



**Brief to the Standing Senate Committee on Human Rights regarding its study on human rights of prisoners in the correctional system:  
The public health and human rights rationale for prison-based needle and syringe programs**

June 2017

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**The Canadian HIV/AIDS Legal Network promotes the human rights of people living with, at risk of or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education and community mobilization.**

*Le Réseau juridique canadien VIH/sida fait valoir les droits humains des personnes vivant avec le VIH ou le sida et de celles qui sont à risque ou affectées autrement, au Canada et dans le monde, à l'aide de recherches et d'analyses, d'actions en contentieux et d'autres formes de plaidoyer, d'éducation du public et de mobilisation communautaire.*

**PASAN is a community-based Harm Reduction/HIV/HCV organization that provides support, education and advocacy to prisoners and ex-prisoners, and is the only community-based organization in Canada exclusively providing HIV/AIDS and HCV prevention, education and support services to prisoners, ex-prisoners and their families.**

## 1. Executive summary

Despite sustained efforts to prevent drug use by people in prison, the reality is that drugs can and do enter prisons. As Canada's former correctional investigator acknowledged, "There has never been a prison that I am aware of anywhere in the world that has been able to be contraband-free, including illicit drugs. Canada does not stand alone in that challenge."<sup>1</sup> Conflict with the law and incarceration are often a result of offences arising out of the criminalization of certain drugs related to financing drug use or behaviours brought about by drug use.<sup>2</sup> In a criminal justice environment where three out of four people enter Canada's federal prisons with substance use problems and substance use is a contributing factor to the criminal behaviour of half the people admitted to federal institutions,<sup>3</sup> it should come as no surprise that many prisoners use drugs, often by injection — a fact confirmed by numerous studies.<sup>4</sup> In spite of this, prisoners are denied access to harm reduction tools that protect against HIV and hepatitis C (HCV) infection, including those already available in the community. Because of the scarcity of injection equipment in prison, prisoners who inject drugs are more likely to share injecting equipment than in the community, thereby increasing their risk of contracting HIV and HCV.

As in many other countries, the extent of injection drug use in Canada's prisons has led to significantly higher rates of HIV and HCV among prisoners than in the community as a whole. Figures released in 2010 by the Correctional Service of Canada (CSC) indicate a rate of HIV and HCV among prisoners of 4.6% and 31% respectively, or 15 and 39 times the prevalence in the wider community. Even higher rates of HIV (11.7%) and HCV infection (49.1%) were reported for Indigenous women in prison.<sup>5</sup> Subsequent studies suggest that about 30% of those in federal facilities and 15% of men and 30% of women in provincial facilities are living with HCV, and 1–2% of men and 1–9% of women are living with HIV.<sup>6</sup>

Programs that ensure access to sterile injecting equipment are therefore an important component of a comprehensive approach to reducing the vulnerability of prisoners to HIV and HCV infection. The best available evidence strongly suggests that in countries where prison-based needle and syringe programs (PNSPs) exist, such programs

- reduce risk behaviour and infection;
- reduce overdose;
- do not increase drug consumption or injecting;
- do not endanger staff or prisoner safety; and
- have other positive outcomes for the health of people in prison, including increasing referrals of users to drug treatment programs.

These findings were confirmed in *Prison Needle Exchange: Review of the Evidence*, a 2006 review by the Public Health Agency of Canada (PHAC) undertaken at the request of CSC,<sup>7</sup> and again in 2015 in *Needle Exchange Programs in a Correctional Setting: A Review of the Clinical and Cost-Effectiveness* by the Canadian Agency for Drugs and Technologies in Health (CADTH), a federal, provincial and territorial government agency tasked with reviewing and making recommendations on health technologies.<sup>8</sup>

Moreover, under Canadian and international law, prisoners deserve the same level of care and protection available to people outside prison, and their right to health includes having access to

tools to protect themselves from infection. By refusing to implement PNSPs, CSC unnecessarily places prisoners who inject drugs, arguably individuals with the most severe drug dependence, at risk of HIV and HCV infection, many of whom may have relied on needle and syringe programs in the community prior to their incarceration. This denial of health care to prisoners not only disproportionately affects federally incarcerated women, Indigenous and other racialized prisoners, but also aggravates the public health by contributing further to the harms associated with unsafe drug use. Conversely, the provision of sterile injection equipment to people in prison benefits not only the prisoners who use drugs, but also other prisoners and prison staff who face far fewer risks of accidental needle-stick injuries in a regulated needle and syringe distribution program, as well as the public as a whole, which ultimately bears the considerable expense of HIV and HCV treatment.

## **2. Public health evidence in support of PNSPs**

As noted above, rates of HIV and HCV in Canada's prisons are significantly higher than they are in the community, and higher still among Indigenous prisoners.<sup>9</sup> Research over many years and from many jurisdictions has demonstrated not only the higher prevalence of both HIV and HCV infections among people in prison, but also the close relationship between such infections and injection drug use, a result of the prevalence of HIV and HCV infections among people who inject drugs in the wider community, the widespread incarceration of people who use drugs, and the lack of harm reduction measures in prisons.<sup>10</sup> CSC's 2010 national survey indicated 34 percent of men and 25 percent of women used drugs since arriving at their institution — with 17 percent of those men and 14 percent of those women reporting drug use by injection.<sup>11</sup> In the same study, approximately half the prisoners who injected drugs reported sharing injection equipment, including with people who had HIV, HCV or unknown infection status.<sup>12</sup> According to a 2003 Vancouver study, incarceration more than doubled the risk of HIV infection among people who use illegal drugs.<sup>13</sup> An independent evaluation of this study also suggested that 21 percent of all HIV infections among people who inject drugs in Vancouver may have been acquired in prison.<sup>14</sup> Globally, a number of outbreaks of HIV and HCV infection in prison have been attributed to the sharing of injection equipment, including in Australia,<sup>15</sup> Lithuania,<sup>16</sup> Russia<sup>17</sup> and Scotland.<sup>18</sup>

CSC's primary response to the ongoing use of injection drugs in federal prisons is to provide bleach to sterilize injection equipment. Yet, as numerous health organizations, including the World Health Organization (WHO), have indicated, bleach is not an adequate substitute for the provision of PNSPs,<sup>19</sup> nor is it still provided in the community as a measure to prevent HIV and HCV transmission among people who inject drugs. Sterile injection equipment that has never been used is safer than previously used needles and syringes that have been cleaned, often imperfectly, with bleach. In the community, needle and syringe programs (NSPs) have been studied in great detail for over 20 years and have been proven to be an important mechanism for reducing the risk of infection from the use of non-sterile injecting equipment. Numerous evaluations of community NSPs have demonstrated that they reduce the risk of HIV and HCV,<sup>20</sup> are cost effective,<sup>21</sup> and facilitate access to care, treatment and support services for people who use drugs.<sup>22</sup>

Since the first PNSP was introduced in a Swiss prison in 1992, a growing number of countries have implemented such health services in a growing number of prisons. To date, PNSPs have been introduced in over 60 prisons of varying sizes and security levels, and operate in Armenia, Germany, Kyrgyzstan, Luxembourg, Moldova, Spain and Switzerland.<sup>23</sup> In Kyrgyzstan, Moldova and Spain, PNSPs have been rapidly scaled up and operate in a large number of prisons. In every case, PNSPs have been a response to evidence of the risk of HIV and HCV transmission within prisons through the sharing of equipment to inject drugs. A number of these PNSPs have undergone systematic evaluations, including in 2004 by the Canadian HIV/AIDS Legal Network and in 2006 by PHAC, at the request of CSC.<sup>24</sup> While these PNSPs have been implemented in diverse environments and under differing circumstances, the results of the programs have been remarkably consistent.

### ***PNSPs are safe***

Injection equipment can be made available in prisons in a manner that is not threatening to staff and that increases staff safety. Since the first PNSP in 1992, there have been no reported cases of PNSP equipment being used as a weapon either against prison staff or other prisoners. Prisoners are also usually required to keep their kits in a pre-determined location in their cells. This arrangement assists staff when they enter a cell to conduct searches and has substantially decreased accidental needle-stick injuries to staff.

### ***PNSPs do not lead to increased drug use***

Evaluations of existing programs have consistently found that the availability of sterile injection equipment does not result in an increased number of people injecting drugs, an increase in overall drug use or an increase in the amount of drugs in the institutions.

### ***PNSPs do not condone drug use***

Drugs remain prohibited in institutions where PNSPs are in place and staff continue to be responsible for locating and confiscating prohibited drugs. However, it is recognized that if and when drugs find their way into the prison and are used by prisoners, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, equipment that is part of the official PNSP is not. In most cases, PNSPs have been introduced as only one component of a more comprehensive approach to dealing with drug-related harms, including drug treatment such as opioid substitution therapy. Evaluations have found that PNSPs actually facilitate referrals of users to drug treatment programs and have led to an increase in the number of people making use of such programs.

### ***PNSPs have been successfully introduced in various prison environments***

While programs were first introduced in small Swiss prisons, they have since been successfully implemented in prisons for men and for women; in small, medium and large institutions; and in prisons of all security classifications. After having been introduced in well-resourced prison systems, programs have also been established in systems with very limited resources. There are several models of distribution of sterile injection equipment, including automatic dispensing machines; distribution by medical staff, counsellors or external agencies; and distribution by prisoners trained as peer outreach workers. What is appropriate in a particular institution depends on many factors such as the size of the institution, the extent of injection drug use, the security level, whether it is a prison for men or for women and the commitment of health-care staff.

### ***PNSPs reduce risk behaviour, thereby helping to prevent disease transmission***

Most importantly, evaluations of existing PNSPs have shown that reports of needle sharing declined dramatically and no new cases of HIV or HCV infection have been attributed to injection drug use since the implementation of the programs. In addition, other positive health outcomes have been documented in some prisons, such as a decrease in fatal and non-fatal overdoses and a decrease in abscesses and other injection-related infections.

Further reinforcing the public health imperative for PNSPs in Canada, a number of organizations, including the Canadian Medical Association,<sup>25</sup> Ontario Medical Association,<sup>26</sup> Correctional Investigator of Canada<sup>27</sup> and Canadian Human Rights Commission<sup>28</sup> have recommended that CSC develop, implement and evaluate PNSPs in prisons under its jurisdiction. The WHO, the Joint UN Programme on HIV/AIDS (UNAIDS) and the UN Office on Drugs and Crime (UNODC) have also endorsed PNSPs as part of a comprehensive national framework for addressing HIV in prisons,<sup>29</sup> and PNSPs are considered by a diverse body of UN agencies as one of 15 “key interventions” for HIV prevention in prisons.<sup>30</sup>

## **3. Human Rights and PNSPs**

### **i. International law**

In the context of PNSPs, two principles are particularly relevant to the rights of people in prison. First, under international human rights law, prisoners retain all fundamental rights and freedoms, apart from those that are unavoidably restricted by the loss of liberty flowing from imprisonment.<sup>31</sup> This includes the right to the highest attainable standard of health, which is recognized in the *International Covenant on Economic, Social and Cultural Rights*,<sup>32</sup> among other regional and international treaties that Canada has ratified.<sup>33</sup> According to the UN Committee on Economic, Social and Cultural Rights, “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.”<sup>34</sup> Since HIV and HCV are potentially fatal diseases, the right to life is also relevant in considering states’ obligation to take effective measures to prevent the transmission of blood-borne viruses in prisons. The UN Human Rights Committee has clarified that under the *International Covenant on Civil and Political Rights* states are obligated to take “positive measures” in order to “increase life expectancy” and “eliminate ... epidemics.”<sup>35</sup>

Second, the “principle of equivalence” entitles people in detention to have access to a standard of health care equivalent to that available outside prison, including preventive measures comparable to those available in the general community. The right of people in prison to access health care equivalent to that available in the community is reflected in declarations and guidelines from the UN General Assembly,<sup>36</sup> WHO,<sup>37</sup> UNODC<sup>38</sup> and UNAIDS,<sup>39</sup> and most recently in the *UN Standard Minimum Rules for the Treatment of Prisoners* (the “Nelson Mandela Rules”), which call for health care services to be organized “in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.”<sup>40</sup> Moreover, numerous international health and human rights bodies support the position that, as a corollary to the right of people in prison to preventive health services, the state

has an obligation to prevent the spread of contagious diseases in places of detention. Prison health standards and declarations from the WHO<sup>41</sup> and the World Medical Association,<sup>42</sup> for example, are clear that incarcerated people must be provided with measures to prevent the transmission of disease. As the former UN Special Rapporteur on the right to health has stated, “If harm reduction programmes and evidence-based treatment are made available to the general public, but not to persons in detention, that contravenes international law.”<sup>43</sup> The former Special Rapporteur has further noted that “in the context of HIV and harm reduction, this demands implementation of harm reduction services in places of detention *even where they are not yet available in the community*, as the principle of equivalence is insufficient to address the epidemic among prisoners” [emphasis added].<sup>44</sup>

The specific issue of providing sterile injection equipment to people in prison as a means of preventing the spread of blood-borne viruses has been considered and supported also by numerous international organizations as a matter of both sound public health policy and human rights. For example, in the *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS and the Office of the UN High Commissioner on Human Rights call on prison authorities to “provide prisoners ... with access to ... condoms, bleach and clean injection equipment.”<sup>45</sup> In its *Guidelines on HIV Infection and AIDS in Prisons*, the WHO recommends that countries provide “clean injecting equipment during detention and on release to prisoners who request it.”<sup>46</sup> In *HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response*, UNODC, WHO and UNAIDS specifically recommend that sterile needles and syringes be accessible to incarcerated people in a confidential and non-discriminatory manner.<sup>47</sup> Furthermore, the “Madrid Recommendations” — a series of recommendations on health protection in prisons that have been endorsed by representatives from 65 countries as well as the WHO, UNODC and the Council of Europe — recognize “the urgent need in all prison systems for measures, programmes and guidelines which are aimed at preventing and controlling major communicable diseases in prisons,” including PNSPs.<sup>48</sup> Two former Special Rapporteurs on torture also have explicitly called for states to implement needle and syringe programs in places of detention.<sup>49</sup> And in 2016, the Committee on the Elimination of Discrimination against Women urged Canada to “expand care, treatment and support services to women in detention living with or vulnerable to HIV/AIDS, including by implementing prison-based needle and syringe programmes, opioid substitution therapy, condoms and other safer sex supplies.”<sup>50</sup>

## **ii. Corrections and Conditional Release Act**

The *Corrections and Conditional Release Act* (CCRA) obligates CSC to “take all reasonable steps to ensure that penitentiaries, the penitentiary environment, the living and working conditions of inmates and the working conditions of staff members are safe, healthful and free of practices that undermine a person’s sense of personal dignity.”<sup>51</sup> In carrying out this obligation, CSC must respect the right of prisoners to “retain the rights of all members of society except those that are, as a consequence of the sentence, lawfully and necessarily removed or restricted.”<sup>52</sup> This includes the right to “essential health care” as well as “reasonable access to non-essential mental health care” that will contribute to an individual’s rehabilitation and reintegration into the community.<sup>53</sup> Prison health care, as stipulated by both the CCRA and CSC Commissioner’s Directive 800 on Health Services, “shall conform to professionally accepted standards,” thereby implying a right to comparable health care as offered in the community at large.<sup>54</sup>

Given the availability of NSPs in the community, the broad definition given to “health care” and the proviso to provide health services “in accordance with professionally accepted standards,” federal prisoners should have access to health services that include PNSPs, particularly in light of the CCRA’s explicit statement that people in prison retain all rights except those lawfully and necessarily restricted by incarceration. The rationale for PNSPs is especially compelling considering the disproportionate impact of HIV and HCV among Indigenous prisoners, women in prison and prisoners who use drugs, and CSC’s obligation to provide health services that are “sensitive to the needs of Aboriginal and women offenders, and offenders with special needs.”<sup>55</sup>

### iii. The Charter

Finally, the denial of sterile injection equipment to federal prisoners engages the constitutional rights of prisoners guaranteed under the *Canadian Charter of Rights and Freedoms*. In particular, CSC’s failure to provide PNSPs prevents safer injection by people in prison, a position that could lead to HIV and HCV infection and potentially death, a violation of prisoners’ right to life and security of the person. According to the Supreme Court of Canada in *Canada (Attorney General) v. PHS Community Services Society*, allowing a criminal prohibition on drug possession to extend to the premises of a supervised injection site violated the right to life and to security of the person because it deprived the clients of the site of lifesaving and health-protecting health services.<sup>56</sup> As the Court noted, “where a law creates a risk to health by preventing access to health care, a deprivation of the rights to security of the person is made out.”<sup>57</sup> Similarly, denying people in prison the health benefits of PNSPs — which include a significantly diminished risk of HIV and HCV infection as a result of reduced syringe sharing — violates their right to health and to security of the person.

Moreover, withholding sterile injection equipment to prisoners may violate their s. 15 Charter rights to equality before and under law, and equal protection and benefit of law, which have been interpreted by the Supreme Court of Canada to include intersecting grounds of discrimination.<sup>58</sup> As noted above, three out of four people enter Canada’s federal prisons with substance use problems; substance use is a contributing factor to the criminal behaviour of half the people admitted to federal institutions.<sup>59</sup> At the same time, First Nations, Inuit and Métis Peoples represent over 25% of people in federal prison, despite comprising just 4.3% of Canada’s population, with Indigenous women being the fastest growing population among prisoners in federal custody.<sup>60</sup> In *Sauvé v. Canada (Chief Electoral Officer)*, Justice McLachlin, writing for the majority of the Supreme Court, noted that the negative effects of the impugned provision prohibiting prisoners from voting in federal elections had “a disproportionate impact on Canada’s already disadvantaged Aboriginal population.”<sup>61</sup> Denying prisoners access to sterile injection equipment would have a correspondingly disproportionate impact on Indigenous people, for whom an estimated 45% of new HIV infections are attributed to injection drug use — more than four times the estimate for the population as a whole.<sup>62</sup> Notably, in federal prisons, women are twice as likely as men to be serving a sentence for drug-related offences, with Indigenous and Black women more likely than White women to be in prison for that reason.<sup>63</sup> HIV and HCV prevalence have also consistently been shown to be higher among incarcerated women than among incarcerated men in Canada,<sup>64</sup> and federally incarcerated Indigenous women have far higher rates of HIV and HCV than federally incarcerated men and non-Indigenous women.<sup>65</sup> As the Canadian Human Rights Commission concluded: “Although sharing dirty needles poses risks for any inmate, the impact on women is

greater because of the higher rate of drug use and HIV infection in this population,” an impact that “may be particularly acute for federally sentenced Aboriginal women.”<sup>66</sup> The absence of sterile injection equipment thus has a disproportionate impact on prisoners who use drugs, Indigenous prisoners and women in prison.

#### **4. Conclusions and recommendations**

An overwhelming body of evidence affirms that PNSPs work to protect the health of people in prison and are a critical part of a larger strategy to improve the health and well-being of people who use drugs, many of whom are the most marginalized people in Canadian society. Denying prisoners access to this key health measure, in a setting where the prevalence of blood-borne infections is high and drugs are available but sterile injection equipment is not, is a recipe for a public health disaster. It is also a blatant violation of prisoners’ human rights: CSC’s failure to implement PNSPs does not meet Canada’s commitments under international human rights law, its mandate under Canadian correctional legislation, or its obligations under the Charter.

People’s lives, both inside and outside prison, are dramatically affected by the lack of sterile injection equipment in prison every passing day. It is thus imperative that CSC implements PNSPs without delay. In line with the new *Canadian Drugs and Substances Strategy*, which formally restores harm reduction as a key pillar of Canada’s drug strategy, we urge the Senate Standing Committee on Human Rights to recommend the immediate implementation of PNSPs in prisons across the country. It is essential that implementation, including the development of PNSP programming, structure and policy, be carried out in ongoing and meaningful consultation with relevant stakeholders including prisoners, and build upon the research and recommendations of *On Point: Recommendations for Prison-Based Needle and Syringe Programs in Canada*, a 2016 study undertaken to consider PNSP implementation in Canada.<sup>67</sup> If CSC truly endeavours to improve the health and safety of the prison environment for prisoners and prison staff and to uphold its obligation to protect prisoners’ health, there is no time to waste.

**People’s lives, both inside and outside prison, are dramatically affected by the lack of sterile injection equipment every passing day. In view of Canada’s new *Drugs and Substances Strategy*, which formally restores harm reduction as a key pillar of Canada’s drug strategy, the tremendous benefits to be gained from implementing PNSPs and the very real adverse consequences of continuing to reject such programs, we urge the Senate Standing Committee on Human Rights to recommend the immediate implementation of PNSPs in prisons across the country, in ongoing and meaningful consultation with relevant stakeholders, including people in prison.**

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- <sup>1</sup> Testimony of Mr. Howard Sapers, Correctional Investigator of Canada, Office of the Correctional Investigator to the Standing Committee on Public Safety and National Security, 1st session, 42nd Parliament, May 31, 2016.
- <sup>2</sup> R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience, Second edition*, Canadian HIV/AIDS Legal Network, 2006.
- <sup>3</sup> Public Safety Canada, *Substance Abuse*, December 2015.
- <sup>4</sup> See, for example, E. van der Meulen, “‘It Goes on Everywhere’: Injection Drug Use in Canadian Federal Prisons,” *Substance Use & Misuse*, February 22, 2017, and D. Zakaria et al., *Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*, Correctional Service of Canada, March 2010.
- <sup>5</sup> D. Zakaria et al.
- <sup>6</sup> F. Kouyoumdjian et al., “Health status of prisoners in Canada,” *Canadian Family Physician* 62 (March 2016): 215–222.
- <sup>7</sup> Public Health Agency of Canada, *Prison needle exchange: Review of the evidence, report prepared for Correctional Service of Canada*, April 2006.
- <sup>8</sup> Canadian Agency for Drugs and Technologies in Health, *Needle Exchange Programs in a Correctional Setting: A Review of the Clinical and Cost-Effectiveness*, September 3, 2015.
- <sup>9</sup> D. Zakaria et al.; F. Kouyoumdjian et al.
- <sup>10</sup> R. Elliott, “Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons,” *Canadian Medical Association Journal* 177,3 (2007): 262–264. See also M.-J. Milloy et al., “Incarceration experiences in a cohort of active injection drug users,” *Drug and Alcohol Review* (2008): 1–7; C. Poulin et al., “Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons,” *Canadian Medical Association Journal* 177,3 (2007): 252–256; European Monitoring Centre for Drugs and Drug Addiction, *Annual report on the state of the drugs problem in the European Union and Norway*, 2002; E. Wood et al., “Recent incarceration independently associated with syringe sharing by injection drug users” *Public Health Reports* 120,2 (March/April 2005): 150–156; W. Small et al., “Incarceration, Addiction and Harm Reduction: Inmates Experience Injecting Drugs in Prison,” *Substance Use and Misuse* 40 (2005): 831–843.
- <sup>11</sup> D. Zakaria et al.
- <sup>12</sup> D. Zakaria et al.
- <sup>13</sup> M. Tyndall et al., “Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic,” *AIDS* 17,6 (2003): 887–893.
- <sup>14</sup> H. Hagan, “The relevance of attributable risk measures to HIV prevention planning,” *AIDS* 17,6 (2003): 911–913.
- <sup>15</sup> K. Dolan and A. Wodak, “HIV transmission in a prison system in an Australian State,” *Medical Journal of Australia* 171,1 (1999): 14–17.
- <sup>16</sup> M. MacDonald, *A Study of Health Care Provision, Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe*, The European Institute for Crime Prevention and Control, 2005.
- <sup>17</sup> A. Bobrik et al., “Prison health in Russia: the larger picture,” *Journal of Public Health Policy* 26 (2005): 30–59.
- <sup>18</sup> A. Taylor et al., “Outbreak of HIV Infection in a Scottish Prison,” *British Medical Journal* 310 (1995): 289–292.
- <sup>19</sup> WHO, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users, Evidence for Action Technical Papers*, 2004. See also Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004; R. Carlson et al., “A preliminary evaluation of a modified needle-cleaning intervention using bleach among injection drug users,” *AIDS Education and Prevention* 10,6 (1998): 523–532.
- <sup>20</sup> R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, WHO, UNODC and UNAIDS, 2007; M. Macdonald et al., “Effectiveness of needle and syringe programmes for preventing HIV transmission,” *International Journal of Drug Policy* 14 (2003): 353–357; R. Bluthenthal et al., “The effect of syringe exchange use on high-risk injection drug users: a cohort study,” *AIDS* 14,5 (2000): 605–611; D. Gibson et al., “Effectiveness of syringe exchange programs in reducing HIV risk behaviour and HIV seroconversion among injecting drug users,” *AIDS* 15,11 (2001): 1329–1341; K. Ksobiech, “A meta-analysis of needle sharing, lending and borrowing behaviours of needle exchange program attendees,” *AIDS Education and Prevention* 15,3 (2003): 257–268; A. Wodak and A. Cooney, “Effectiveness of sterile needle and syringe programmes,” *International Journal of Drug Policy* 16S (2005): S31–S344.
- <sup>21</sup> Canadian Agency for Drugs and Technologies in Health, *Needle Exchange Programs in a Community Setting: A Review of the Clinical and Cost-Effectiveness*, September 14, 2015; M. Gold et al., “Needle exchange programs: an

economic evaluation of local experience,” *Canadian Medical Association Journal* 157,3 (1997): 255–262; F. Laufer, “Cost effectiveness of syringe exchange as an HIV prevention study,” *Journal of Acquired Immune Deficiency Syndrome* 28,3 (2001): 273–278.

<sup>22</sup> R. Heimer, “Can syringe exchange serve as a conduit to substance abuse treatment?” *Journal of Substance Abuse Treatment* 15,3 (1998): 183–191; H. Hagan et al., “Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors,” *Journal of Substance Abuse Treatment* 19,3 (2000): 247–252.

<sup>23</sup> R. Jürgens, *Interventions to Address HIV/AIDS in Prisons*; Harm Reduction International, *Global State of Harm Reduction 2016*, 2017.

<sup>24</sup> R. Lines et al, *Prison Needle Exchange*; PHAC, *Prison needle exchange*; K. Stark et al., “A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany,” *Epidemiology and Infection* 13,4 (2006): 814–819; H. Stöver and J. Nelles, “10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies,” *International Journal of Drug Policy* 14 (2003): 437–444; S. Rutter et al., *Prison-Based Syringe Exchange Programs: A Review of International Research and Program Developments*, NDARC Technical Report No. 112, 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?” *British Medical Journal* 317,7153 (1998): 270–273; K. Dolan et al., “Prison-based syringe exchange programmes: a review of international research and development,” *Addiction* 98 (2003): 153–158; J. Nelles et al., *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 and A. Fuhrer (eds.) *Harm Reduction in Prison* (Berne: Peter Lang, 1997), 239–262; H. Stöver, “Evaluation of needle exchange pilot projects show positive results,” *Canadian HIV/AIDS Policy & Law Newsletter* 5,2/3 (2000): 60–64; C. Menoyo et al., “Needle exchange programs in prisons in Spain,” *Canadian HIV/AIDS Policy & Law Review* 5,4 (2000): 20–21; Ministerio Del Interior/Ministerio De Sanidad y Consumo, *Needle Exchange in Prison: Framework Program*, 2002; J. Sanz Sanz et al., “Syringe-exchange programmes in Spanish prisons,” *Connections: The Newsletter of the European Network Drug Services in Prison & Central and Eastern European Network of Drug Services in Prison* 13 (2003): 9–12; N. Bodrug, “A pilot project breaks down resistance,” *Harm Reduction News* 3,2 (2002): 11.

<sup>25</sup> Canadian Medical Association, *Annual Meeting Resolution 26*, August 17, 2005.

<sup>26</sup> Ontario Medical Association, *Improving our Health*.

<sup>27</sup> See Annual Reports of the Correctional Investigator 2003–2004, 2005–2006, 2006–2007, 2009–2010 and 2015–2016.

<sup>28</sup> Canadian Human Rights Commission, *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*, 2004.

<sup>29</sup> See OHCHR and UNAIDS, *International Guidelines*, Guideline 4 at para. 21(e); WHO, *WHO Guidelines*, Guideline 24; UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006, Recommendation no. 60.

<sup>30</sup> UNODC, International Labour Organization (ILO), UNDP, WHO and UNAIDS, *HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions*, 2013.

<sup>31</sup> See, for example, UN General Assembly, *UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, Resolution 70/175, Annex, adopted on December 17, 2015, Rules 3 and 5 and UN Human Rights Committee, General Comment No. 21: Article 10 (Humane treatment of persons deprived of their liberty), UN Doc. HRI.GEN.1.Rev.1 (1992), para. 3.

<sup>32</sup> See Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights*, December 16, 1966, 993 UNTS 3 (entered into force January 3, 1976) [ICESCR].

<sup>33</sup> See, for example, Article 12 of the *Convention on the Elimination of Discrimination Against Women (CEDAW)*.

<sup>34</sup> UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health (22nd Session, 2000), UN Doc E/C.12/2000/4, para. 34.

<sup>35</sup> UN Human Rights Committee, General Comment No. 6: The right to life: Art. 6 (16th Session, 1982), UN Doc. HRI.GEN.1.Rev.1, para. 5.

<sup>36</sup> UN General Assembly, *Basic Principles*, para. 9.

<sup>37</sup> WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993.

<sup>38</sup> UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings*.

<sup>39</sup> 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), p. 3.

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- <sup>50</sup> UN Committee on the Elimination of Discrimination Against Women, *Concluding Observations: Canada*, November 2016, para. 49.
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- <sup>52</sup> CCRA, s. 4(d).
- <sup>53</sup> CCRA, ss. 85–88.
- <sup>54</sup> CSC, *Commissioner’s Directive 800: Health Services*, 2015, s. 2(a).
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- <sup>57</sup> *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para. 93.
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