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Responding to HIV/AIDS in European prisons, 1980s–2000s

Janet Weston

The impact of HIV/AIDS on prisons (and vice versa) has received minimal attention within histories of the epidemic. Yet, researchers agree that 'HIV hit prisons early and it hit them hard'.[1] Prisons were flagged as locations of concern very early on. Their residents, like other already-marginalised groups whose lives became entangled with HIV/AIDS, became a source of anxiety among policy-makers and the media alike. Injecting drug use before and during incarceration, sex between men in prison, violence among inmates and towards staff, overcrowding and bad hygiene, and the poor general health of many of those behind bars were all highlighted as factors potentially contributing to the rapid spread of disease.[2] This, coupled with concern about the provision of adequate clinical and palliative care for prisoners affected by HIV/AIDS and possible infringements of their rights, prompted international organisations to gather information and issue specific recommendations for HIV/AIDS and prisons in 1987–8.[3] Such recommendations emphasised education, integration of people with HIV/AIDS into normal prison life, special efforts to avoid stigma and discrimination, and the need for services and standards of healthcare within prisons to match those existing elsewhere in the community.

Despite these clear recommendations, policy and practice in prisons remained the object of criticism throughout the 1990s and into the 2000s.[4] These ongoing concerns, along with some elements of secrecy and stigma adhering to prisons, help to explain why prisons and their occupants have featured little in histories of HIV/AIDS; successful activism, charismatic leadership, and a clear trajectory of change is difficult to locate. Researchers from contemporary and historical perspectives alike have ascribed the lack of

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agreement and action in the 1980s and 1990s regarding prisons and HIV/AIDS to the fact that medicine occupied an unusual position in this setting. As Virginia Berridge has argued with reference to the UK, fields in which the role of medicine was uncertain, including the insurance industry and drug addiction services as well as prisons, tended to struggle to agree and implement policies on HIV/AIDS.[5] Across Europe, prison medicine was isolated from mainstream medical services and public health, managed instead by departments of justice. Prison medicine was also closely involved in matters of discipline, approving individuals for punishments, special diets, or particular forms of work, and it traditionally adhered to local rather than national guidelines. In combination, these factors meant that the national and international policy consensus on HIV/AIDS, which was strongly influenced by medical and public health expertise, struggled to find purchase within prisons.

This chapter uses international evaluations and research from the 1980s, 1990s, and 2000s, along with media coverage, parliamentary debate, and oral histories, to develop these insights. It begins with a review of prison policy relating to HIV/AIDS across Western Europe, setting this against the guidelines and recommendations emerging from the World Health Organization (WHO) and Council of Europe. This reveals that many regions, if not most, did make efforts to meet international standards, especially from the 1990s onwards. Initial reactions to HIV/AIDS within prisons were often far from ideal, however, with widespread practices of segregation and breaches of medical confidentiality. In later years, particular sticking points were the provision of condoms and sterile injecting equipment to those in prison. A closer examination of two contrasting national responses, from the Republic of Ireland and Switzerland, helps to shed light on the reasons for national variation. International recommendations and activities were influential and could help those working towards change, but they could not override the broader national context within which prisons operated.

By highlighting the impact of HIV/AIDS on drug users and addiction services, this chapter forms part of recent attention to healthcare within prisons in the past, as well as gaps in our understanding of the history of HIV/AIDS.[6] The impact of HIV/AIDS on drug treatment has been widely recognised within the field

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of addiction research, but has slipped out of sight within mainstream HIV/AIDS histories.[7] Those who injected drugs, and who often faced unemployment, poverty, homelessness, incarceration, and poor health unrelated to HIV/AIDS, were dramatically affected by the epidemic. So, too, were their families, and the volunteers and professionals that provided services and care. Their omission from these mainstream histories threatens a second form of marginalisation. Activism also took a different form in the context of addiction work and prisons, and has not typically been included within the traditional roster of HIV/AIDS protest and direct action – with a few exceptions.[8] Action often demanded a very low profile, with staff discreetly bending or putting pressure on official rules to generate practical or policy change. More public action was led by individuals at some personal risk but, as with hidden prison activism, its impact was rarely obvious or clear-cut. The example of prisons suggests that HIV/AIDS activism should be conceived more broadly, to incorporate covert action, activities that tested professional boundaries, and individual risk-taking, even when those actions did not prompt immediate or obvious change. Interventions to improve policies or conditions concerning HIV/AIDS and prisons rarely made the headlines and were not always successful, as the case studies of Switzerland and the Republic of Ireland show. First, though, we should consider the international recommendations for prisons that emerged in the late 1980s, and the extent to which these were adopted and resisted.

International recommendations and their implementation

The WHO Special Programme on AIDS held its first consultation on HIV/AIDS in prisons in November 1987, as did the Council of Europe's Social and Health Affairs Committee. Both bodies issued their initial recommendations soon thereafter. These were very similar to each other, emphasising the need for education for staff and prisoners about HIV/AIDS, voluntary rather than mandatory testing, and full integration of prisoners with HIV/AIDS into standard prison routines rather than any form of segregation. They also recommended the provision of condoms to prisoners, and, in more cautious terms, careful consideration of whether to provide

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sterile injecting equipment to prisoners in some circumstances.[9] The transmission of HIV within prisons via injecting drug use was addressed more forcefully in 1993, when further consultations on the situation in prisons prompted more comprehensive guidelines.[10] These were emphatic in recommending an absolute ban on compulsory HIV testing of prisoners, and highlighted prisoners' rights to healthcare, 'including preventive measures, equivalent to that available in the community'. Drawing special attention to the realities of HIV transmission within prisons, 'notably needle sharing among injecting drug users and unprotected sexual intercourse', the 1993 recommendations reiterated the need for condoms to be made available and called more definitively for the provision of disinfectant and clean injecting equipment inside prisons in countries where these were available to non-incarcerated drug users.

These recommendations reflected the broader international policy consensus that eventually emerged in response to HIV/AIDS, which favoured education, voluntarism, and the minimisation of harms and was sensitive (at least in theory) to the implications of discrimination and inequality. International recommendations were significant not only for setting standards and expectations, but also because their production generated some of the only pan-European data on HIV/AIDS in prisons. Figures gathered by the Council of Europe in 1987–8 showed that only Spain had so far identified significant numbers of people in prison with HIV/AIDS, but there was a clear belief that other countries would quickly follow suit.[11] By the mid-1990s, Italy, Spain, Scotland, and Berlin had the highest known rates of HIV infection within their incarcerated populations, with data from Denmark, France, and the Netherlands also indicating that a significant proportion of their prison populations may be affected.[12] Italy, it was reported, faced the highest numbers in Europe; in 1995, its prisons housed some 7,500 individuals with HIV/AIDS.[13] Extremely low figures, which may have reflected low rates of HIV testing as much as prevalence, were reported from most of Southeastern Europe. Of particular concern for Western Europe was the fact that rates of HIV infection appeared to be so much higher within prisons than in the general population; small studies from France and Switzerland suggested rates between 50 and 200 per cent higher, and researchers regularly pointed out that

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most people were in prison for a short time only and therefore presented a risk to the wider public upon their release.[14]

Many prison administrations in Western Europe had been spurred into action in 1985, when a test for HIV became available. Confirmed cases of HIV prompted an element of panic at this time, within prisons as elsewhere in society. Overcrowding and unhygienic conditions within most prisons, combined with concerns among staff about anything that might disrupt good order and control, meant that anxiety within prisons about HIV/AIDS was particularly intense. In some locations, including the Republic of Ireland and Scotland, prisoners diagnosed as or even simply suspected of being HIV-positive were immediately released.[15] In England, all movement in or out of one prison was temporarily halted in an attempt to create a localised quarantine.[16] In Norway, the situation in Oslo's prison was briefly 'turbulent', with some prisoners successfully demanding the separation and isolation of those among them testing positive for HIV.[17] In Belgium, pressure came from staff; a threatened strike in December 1985 led to the creation of an 'AIDS ward' in one prison, where the five prisoners known to have HIV were to be housed.[18] This practice of segregation in a separate wing or unit was also adopted in the Republic of Ireland and Portugal, and later in Greece, Sweden, and Bulgaria as well.[19] In 1987, only six countries reported no special restrictions at all on the accommodation, movement, or activities of prisoners with HIV/AIDS: Austria, Denmark, France, Italy, Spain, and Switzerland.[20]

It is notable that these decisions to implement special restrictions or separate units were often driven by direct action in various forms. Those in prison – inmates and staff alike – expressed their demands in relation to HIV/AIDS, and the resultant or threatened disorder was sometimes sufficient for those demands to be met. Given that these demands tended to favour discrimination and segregation, they might find little sympathy today, but they are nonetheless part of the picture of direct action inspired by HIV/AIDS. It is also notable that locations avoiding special restrictions included those with the highest rates of HIV/AIDS among their prison populations. This suggests that known prevalence had a significant impact on responses to HIV/AIDS within prisons. Paradoxically, perhaps, a small number of confirmed cases of HIV/AIDS was more likely to provoke extreme reactions than large numbers of

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diagnoses. Segregating a handful of individuals was easy, and in fact a natural solution to the perceived problem. Most prison systems already featured separate institutions, wings, units, or cells for particular types of inmate. Individuals could also be isolated for their own safety or the safety of others, or in the interests of discipline. Resources and procedures were therefore already in place for separating out a new classification of prisoner – those with HIV/AIDS. But segregating or putting special measures into place for much larger numbers, or large proportions of the total prison population, was much more difficult in practical terms.

First reactions tended to have a long afterlife. In many of the countries where segregation for prisoners with HIV/AIDS was initially adopted, this practice outlasted initial waves of panic by some margin. Segregation could quickly become a new norm, justified in the interests of good order as well as safety. The existence of a separate 'HIV unit' was challenged but upheld by the Belgian courts in 1989, although the unit was closed the following year after ministerial intervention. A separate unit survived in Dublin well into the 1990s, as discussed below.[21] Even where there was no formal policy of segregating all prisoners with HIV/AIDS, it was not unusual for segregation to be permitted more widely than official guidelines implied. Policy in England and Wales as well as in Norway followed this line, allowing segregation of individuals with HIV/AIDS on a case-by-case basis. This permissive policy engendered rather different outcomes in the two locations, with some English prisons developing their own informal policies of blanket segregation, while evidence from Norway suggests that segregation was used rarely, if at all.[22]

Segregation was criticised for creating a false sense of security, and for acting as a powerful disincentive to HIV testing. Officially, policies on HIV testing quickly fell into line with the overwhelming international consensus that testing must be voluntary, but in the prison context the line between voluntary and compulsory was often blurred. Anyone refusing an HIV test in a Luxembourgian prison, for example, was placed in isolation, and the same applied in some English prisons. Wandsworth Prison in London maintained a separate 'Viral Infection Restriction Unit' for prisoners considered to be 'high-risk' who had refused an HIV test, as well as those already diagnosed, until at least 1995.[23] In Germany, mandatory tests were still permitted in Bavaria as late as 1994, and elsewhere 'those who

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refuse are treated as if they were HIV positive until tested', meaning that in practice very few did refuse.[24] Cyprus, Italy, and Spain all reported the impressive fact that not one single prisoner from an 'at-risk group' had refused to undergo a test, which raises some questions about how voluntary these tests really were.[25] This is also indicative of persistent stigmatisation and discrimination within prisons on the basis of known or suspected HIV status, not fully captured in official policy and reports.[26]

By the early 1990s, the importance of educating staff and prisoners to reduce risky behaviour and stigma alike was widely accepted, and almost all European prison systems were providing information about HIV/AIDS via multiple media. The only known exceptions were two German states, both formerly in the German Democratic Republic (GDR), where no cases of HIV or AIDS had been identified among prisoners and the need for information on the subject was still denied.[27] Elsewhere, though, innovative methods of providing information to prisoners were reported, including theatrical productions, posters designed by fellow inmates, and quizzes with prizes. Dedicated HIV/AIDS teams had been established in many locations; a special team of medical and disciplinary staff was set up at Saughton Prison in Scotland, for example, to provide education and counselling.[28] Such efforts were not without problems of their own. One issue, mentioned only rarely in the 1990s, was that a small but significant number of prisoners across Europe did not speak the local language to a high standard and would not benefit from standardised education programmes. Others, it was suggested, might need interventions tailored to particular cultural backgrounds and beliefs, as well as languages. In 1993 in Amsterdam, an external welfare organisation delivered information to groups of Turkish and Moroccan prisoners in their first language and without prison staff present, which reportedly allowed for more open discussion and better results than the usual education sessions, but this remained a rarity.[29] Similarly, information and services tailored to the needs of women and young people in prison were flagged in the 1990s as having received very little attention, but remained slow to develop.[30] Despite these criticisms, education was one area, at least, where widespread efforts were in evidence and good intentions (if not always good delivery) were generally praised.

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Much more controversial was the issue of condoms for those in prison. In 1986, condoms were reportedly available in a small number of prisons, in parts of Switzerland and possibly also Spain, but a swift rejection of the idea in both France and Britain was a cause for concern.[31] However, within a few years French policy had reversed, and 'initial refusal on legal grounds has been replaced by a policy of availability on public health grounds' in 1988.[32] Other nations gradually followed suit, sometimes propelled by prisoners' demands. In Germany, for example, a prisoner strike in 1992 led to scrutiny of the status quo concerning HIV/AIDS, followed by a pilot study for providing condoms.[33] By the mid-1990s a significant minority of countries were still insistent on their refusal to provide condoms to prisoners under any circumstances, including in open prisons (where inmates have limited supervision and can leave the prison for work or education) or on release, including Bulgaria, Cyprus, former GDR states, Iceland, Ireland, and across the UK.[34] Even where official policy had become permissive, practice was variable. In the Netherlands, condoms were officially available, but this was overshadowed by emphatic prohibitions on sex between men in prison and few prisoners ever asked for them. At one Dutch prison, they were not available at all because the governor objected.[35] A similar pattern of variability, often depending on individual governors or doctors, was reproduced in England and Wales when policy changed to become more permissive in the mid-1990s.[36]

The prisoners' strike in Germany is a rare example of direct action on the part of prisoners that saw positive results. More commonly, such activism in support of the wider distribution of condoms was not wholly successful and is now little-known. Glen Fielding's efforts are typical in this respect. Fielding had been imprisoned in England, and after being refused condoms he used the courts (and associated publicity) to try to generate a change in policy – a protracted form of action that outlasted his prison sentence but did not end in definitive success. The court held that the policy of the prison service had been misinterpreted in Fielding's case, but that it was itself lawful. This was reported in some quarters as a victory, but for those involved it was a partial disappointment, and its impact on the prison service, if any, was unclear.[37]

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More controversial even than condoms was the question of services for those injecting drugs while in prison. This mirrored hesitation in the wider community, where 'harm-reduction' approaches, such as the prescribing of opioid substitutes like methadone or the provision of clean injecting equipment or disinfectant and advice on safer injecting, were introduced in a much slower and more piecemeal fashion than condoms and messages about safer sex. Denmark had begun to provide sterile needles to prisoners by 1992, but only on release and only if used equipment had been confiscated upon detention.[38] The Swiss prison system was the first in Europe to offer a needle exchange programme within its prison establishments, as will be discussed in more detail below. Early experimentation began in several Swiss prisons in around 1992 and was formalised a few years later. Success there was persuasive in the mid-1990s for some prisons in Germany, as well as elsewhere in Switzerland.[39] But these remained the exception rather than the rule; as of 2018, within Western Europe only Switzerland, Germany, Luxembourg, and Spain offered any needle exchange programmes at all for those in prison.[40]

The provision of disinfectants to allow prisoners to clean their injecting equipment was slightly more popular. 'Hygiene kits' including disinfectant and instructions on cleaning syringes had been introduced into some Swiss and Catalan prisons as early as the late 1980s.[41] By 1992, disinfectant was also available in Belgium, Luxembourg, the Netherlands, Spain, and some prisons in Denmark, France, and Germany as well. Scotland was then spurred into action by confirmation that HIV transmission had occurred within one of its prisons, Glenochil, in 1993, and began to provide sterilising tablets alongside information about the risks of injecting.[42] Localised and informal efforts to provide disinfectant were also attempted in the Republic of Ireland, as discussed below, but here, as in England and Wales, such efforts struggled to take root. A pilot scheme for disinfecting tablets was run in England in the late 1990s and received a positive evaluation, but a wider roll-out was delayed and then implemented in only a few locations.[43]

Overall, then, it took time for international recommendations to be translated into practice within prison settings, and some recommendations remained unmet. In the mid-1990s, two leading researchers concluded pessimistically that 'clear guidelines from

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international organisations carry little weight in the context of the security dominated world of penal systems', and were 'largely ignored'.[44] This overview, borne of frustration at the slow progress being made with harm-reduction initiatives within prisons, overlooked many of the positive effects that international recommendations had already had – particularly concerning education, integration, and, to a lesser but still significant extent, the provision of condoms. Prisons also continued to move towards ever greater adherence to these guidelines as the 1990s progressed.

Numerous barriers to faster and more fulsome compliance were identified, including a lack of awareness or resources, the weakness of prison medicine, especially within an environment that prioritised security and control over health, and national laws or local rules that stood in the way. The controversial nature of some of the recommendations was also acknowledged as a factor.[45] These issues all played their part, but as the case studies of Switzerland and the Republic of Ireland show, what was perhaps even more influential in determining how prison systems responded to HIV/AIDS was the broader context of prison management, addiction work, and public health within which prison policies on HIV/AIDS had to operate. The profile of the HIV/AIDS epidemic and the prison populations in these two countries was similar, with injecting drug use featuring prominently. Both also had relatively small prison populations, and of course they were presented with the same international and European guidelines. But while Switzerland became a trailblazer in harm-minimisation approaches in the late 1980s and 1990s, setting the scene for equally radical efforts within its prisons, changes in the Republic of Ireland are harder to detect. International guidance and the exchange of ideas across borders could inspire at the individual level but required the right local context before they could truly take root.

Irish and Swiss prisons: a comparison

When HIV/AIDS emerged in the Republic of Ireland, it was largely viewed as part of the growing problem of injecting drug use. Addiction to heroin had been attracting some attention and concern within medical circles since the early 1980s, following a

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very rapid increase in the numbers of young people in Dublin identified as heroin users and experiencing serious health problems.[46] A national committee was set up to address this in early 1985, and by the time of its first report a year later, HIV/AIDS was one of its key areas of interest.[47] References to HIV/AIDS and prisons were first uttered in the Dáil Éireann (parliamentary assembly) as part of this wider discussion about heroin addiction, and inmates with HIV/AIDS were universally characterised as drug users by officials and family members alike.[48] Homosexuality remained illegal in the Republic of Ireland until 1993, and this along with the influence of the Church over matters of sexuality and health may have made it easier for individuals and policy-makers to attribute HIV/AIDS to drug use rather than sex, potentially distorting the epidemiological picture. As one addiction worker later remarked, 'everybody found it much easier to talk about drug use and injecting than safer sex'.[49] Nevertheless, research from the early 1990s showed that a 'substantial proportion of Ireland's total HIV-infected population have spent time in custody in Mountjoy prison' in Dublin, placing this prison and its actions at the heart of Ireland's HIV/AIDs epidemic.[50]

The issue of HIV/AIDS in Irish prisons erupted in late 1985. The first diagnosis of HIV within a prison was made in October, after a prisoner requested a test, and was handled poorly.[51] By January 1986 around fifty individuals in Mountjoy's male and female prisons – comfortably over 10 per cent of the prison's population – had been identified as HIV-positive.[52] An 'official party' urgently visited Britain to 'see at first hand what steps were being taken to deal with prisoners found to be HTLV III positive' there. Irish prison staff also reportedly received information about this new health crisis from prison medical officers to allay their concerns.[53] However, at this time there were no full-time prison medical officers in the country and no nursing staff at all; 'prison medical officers' were a handful of GPs who would visit prisons on a part-time basis and were held in very low regard.[54] This calls into question the quality of any information received by prison staff, and makes their reaction to HIV/AIDS less surprising. Staff, through the Prison Officers' Association, placed pressure on prison administrators to segregate those with HIV/AIDS. Doctors shared the identities of those testing positive with prison management, and

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after an unsuccessful attempt to house this group in an alternative prison on the outskirts of the city, an area of Mountjoy already used for segregation was adopted for those with HIV/AIDS in 1986.

By 1987, 136 prisoners in the Republic of Ireland had been identified as HIV-positive.[55] Segregation continued, despite concerns over suicides and reports of poor mental health among those held in segregation, particularly as deaths from AIDS-related conditions began to occur. But among staff and prisoners alike, many remained unwilling to countenance reintegration. Segregation had encouraged a belief in all quarters that those with HIV/AIDS presented serious risks to the general prison population. For those held in the separate unit, their special status meant that they could receive extra foods and welfare services, including access to a different doctor who had a particular interest in HIV/AIDS, all of which might be lost if they returned to normal accommodation.[56] Any attempt to reintegrate prisoners with HIV/AIDS would therefore be met with protest from all quarters. The Irish prison service was not blind to this problem and the inflexibility of its staff, and submitted a request to the Council of Europe for 'information from Member States on the problems caused by AIDS in prisons and the reactions of prison staff to the crisis'. This led to the Council's initial research and recommendations on the subject,[57] but change was slow to occur in the Irish prison system. Although more vocal criticisms of the prison service's response in general, and the segregation unit in particular, began to emerge, the segregation unit was not fully disbanded until 1995 – making it one of the last of its kind in Western Europe.[58]

Alongside the problem of segregation and the associated lack of medical confidentiality for those with HIV/AIDS in prison, the issue of drug addiction continued and grew. In the community, services began to favour methods of harm-minimisation, including the provision of sterile needles and longer-term prescribing of methadone, but this was somewhat tentative and covert[59] and had little direct impact within prisons until the late 1990s.[60] Yet, as community services began to change, doctors and addiction workers did not ignore the needs of drug users in prison – not least because prison was a semi-regular aspect of many of their service users' lives.[61] When steps were taken to bring the European Peer Support

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Project (EPSP) to Dublin, its organisers were keen to include prison officers and former prisoners for this reason. The EPSP exemplifies the international networks and conversations that sprang up around addiction in response to HIV/AIDS, but events in Ireland demonstrate their limited impact on prisons where local conditions were not right.

The EPSP began in 1993, inspired by self-organisation among drug users in the Netherlands.[62] This had suggested the potential for peer support to improve the health and wellbeing of drug users. The EPSP was funded by the European Commission and aimed to 'encourage, develop, and support professional drug aid services and drug-user self-organizations and networks to start or extend peer support strategies, especially in the field of AIDS prevention'.[63] As part of the second phase of this programme, which focused on European regions where peer support was not yet developed, a three-day seminar was held for prison staff, statutory addiction workers, voluntary workers, and drug users in Dublin in late 1995.[64] This was jointly coordinated and led by Dutch and Irish addiction specialists, who sought out a range of participants, including those from the prison staff who were 'sitting on the fence': not already persuaded of the value of peer support or harm-reduction approaches, and not adamant that they were doomed to fail. Many of the drug user participants and prison staff knew each other from the prison setting, leading to some tension and hostility at the outset, but over the three days 'there was a lot of learning' and, 'by the end of it, that business of "You're a human being too" ' began to emerge.[65]

The seminars addressed attitudes, myths, and realities around drug use, and the risks of HIV and hepatitis, combining education with personal storytelling to encourage awareness of different perspectives and experiences. Dutch participants also shared their experience of initiatives such as needle exchanges, generating discussion and, in one participant's view, a new 'openness' among Irish prison staff to these ideas. Prison staff reported feeling safer in their work as a result of the seminars, having come to appreciate where the risks lay, the kinds of experiences that drug users encountered, and what could be done to help reduce dangers to everyone. After the seminar, thanks to the interest and enthusiasm of one or two officers in particular, participants (including drug users) were

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invited to deliver training on safer injecting and blood-borne viruses to prison staff on four or five occasions.

To illustrate the kind of changes in approach and attitude that this initiative brought about, one participant recalled the feedback she had received. 'One prison officer said to me … before he did the training, if he approached a cell and saw someone starting to inject, he would've gone in to interrupt and to stop that injecting. He was asked the question [during the training] why, because you're not going to stop their drug use, and he'd never thought of it like that.' Afterwards, he reflected that 'I would now be saying to my colleagues close the door, and let them finish, because we're more at risk if we make them stop because that person is so desperate' (Ibid.). Recognition of the realities and risks of injecting drug use brought about these modest examples of attitudinal and practical change. Community workers began to hear that those in prison had more confidence in certain officers – particularly those who had undertaken the training – and would feel able to turn to them with any concerns. Notably, some staff began covertly leaving quantities of disinfectant or extra spoons around their prison, and taking time to check the wellbeing of particular individuals known to be injecting.[66] These could be included as forms of HIV/AIDS activism, albeit ones that were necessarily covert or at least discreet, given the particular context of the prison environment.

The long-term consequences of the EPSP in Ireland were significant. The Union for Improved Services, Communication and Education was set up to represent the interests of drug users in Ireland, emulating similar organisations elsewhere, and for many of the individual participants it was a transformative experience. Yet, initiatives such as providing disinfectant within prisons relied on the presence and energy of a small number of people who soon moved on in their careers. Some elements of this harm-minimisation approach may have survived within prison cultures, encouraged by broader shifts in services and standards, but official policy on disinfectant and needle exchanges remained unmoved. The idea of enabling safer injecting within Irish prisons is still sufficiently controversial for some of those involved in the mid-1990s to want to remain anonymous. This was not a form of activism or international exchange with a clear or rapid trajectory of success.

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One former prison doctor in Dublin, reflecting on the 1990s, recalled seeing 'a lot of discussion in the media in the world about needle exchanges, in Geneva or Zurich, but it was never relevant to Ireland'.[67] Switzerland became a high-profile pioneer in harm-reduction initiatives in the 1990s, and its story was indeed markedly different from the Irish example. HIV/AIDS hit Switzerland particularly hard and, as in the Republic of Ireland, its epidemic was closely associated with injecting drug use. By 1992, Switzerland (along with Italy) was said to have 'the highest cumulative incidence of AIDS cases in Europe, long established drug markets, and a substantial percentage of AIDS cases accounted for by drug use'.[68] The first reports of prisoners with HIV emerged in late 1985 from Basel-Stadt, and soon it seemed that something like 10 per cent of those in prison were affected.[69] In contrast with the Irish case, though, practices of segregation did not follow these diagnoses. This is not to say that fear and attempts at quarantine were entirely absent; there is some evidence of hostile reactions to individuals thought to be infected, and steps to separate them from the general prison population or to ban, for example, those with HIV/AIDS from work in prison kitchens.[70] Yet, these initial sparks of panic do not seem to have solidified into general policy or practice.

The number or proportion of prisoners affected by HIV/AIDS does not seem to explain this variation, as both locations saw similar prevalence rates. Three differences between the prison systems of these countries stand out as potentially relevant. First, segregation had been practised fairly commonly in Mountjoy Prison in the 1970s in dealing with political prisoners, meaning that the facilities and a culture to support segregation were already in place there. Second, the first volunteers for HIV tests from Swiss prisons included staff as well as inmates, suggesting that information about HIV transmission and testing was provided to both groups in a more formal capacity and on an equal footing. This might also mean that there were plans in place in the event of positive test results, whereas in Dublin the impetus for testing came from inmates themselves and the prison administration was entirely unprepared.

Last, it also appears that Swiss prison medical personnel were less willing to serve the demands of prison management than their Irish counterparts. In late 1985, a doctor at Thorberg prison in the canton of Bern refused to report cases of AIDS to the management of their

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institution, citing the need to respect medical confidentiality, and subsequently resigned over the issue.[71] This public act – arguably a form of activism in itself – placed a spotlight on tensions between medical standards and prison demands, prompting questions in the Nationalrat (federal assembly) as to whether prison doctors could or should breach confidentiality in the specific context of HIV/AIDS in prisons. Subsequently, prison governors in Switzerland were at pains to stress that prison doctors would *not* share test results, suggesting that medical standards had won out on this occasion.[72] This may simply have been a question of personality, with one particularly vocal and independently minded doctor in Bern forcing the issue, and in so doing pushing policy-makers to give clear guidance. It may also indicate a medical service that was, as a whole, better informed about HIV/AIDS or more philosophically attuned to public health priorities over those of penal discipline. In either case, greater medical influence within Swiss prisons may well have steered managers away from any impulse to segregate.

In terms of drug addiction, Switzerland was an early adopter of harm-reduction approaches in the community. By the early 1990s it was at the cutting edge of harm-reduction initiatives, which were widely discussed and debated internationally. A needle exchange programme was launched in Zurich in 1988, where the majority of Swiss injecting drug use was to be found. This programme also supplied 'hygienic cotton swabs and vein creams, condoms, tea and fruit; it provided primary medical care, hepatitis-B vaccination and information on treatment options, as well as instruction in safe sex, hygiene and health behaviour'.[73] Methadone-prescribing programmes tripled between 1986 and 1990, and the prescribing of heroin was also trialled, although hindered by international controls on the importation of the drug. Out-patient services began to include 'street rooms' where injecting drug use under hygienic conditions, with showers and medical supervision, was tolerated.[74] Elements of these radical programmes were extended to Swiss prisons, including the 'hygiene kits' already mentioned, trials of heroin prescription, and methadone maintenance programmes in Basel, Bern, Geneva, and Zurich in the early 1990s.[75]

Swiss prisons also began to adopt syringe exchange programmes. In around 1992, at Oberschöngrün prison in Solothurn, a part-time medical officer who saw that many patients were clearly injecting

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drugs on a regular basis began to dispense sterile injecting equipment. When this was discovered, the governor of the prison reportedly 'listened to his arguments about prevention of transmission of HIV and hepatitis, as well as injection-site abscesses, and sought approval from the Cantonal authorities to sanction the distribution of sterile needles and syringes'. This was characterised by its supporters as a brave 'act of medical disobedience' on the part of the medical officer,[76] setting the stage for prisons elsewhere in the country to follow this lead. Where researchers and advocates saw admirable disobedience, historians might also see another atypical form of activism, enacted by both medical and disciplinary staff (just about) within professional boundaries but no less significant for that.

At around the same time, the medical staff at Hindelbank, a prison for women in the canton of Bern, began calling for a needle exchange programme. Staff reported high rates of needle sharing, and voluntary organisations may already have started to distribute syringes as an emergency response within the prison.[77] A formal pilot was launched in 1994, after several years spent winning support at the federal level in order to overcome cantonal opposition. The Federal Office of Health backed the scheme on the grounds that its own health strategy promised that those in prison would receive the same healthcare as those outside. The Federal Office of Justice was also involved, seeking and obtaining legal confirmation that a pilot could proceed.[78] The pilot included lectures, group lessons, counselling, and machines to dispense condoms and sterile injecting equipment. It was evaluated positively, and subsequently rolled out in Swiss and also German prisons.[79] By 1999, further pilots of vending machines to distribute sterile injecting equipment were still being rolled out across Swiss prisons, suggesting that acceptance and implementation was relatively slow, but still forthcoming.[80]

All this is not to say that the responses to HIV/AIDS within Swiss prisons at the end of the twentieth century were flawless, by any means. There was considerable regional variation, and even variation from prison to prison, with a minority of establishments adopting fulsome harm-reduction measures. (The criminalisation of HIV transmission in Switzerland raises its own concerns.) Nevertheless, Switzerland was frequently held up as a trailblazer in the field of HIV/AIDS prevention in prisons, and clearly followed a different path to the Irish prison service over the 1980s and

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1990s. This was largely a reflection of the approach to addiction in wider community services, but that is not quite the whole story. Researchers in the 1990s argued that individual disobedience and a willingness to engage in 'courageous experiment' in Switzerland were the factors that changed prison policy, but Irish prison officers engaged in such disobedience and experimentation, particularly following their interactions with the EPSP, and this did not lead to nationally recognised pilot studies or changes in policy. Something was clearly different in Switzerland.

What stands out from these two case studies is the decentralisation (or otherwise) of prison management and the role of prison medical staff. The prison service was tightly centralised in Ireland, with all decisions flowing directly from the Department of Justice.[81] Policy change had to come from the top. In Switzerland, each of the twenty-six cantons managed its own prisons and made its own arrangements for healthcare, encouraging much greater independence. Regional variation could be more marked (and, as Hindelbank showed, regional government did not always support change), but local innovation was more likely. Innovation among medical personnel was particularly important, as medical expertise could be extremely influential. Disobedience among prison officers in Dublin could not change policy on the provision of disinfectant, but disobedience among doctors might have been different.[82] There is no reason to think that Irish prison doctors would have been less influential then their Swiss counterparts, and, indeed, one well positioned observer in Ireland felt strongly that the doctors she worked with in prisons could have demanded change.[83] The realisation of this influence was hindered by that tightly centralised system, as well as the broader picture of harm minimisation in the community.

Conclusion

By the late 1980s, both Switzerland and the Republic of Ireland faced a significant number of prisoners with HIV/AIDS, as did many other regions of Europe. The extent of HIV/AIDS within prisons was closely associated with the extent of injecting drug use, and the use of custodial sentences for drug-related offences. The adoption of international recommendations within prisons, particularly those

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concerning controversial harm-reduction measures such as needle exchanges, echoed harm-reduction initiatives in the wider community. Where harm-reduction measures had been adopted early and energetically in community healthcare, prisons were more likely to meet international guidelines regarding safer injecting, as in the case of Switzerland. In contrast, where harm reduction struggled to attain a foothold in community services, it remained unthinkable for prisons.

This does not mean that international recommendations focusing on prisons served no purpose. Pressure from international bodies such as the Council of Europe, and from critical reports drawing on these international standards, encouraged prisons away from practices of segregation and towards education and respect for confidentiality. Among those working in prisons, contact with European networks provided information and ideas, and sometimes prompted radical experimentation. This experimentation can be seen as a form of HIV/AIDS activism, albeit one that was not always successful. As the Irish and Swiss examples show, these experiments required medical endorsement and a responsive prison administration in order to flourish; the ways in which prison management was organised, just as much as prison healthcare, could have a significant impact.

This raises questions about what is included and remembered as HIV/AIDS activism. In the context of prisons, activism was often discreet and rarely met with immediate results. Sometimes, as with the prison doctor in Bern who resigned over confidentiality concerns, the result was not one single event or decision, and its impact is only detectable with hindsight. Perhaps inevitably, such actions have rarely been celebrated as examples of activism. The actions of Swiss prison doctors and public health workers in providing sterile injecting equipment are almost an exception, but these actions were carried out more or less within the boundaries of professional and expert decision-making. Can such actions be activism? A fuller history of HIV/AIDS may require our definitions of activism to expand to include those who tested such boundaries, who took decisions that were personally risky, who pressed their colleagues to do the same – and those who tried to do these things but failed. Nor was all activism within prison settings something to celebrate. Actions by prisoners and staff alike to demand the

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segregation of those with HIV could have negative and long-lasting consequences, but it was activism nonetheless.

Finally, these examples also begin to hint at some of the experiences of HIV/AIDS that have so far been largely overlooked and require much greater attention. For those working in the field of addiction or with communities affected by heroin use in the 1980s, HIV/AIDS brought enormous change. For injecting drug users and their families and friends, its toll was enormous and devastating. And for prisons across Europe, a new role in public health was formulated, resisted, and cautiously embraced.

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