ELEMENTS OF PRISON NEEDLE SYRINGE PROGRAMMES

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).
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.

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HAND-TO-HAND DISTRIBUTION BY PRISON NURSE AND/OR DOCTORS	
ADVANTAGES	**DISADVANTAGES**
Allows for personal contact with prisoners and an opportunity for counselling	Limited anonymity and confidentiality may reduce the participation rate
Can facilitate outreach to and contact with drug users	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).
Prison maintains high degree of control over access to syringes	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
One-for-one exchange or multiple syringe distribution possible.	

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-forone 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

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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.

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HAND-TO-HAND PROVISON BY TRAINED PEER OUTREACH WORKERS (VOLUNTEETS)	
ADVANTAGES	**DISADVANTAGES**
High level of acceptance by prisoners	No direct staff control over provision and no formal monitoring system, which can lead to increased fears about workplace safety among staff
High degree of anonymity and trust, with lower fear of disclosure to prison authorities	Volunteers might blackmail other prisoners by disclosing information about their participation.
High degree of accessibility (peer outreach workers live in the prison units and are available at all hours)	Volunteers might sell syringes and injection equipment to other prisoners
Easy access to a wide range of harm reduction materials (condoms, paraphernalia, etc.)	Selected prisoners might not provide reliable services to fellow prisoners (e.g., by demanding other goods or services in return)
Prisoner in charge of the PNSP can also provide information and deliver peer harm prevention and health promotion advice to other prisoners	High turnover of prisoners and need for continuous training
Can include peer-based overdose prevention, including access to naloxone	

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-topeer 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.

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HAND-TO-HAND PROVISON BY EXTERNAL NGOs OR HEALTH-CARE PROFESSIONALS NOT EMPLOYED BY PRISON ADMINISTRATION	
ADVANTAGES	**DISADVANTAGES**
Provides a higher degree of confidentially.	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).
Personal contact with prisoners and an opportunity for counselling.	Anonymity and confidentiality may be compromised by policies that require the external agency to provide information to the prison on prisoners' participation
Facilitates outreach to and contact with previously unknow drug users.	Potential that prison staff may mistrust the external organization providing syringes.
Prison can maintain a high degree of control over access to syringes.	External workers may experience more barriers in dealing with the prison bureaucracy then internal prison health staff.
One-for-one exchange or multiple syringe provision are possible .	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.
Can facilitate continuity of care when prisoners are released.	

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

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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.

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.

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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)	Machines are vulnerable to vandalism by prisoners or sabotage by staff who are not in favour of the programme.
High degree of anonymity, as there is no involvement with staff	Technical problems with functioning of the dispensing machines can make syringes unavailable for periods of time
High acceptance by prisoners	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)
Strict one-for-one exchange (which could be seen as a disadvantage as well)	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. All prisoners are offered dummy syringes at the start of the programme, and new prisoners are offered dummy syringes upon entering the prison. The dummy syringe or the used syringe is inserted in the machine, which gives a new sterile syringe in exchange.

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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. 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.

- **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.
- **PNSP should be equitable, non-discriminatory and non-stigmatizing**: PNSP are health interventions. There should 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.
- **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.

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- **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.
- **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.
- **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.
- **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. 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.

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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.

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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 in this course.

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