INTRODUCTION

HIV hit prisons early and hit them hard. The rates of HIV infection among prisoners in many countries are significantly higher than those in the general population. HCV seroprevalence rates are even higher. While most of the prisoners living with HIV in prison contract their infection outside prison before imprisonment, the risk of being infected in prison, in particular through sharing of contaminated injecting equipment and through unprotected sex, is great. Studies from around the world show that sexual activity, including rape and other forms of sexual violence, occur in prisons and result in transmission of HIV and other STIs.

The importance of implementing HIV interventions in prisons was recognized early in the epidemic. As early as 1993, WHO, in its Guidelines on HIV Infection and AIDS in Prisons, recommended that condoms be made available to prisoners throughout their period of detention" and "prior to any form of leave or release" (page 20). The same recommendation was made by UNAIDS (1997a; 1997b) and in joint documents issues by WHO, UNAIDS, and UNODC (WHO, UNAIDS, UNODC, 2004; UNODC, 2006). Provision of female condoms and dental dams4 to female prisoners has also been recommended (Correctional Service of Canada, 1994; UNODC, 2007).

As early as 1991, a WHO study found that 23 of 52 prison systems surveyed provided condoms to prisoners (Harding & Schaller, 1992). By August 2001, 18 of the 23 prison systems in the pre-expansion European Union were making condoms available (Stöver et al., 2001). Today, many prison systems in other parts of the world, including in Canada, Australia, parts of the former Soviet Union, Brazil, South Africa, the Islamic Republic of Iran and Indonesia, also make condoms available to prisoners. In the United States, condoms are available only to the prisoners in a few jail and prison systems (Braithwaite, Hammett, & Mayberry, 1996), constituting less than 1% of all correctional facilities in the United States.

Research has shown that even where condoms, in theory, are available to prisoners, in reality they are often not accessible.

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In prison settings, obstacles to condom distribution include opposition to male-to-male sex from prison officers and authorities (Dolan, Wodak, Penny, 1995), and is based on a combination of factors including Dental dams are small, thin, square pieces of latex that are used for oral-vaginal or oral-anal sex. They get their name from their use in dental procedures. cultural objections, workload, institutional prohibition of sexual activity, and security concerns (May and Williams, 2002; Cregan, Kippax, Crawford, 1996). Critics of condom distribution to prisoners have argued that the provision will lead to an increase in both consensual and non-consensual sexual activity among prisoners. Specifically, some prison officials contend that providing condoms would send a mixed message and be interpreted as condoning sexual relations (Okie, 2007; Spaulding, Ballard Lubelczyk & Flanigan, 2001). Another rationale often given is that condoms filled with drugs could be swallowed and used as vehicles to move drugs behind bars (Cregan, Kippax, Crawford, 1996). However, there are no similar prohibitions against plastic storage bags, which could also be used to hide contraband (Spaulding, Ballard Lubelczyk & Flanigan, 2001). Finally, there are also worries that condoms would be used as weapons against prison staff.

Evidence from community settings

Prevention is the mainstay of the response to HIV/AIDS and condoms are an integral and essential part of comprehensive prevention and care programmes (WHO, UNAIDS, UNFPA, 2004). In the late 1990s, however, questions were raised about the effectiveness of condoms as a means to prevent sexually transmitted infections (STIs), including HIV. An extensive review of all available studies was conducted by a panel convened by the US National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) in June 2000 in the United States, with the participation of WHO. The review concluded that:

- The consistent use of male latex condoms significantly reduces the risk of HIV infection in men and women and of gonorrhoea in men.
- Laboratory studies have established the impermeability of male latex condoms to infectious agents contained in genital secretions, including the smallest viruses.
- Male condoms may be less effective in protecting against those STIs that are transmitted by skin-to-skin contact, since the infected areas may not be covered by the condom.

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In Thailand, the promotion by the government of 100% condom use by commercial sex workers led to a dramatic increase in the use of condoms (from 14% in 1990 to 94% in 1994), an equally dramatic decline in the nation-wide numbers of bacterial STD cases (from 410,406 cases in 1997 to 27,362 cases in 1994), and reduced HIV prevalence in Thai soldiers (Hanenberg et al. 1994; Nelson et al. 1996).

The most convincing data on the effectiveness of condoms in preventing HIV infection has been generated by prospective studies undertaken on serodiscordant couples, when one partner is infected with HIV and the other is not. These studies show that, with consistent condom use, the HIV infection rate among uninfected partners was less than 1% per year (de Vincenzi, 1994).

In 2004, in a joint position statement on condoms and HIV prevention, WHO, UNAIDS, and UNFPA concluded that "the male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted diseases" (WHO, UNAIDS, UNFPA, 2004). Water-based lubricants reduce the probability of condom breakage and/or rectal tearing, both of which contribute to the risk of HIV transmission (Schoub, 1995).

Dental dams reduce the risk of STI transmission during oral sex by acting as a barrier to vaginal and anal secretions that contain bacteria and viruses (Centers for Disease Control and Prevention).

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