

BETWEEN:

John SHELLEY

Applicant

- and -

THE UNITED KINGDOM

Respondent Government

SUBMISSIONS OF THE INTERVENORS
the IRISH PENAL REFORM TRUST and the CANADIAN HIV/AIDS LEGAL NETWORK

INTRODUCTION

1. The Irish Penal Reform Trust (“IPRT”) is Ireland’s leading non-governmental organization campaigning for the rights of people in prison and the progressive reform of Irish penal policy. The Canadian HIV/AIDS Legal Network (“Legal Network”) is one of the world’s leading advocacy and policy organizations working on the legal and human rights issues raised by HIV/AIDS. Each organization has a long history of legal and policy research and analysis, both in our respective countries and internationally, and has particular expertise on legal and human rights issues related to HIV/AIDS in prisons. Both are NGOs in Special Consultative Status with the Economic and Social Council of the United Nations.
2. We respectfully submit that prison needle exchange programmes (“PNEPs”)¹ protect and promote public health and are necessary to respect, protect and fulfill the human rights of prisoners as established under international law, including the *Convention for the Protection of Human Rights and Fundamental Freedoms* (“*European Convention on Human Rights*”). The health of prisoners is an issue of broad public health concern, as prisoners come from and return to communities. There is significant evidence that PNEPs reduce risk behaviours associated with HIV and hepatitis C (“HCV”) transmission, result in other health benefits for prisoners, do not pose health and safety risks to prisoners or prison staff, and do not increase drug use or injecting. Enhancing community safety is a central responsibility of prison systems. States themselves have declared that protecting and promoting the human rights of all persons is “the first responsibility of Governments.”² Moreover, states have a heightened obligation to protect the health of prisoners given that, as a result of incarceration, their integrity and well-being is dependent upon the actions of prison authorities.
3. These submissions are divided into two parts. Part I sets out factual information, statistics and research data concerning PNEPs and the role of such programmes in protecting the health of prisoners, including preventing HIV and HCV infection in prison. In light of this evidence, Part II reviews international health law and human rights standards (including the *European Convention on Human Rights*) relevant to the question of implementing PNEPs. We have included in the Book of Authorities that accompanies these submissions certain of the sources cited herein, such as various articles, reports or policy documents that may be of particular interest to the Court and/or may not otherwise be readily available. We have not included all the scientific studies cited herein, but only a few items that summarize the available evidence from those studies. We would be pleased to provide copies of any document cited should it please the Court.

**PART I: The Need for and Experience with Prison Needle Exchange Programmes:
An Overview of the Evidence**

4. The Legal Network published in 2004, and updated in 2006, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience* [Book of Authorities, Tab 1].³ This report represents the most comprehensive global review of needle exchange programmes in prisons available. Jurisdictions studied in the report include several member states of the Council of Europe, such as Switzerland, Germany, Spain, Moldova, Armenia and Ukraine. The reports' authors conducted extensive documentary research and site visits, and corresponded with prison authorities and non-governmental organisations involved in the development, implementation, operation, and evaluation of PNEPs. The Legal Network continues to monitor international developments regarding PNEPs. Unless otherwise indicated, the information in Part I of these Submissions is drawn from the Legal Network report and subsequent research.
5. As of 1 January 2007, PNEPs were operating in at least one prison in nine jurisdictions: Armenia, Belarus, Germany, Kyrgyzstan, Luxembourg, Moldova, the United Kingdom (Scotland only), Spain and Switzerland. All but two of these states are members of the Council of Europe. In addition, PNEPs are in development in five countries, three of which are members of the Council of Europe: Belgium, Iran, Portugal, Tajikistan, and Ukraine. In every case, PNEPs have been a response to evidence of the risk of HIV and HCV transmission within prisons through the sharing of syringes to inject illicit drugs.

Risks associated with syringe-sharing in prison

6. Drug use is common in prison. A 2002 report of the European Union, for example, showed that the number of prisoners who report ever having used illegal drugs is between 29% and 86%, with most studies reporting figures of 50% or greater.⁴ The number of prisoners actively using drugs during incarceration ranges between 16% and 54% in various studies.⁵ EU studies indicate that figures for drug use are higher among incarcerated women than men.⁶
7. Sharing needles among injecting drug users ("IDUs") is a high-risk activity for the transmission of HIV and HCV, because of the presence of blood in needles after injection.⁷ While it is true that some people stop injecting drugs once imprisoned, some people continue to do so. A 2002 report prepared for the European Union showed that 0.3% to 34% of the prison population in the European Union and Norway injected while incarcerated. The report also found that 0.4% to 21% of people who inject drugs *started* injecting in prison, and that a high proportion of people who inject drugs in prison share injection equipment. For those people who continue to inject drugs, or people who inject drugs for the first time, in prison, imprisonment increases the risk of contracting HIV and HCV because of the prevalence of needle-sharing among large groups of prisoners, a disproportionate number of whom are infected with HIV and/or HCV.⁸ Typically, needles are scarce. As a result, prisoners who inject drugs share and reuse syringes out of necessity. A needle may circulate among large numbers of prisoners who inject drugs, thus increasing the likelihood of disease transmission. HIV and HCV outbreaks among prisoners have been documented in a number of prisons in a number of countries,⁹ and other studies have concluded that a significant percentage of cases of HIV infection among injecting drug users were acquired in prison (e.g., approximately 20% in studies in both Ireland and Canada).¹⁰ Sometimes the equipment used to inject drugs is homemade, with needle substitutes fashioned out of available everyday materials, often resulting in vein damage, scarring, and injection-site and other infections.¹¹ The elevated risks of HIV and HCV infection because of sharing injecting equipment within prisons has led the

World Health Organization's Regional Office for Europe ("WHO Europe") to recommend PNEPs as part of minimum standards in responding to HIV in prisons [Book of Authorities, Tab 2].¹²

8. HIV prevalence in prisons in Council of Europe member states is closely related to two factors: (1) the proportion of prisoners who injected drugs prior to their incarceration, and (2) the prevalence of HIV infection among people who inject drugs in the wider community. Aside from countries in which a significant proportion of cases of HIV infection are attributed to heterosexual sexual transmission, the jurisdictions with the highest prevalence of HIV infection among prisoners are those where, outside prison, HIV infection is "pervasive among IV drug users, who are dramatically over-represented in correctional institutions".¹³ For example, in Spain, it is estimated that the overall prevalence of HIV infection among prisoners is 16.6%, with a figure as high as 38% among some prison populations.¹⁴ In Italy, a prevalence of 17% has been reported.¹⁵ High HIV prevalence among prisoners has also been reported in France (13%; testing of 500 consecutive entries), Switzerland (11%; cross-sectional study in five prisons in the Canton of Berne), and the Netherlands (11%; screening of a sample of prisoners in Amsterdam).¹⁶ Similarly, high HIV prevalence within prisons has been reported from Ukraine (7%), the Russian Federation (4%) and Estonia (12%).¹⁷
9. In many countries, the high prevalence of HIV infection among the prison population is eclipsed by the even higher prevalence of HCV infection, another bloodborne viral infection that can be easily transmitted via needle-sharing. The vast majority of peer-reviewed published studies have found that between 20% and 40% of prisoners are living with HCV and, within study samples, HCV prevalence among prisoners who inject drugs is routinely two to three times higher than among prisoners who have no history of injecting drug use.¹⁸
10. The costs of treating chronic infections such as HIV and HCV are significant. A study published in the United Kingdom in 2006 revealed that the cost of simply the antiviral medication used to treat hepatitis C (and excluding associated treatment costs) was £7,141, while the total cost of a liver transplant necessitated by advanced hepatitis C was £50,313.¹⁹ In the United States, a 2004 article estimated that the annual medical expenditures, including antiviral therapy, per case of HIV infection was approximately US\$20,000; a 2006 article estimated the life-time cost of treating a single case of HIV infection in the United States to be US\$618,900.²⁰

Risks associated with shared injection equipment not eliminated by disinfectant

11. Cleaning syringes with disinfectant such as bleach does not sufficiently reduce the risk of HIV and HCV infection among people who share drug injecting equipment. Bleach is not fully effective in reducing HCV transmission,²¹ a finding recently confirmed by a study examining the incidence of HCV among Scottish prisoners (to whom disinfecting tables have been available since 1993).²² In addition, while research has demonstrated that thorough, repeated applications of bleach may eliminate HIV in syringes,²³ field studies also indicate that many injecting drug users have trouble following the correct procedure to properly disinfect syringes (of HIV) using bleach and have concluded that disinfection with bleach appeared to offer no protection, or at best little protection, against HIV infection.²⁴ In numerous studies, half or more of injecting drug users do not know or do not practise the proper method of using bleach effectively for disinfecting needles.²⁵
12. Furthermore, evidence from Australia indicates that, for various reasons, a substantial proportion of prisoners do not avail themselves of bleach even when it is made available.²⁶ The probability of effective decontamination of needles using bleach is further decreased in prison because cleaning is a time-consuming procedure; some prisoners are reticent to engage in any activity that increases the risk of alerting prison staff to their illicit drug use, given the penal consequences that follow, a

point that has been noted by WHO Europe in recommending access to sterile syringes for prisoners.²⁷

13. Thus, the available evidence indicates that bleach disinfection of syringes is not a substitute for the use of sterile needles. The UK Department of Health has also stated that cleaning injection equipment with disinfectant tablets “has only been shown to reduce the risk of HIV and may offer little or no protection against the more enduring and prevalent hepatitis C” and advises that “it is best to always use sterile needles and syringes each time”.²⁸ WHO Europe states that disinfection is a “second-line strategy” to needle exchange programmes.²⁹ In a comprehensive review of the available evidence as of 2004, WHO has also concluded: “Bleach and other forms of disinfection are not supported by good evidence of effectiveness for reducing HIV infection.”³⁰

Positive outcomes of prison needle exchange programmes

14. In the community, needle exchange programmes have been studied in great detail for over 20 years. In preparing a policy brief on provision of sterile injecting equipment to reduce HIV transmission, in 2004 WHO prepared a technical paper with an extensive review of the evidence for the effectiveness of sterile needle distribution in reducing HIV/AIDS among IDUs (both of which are attached) [Book of Authorities, Tab 3].³¹ The primary conclusion of this comprehensive, rigorous study was that “there is compelling evidence that increasing the availability and utilization of sterile injecting equipment by IDUs reduces HIV infection substantially.”³² The study also concluded that “there is no convincing evidence of any major, unintended negative consequences” from such programmes — specifically, “there is still no persuasive evidence that needle syringe programmes increase the initiation, duration or frequency of illicit drug use or drug injecting.”³³
15. The first NEP in a prison began operation in 1992 in Oberschöngrün prison for men in the Swiss canton of Solothurn. Since that time PNEPs have been introduced in over 50 prisons in nine countries. The Legal Network report studied extensively PNEPs in Belarus, Germany, Kyrgyzstan, Moldova, Spain, and Switzerland. While these PNEPs have been implemented in diverse environments and under differing circumstances, the results of the programmes have been remarkably consistent.
16. The evidence and experience from the aforementioned countries demonstrated that PNEPs: (1) reduce needle-sharing; (2) reduce drug overdoses; (3) lead to a decrease in abscesses and other injection-related infections; (4) facilitate referral of users to drug addiction treatment programmes; (5) have been effective in a wide range of institutions — men’s and women’s, of different security levels and prisoner populations, open and closed environments, barracks and cells; and (6) have effectively employed different methods of needle distribution — such as hand-to-hand distribution by prison health care staff or outside agencies and automatic dispensing machines.³⁴
17. Recently the Public Health Agency of Canada (“PHAC”) prepared for the Correctional Service of Canada (CSC), the federal prison system responsible for 52 institutions, an exhaustive report entitled *Prison needle exchange: Review of the evidence* [Book of Authorities, Tab 4].³⁵ Two of the objectives of the report were to provide scientific, medical and technical advice on the effectiveness, and adverse outcomes if any, of PNEP from a public health perspective, and to provide a comprehensive scientific analysis of available published and unpublished information on PNEPs. As part of the research, over 200 documents were reviewed, a team visited PNEPs in Germany and Spain, and a two-day expert consultation was convened. The PHAC report concluded that evidence from numerous jurisdictions showed that PNEPs: (1) decreased needle-sharing practices among prisoners; (2) increased referrals of prisoners to drug addiction treatment

programmes; (3) decreased need for healthcare interventions related to injection-site abscesses; and (4) decreased the number of overdose-related healthcare interventions and deaths.

Speculative negative consequences of PNEPs have not materialized

18. Prison authorities often oppose needle exchange programmes based on the supposition that such programmes would lead to increased drug use by injecting and that needles would be used by prisoners as weapons. Such objections are based solely upon conjecture, and are specifically refuted by the operational experience and evaluations of PNEPs over more than a decade.
19. The Legal Network report detailed evidence and experience that in the six countries studied, PNEPs did not result in: (1) increased drug consumption among prisoners; (2) an increase in drug injection among prisoners; or (3) any instances where a syringe obtained through a prison needle exchange program was used as a weapon either against prison personnel or another prisoner.³⁶
20. With respect to institutional security and safety, the PHAC report similarly concluded that the current body of evidence indicates that PNEPs did not result in: (1) PNEP syringes being used as weapons; (2) increased institutional violence; (3) any increase in needle-stick injuries; (4) increased seizures of illegal drug or drug paraphernalia; (5) increased drug use; or (6) increased initiation by prisoners of injecting drug use. Moreover, the PHAC report concluded that prison staff in institutions with PNEPs see such programmes as an important and necessary addition to a range of harm reduction services and health and safety interventions.

Legal foundation of Spanish PNEPs

21. Spain has the most thoroughly articulated legal foundation for PNEPs, set out in documents described and collected in a joint 2002 publication of the Ministerio Del Interior and Ministerio De Sanidad y Consumo, entitled *Needle Exchange in Prison: Framework Program* (“Framework”) [Book of Authorities, Tab 5].³⁷ In 1995, a Basque Parliament Green Paper urged the Basque Government to implement a pilot PNEP, which led to the pilot program in 1997. In 1996, Decision 247 of the Provincial Court of Navarra ordered the Pamplona prison authorities to establish a PNEP based on the duty to protect the life and health of prisoners, including protection from infectious diseases, under Spanish law, including the Spanish Constitution. (A copy of that judgment is found in the materials at Tab 5 of the intervenors’ Book of Authorities.) In 1997 the Ombudsman for prisons urged the implementation of PNEPs. Since 1998, the Directorate and Subdirectorate for Prisons have issued a number of directions in relation to PNEPs, culminating in an October 2001 directive requiring PNEPs in all Spanish prisons by January 2002. In 2001, a Green Paper approved by the Spanish Parliament urged the government to adopt PNEPs. The autonomous communities of Castilla and León have mandated PNEPs in legislation on drug addiction.
22. The Spanish Framework endorses a public health, harm reduction and legal rights approach to PNEPs. It recognizes that “[n]eedle exchange in prisons is a harm reduction program that is introduced to prevent the transmission of diseases among injecting drug users ...therapeutic intervention on their addictive process is not the primary objective of the program.”³⁸ Moreover, “... health care professionals working in prisons have the affirmative duty to apply those [public health] measures of proven effectiveness to control” HIV and HCV.³⁹

Scottish Prison Service recommends PNEPs

23. In 2005, the Scottish Prison Service (“SPS”) recognized the need for an integrated harm reduction strategy, including PNEPs. In *The Direction of Harm Reduction in the SPS: From Chaotic Drug*

Use to Abstinence [Book of Authorities, Tab 6], the SPS notes that published scientific studies have documented the spread of HIV in two prisons, demonstrating that needle-sharing translates in the spread of actual disease.⁴⁰ The report discusses the risks if SPS does not change its approach, including increasing infection with HIV and hepatitis B and C among prisoners, the threat of infection through needle-stick injuries, and risks extending to the health of the wider community. The report also notes that the “SPS, in not providing equivalent services as those provided in the community, may be in breach of the positive obligations of articles, 2, 3, 8 and 14 of the European Convention on Human Rights ... The potential for litigation is unprecedented.”⁴¹ To wit, the report notes that there is widespread distribution of injecting equipment in police custody and provision of sterile injecting equipment in the community is long-established as part of public health efforts.

24. The SPS report advocates for an approach to address drug use based on the community standard established by the Scottish Department of Health and the Advisory Council on the Misuse of Drugs, one based on reducing harm. The first step identified is reducing the sharing of injecting equipment by providing clean injecting equipment. Thus, the report recommends, *inter alia*, that “the distribution of sterile injecting equipment be introduced as part of an integrated and expanded Health Care Standard.”⁴² The report concludes by advocating that “[r]isk assessments of individual elements and robustly evaluated pilot schemes should form the basis for any planned implementation.”⁴³

PART II: International Human Rights Law and Health Standards in Relation to PNEPs

Prisoners’ right to health and states’ obligations

25. It is a well-established legal principle that prisoners do not surrender their rights upon incarceration, but instead retain all rights “subject to the restrictions that are unavoidable in a closed environment.”⁴⁴ This approach is reflected within the case law of the United Kingdom, the respondent state in this application.⁴⁵
26. The right to the highest attainable standard of health (recognized, *inter alia*, in Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, to which the United Kingdom is a State Party), as well as the right to equality in the enjoyment of human rights (except insofar as necessarily limited by incarceration), are explicitly retained by persons in detention. According to the UN Committee on Economic, Social and Cultural Rights, the body of independent experts tasked with clarifying and monitoring states’ progress in implementing their Covenant obligations, “States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees...to preventive, curative and palliative health services” [Book of Authorities, Tab 7].⁴⁶ The right of people in prison to be provided with “equal access” to the health care services available in the community is reflected in international declarations and guidelines from the United Nations General Assembly [Book of Authorities, Tab 8],⁴⁷ the WHO in its 1993 *Guidelines on HIV Infection and AIDS in Prisons* [Book of Authorities, Tab 9],⁴⁸ the United Nations Office on Drugs and Crime (UNODC) [Book of Authorities, Tab 10],⁴⁹ and the Joint United Nations Programme on HIV/AIDS (UNAIDS) [Book of Authorities, Tab 11].⁵⁰
27. The right of persons in detention to access a standard of health care equal to that available outside of prisons is known as the “principle of equivalence” — which is correctly understood as requiring standards that achieve equivalent health *objectives*, which in some cases will require that the scope and accessibility of prison health services be higher than that outside of prison (see article at Book of Authorities, Tab 12).⁵¹ At the European level, the principle of equivalence is supported by the

Council of Europe [Book of Authorities, Tab 13],⁵² the European Prison Rules [Book of Authorities, Tab 14],⁵³ and the WHO Regional Office for Europe [Book of Authorities, Tab 15].⁵⁴ The European Committee for the Prevention of Torture (CPT) has been unequivocal in its support for this principle: “An inadequate level of health care can lead rapidly to situations falling within the scope of the term ‘inhuman and degrading treatment’” [Book of Authorities, Tab 16].⁵⁵ The CPT has noted that the principle of equivalence is reflected in national prison legislation or policy in most European states,⁵⁶ and stated policy in the UK is “[t]o provide prisoners with access to the same range and quality of health services as the general public receives from the National Health Service” [Book of Authorities, Tab 17].⁵⁷

28. Given that HIV and HCV are potentially fatal diseases, the right to life is also of relevance in considering states’ obligation to take effective measures to prevent the transmission of blood-borne viruses in prisons by, *inter alia*, the provision of sterile syringes. The UN Human Rights Committee, the body of independent experts tasked with monitoring and adjudicating states’ compliance with the *International Covenant on Civil and Political Rights*, has clarified that under Article 6 of the Covenant states are obligated to take “positive measures” in order to “increase life expectancy” and “eliminate...epidemics” [Book of Authorities, Tab 18].⁵⁸ Furthermore, the Committee has stressed that “the State party by arresting and detaining individuals takes the responsibility to care for their life.”⁵⁹ According to the Committee, it is therefore “incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection.”⁶⁰
29. While the *European Convention on Human Rights* contains no explicit right to health, this Court has taken the approach that both Articles 2 and 3 impose upon States a duty to protect the lives and well-being of people held in detention, a duty which has been interpreted to include providing detainees with adequate health care (for a review of the jurisprudence, see article at Book of Authorities, Tab 19).⁶¹ Indeed, the Court has found that the right to life “enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction”.⁶²
30. People in prison also have the right to preventative health measures, and numerous international health and human rights bodies support the position that the state has an obligation to prevent the spread of contagious diseases in places of detention. Prison health standards and declarations from the World Health Organization⁶³ and the World Medical Association,⁶⁴ for example, are clear that prisoners must be provided with measures to prevent the transmission of disease. The Council of Europe has also stated that, “respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment”.⁶⁵ The United Nations *Rules for the Protection of Juveniles Deprived of their Liberty* specifies that all juvenile detainees shall receive preventive health care,⁶⁶ and in line with their general comments, both the UN Human Rights Committee⁶⁷ and the UN Committee on Economic, Social and Cultural Rights⁶⁸ have expressed concern, in their observations regarding specific Council of Europe states, about the spread of contagious diseases in prisons, calling upon the states in question to take steps to combat disease transmission among persons in detention.
31. The specific issue of providing sterile syringes to prisoners as a means to prevent the spread of bloodborne viruses has also been considered and supported by numerous international organisations, as a matter of both sound public health policy and human rights. As early as 1988, the Council of Europe recommended “clean, one-way syringes and clean needles being made available to intravenous drug abusers in prison” [Book of Authorities, Tab 20].⁶⁹ In the nearly twenty years since this recommendation was made, the provision of sterile syringes to prisoners as an HIV prevention measure has been supported by the WHO in its 1993 *Guidelines on HIV*

Infection and AIDS in Prisons,⁷⁰ UNAIDS and the Office of the UN High Commissioner on Human Rights in the *International Guidelines on HIV/AIDS and Human Rights* [Book of Authorities, Tab 21],⁷¹ and UNODC, WHO and UNAIDS in *HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response*, a global action plan to address HIV/AIDS in prisons published jointly in 2006.⁷² In this last publication, these three UN bodies recommend that prison systems ensure that measures available outside of prisons to prevent HIV transmission be made available to prisoners — and specifically, they recommend that sterile needles and syringes be accessible to prisoners in confidential and non-discriminatory manner.⁷³ This recommendation is in keeping with one of eleven general principles identified in the report — the requirement that prison healthcare be equivalent to that available in the outside community, including preventive measures.

32. Despite stated policies that European prisons be drug-free, there is extensive evidence of injecting drug use, syringe-sharing, and HIV and HCV transmission resulting from unsafe injecting in many prison systems, as documented above in Part I. This body of research makes it difficult to suggest that a totally drug-free prison is even a realistic proposition, let alone one that addresses the risks to health from unsafe injecting in a manner consistent with state obligations. The prohibited or illegal nature of the activity in question does not reduce the state's positive obligations under Article 3 of the *European Convention*.⁷⁴ We respectfully submit that states' obligations to safeguard the well-being of prisoners should be interpreted in light of this scientific evidence, which highlights a social need that is particularly pressing given the epidemics of HIV and HCV, both incurable diseases easily and rapidly spread via shared injecting equipment. The principle of equivalence demands that where these programmes are available in the community they also be provided in prisons.
33. In summary, we submit that, in considering the right of persons in prison to have access to effective means of preventing HIV and HCV transmission, this Court should have regard to the strong international consensus regarding (1) the principle of equivalence in healthcare standards, long established in law; (2) the state's obligations to take effective measures to prevent the spread of contagious diseases among prisoners; and (3) the importance of access to sterile syringes in prisons as part of an effective HIV and HCV prevention strategy among some of those who are most vulnerable to infection and to whom the state's responsibility is heightened given their incarceration. Where syringe exchange programmes form part of national strategies to prevent the spread of bloodborne viruses in the general population, the state is obliged to promote the same healthcare standards for persons in detention.

Doctrine of margin of appreciation should not be used to justify inaction on PNEPs

34. Prison authorities often suggest that the issue of PNEP is one of domestic policy, and that the lack of consistent state practice in this regard means that it is a matter falling within the state's margin of appreciation. However, this position contradicts the broad international consensus on prisoners' equal right to health and the positive obligations of states outlined above. We respectfully suggest that this Court should interpret the state's margin of appreciation within the above international consensus on health and human rights norms, rather than simply the number of Council of Europe states that have acted to meet these agreed standards. The fact that many states continue to fail to meet internationally recognized health and human rights standards is no comment on the validity of those standards themselves, but rather an illustration of the widespread denial of the rights of people in prison based solely on their incarcerated status. As a result, we respectfully suggest that this is exactly the sort of situation in which the Court should intervene to ensure protection and fulfilment of fundamental human rights of a most vulnerable population.

35. Because the use of illicit drugs is prohibited within prisons (as it generally is outside), it might be argued that expecting prisoners to refrain from drug use is a legitimate aim of imprisonment — and therefore, that a policy against providing sterile syringes forms a reasonable part of said punishment and a practical demand of imprisonment rather than an undue limitation on the rights of people in detention. However, the state’s desire for drug-free prisons does not override its positive obligation to protect the health of people in detention, and its obligation to take effective measures toward this end.
36. Furthermore, this argument is logically unsound and demonstrably so. It is not a necessary consequence of prohibiting illicit drug use in prison that prisoners be denied access to sterile equipment that would lower the risk of harm associated with that use should it occur (which the evidence consistently indicates is the case). The operation of state-funded syringe exchange programmes outside of prisons in countries across the Council of Europe, in a legislative context where drug possession and/or use remains illegal, provides the clearest refutation of this argument. Rather, the provision of sterile syringes to people who continue to inject drugs (despite their illegality) is a pragmatic public health measure, one complementary to other government strategies to address the use of illegal drugs and the related risk of HIV and HCV transmission. As described in a policy brief recently published by WHO, UNODC and UNAIDS, “[t]he provision of access to sterile injection equipment for injecting drug users and the encouragement of its use are essential components of HIV/AIDS prevention programmes, and should be seen as a part of overall comprehensive strategies to reduce the demand for illicit drugs.”⁷⁵
37. It is important that the programmes themselves are implemented in a manner that is most safe and effective given the physical, social, and security specificities of differing prison systems. For this reason, international best practice has shown it most effective to implement syringe exchange on a pilot basis first, and evaluate that pilot, and then move to mainstreaming syringe exchange across the system as a whole.⁷⁶ In this regard, the call for a pilot syringe exchange programme does not reflect any weakness in the scientific evidence or international support for these programmes, nor is it correctly understood as negating or weakening the legal obligation on states to include such programmes among the reasonable, positive steps they must take to ensure access for prisoners to tools needed to protect themselves from incurable infectious disease. Rather, it is a practical operational step toward the full implementation of PNEPs. Indeed, given the scope of the health issues involved and states’ obligation to safeguard the health of people in detention, it is imperative that PNEPs be scaled up and made available in all prisons as rapidly as possible following a pilot phase to evaluate how best to implement them in the local context and achieve their beneficial health outcomes.
38. Prison syringe exchange programmes have been successfully and safely implemented in dozens of European prisons in several countries over the past decade. The state’s refusal to implement these programmes on the basis that they are ineffective or unsafe is not supported by the evidence, and represents both poor scientific judgment and bad public health policy. Rather, such refusal is likely based on political concern that implementing such programmes may be controversial. We respectfully submit that the state cannot be allowed to decide which legally-binding human rights it chooses to fulfill on the basis of public opinion.

Respectfully submitted this 19th day of January, 2007
by the Canadian HIV/AIDS Legal Network and the Irish Penal Reform Trust

References

¹ The terms “needle exchange” and “syringe exchange” are used to refer to the one-for-one exchange of a used needle for a sterile needle, as well as to the distribution of sterile needles without exchange. Unless otherwise indicated explicitly or by context, the terms “needle” and “syringe” mean a device used to inject fluids into the body, and are used interchangeably throughout these Submissions.

² *Vienna Declaration and Program of Action*, World Conference on Human Rights, Vienna, 14-25 June 1993, UN Doc. A/CONF.157/23, at para. 1, online: www1.umn.edu/humanrts/instreet/11viedec.html.

³ R. Lines *et al.*, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2nd ed. (Canadian HIV/AIDS Legal Network, 2006).

⁴ European Monitoring Centre for Drugs and Drug Addiction, *Annual report on the state of the drugs problem in the European Union and Norway* (Luxembourg: Office for Official Publications of the European Communities, 2002) at 46, online: <http://ar2002.emcdda.europa.eu/en/home-en.html>.

⁵ *Ibid.*

⁶ *Ibid.* at 47.

⁷ See, for example, S.M. Shah *et al.*, “Detection of HIV-1 DNA in needle/syringes, paraphernalia, and washes from shooting galleries in Miami: a preliminary laboratory report” (1996) 11:3 *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology* 301; P. Shapshak *et al.*, “HIV-1 RNA load in needles/syringes from shooting galleries in Miami: a preliminary laboratory report” (2000) 58:1-2 *Journal of Drug and Alcohol Dependency* 153; R.H. Needle *et al.*, “HIV risk behaviors associated with the injection process: multiperson use of drug injection equipment and paraphernalia in injection drug user networks” (1998) 33:12 *Substance Use & Misuse* 2403; B. Jose *et al.*, “Syringe-mediated drug-sharing (backloading): a new risk factor for HIV among injecting drug users” (1993) 7:12 *AIDS* 1653, erratum in (1994) 8:1 *AIDS* following 4.

⁸ EMCDDA, *supra* note 4. With respect to the U.K. specifically, see: “HIV/AIDS Risk Behaviour Among Adult Male Prisoners”, *Research Findings No. 82* (London: Home Office Research, Development and Statistics Directorate, 1998) [Application Record of John Shelley, pp. 194-199]; Prison Reform Trust & National AIDS Trust, *HIV and hepatitis in UK prisons: addressing prisoners’ healthcare needs* (London: PRT & NAT, 2005). See also other reports of high rates of syringe-sharing among prisoners in Council of Europe countries: P.B. Christensen *et al.*, “Prevalence and incidence of bloodborne viral infections among Danish prisoners” (2000) 16:11 *European Journal of Epidemiology* 1043; M. Malliori *et al.*, “A survey of bloodborne viruses and associated risk behaviours in Greek prisons” (1998) 93:2 *Addiction* 243; G. Koulierakis *et al.*, “Injecting drug use amongst inmates in Greek prisons” (1999) 7:3 *Addiction Research* 193; G. Koulierakis *et al.*, “HIV risk behaviour correlates among injecting drug users in Greek prisons” (2000) 95:8 *Addiction* 1207; S. Allwright *et al.*, “Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross sectional survey” (2000) 321 *British Medical Journal* 78-82; D. Kennedy *et al.*, *Illicit drug use, injecting, and syringe sharing in Scottish prisons in the 1990s: final report for the Nuffield Foundation* (Glasgow: Ruchill Hospital; 1990); A. Edwards *et al.*, “Survey of risk behaviour and HIV prevalence in an English prison” (1999) 10:7 *International Journal of STD & AIDS* 464; A.R. Weild *et al.*, “Prevalence of HIV, hepatitis B, and hepatitis C antibodies in prisoners in England and Wales: a national survey” (2000) 3:2 *Communicable Disease and Public Health* 121; K Dolan *et al.*, “Drug injecting and syringe sharing in custody and in the community: an exploratory survey of HIV risk behaviour” (1990) 29:3 *Howard Journal of Criminal Justice* 177; H. Pickering & G. Stimson, “Syringe sharing in prison” (1993) 342 *Lancet* 621.

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¹⁴ Spanish Focal Point, *National Report 2001 for the European Monitoring Centre for Drugs and Drug Addiction* (Madrid: Government Delegation for the National Plan on Drugs, October 2001) at 84, with reference.

¹⁵ T. Harding & G. Schaller, “HIV/AIDS Policy for Prisons or for Prisoners?” in J. Mann, D. Tarantola & T. Netter, eds., *AIDS in the World* (Cambridge, MA: Harvard University Press, 1992) 761 at 762; with reference to T. Harding, “AIDS in prison” (1987) 2 *Lancet* 1260.

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²⁶ K.A. Dolan *et al.*, “A bleach program for inmates in NSW: an HIV prevention strategy” (1998) 22:7 *Australian and New Zealand Journal of Public Health* 838.

²⁷ WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, *supra* note 12 (at 12), noting: “Serious problems are related to the use of bleach in prisons. For example, prisoners are highly to unlikely to spend 45 minutes shaking the syringes to clean them while waiting to inject in some hidden corner of the prison. Bleach can therefore create a false sense of security between prisoners sharing paraphernalia.”

²⁸ “Drug Misuse and Dependence – Guidelines on Clinical Management” (London: Department of Health, 1999).

²⁹ WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, *supra* note 12 at 12.

³⁰ WHO, *Effectiveness of Sterile Needle and Syringe in Reducing HIV/AIDS Among Injecting Drug Users*, Evidence for Action Technical Papers (Geneva: WHO, 2004) at 28.

³¹ *Ibid.*; WHO/UNAIDS/UNODC, *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*, Evidence for action on HIV/AIDS and injecting drug use (Geneva: WHO, 2004), Doc. WHO/HIV/2004.03.

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³³ *Ibid.*

³⁴ K. Stark *et al.*, “A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany” (2006) 13:4 *Epidemiology and Infection* 814; H. Stöver & J. Nelles, “10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies” (2003) 14 *International Journal of Drug Policy* 437; S Rutter *et al.*, *Prison-Based Syringe Exchange Programs. A Review of International Research and Program Developments*, NDARC Technical Report No. 112 (Sydney, National Drug and Alcohol Research Centre, University of New South Wales, 2001); J. Nelles *et al.*, “Provision of syringes: the cutting edge of harm reduction in prison?” (1998) 317 *British Medical Journal* 270; K Dolan *et al.*, “Prison-based syringe exchange programmes: a review of international research and development (2003) 98 *Addiction* 153-158; J. Nelles, A. Fuhrer & I. Vincenz, *Prevention of drug use and infectious diseases in the Realta Cantonal Men’s Prison: Summary of the evaluation* (Berne: University Psychiatric Services, 1999); J. Nelles *et al.*, “Provision of syringes and prescription of heroin in prison: The Swiss experience in the prisons of Hindelbank and Oberschöngrün” in: J. Nelles & A Fuhrer, eds. *Harm Reduction in Prison* (Berne: Peter Lang, 1997) at 239; H. Stöver, “Evaluation of needle exchange pilot projects show positive results” (2000) 5:2/3 *Canadian HIV/AIDS Policy & Law Newsletter* 60-64; C. Menoyo *et al.*, “Needle exchange programs in prisons in Spain” (2000) 5:4 *Canadian HIV/AIDS Policy & Law Review* 20; Spanish Focal Point, *supra* note 14; Ministerio Del Interior/Ministerio De Sanidad y Consumo, *Needle Exchange in Prison: Framework Program*, *infra* note 37; J. Sanz Sanz *et al.*, “Syringe-exchange programmes in Spanish prisons” (2003) 13 *Connections: The Newsletter of the European Network Drug Services in Prison & Central and Eastern European Network of Drug Services in Prison* 9-12; N. Bodrug, “A pilot project breaks down resistance” (2002) 3:2 *Harm Reduction News* 11.

³⁵ Public Health Agency of Canada, *Prison needle exchange: Review of the evidence*, Report prepared for Correctional Service Canada (April 2006).

³⁶ See Lines *et al.*, *Prison Needle Exchange*, *supra* note 3.

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³⁸ *Ibid.* at 4, 5.

³⁹ *Ibid.* at 1.

⁴⁰ Scottish Prison Service, *The Direction of Harm Reduction in the SPS: From Chaotic Drug Use to Abstinence* (2005), with reference to: A Taylor *et al.* Outbreak of HIV infection in a Scottish prison, (1995) 310 *British Medical Journal* 289–292; D.L. Yirrell *et al.*, “Molecular investigation into outbreak of HIV in a Scottish prison” (1997) 314 *British Medical Journal* 1446–50.

⁴¹ *Ibid.* at 16.

⁴² *Ibid.* at 19.

⁴³ *Ibid.* at 20.

⁴⁴ UN Committee on Human Rights, General Comment No. 21, Article 10 (Humane treatment of persons deprived of their liberty), UN CHROR, 44th Sess. (1992), UN Doc.HRI/GEN/1/Rev.6(2003) at 153, para 3; *Standard Minimum Rules for the Treatment of Prisoners*, UN Doc. A/CONF/611 (1955), amended UN Doc. E/5988 (1977); Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111, UN Doc. A/45/49 (1990); World Health Organization, *WHO Guidelines on HIV Infection and AIDS in Prisons* (Geneva: WHO, 1993). See also domestic case law such as the judgment of the Indian Supreme Court in *Sobraj v. The Superintendent, Central Jail Tihar*, [1978] I.N.S.C. 153, [1979] 1 S.C.R. 512 stating (at 518) that “prisoners retain all rights enjoyed by free citizens except those that are lost necessarily as an incident of confinement.” See also statutory law, such as Canada’s *Corrections and Conditional Release Act*, S.C. 1992, c. 20, s. 4(e), which states “that offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence...”.

⁴⁵ The House of Lords found in *Raymond v. Honey* (1983), [1983] 1 A.C. 1 that, "under English law, a convicted prisoner, in spite of his imprisonment, retains all civil rights which are not taken away expressly or by necessary implication" (at 10). This position was reaffirmed by the House of Lords in *R. v. Secretary of State for the Home Department, ex parte Daly* [2001] UKHL 26, [2001] 2 A.C. 532: “Any custodial order inevitably curtails the enjoyment, by the person confined, of rights enjoyed by other citizens. He cannot move freely and choose his associates as they are entitled to do...But the order does not wholly deprive the person confined of all rights enjoyed by other citizens. Some rights, perhaps in an attenuated or qualified form, survive the making of the order. And it may well be that the importance of such surviving rights is enhanced by the loss or partial loss of other rights... Such rights may be curtailed only by clear and express words, and then only to the extent reasonably necessary to meet the ends which justify the curtailment.” (at para. 5).

⁴⁶ UN Committee on Economic, Social, and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, 22nd Sess., (2000) UN Doc E/C.12/2000/4 at para 34 [emphasis in original].

⁴⁷ Basic Principles for the Treatment of Prisoners, UNGAOR, 45th Sess., Supp. No. 49A, UN Doc A/45/49 (1990) at para 9.

⁴⁸ *WHO Guidelines on HIV Infection and AIDS in Prisons*, *supra* note 44.

- ⁴⁹ UNODC, WHO & UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* (Vienna & New York: UNODC/WHO/UNAIDS, 2006) at 10.
- ⁵⁰ UNAIDS, “Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996” in *Prison and AIDS: UNAIDS Point of View* (Geneva: UNAIDS, 1997) at 3.
- ⁵¹ R. Lines, “From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health standards higher than those outside prisons” (2006) 2 *International Journal of Prisoner Health* 269.
- ⁵² Council of Europe, *Recommendation R(98)7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison, adopted 8 April 1998, 627th Meeting of the Ministers’ Deputies*; as well as Council of Europe, *Recommendation R (93)6 of the Committee of Ministers Concerning Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and related Health Problems in Prison, adopted 18 October 1993, 500th Meeting of the Ministers’ Deputies*.
- ⁵³ Council of Europe, *Recommendation R (2006)2 of the Committee of Ministers on the European Prison Rules, adopted 11 January 2006, 952nd Meeting of the Ministers’ Deputies*, at para 40.3.
- ⁵⁴ WHO Europe, *The Moscow Declaration: Prison Health as part of Public Health* (March 24, 2003), online at WHO Europe Health in Prisons Project www.hipp-europe.org/NEWS/moscow_declaration_eng04.pdf.
- ⁵⁵ Council of Europe, Committee for the Prevention of Torture, *3rd General Report on the CPT's activities covering the period 1 January to 31 December 1992* (1993) at para. 31 [excerpt].
- ⁵⁶ *Ibid.* at para 30.
- ⁵⁷ [UK] Department of Health, *Health Services for Prisoners: Prison Service Performance Standard No. 22* (2004).
- ⁵⁸ UN Human Rights Committee, *General Comment No. 6: The right to life (Article 6)*, 16th Sess., (1982) UN Doc. HRI\GEN\1\Rev.1 at 6, para 5.
- ⁵⁹ *Lantsova v. Russian Federation*, CHR Comm. 763/1997, UNCHR 74th Sess. (2002), UN Doc. CCPR/C/74/763/1997 at para 9.2.
- ⁶⁰ *Ibid.*
- ⁶¹ E.g., see: *Hurtado v. Switzerland*, no. 17549/90, [1994] E.C.H.R. ser A 280A at para. 79; *Kudla v. Poland*, no. 30210/96, [2000] 35 E.H.R.R. 11 at para. 94. See also: R. Lines, “Injecting Reason: Prison Needle Exchange and Article 3 of the European Convention on Human Rights”, 2007 1 E.H.R.L.R. (forthcoming).
- ⁶² *Edwards and another v. United Kingdom*, Application no. 46477/99, [2002] 35 E.H.R.R. 417 at para. 54. See also *Osman v United Kingdom*, Application no. 23452/94, [1999] 29 E.H.R.R. 45.
- ⁶³ *WHO Guidelines on HIV Infection and AIDS in Prisons, supra* note 44.
- ⁶⁴ World Medical Association, *Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases* (2000), online: www.wma.net/e/policy/p28.htm.
- ⁶⁵ *Recommendation R (98)*, *supra* note 52.
- ⁶⁶ *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*, UNGAOR 45th Sess., Supp. No. 49A, UN Doc.A/45/49 (1990) at para. 49.
- ⁶⁷ *Concluding Observations of the Human Rights Committee: Republic of Moldova*, UNCHROR, 75th Sess., UN Doc CCPR/CO/75/MDA(2002) at para. 84(9).

⁶⁸ *Conclusions and Recommendations of the Committee on Economic, Social and Cultural Rights, Russian Federation*, UNCESCROR, 1997, UN Doc. E/1998/22 at para. 112; *Conclusions and Recommendations of the Committee on Economic, Social and Cultural Rights, Russian Federation*, UNCESCROR, 2003, UN Doc. E/2004/22 at paras. 33, 61; *Conclusions and Recommendations of the Committee on Economic, Social and Cultural Rights, Republic of Moldova*, UNCESCROR, 2003, UN Doc. E/C.12/1/Add.91 at paras 25, 47.

⁶⁹ Council of Europe, P.A. Standing Committee, *Recommendation 1080 (1988) On a Co-ordinated European Health Policy to Prevent the Spread of AIDS in Prison*, para 14(viii).

⁷⁰ *WHO Guidelines*, *supra* note 44.

⁷¹ *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, (Geneva: Office of the United Nations High Commissioner for Human Rights & UNAIDS, 2006), UN Doc. HR/PUB/06/9. Guideline 4 recommends that States review, *inter alia*, correctional systems to ensure that they are consistent with international human rights obligations. The commentary to Guidelines 4, at paragraph 21(e), calls on prison authorities to, *inter alia*, “provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary counselling, means of protection (condoms, bleach and clean injection equipment”.”

⁷² *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, *supra* note 49.

⁷³ *Ibid.*, Recommendation no. 60.

⁷⁴ *McFeeley v. United Kingdom* (1981) 3 EHRR 161 at paras. 45-46; *Iorgov v. Bulgaria*, Application no. 40653/98 (judgment of 11 March 2004) at para 85.

⁷⁵ *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*, *supra* note 31 at 1.

⁷⁶ Lines *et al.*, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, *supra* note 3 at pp. 55-56; *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, *supra* note 49, Recommendation No. 2.