. The influence of peer groups has proven to be essential in any successful intervention strategy as the credibility of the communicator has a significant impact on the capacity of the message to engender behavioural change. This credibility should be determined within the context of the prison population, because

what might be valued by the average citizen outside of the prison is not the same as that appreciated by the average prisoner.<sup>154</sup>

The general consensus regarding peer education is that, “accepted norms of the target group play a larger part in influencing behaviour than does outside intervention by authorities or health educators.”<sup>155</sup>

A study in Scotland attempted to determine the effectiveness of two different HIV/AIDS education programmes, one designed by prisoners and one designed by the state. The study found that a video followed by a group discussion was the most effective means of conveying information about HIV/AIDS to prisoners. Two videos were shown in the study. One, “AIDS: A Bad Way to Die”, was put together by prisoners at Sing Sing prison in New York City and the other was produced by the British government. The prisoners in the survey responded significantly better to the New York video, which featured three actual prisoners who spoke about how they contracted HIV, how it affected their lives and their families, and also discussed their symptoms.

In addition to the prisoners’ stories, the video showed medical experts who discussed transmission precautions and also emphasised that HIV cannot be transmitted by casual contact. The video concluded with each of the three prisoners’ death from AIDS. In the discussion groups which followed, prisoners filled out questionnaires to assess the impact of the video. The study found that of the prisoners who watched the New York video, more than 90% responded that they would stop sharing or would try to sterilise injection equipment and the same percentage also claimed that they would use condoms.<sup>156</sup>

## Condoms

A policy to distribute condoms in prison is often very controversial because government officials do not wish to discuss homosexual activity in prisons, and a good portion deny that any such activity takes place at all. If sex is thought a taboo subject even in a modern democracy, homosexual activity is even more often considered not a topic fit for parliamentary debate. In some countries, condoms are not available in prison because top prison officials either refuse to acknowledge that homosexual activity takes place or have set regulations which forbid such activity in their correctional facilities. The argument is then that condom distribution would compromise the authority and security of the prison because it implicitly condones an activity which is prohibited.

However, this is a relatively minor obstacle compared to the significant number of countries which outlaw homosexual activity in the general population. In Malawi's prisons, where HIV prevalence and the incidence of homosexual activity are both high, condoms are not available. Any attempts to introduce a condom distribution policy must first deal with the fact that homosexual activity is illegal in Malawi. Described as an "unnatural offence" in the Malawi Penal Code, conviction results in a prison sentence of 14 years.<sup>157</sup>

One reason that prison officials may not be willing to admit that sex takes place in prison is because then they would be forced to address the increased risk of HIV transmission created by the unprotected sexual activities of inmates. With the understanding that many prisoners are not willing to disclose their participation in homosexual activities, the policy recommended by UNAIDS is to provide "discreet and easy access to condoms."<sup>158</sup>

Because sex in prison is primarily anal sex between men, it is also important to make lubricant available. One reason that receptive anal intercourse carries the highest probability of HIV transmission is because of the attendant tearing in the rectum.<sup>159</sup> Not only can this tearing be reduced by using lubrication, but the likelihood that a condom will break during anal intercourse is also reduced by the presence of appropriate lubrication. In France, condoms and lubricant are available, and are placed "in open containers in reception, the health care centre, and other locations where potential users...have the opportunity to take them unobserved."<sup>160</sup>

## **Disinfectants and sterilised needles**

Use of contaminated cutting or piercing instruments has been shown to be a high risk behaviour for transmitting HIV in prisons, particularly in the case of sharing needles for IV drug use. Distributing sterilisation tablets, or bleach, to prisoners is a policy that is gaining popularity in countries where IV drug use is a primary means of transmission.

At Hindlebank women's prison in Switzerland, a one year experimental project provided sterile needles to the 100 inmates, most of whom were convicted of drug offences. The sterile needles were available from dispensing machines in accessible locations, such as toilets, showers and storage areas. Prisoners were not permitted to keep more than one needle and were required to store their injecting equipment in a designated cabinet. An evaluation of the project found that there were no new cases of HIV, prisoner

health had improved, needle-sharing decreased, drug use remained stable, and there were no instances of needles being used as weapons. At the end of the year, the project was considered a success and was continued.<sup>161</sup>

Rather than provide sterile needles, a more popular approach to the problem of shared IV drug use equipment is to provide sterilisation materials for the inmates. This policy meets with similar arguments as the condom distribution policy, citing the principle that providing bleach or other disinfectants implies approval of illegal or prohibited activities. Nonetheless, an increasing number of prison systems are introducing bleach distribution programmes. In Spain, a bottle of bleach is provided to each prisoner upon entry into prison and each month thereafter, in addition to being available as needed. Other countries which distribute bleach to a similar extent include Australia, Belgium, Canada, France, Germany, the Netherlands, and Luxembourg.<sup>162</sup>

The arguments against providing disinfectant materials for prisoners are that it is not necessary or that the disinfectant will be used as a weapon or in some other manner that would constitute a threat to security. After a bleach distribution pilot project in Canada, an evaluation questionnaire found that 99% of respondents felt that having bleach available to inmates is “very important” and all but one injecting drug user responded that they would use bleach to sterilise injecting equipment.<sup>163</sup> According to Ralf Jürgens of the Canadian HIV/AIDS Legal Network, “There are no reported incidents of any negative consequences of making bleach available. This is consistent with the Canadian experience.”<sup>164</sup>

## **HIV treatment**

The recommended treatment for HIV is anti-retroviral (ARV) therapy. This is a combination of several drugs, which usually must be taken at different times with various specific directions as to accompaniment with meals or fluids and other such requirements. ARV treatment is complicated and expensive, and the prison environment poses serious challenges to its effectiveness. The administration of the complicated treatment regime is usually the realm of specialists, and not something a typical prison health facility is able to provide. In addition, the lack of privacy intrinsic to any prison situation means that a prisoner undergoing ARV treatment will have difficulty concealing his or her HIV status from prison officials or other prisoners.

ARV treatment is not available from state hospitals in South Africa. Although the drama is currently unfolding as the South African government is pressured

to roll out a national treatment plan including the use of lower cost generic drugs, it is still not likely that these will be made universally available to the extent that access would be extended to prisoners in the near future.

Some of the arguments in favor of a national treatment plan include the premise that providing treatment will help to reduce transmission, and that targeted education accompanied by political leadership and a multi-level multi-sectoral commitment will reduce if not eliminate concerns about regimen adherence. The prisons are an excellent opportunity to apply these recommendations with maximum effect. If ARV is extended to the general community, but not to prisoners, then the effectiveness of any universal treatment plan will be gravely endangered.

In the absence of ARV therapy, the recommended treatment for HIV positive individuals is “symptomatic management” of the disease.<sup>165</sup> This usually requires treating and preventing the more common opportunistic infections associated with HIV, namely pneumonia and TB. Both of these illnesses can be cheaply treated and even prevented. Prison hospitals normally administer INH and Bactrim for HIV positive patients, but their supplies are sometimes changed and interrupted as a result of unreliable distribution services.<sup>166</sup>

Consistent and continued doses as part of the prescription programme for TB is extremely important because non-adherence to the treatment regime can result in treatment resistance. Those who develop a treatment resistant strain of TB can infect others, who will then also not be cured by the usual drug treatments. Multi-drug resistant tuberculosis (MDRTB) is much more difficult to cure, the required medicines are more expensive and have deleterious side effects. MDRTB can result in death if treatment is not available.<sup>167</sup> For these reasons, it is critical that prison administrations implement appropriate policies to ensure that TB medicine is both consistently and readily available and that sufficient health staff are on hand to ensure treatment adherence.

## Early release

WHO guidelines advocate early release of prisoners in the advanced stages of AIDS. The motivation behind a policy of early release is to allow a person to die in dignity, either in their own home or with their family, rather than forcing them to die isolated and alone in prison.

Italian law prevents anyone with overt AIDS from being held in prison custody. The definition of ‘overt AIDS’ is clinically established as a patient whose

number of T/CD4+ lymphocytes are equal to or lower than 100/mmc. To determine this, the prisoner is administered two consecutive tests, 15 days apart.<sup>168</sup> Other alternatives suggest that prisoners with AIDS be released from prison but held under house arrest, admitted to a public health institution, or that the sentence be remitted indefinitely.

There are some unintended consequences of establishing an early release programme for prison inmates with AIDS. In Poland, a policy was adopted very early on which allowed AIDS prisoners to be released and transferred to an open hospital. The unfortunate result was that prisoners began to buy infected blood from HIV positive prisoners in the hope of getting released.<sup>169</sup> A particularly disturbing report describes a prisoner who traded a pack of cigarettes and some tea for an inch of HIV positive blood. When he couldn't find a vein with the borrowed syringe, he was worried he wouldn't become infected and so he asked for another inch of infected blood in order to be sure. His actions were encouraged by an HIV positive inmate who assured him that HIV positive status was a guaranteed way to be released from prison.<sup>170</sup>