AIDS Strategies and Australian Prisons

by
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The Honourable Justice Kirby is well known to Australians for his work in a great number of fields of endeavour, both at home and overseas. Indeed it would take as much space as his entire paper to attempt a chronicle of his community activities. Suffice it to say that following his education at the famous Forte Street High School and the University of Sydney, he has thrown himself wholeheartedly into a lifetime of service to the Australian community. He has been President of the Court of Appeal of the Supreme Court of New South Wales since 1984 and a Commissioner of the International Commission of Jurists since the same year. He has been a Commissioner of the World Health Organisation Global Commission on AIDS and a Trustee of the AIDS Trust of Australia of recent years.

In the latter portion of last year, he was invited by the South Australian Justice Administration Foundation to present that body's Eighth Annual Oration. The South Australian Justice Administration Foundation seeks to promote research and education in the fields of common interest to persons who are engaged in or interested in the administration of justice.

Over the years since the formation of the Foundation, the presentation of the Annual Oration has become a significant event. We acknowledge with gratitude the permission of both His Honour and the Foundation to reproduce the Oration presented by His Honour on the 6th August, 1990.

RETURN FROM KOREA

A little more than a week ago I was in Seoul in the Republic of Korea. There is little evidence to be seen there of the ancient civilisation of that peninsula. Devastated by war and successively over-run by advancing and retreating troops, the city bears all the hallmarks of modernity. It is a place of crowded populations, super highways – a desert of concrete. Now it is concerned about a new enemy.

The purpose of my visit was to attend a meeting called by the World Health Organization (WHO). The regional office for Asia and the Western Pacific had summoned the meeting on the legal and ethical issues of AIDS. I am a member of the WHO Global Commission on AIDS. That is a body of twenty-five Commissioners, appointed from the four corners of the world, and with different expertise, to advise the Director General of WHO (Dr H Nakajima) on worldwide strategies to combat the spread of the AIDS epidemic. Among the Commissioners are the two scientists credited with the isolation of the human immuno-deficiency virus (HIV), which is the cause of AIDS: Dr Luc Montagnier of France and Dr Robert Gallo of the United States. Membership of this body has given me a rare and privileged insight into the battle against a global epidemic of frightening potential.

Epidemics are not new. Any visitor to a garrison, church or graveyard in the outposts of empire will see reminders of earlier epidemics. The history is chartered from the very earliest days of the Australian colonies. Smallpox, the plague, cholera – the epidemics of the past — have regularly carried off millions throughout the world. Traditionally, they were seen as God's work. Economically, they were described as a natural check on over-population. The history of humanity has been a history of epidemics. It is only in our century that we came to the dazzling belief that we could conquer such challenges to public and individual health. The advent of HIV, and the toll of AIDS throughout the world, have served as reminders of our humanity and the persisting limitations of our scientific skills.

To this time, AIDS has been a relatively small problem in our region. In terms of numbers, Australia and New Zealand show the greatest penetration of the epidemic. To the 30th June 1990, Australia had notified 1861 cases of AIDS to the WHO. New Zealand had notified 160. Japan with 189 cases is second highest in total notifications. However, proportionate to its population, the epidemic is still at an early stage in that country. In Asia the most pressing concern is the rapid rise in reports of sero conversions amongst intravenous drug users in Thailand. Whereas two years ago only 3% of a sample of these persons was found to be HIV positive, a similar test this year revealed more than 40% presenting with evidence of exposure to the virus. Obviously, with huge populations,

comparative poverty in many countries, multiple health problems and scarce resources, the concern about the potential of AIDS to wreak devastation in the region is acute.

The participants in the Seoul conference agreed upon a checklist of measures which should be adopted in considering the introduction of laws to deal with HIV and AIDS.[1] One of the most interesting sessions concerned the subject of AIDS in prisons. It was interesting because of the perspectives of scientists and lawyers from such diverse cultures, tackling a problem common for humanity. They came to the problem from different backgrounds. Yet the need for common strategies was recognised. So was the need for global cooperation.

It is easy, in our busy lives, to be preoccupied with the problems of the moment. For prison administrators, correctional policies in hard economic times present special challenges. The needs for reform of the law, of practices and of the resources devoted to institutional facilities press hard upon those who have the responsibility for Australia's prisons. Among the many issues which confront such officials, HIV and AIDS must presently seem low in the order of priorities. Yet, as I shall seek to show, the potential significance of HIV/AIDS in prisons in Australia is such that our community should be looking most closely at the policies that must be put in place at this time for the protection of the prison population and of the community to which that population eventually returns. So much was recognised by the experts in Seoul. So much should be recognised by people of responsibility in Australia.

THE VIRUS AND MODES OF TRANSMISSION

A useful rule for the development of any law or policy – but imperative in the control of an epidemic such as AIDS – is the necessity to have a clear understanding of the features of the target. Good ethics, effective policies and just laws are more likely to emerge from a clear understanding of the features of the epidemic, its modes of transmission and its characteristics in the community than from preconceptions based upon fear, hysteria, religious conviction or other grounds. If we are truly serious about mobilising whatever fragile and imperfect assistance we can give to impede the spread of HIV and AIDS, it is self-evident that people with relevant responsibilities should be aware – at least in general terms – of the nature of the epidemic and of the virus which causes its spread. To ensure that we keep our sense of proportion, it is also useful to know something about the present size and projected enlargement of the problem. We should be aware of the available therapies and the prospects for a vaccine and cure. Knowledge of the latter reinforces a proper sense of urgency about developing effective policies and laws which protect society, and the individuals who make it up, from the spread of this life threatening virus.

AIDS is a viral infection which suppresses the body's immune system.[2] In the worst cases it goes on to destroy that system, leaving the patient vulnerable to opportunistic infections which would otherwise be resisted. The HIV virus invades and kills the body's white blood cells (called T lymphocytes or T-cells). As this occurs, diseases which rarely affect a person with an immune system which is intact can prove seriously debilitating (and later fatal) to those infected with HIV. AIDS, caused by HIV, is thus the precondition of a serious and usually, eventually, fatal illness. The end stage illness will typically involve one of a number of infections or malignancies, many of them otherwise quite rare.

The HIV virus has been isolated in most body fluids, including saliva, tears and urine. However, only blood and semen have, so far, been implicated by epidemiological evidence in the transmission of the virus from one human to another. Mosquito bites, sneezing, casual contact, social interaction and shared toilet seats can be ruled out as modes of transmission. Fortunately for humanity, the HIV virus is not easily acquired. It is important to make this point to repel the worst fears, sometimes held by people who should know better. Irrational fears about earlier epidemics have taken their toll in the past. At the turn of the 20th century, it was seriously thought in public health circles that syphilis (a condition then bearing many parallels to contemporary AIDS) was transmitted by the shared use of pencils, pens, towels and bedding. Naval regulations were promulgated during the First World War requiring the removal of doorknobs from United States battleships because of the belief that they caused the spread of syphilis amongst the sailors.[3] We now know that the causes were something rather less impersonal than a doorknob.

AIDS represents the third, or end, stage of the progress of infection with HIV. Like syphilis, AIDS has a typically long period of latency, although this varies according to the subject's age, environmental factors, etc. The long first period of HIV infection may last indefinitely. However, typically, in the adult it lasts about 8 years. The second stage (ARC) sees the development of "AIDS related complex" – with the onset of certain physical signs and symptoms. These usually accompany a significant drop in the T-cell count. It is the third stage which is AIDS – a condition diagnosed by reference to a number of now internationally accepted criteria.

Although progress from one stage to the next, and from AIDS to death, can be interrupted or slowed in some cases by therapeutic drugs, the available therapies are imperfect. They are also expensive. The most effective of them (AZT) costs (depending on dosage) about $4,000 per person per year. Obviously in poorer countries – such as some of those represented in the meeting in Seoul – drugs such as AZT are simply not available, whether to prisoners or to other citizens. But even in comparatively wealthy countries, such as the United States and Australia, controversies have also arisen concerning the availability of AZT therapy. Some views have been expressed that even people in the first stage of symptom-free HIV infection would benefit from AZT therapy. The cost of providing such therapy would be enormous, particularly in the United States where it is estimated that more than a million persons are infected with the virus. Three thousand new cases are reported each month in that country. In Australia, complaints have also been made about the availability of AZT. However, at least we have a national health system and standard criteria by which therapeutic decisions on this and other drugs can be made with a measure of equity.

The dimension of the problem we are facing with AIDS is clearly presented by the fact that the number of reported cases of AIDS represents only a portion of those persons with the condition. There are still various pressures to ascribe illnesses and eventual death to the opportunistic infection rather than to AIDS. In this way the dimension of the problem continues to be under-estimated. And cases of AIDS represent only the tip of the iceberg of persons infected with the HIV virus. Various estimates have been given for the numbers in Australia. Those

estimates have recently been revised downwards. But it seems likely that at least 30,000 Australians have been infected. Most of them are young, symptom-free, apparently healthy, at the peak of their economic and social utility. As such, these people provide no risk to other citizens with whom they come in contact. It is not people or groups who present a problem for the spread of HIV. It is particular behaviour.

At first, a significant mode of transmission of HIV in Australia was through contaminated blood products (especially blood transfusions). This source of the epidemic has been stemmed in Australia but not, appallingly enough, in many developing countries of Africa and Latin America. The remaining modes of transmission are well known. They are sexual intercourse, sharing of contaminated intravenous drug equipment and perinatal transmission. The last is now a major source of transmission of the virus in the Untied States and in parts of Africa. The first two represent the source of the challenge of AIDS in the context of prisons.

PRISONS: AN INCUBATOR?

There are no reliable figures for the prevalence or incidence of HIV infection in Australian prisons. [4] However, a recent article on the subject has suggested that the prison environment, at least in Australia, is, by its very nature, a potential reservoir for the spread of HIV-AIDS because of the established incidence in prisons of high risk activities which cannot, responsibly, be ignored. [5]

The position in prisons overseas is better documented or estimated. In a recent paper published in the *Medical Journal of Australia,* Dr Jael Wolk and others referred to the spread of AIDS to the community by reason of infection acquired in prison:

> "Needle sharing and unsafe sexual practices are both generally considered to be prevalent within prisons, although the extent to which they occur is unknown. In the United States the number of AIDS cases in prisons increased by 157% between January 1986 (766 cases) and October 1987 (1964 cases) and the majority of cases were [intravenous drug users]. Studies of HIV sero prevalence in Argentine and Brazilian prisons in 1988 showed that 17% and 18.3% respectively of inmates were infected and the majority of the infected prisoners [are intravenous drug users]. HIV sero prevalence ranged from 11% to 48% in European prisons in 1987/88. There is also evidence that HIV infection is occurring in prisons: 2 of 137 inmates incarcerated for 9 years in Merryland, USA, tested HIV positive as did 6 inmates incarcerated for between 4.6 and 7 years in New York."[6]

Further statistical data on the presentation of HIV in prisons is collected in a paper on the topic of Hans Heilpern and Sandra Egger.[7] Most of the data collected by them refers to Europe and North America.

So far as Europe was concerned, the highest figure reported was from Spain where screening among high risk prisoners revealed that 25.7% were sero positive. Other high figures were reported from France: 13% (testing of 500 consecutive entries); Italy 16.8% (screening of 30,392 prisoners in 1986); Switzerland 11%. And the Netherlands 11% (screening of a sample of prisoners in Amsterdam). The low figure returned by the United Kingdom (0.1%) was regarded as reflecting a low level of screening rather than a genuine low level of prevalence in that country.

On the basis of these to other studies, an estimate was put forward that the overall prevelance of sero positivity in European prisons was in excess of 10%.[8] Amongst IV drug users in prisons the level of sero positivity was much higher. In one study of IV drug user prisoners in Fresnes in France, it was found that 61% were sero positive. More recent research in France paints a still grimmer picture of the French prisons surveyed. Twelve percent of prisoners admitted in 1987 admitted to drug dependence; an estimated 50% of IV drug user prisoners were deemed HIV positive. The overall HIV sero positive rate in French prisons was estimated to be 6% – a rate 20 to 30 times higher than in the general population. Overcrowding was such as to exacerbate these difficulties. And perhaps the most telling statistic was the rapid increase in the rate of HIV sero prevalence. In one Spanish prison, for example, it almost doubled in one year from 24% in 1986 to 46% in 1987.

Similar patterns emerge from studies in the United States Two national prison project surveys in 1985 and 1987 showed a 293% increase in the number of cases of inmates with AIDS (420 to 1650). In both cases the death rate within a year was approximately 50%. At October 1987, there had been a cumulative total of 1964 AIDS cases amongst prison inmates in the United States. Five percent of inmates with AIDS were women. The correctional administrators attributed approximately 66% of the males cases to pre-prison homosexual activity. However, other opinions expressed the view that IV drug use is a much more important transmission category in correctional AIDS cases than in the population at large.

WHO PRINCIPLES

Against the background of accumulating data on the incidence of HIV in prisoners in many countries – and the perceived importance of the issue to the future course of the AIDS pandemic – the World Health Organization convened a meeting on the subject in November 1987 in Geneva. Thirty-seven specialists from twenty-six countries participated. They included experts in public health, prison and medical administration, prisoner care, occupational health and safety, epidemiology and health policy. At the end of the consultation a statement, reached by consensus, was approved.[9] This is a common procedure adopted by WHO to provide guidance to member countries from the international pool of talent and expertise available in dealing with major world health problems, including AIDS.

The WHO experts stressed the need to perceive control and prevention of HIV infection in the context of the larger obligation significantly to improve overall hygiene and health facilities in prisons. They recognised that in many countries there may be substantial numbers of prison inmates who have a history of high-risk behaviours such as intravenous drug use, prostitution and "situational homosexual behaviour" in the prison environment. These considerations imposed upon prison authorities a "special responsibility" to inform prisoners of the risk of HIV infection. Many of the persons making up the prison population were thought to be "unlikely to have received such education in the general community". If there is ignorance about AIDS and its transmission in the general community, it may fairly be assumed to be a still larger problem in prisons. There, socially deprived persons with lower than average education tend to predominate. The experts urged that policies of prison administrations to deal with HIV/AIDS should be developed "in close cooperation with health authorities". They stressed the need for independent

advice in the interests of prisoners by prison medical services. They urged the adoption of prison policies along the guidelines which took into account a number of considerations. These included:

1. The responsibility of prison administrations to minimise HIV transmission in prisons; and
2. Prisoners' rights of access to educational programmes, voluntary testing, confidentiality of results, availability of counselling, medical services equivalent to those available to AIDS patients in the community at large and information on treatment programmes.

The WHO report suggested that prisoners with AIDS should be considered for compassionate early release "to die in dignity and freedom". The need to prevent discriminatory practices relating to HIV infection or AIDS "such as involuntary testing, segregation or isolation, except when required for the prisoner's own well being" was clearly stated. The necessity to provide prison staff with up to date information and education was also stressed. The experts went on:

> "Homosexual acts, intravenous drug abuse and violence may exist in prisons in some countries to varying degrees. Prison authorities have the responsibility to ensure the safety of prisoners and staff and to ensure that the risk of HIV spread within prison is minimised. In this regard prison authorities are urged to implement appropriate staff and inmate education and drug user rehabilitation programmes. Careful consideration should be given to making condoms available in the interest of disease prevention. It should also be recognised that within some lower-security correctional facilities, the practicability of making sterile needles available is worthy of further study."

Perhaps most boldly the experts urged that governments:

> "May also wish to review their penal admission policies particularly where drug abusers are concerned in the light of the AIDS epidemic and its impact on prisons."

AUSTRALIA'S REACTION

Against the background of these internationally stated guidelines, it is relevant to examine the response by governments and prison administrators in Australia where prisons are generally a State responsibility. Recent developments in New South Wales illustrate the fact that it is difficult to be sure of the most up to date information on this score. Certainly, compulsory testing of all prisoners, including unsentenced prisoners, entering the correctional system is undertaken in Queensland, South Australia, Tasmania and the Northern Territory.[10]. Compliance with the obligation is obtained through the use of what are described as "correctional sanctions". In South Australia and Tasmania, a repeat test is undertaken after three months of imprisonment. The purpose of this test is to overcome the possible inaccuracy of the initial test based upon the established numbers of false positives and false negatives (due to imperfections of the test) or the possibility that the prisoner was in the "window period" at admission, when first tested. As is now widely known, the test commonly in use to establish the presence or absence of HIV infection responds to the antibodies produced following exposure to the HIV virus. These antibodies take a time to present in sufficient degree to produce a positive test result. Estimates of the "window period" vary. However, three months would appear to be safe for the purpose of catching cases missed in this way. In Queensland, retesting is conducted at twelve monthly intervals. It may also be repeated on prisoners assessed as possibly engaging in "high risk behaviour".[11]

In the other States, at least until recently, voluntary testing programmes were offered and indeed encouraged. In Victoria, all prisoners are offered the opportunity to be tested upon admission. Reluctant prisoners are counselled and encouraged to volunteer. A very high compliance rate (98%) is reported.[12] In Western Australia, a voluntary testing programme was offered; but few prisoners were reported as seeking to be tested.

Until mid-1990, the policy of New South Wales prisons was to provide for voluntary tests only. At least until 1989 the number of prisoners volunteering for the test was quite low (estimated at 5%). This was because of the consequences of a seropositive result. Prisoners found to be HIV positive were segregated. They lost the opportunity to participate in many prison activities, eg industry, eduction, work release. In these circumstances it was little wonder that the volunteers were few. Their number reportedly increased upon the abandonment of segregation. As well, prison authorities provided much information to prisoners about HIV/AIDS. In-house prisoner newsletters also contained much beneficial discussion of the subject and of the special risks presented by prison life.

The results of the testing systems outlined above are not (as has been said) entirely satisfactory. By the beginning of 1989, the cumulative number of HIV positive prisoners in Australia revealed by such testing procedures was 99. As the total Australian prison population at any given time is of the order of 11,000 and as total annual admissions amount to about 33,000 prisoners, it can be seen that the present testing procedures reveal quite a low incidence of HIV in Australia's prisons. But these figures obviously mask a larger problem. Sources of the problem, and of the unreliability of the available statistics are:

1. The numbers of false negatives/positives in jurisdictions where tests are not repeated;
2. Prisoners in the "window period" where tests are not repeated;
3. Self-selection and exclusion in jurisdictions where tests are voluntary; and
4. Exclusion of long-term prisoners in systems reliant upon more recently introduced testing on admission.

There seems little objective reason why Australia's prisons should be immune, at least in the long run, from the kinds and levels of infections revealed in Western Europe and North America. The same phenomena exist to give rise to the same problems, namely;

(a) High levels of drug using persons who –
  (i) are imprisoned for drug related offences, or
  (ii) gain access to injected drugs in prisons; and
(b) High levels of young male prisoners, deprived of heterosexual outlet, thrown together often in crowded conditions which may give rise to "situational homosexual conduct" at levels significantly higher than would exist in civilian life.

It is in these circumstances that HIV is specially relevant to prisons. For these features of prison life mirror, unfortunately, the major known modes of transmission of the HIV virus.

The precise levels of access to injected drugs in prisons in Australia is unknown. Professor John Dwyer estimated in 1988 that in Long Bay prison in Sydney, about 60% of inmates used intravenous drugs once or twice a week.[13] If this is even partly right, it represents a very high exposure rate to the risk of infection from unsterile injecting equipment. The figure may seem very high to a causal observer of the problem. In any case, figures in Sydney, the major port of entry into Australia of illegal injected drugs, may make figures in New South Wales prisons unrepresentative of prisons in Australia generally. But that drugs do enter the prison system is indisputable. It is proved by the occasional cases of criminal charges brought against prison officers and prisoners. It is established by reliable anecdotal evidence. It reflects, in part, the fact that a very high proportion (said to be more than 70%) of all persons sent to prison in Australia have some civilian contact with illegal drugs. Because of mandatory or otherwise high prison sentences for drug related offences, it is inevitable that, at any time, many prisoners, in Australian prisons, will have had exposure to illegal injected drugs before admission. It is also true that many non-drug offences, particularly of larceny and robbery, can be traced to crimes committed, allegedly, to provide funds to feed an illegal drug habit. Likewise male and female prostitution are in some cases associated with that need. It is enough to say that the pre conditions for the high increase in HIV through drug injection exist in the very nature of the client population of Australian prisons. Lack of effective alternative programmes, lack of motivation to escape drug use, lack of resources to ensure adequate surveillance, the limits, in any case on complete surveillance and the advantages which can sometimes result from addicted prisoners who have access to their drugs all conspire to provide the environment in which even honest prison officers may fail to eradicate drug use in prisons.

The level of homosexual activity between prisoners is likewise difficult to estimate. At the meeting in Seoul, Korea, the representative of Vietnam, an epidemiologist, reported that there were no such cases in Vietnamese prisons because homosexuality was completely unknown in Vietnamese society. This information was received with a degree of scepticism. The Chinese medical participants reported that homosexual activity in Chinese prisons was at a very low level of incidence, but doubtless did occur. Crowding together of young male prisoners was recognised as a circumstance which could give rise to sexual conduct. Overseas studies report that 20 to 30% of prisoners engaged in sexual activity at least one time whilst in prison.[14] A 1989 study of a sample of prisoners in the South Australian prison system reported that about 42% of prisoners engaged in risk behaviour at least once whilst incarcerated. Thirty-seven percent were estimated to use drugs intravenously. Twelve percent were reported as having engaged in unprotected anal intercourse.[15] There are numerous constraints upon accurate investigation of this phenomenon, including the cultural norms typically prevailing in men's prisons. Some cases of non-consensual sexual intercourse come to notice when charges are laid. It is reasonable to infer that these represent but the tip of the iceberg. Quite apart from violent activity of this kind, consensual homosexual acts undoubtedly do exist. The debate is thus about the level of prevalence.

WHAT CAN BE DONE?

What then can be done to protect prisoners from infection with HIV whilst in prison? About some matters there need be little debate.

Few observers would dispute the need to:

1. Provide information, education and training to prisoners and to prison officers, administrators and all those responsible for prisons about the special risks of HIV/AIDS in the prison context;
2. To provide facilities for antibody testing on a voluntary basis whenever a prisoner reasonably wishes to undergo the test;
3. To provide for strict confidentiality in the results of the test and for counselling both before and after testing is conducted. Discovery of seropositivity, particularly in a prison environment with a lack of support that may be available outside, add to the need for understanding and assistance to prisoners found to be HIV positive. Prolonged periods of idleness, and the absence of the distractions available to a person pursuing an ordinary life in the community, mean that the impact of knowledge of seropositivity will be even greater in the case of a prisoner than otherwise;
4. Attention to tattooing by unsterile tatooing equipment is another special concern in the Australian prison culture. It provides a reason for the provision of bleach or other cleaning materials so long as in house tattooing occurs;
5. Facilities for treatment, as with AZT, therapy and therapeutic counselling should be available from prison medical staff to seropositive prisoners. Such staff should be provided with information about HIV/AIDS with the latest medical and non-medical supports available to persons infected; and
6. For the purpose of tracing the problem and constantly reviewing policies in relation to it epidemiological data on the incidence of HIV among prisoners, provided on a purely statistical footing, should be pooled and distributed to correctional authorities throughout the country. Personal identifiers should be removed from such data.

Fortunately, certain studies including the one on South Australian prisons, reveal relatively high levels of accurate knowledge about HIV and its modes of transmission within prisons.[16] The bad news, however, is that, despite this information, prisoners and prison officers believe that there has not been a resultant substantial reduction in risk behaviour, particularly in respect of intravenous drug use.[17] Clearly prison journals should be used and prisoners themselves consulted on ways in which information can be effectively disseminated in the prison environment to ensure necessary behaviour modification.

TESTING, CONDOMS AND BLEACH

Mandatory screening: This leaves three issues of controversy upon which there is no unanimity. The first is whether compulsory testing of prisoners should be supported. Its introduction in New South Wales was accompanied by considerable debate including, apparently, within the Government. There is a tendency with AIDS To resort to mandatory screening. The Government is then seen to be acting. It is usually directed at powerless, voiceless groups (such as prisoners, overseas migrant applicants and members of disciplined services). It has the colour of a medical response to a medical problem. We remember the widespread useful testing for tuberculosis. It is relatively cheap. It has some epidemiological utility. It may also provide prisoners with some proof in the event that they later wish to bring an action for negligent care against the government or prison authorities.

The arguments in favour of mandatory testing of all prisoners for purely statistical data are strong. But, as introduced in Australia, identifiers have not been removed. Confidentiality has not been observed. In some prisons, the prisoners are segregated and lose valuable rights. In others, their confidences have been betrayed, as when one prison officer told a family member that his father would take a time to get to the interview room because he was "in the AIDS wing". Testing leads to no cure. Unless accompanied by strict confidentiality (which it is difficult anyway to maintain in a prison environment) it leads to discrimination, hatred and even retaliation out of fear. Unless a strict policy of separate prisons and segregation is adopted the testing leads, effectively, nowhere. As well, it is subject, unless constantly repeated, to the defects of false positives and negatives and to the window period. It may lead to false confidence about HIV status. It does not have the advantage which "encouraged" voluntary testing presents as a first step in personal responsibility and behaviour modification which are essential for the containment of the HIV epidemic – especially in the artificial environment of prisons.

Whilst, therefore, I understand the political forces which lie behind compulsory testing of prisoners, I do not believe that it can be justified as an effective strategy against the spread of HIV in prisons, at least as presently undertaken. It is, I regret to say, politically attractive in part because it is cheap and has little consequence but involves doing something. I consider that the WHO guidelines which exclude such involuntary screening show greater wisdom.

Condoms: The provision of condoms in prisons has been opposed by prison officers' associations. In New South Wales, they even threatened to go on strike if any condoms were distributed in prisons.[18] As a result of this threat it was agreed that the proposal would be "kept on ice" for the time being. The *Sydney Morning Herald* reported that it was understood that "Ministers feared that any unexpected confrontation with prison officers would seriously jeopardise legislation aimed at introducing compulsory AIDS testing for all New South Wales prisoners".

A number of arguments are raised against the provision of condoms in prisons. Some of them are based upon the assertion, as in Vietnam, that homosexual activity does not exist. This is a factual issue. It appears to defy such anecdotal and research information as is available. In some cases it is opposed on the basis that the provision of condoms would condone sexual activity, to the decline of prison discipline. However, in many of the responses to the AIDS epidemic, authorities have had to face cold reality. In the name of the higher good of preventing the spread of a deadly condition, which should certainly not be acquired whilst a person is the responsibility of a State in a prison, steps have been taken which, even recently, would have been considered unthinkable. The most obvious of these involves the needle exchange scheme.

It is said that prison officers should not be demeaned by handing out condoms. I entirely agree. Such a procedure would, in any case, greatly discourage their use. Condoms should be readily available from medical services. At the least they should be available from vending machine or prison stores. Prisoners cannot walk into a pharmacy and purchase them, as ordinary citizens may. They should not, by reason of their imprisonment, be exposed to the risk of a deadly condition which can be avoided (or the risk greatly reduced) by the use of condoms.

Then it is said that condoms will break and are not suitable to anal intercourse. New and safer condoms have been developed. Furthermore, it is not only for anal intercourse that condoms should be used. Condoms reduce the risk of sexually transmitted diseases spreading by other means of sexual intercourse. No-one suggests that condoms are a complete answer to sexual transmission of HIV/AIDS. But they clearly reduce the risk very substantially. They would not be likely to be used in violent sexual acts, eg rape in prison. But for reducing the transmission of HIV in prisons at least by consensual sexual activity, condoms should in my opinion be made available free of charge. Whilst it is true that there is some risk that they may be used for secreting drugs or other objects, it is necessary in HIV prevention to balance risks. One thing is sure about HIV: once acquired there is no cure. In most, if not all, cases, it leads to death. I therefore find myself in agreement with the leader of the Sydney Morning Herald:[19]

> "There are more private ways of distributing condoms. In other countries condoms are simply sold across the counter in prison canteens or from vending machines. For six years, NSW Prison Officers have maintained that they will not accept the State-sanctioned introduction of condoms.This obstruction is a major political problem ... there is ... a fear that condoms would be used to conceal contraband in body cavities. This is indeed a risk. But it is less serious than the dangers of the spread of AIDS in NSW prisons and its implications for society outside the prisons."

IV DRUG USE

The most controversial issue is whether sterile syringes should be made available to prisoners or, at the least, bleach and other cleaning material to reduce the risk of spreading HIV through unsterile needles infected with contaminated blood. That risk is greater in the prison context because of the likelihood that, if illicit drugs are available, they will be administered with equipment which must be repeatedly used and shared amongst many users. To the subcultural forces which promote sharing of unsterile needles in civilian society, is typically added the imperative of unavailable alternatives in the prison context. It is not as if the prisoner can participate in the needle exchange scheme which has been introduced. He or she, if addicted, will usually have access only to imperfect equipment: just the kind likely to provide the perfect vehicle for the spread of contaminated blood.

I can understand the attitude of politicians and prison officers who resist the notion of providing sterile needles or even cleaning materials in a prison context. To many this would seem the final abandonment of the "war against drugs" and in a disciplined context. It would appear, in an environment designed to uphold the law, to condone illegal drug use: a contradiction in terms. Many of these arguments were presented by analogy, when the proposal for needle exchange was made. In a rare and bold move with bipartisan support, governments in Australia, New Zealand and elsewhere have concluded that the risks of HIV/AIDS, and the usually fatal result of the infection, require radical and even unpalatable steps to be taken.

It is my belief that in due course even more radical steps will be needed as the AIDS epidemic penetrates western societies by the vectors of drug infected heterosexual males and females. Already we are beginning to see serious calls to address the problems of drug addiction by the techniques of

public health rather than the imperfect mechanisms of law and order.[20] But this will remain a long-term strategy – one of great significance for the prison system. It would be a suitable topic for a future oration in this series. In the short term, in prisons, as in society, contradictions must be tolerated precisely because HIV once acquired has such devastating, horrible consequences. Offenders are imprisoned as punishment and not for punishment. They certainly do not go to prison to be exposed to the risk of acquiring a fatal condition there. Unless governments and prison administrators can absolutely guarantee a totally drug-free environment, it is their plain duty to face up to the risks of the spread of HIV infection by the use of unsterile injecting equipment in prisons. If it is too much to adopt a similar exchange system (unused for used needles) at the very least cleaning bleach should be provided in discrete ways for use by prisoners. Such provision must be backed up by education about the great dangers of IV drug use today. It must be supported by the expansion of methadone and drug rehabilitation programmes both within prison and afterwards.[21] Again, I agree with the *Sydney Morning Herald* leader:

> "Dr Alex Wodak, Director of the St Vincent's Hospital Drug & Alcohol Service said this week [that] prisoners [should be supplied with] condoms and provided with bleach for cleaning needles. It is advice to which [the Minister] should listen."

The subject of this oration has illustrated the challenge to our correctional policies and institutions posed by an epidemic which was completely unknown and unexpected fifteen years ago. However, it is now upon us. As overseas experience shows it has special significance for the Australian prison system. We must ready ourselves, as a civilised community, to ensure that prisoners are not unnecessarily exposed to acquiring a fatal condition whilst in prison. If we do not take proper steps, we will stand condemned as irresponsible and morally negligent in the safekeeping of prisoners. Winston Churchill's adage remains true. The civilisation of a country can still be tested by the way in which it treats its prisoners.

The World Health Organization has provided sensible guidelines. Sadly, Australian politicians and prison administrators have not adhered to them. Not enough has been done to spread and repeat the educational messages to the constantly changing prison population. Political gestures, such as mandatory testing, have been taken with little practical utility in addressing the real problems of HIV infection in prison. Prisoners found to be infected are not isolated. The only advantage of this testing is that it will provide evidence upon which prisoners will be able to rely in actions against governments in negligence in other respects to HIV acquired in prison. I rather doubt that this was the policy which lay behind the strategies of mandatory testing of prisoners. As is usually the case, those strategies are based either on ignorance of prejudice or real indifference to the true problems of containing the AIDS epidemic.

In the potential incubator of prisons those true problems derive from the established modes of transmission of the HIV virus. These are by IV drug use an unprotected sexual intercourse. Advice, educational and counselling (including to the point that the highest protection exists in avoiding entirely risky activities) must be given. But for those who cannot, or will not, take such advice, practical steps must also be taken. These include the availability of condoms and of cleaning bleach to prisoners.

Death, as they used to say in the old road safety advertisements, is "so permanent". If overseas experience is any guide, many prisoners will become infected with AIDS in prison. They will mirror the sexual orientation of the general population. They could then become vectors for spreading a deadly virus through our population. We owe it to the prisoners – but if this is unconvincing, we owe it to our community – to protect prisoners from infection whilst in prison. This requires radical steps before it is too late. Just as we have taken them with the needle exchange scheme in civilian society. Such steps may seem unpalatable. But the death of a person who is in the custody of society, because society has preferred to turn the other way, is even more unpalatable. Most unpalatable of all is the failure of elected governments to act because of industrial threats by Crown offices of a disciplined service whose duty it is to comply with the law made by the elected representatives of the people.

I therefore hope that we will go back to the WHO guidelines on prisons. And, that we will see less show-biz politics and fewer empty gestures – and more real concern to protect prisoners, and ourselves. Only in that way will we halt the needless spread of this most terrible virus which imposes a great economic burden on society, strikes down the young, uses pleasure as its agent of spread and inflicts a long, cruel one-way journey to death which causes great suffering to those infected and to those who, helplessly, see them die.

FOOTNOTES

1. World Health Organization, Regional Office for the Western Pacific, Regional Workshop and Legal and Ethical Aspects of AIDS and HIV Infection, Seoul, Republic of Korea, 25 July 1989, *Guidelines for Reviewing and Elaborating Legal Measures in AIDS Prevention and Control* (as yet unpublished).
2. See K Mutton and I Gusi, "Acquired Immune Deficiency Syndrome" (1983) *Medical Journal of Australia* 540.
3. A M Brandt, "AIDS In Historical Perspective: Four Lessons from the History of Sexually Transmitted Diseases" 78 *American Journal of Public Health* 4,367 (1988).
4. H. Strang, "AIDS in Prisons" (1990) 4 *National AIDS Bulletin* #6, 42.
5. Ibid.
6. J. Wolk, A. Wodak, A Mortlet et al, "HIV-Related Risk-Taking Behaviours, Knowledge and Sero Status of Intravenous Drug Users in Sydney" (1990) 152 *Medical Journal of Australia,* 453.
7. H. Heilpern and S. Egger, *AIDS in Australian Prisons Issues and Policy Options,* March 1989, Report commissioned by the Federal Department of Community Services and Health, Canberra, 21.
8. Ibid, 23
9. World Health Organization, *Consultation on prevention and control of AIDS in prisons,* 16-18 November 1987, WHO, Geneva.
10. Heilpern and Egger, 29.
11. *Id,* 30.
12. Loc cit.
13. J Norberry and D Chappel, "AIDS and Prisons" in *Australian Institute of Criminology, Trends and Issues No 21,* Canberra, 1989. See Strang (above) 42.
14. P L Nakki and T R Kane, "Intimate Sexual Aggression: Some Evolving Propositions, Empirical Findings and Mitigating Counterforces" in *Gender Issues, Sex Offences and Criminal Justice,* The Hayworth Press Inc, Washington DC, 1984. See Strang 42.
15. R M Douglas, R L Gaughwin, L M Davies et al, "Risk of Transmission of the Human Immunodeficiency Virus in the Prison Setting" (1989) 150 *Medical Journal of Australia* 722.
16. M D Gaughwin et al, "Preventing Human Immunodeficiency Virus (HIV) Infection Amongst Prisoners: Prisoners' and Prison Officers' Knowledge of HIV and their Attitudes to Options for Prevention in (1990) 14 *Community Health Studies* 61.
17. Ibid, 63.
18. *Sydney Morning Herald* 14 June 1990, 3.
19. Ibid, 30.
20. See eg Australian Parliament, Parliamentary Joint Committee on the National Crime Authority, Rethinking Drug Policy, Canberra, 1989; A Wodak, "Heroin Legalisation, Totem and Taboo Revised" in *Modern Medicine of Australia,* May 1990, 76; J Kaplan, "Taking Drugs Seriously" in 92 *The Public Interest,* 32 (1988).
21. See Strang (above). See also report of the Victorian Ombudsman (Mr N Geschke) reported *The Age,* 20 July 1990, 16.
22. See *Sydney Morning Herald* 14 June 1990.