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NEEDLE EXCHANGE IN PRISON

FRAMEWORK PROGRAM

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FOREWORD

The first needle exchange program in Spanish prisons was introduced at Basauri Prison in July 1997. As parenterally transmitted diseases are one of the most important public health problems faced by prisons and needle exchange programs are an effective tool for their prevention, and also considering the impact of the health situation in prisons on the overall epidemiology of these diseases, verification of the feasibility of these programs in the prison setting was a measure of great significance for public health in both prisons and society as a whole.

The first pilot program at Basauri Prison was followed by a second pilot program at Pamplona Prison in 1998, and in 1999 the Orense and Tenerife Prisons also voluntarily joined in this initiative. Based on the experience available at that time, the document “Key issues for implementation of needle exchange programs in prison” was written and jointly published by the Ministry of Health and Consumer Affairs and the Ministry of the Interior in April 2000. The program was subsequently extended to Martutene, A Lama, Bonxe, Monterroso, Teixeiro, Nanclares and Villabona Prisons, so that by the end of 2001 the program was in use in eleven prisons, which contributed new elements not known in the year 2000. The effectiveness and feasibility of this type of program in prisons is considered to have been sufficiently well established and therefore it is time for its implementation on a general basis.

The experience accumulated in the above prisons, collected in various evaluation documents and transmitted in numerous contacts with prison authorities, is highly valuable for guiding implementation of the program in other prisons. This document, based on this experience, aims to respond to many questions raised by prisons currently in the initial stages of implementation of the program. The objective is for each prison to design its own specific program within a common framework which, in addition to ensuring the necessary uniformity of this activity within the Prison System, enables them to benefit from the previous experiences of other prisons to achieve the best results from the start.

Prisons that are currently in the process of designing their programs should do so within the framework laid out in this document, whereas prisons that have already implemented the program should gradually adapt it to the guidelines established here, without prejudice to also taking advantage of the conclusions arising from specific evaluations of their own programs.

From here, I would like to thank the prisons that first took the initiative to implement this innovative activity, and also to thank in advance the work that will be carried out by the health care professionals in all prisons, as well as the cooperation of the rest of the members of the Prison System, which is indispensable for achieving the objectives sought. This program will complement other activities already being carried out to control these and other health problems in prisons, and it will undoubtedly help to gradually improve the level of health of the inmate population and hence of the whole of society.

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I. RATIONALE

Parenterally transmitted diseases are highly prevalent in prisons. It is currently estimated that infection by human immunodeficiency virus (HIV) has a prevalence of 14% and infection by hepatitis C virus (HCV) a prevalence of 40%. These diseases have major impact, not only because of their serious effects on individual health, but also because of their communicable nature and high treatment cost. It is also important to take into account the impact of HIV infection on the epidemiology of tuberculosis, another major public health problem, particularly in prisons.

Prevention of parenterally transmitted diseases is therefore one of the foremost priorities in public health policies for prisons. The importance of control of these diseases in the inmate population goes beyond the prison setting and affects all of society, in the same way that measures to control these diseases outside of prisons impacts directly on the epidemiological situation inside prisons. A large part of the population affected by this disease is concentrated in prisons: thus, whereas prison inmates account for approximately 1 person per thousand inhabitants, over 7% of acquired immunodeficiency syndrome (AIDS) cases reported in Spain were diagnosed in prison.

Consequently, health care professionals working in prisons have the affirmative duty to apply those measures of proven effectiveness to control these diseases, giving higher priority to the most cost-effective measures for greater efficiency.

Injecting drug use is by far the most frequent route of transmission of these diseases in our setting. Thus, approximately 90% of AIDS cases reported in prisons list injecting drug use as a risk practice. Sexual transmission is the other route with significant frequency, and over half of the persons presumed to have been infected by this route have had sexual relations with injecting drug users (IDU). Therefore, injecting drug use is either directly or indirectly the cause of the vast majority of AIDS cases in prisons.

In recent years, a variety of measures have been applied to prevent parenterally transmitted diseases both inside and outside of prisons: health information campaigns, health education programs, “peers-education” training programs, hepatitis B vaccination, methadone maintenance programs and needle exchange programs (NEP). These measures have produced significant results: the incidence of hepatitis B in prisons has been reduced to minimal levels (13 cases in 2001) thanks to the high vaccine coverage achieved, the prevalence of HIV infection has been reduced from 32% observed in the first cross sectional study in 1989 to the current 14%, and the prevalence of HCV infection is estimated to have been reduced by 6 points (46% to 40%) from 1998 to 2001. However, parenterally transmitted diseases remain a major problem and it is essential that these measures be maintained and completed so that continued progress can be made in the prevention of these diseases.

II. BACKGROUND

In 1999, a Working Party on Needle Exchange in Prisons was set up in the Secretariat of the National AIDS Plan, composed by persons belonging to the Secretariat, the Directorate General for Prisons and a number of Autonomous Communities. This Working Party prepared the document “Key issues for implementation of needle exchange programs in prisons”, which was jointly published by the Ministry of Health and the Ministry of the Interior in April 2000.

This document specified the basic principles for the implementation of needle exchange programs in prisons, which were set out in general in the “Guide for implementation of needle exchange programs” published by the Secretariat for the National AIDS Plan in 1996.

In February 2000, 5 NEPs were operating in Spanish prisons and some had already been evaluated; by the end of 2001, NEPs had been implemented in 11 prisons. The most relevant conclusions of the evaluations of these programs include:

- Implementation of a NEP, as in the community outside of prisons, is feasible and adaptable to the conditions of execution of the prison sentence.
- NEPs in prison, as in the community outside of prisons, produce behavioral changes that lead to a reduction in the risks associated with injecting drug use.
- NEPs in prison facilitate referral of users to drug addiction treatment programs.
- Implementation of a NEP does not generally cause an increase in drug use or specifically an increase in parenteral heroin or cocaine use.
- A NEP in prison should operate with certain degree of flexibility and tailored to the individual circumstances of each inmate, but without forgetting the conditions for implementation established in each program.
- It is feasible for a NEP and other drug addiction prevention or intervention programs to coexist.

After verifying the effectiveness and feasibility of NEPs in Spanish prisons through the successive evaluations conducted, the program was extended for general use in all prisons in January 2002.

With regard to the legal and regulatory measures (see annex), that preceded the start-up of the programs and in other cases confirmed NEP-related activities, the following should be noted:

- In December 1995, a Basque Parliament green paper urged the Basque Government to request the State Secretariat for Prison Affairs to start up a needle exchange program on a pilot basins in one of the three prisons of the Basque Autonomous Community, whose evaluation would allow a uniform and reasoned decision to be made on the introduction of needle exchange in prisons. The first NEP was introduced at Basauri Prison in July 1997.

- In October 1996, Decision 247 of the Provincial Criminal Court of Navarra ordered Pamplona prison authorities to start up a needle exchange program as a benefit of the Prison System provided as part of the health care for inmates foreseen in Prison Rules, either directly or through the agreements, arrangements or contracts it deemed appropriate.
- Since 1997, the Ombudsman, in response to successive complaints brought before to him, has urged the Prison System to implement NEPs in its prisons.
- In March 2001, a green paper approved by the Spanish Parliament urged the Government to adopt the necessary measures to implement free distribution of needles to drug user inmates in all prisons.
- In their legislation on drug addiction, certain Autonomous Communities, such as Castilla and León, have specifically indicated the need to institute NEPs in prisons located in their territories.

Regarding prison regulations, the background is as follows:

- In November 1998, the Directorate General for Prisons issued a recommendation to all prisons to implement harm reduction measures in IDUs, which contemplated the use of needle exchange as a means to prevent parenterally transmitted diseases and to reduce other potential harm associated with intravenous drug use.
- In June 2001, the Directorate General for Prisons issued a directive requiring generalized implementation of NEPs in all prisons according to the implementation plan prepared by the Subdirector General for Prison Health. Prior to this directive and owing to the need to modify the internal rules of the prisons that had already implemented NEPs, the Directorate General for Prisons sent instructions to each of these prison authorizing the changes starting in July 1997.
- In October 2001, the Subdirector General for Prison Health established that NEPs had to be implemented in all prisons by January 2002.
- In March 2002, the current “Needle Exchange in Prison. Framework Program”, based on the theoretical corpus of the above documents, but applying pragmatic and operational criteria, was prepared and distributed to all prisons.

NEPs are prepared, implemented and evaluated by prison health care personnel and are treated in the same way as other health programs. The NEP should help to reduce the morbidity and mortality associated with the use of nonsterile needles for intravenous drug use and also to establish an initial health contact with some IDUs.

Each prison prepares its own NEP, which must be approved by the Board of Directors of the prison (as an example, see the order by the Management Board of El Dueso Prison in the annex on regulations). To prepare the NEP, the prison health team contacts the persons responsible for prevention of AIDS and drug addiction in their Autonomous Community to request their cooperation, either in the form of technical support or to provide the prison with the same type of kits as those that are used in needle exchange programs outside of prisons.

Evaluation of the NEPs started in the pilot projects (Basauri and Pamplona), as well as subsequent evaluations of the programs that were successively implemented in other prisons (Teixeiro, Bonxe, Monterroso, A Lama and Orense), revealed that NEPs were as effective in prisons as outside of prisons and it was confirmed that initial fears about possible undesirable effects resulting from the particularities of the prison setting were unwarranted. In view of the experience accumulated and when we attend the generalized use of NEPs for all prisons, this Framework Program has eliminated the specific requirement of a Program Coordination, Evaluation and Monitoring Committee, whose existence was logically necessary in the pilot projects, which is now left to the discretion of each prison.

A minimum set of quantitative data is collected in prisons and evaluated on a centralized basis every six months. In addition to the routinely collected data, this Framework Program recommends that regular program evaluations be made in prisons to know how well they are functioning and to correct any deviations that could occur.

III. DEFINITION OF THE PROGRAM

Needle exchange in prisons is a harm reduction program that is introduced to prevent the transmission of diseases among injecting drug users from shared use of injection equipment.

Although contacts between the prison health team and IDUs can and should be taken advantage of to counsel them on aspects related to protection of their health, therapeutic intervention on their addictive process is not the primary objective of the program. The activities of the program therefore aim only to improve the health of the inmate population, which is independent of the therapeutic approach to the inmate's addiction, and they should not alter or interfere with the prison's policies for treatment of drug addiction or control of drug use and traffic in the prison.

IV. OBJECTIVES

General objectives

- Prevent infections by HIV, HBV, HCV and other pathogenic agents associated with injecting drug use in the prison population.
- Integrate harm reduction programs into health and social services offered by the prison.

Specific objectives

- Reduce the frequency of multiperson use of needles and syringes for drug injection through the distribution of sterile injection material.
- Improve conditions of hygiene for self-injection through health information and education, and encourage modification of other risk behaviors to prevent sexual transmission of these diseases.

Complementary objectives

- Facilitate communication between IDUs and health care professionals to foster referral to drug addiction treatment programs.
- Determine the characteristics and needs of the IDU population so that appropriate counseling and health education interventions can be designed and prioritized.
- Motivate and increase the awareness of prison workers about the benefits of NEPs.

V. TARGET POPULATION

The target population comprises all prison inmates who are injecting drug users. However, due to the characteristics of prisons regulations, injecting drug users are often unwilling to request syringes from fear of hypothetical negative consequences on the prison benefits they may be entitled to. In these circumstances, noninjecting inmates may act as intermediaries in obtaining syringes for the actual users. Although this is not an ideal situation, it is a positive step toward achievement of program objectives. Therefore, all inmates, whether or not they are IDUs, should be considered potential beneficiaries of needle exchange.

Special situations

- *Psychotic or psychiatrically impaired inmates.* When a patient of these characteristics requests to participate in the NEP, his case should be studied individually and the physician responsible for his care should decide if his request should be accepted or not after consulting the psychiatrist who is treating him, if appropriate.
- *Inmates included in drug addiction treatment programs.* Inmates included in these programs (methadone, naltrexone, drug-free programs) should have access to needle exchange whenever they request it. Inmates in methadone maintenance programs who request syringes generally use them to inject cocaine, but the inmate should be asked what type of drug he consumes, since continued use of heroin usually indicates that the methadone dose is inadequate. Request by an inmate in a drug-free program should be approached from a therapeutic point of view, and appropriate therapeutic measures taken to help him to overcome the relapse, but access to sterile injection material should never be denied.
- *Especially dangerous inmates.* From a health perspective, all inmates should be given the same opportunities to access sterile injection material. Prison authorities should regulate the means of access by especially dangerous inmates, bearing in mind that it is always preferable to adopt special security rules with these inmates than to deny access to sterile syringes.

VI. PROCEDURE FOR IMPLEMENTATION

1. Start-up procedure

Before starting needle exchange, inmates and prison workers should be fully informed about the NEP using the procedures considered most appropriate (e.g. talks, posters, leaflets, personal interviews, etc.). Any inmate wishing to participate in needle exchange should request the first kit from his physician or nurse or the persons in charge of implementing the NEP.

New inmates entering the prison should be informed at the first scheduled consultation of the existence of a NEP as well as the other health programs available, and given the option to obtain the first kit. It is recommendable to provide the information in writing as well as orally.

If any syringe not belonging to the program is found, it should be reported to the health team so that it can be replaced by a syringe from the program, thus favoring access to needle exchange by IDU inmates.

2. Procedures with participating inmates

2.1 Prior information

All inmates wishing to participate in needle exchange should be given information about the risks involved in drug injection, the alternative treatments available for treatment of drug addiction, safe injection techniques and the rules of the NEP. Regarding safe injection, it is important that they understand that not only the syringes, but also the filters and spoons or other containers where the drug is dissolved may be vehicles for disease transmission, and therefore they should never share any of these instruments. Inmates should also be instructed not to share the material supplied to them with anyone and to exchange or return the syringe as soon as possible after use.

2.2 Supply, exchange and collection of kits

This is the main activity of the program. After the first kit is supplied, the rule should be exchange, i.e., the previous syringe must be returned before a new kit is handed out. While this rule should be clear for all users, a flexible attitude should be maintained towards its application keeping in mind that the primary objective of the program is to prevent shared use of syringes. Some inmates may also prefer to return the syringe immediately after its use and request a new one later when they plan to take drugs again.

An excessive number of rules should not be established as this distracts attention from the fundamental compulsory rules that all inmates should know and which are the following:

- Syringes should always remain in their pack inside their closed rigid container.
- In the event of being searched, the inmate should advise the officer of the fact that he has a syringe.
- In the event of custodied leave, the inmate will not be allowed to take the syringe with him.

2.3 Follow-up actions

No specific monitoring is required after syringes are supplied. However, participation in exchange should be considered when setting priorities for individualized counseling in scheduled consultations, as well as inclusion in group activities on health education related to parenterally transmitted diseases, safe drug use and safe sex. Health education activities carried out with these inmates should place special emphasis on the following points:

- Recommend and foster a change of route by explaining the added risks of injecting drug use.
- Explain other possible mechanisms for transmission of HIV and HCV, particularly shared use of other injection instruments, tattoos and unprotected sexual relations.

2.4 Referral to drug addiction treatment programs

All inmates participating in needle exchange should receive information and counseling on an individual basis about drug addiction treatment programs. Heroin addicts should be encouraged to join the methadone maintenance program. However, joining these programs should never be imposed on inmates.

3. Termination of exchange

Exchange may only be terminated if requested by the inmate. In the event of release from prison or interprison transfers, the inmate will have access to exchange either through the resources available outside of prison or in the in-transit or destination prison. For the purpose of data collection, all these cases will be specified as withdrawals in the prison of origin. Inclusion in a methadone maintenance program or other treatment programs should not be incompatible with exchange, unless so decided by the inmate. Access to syringes should not be refused except under very exceptional circumstances (assault with a syringe, flagrant repeated failure to comply with program rules resulting in a hazard to other persons). In this regard, it should be remembered that the main objective of this program is to prevent the transmission of diseases and therefore to ensure the availability of sterile injection material.

4. Record of activities

At the time of exchange, the following program activity indicators will be collected for each user:

- number of syringes supplied.
- number of syringes returned and used.
- enrollment and withdrawal date from the exchange program and reason for withdrawal (referral to a drug-free program, methadone program, interprison transfer, release...)

To safeguard the confidentiality of the information or to increase the inmate's confidence in the program, the code assigned by the SANIT computer software or a pseudonym chosen by the user may be used instead of the user's name on the data recording sheets.

Entry of the data into the SANIT program will allow statistical summaries to be easily obtained and ensure that reliable and uniform data are available from all prisons.

VII. ORGANIZATION OF ACTIVITIES

The program will be implemented by the health care team of the prison. Exceptionally, when funds are available and the circumstances make it advisable, support may also be provided by external personnel collaborating in the care of drug addicts in the prison. All members of the prison health team may participate in the conduct of the program, including physicians, nurses and nurse assistants. Each health team will decide which persons will be in charge of exchange, as well as the location, frequency and hours when exchange is to take place, based on available resources and taking into account that:

- The location and hours chosen should ensure access to the program and its confidentiality.
- A higher frequency of distribution, in addition to improving accessibility, reduces the time during which the inmate has a contaminated syringe, and therefore the probability of it being reused by him or by other inmates.

VIII. EXCHANGE MATERIAL

The exchange kit should contain at least the following items:

- Syringe and needle in a transparent or translucent rigid case
- Disinfectant towelette
- Distilled water

Two sizes of needles can be used: American (0.33 x 12.7) or Spanish (0.5 x 16). Injection of cocaine requires the larger gauge needle, while the smaller gauge is sufficient for heroin injection. It is advisable to have both types.

Supplying a filter and a sterile cup (*Stéricup*) for injection preparation may also be considered. In order to encourage a change of route, providing aluminum foil to users who request it may also be considered.

The number of kits to be supplied depends on the frequency of exchange and the user's consumption habits: it should be sufficient to cover the inmate's needs so that he does not have to reuse the syringe before the next day of exchange.

IX. CONFIDENTIALITY

The NEP is a health intervention in which prevention of disease in the drug addict takes precedence over treatment of his addiction. It is therefore a program that aims only to improve the health of the prison population. Because of this, it must conform to the confidentiality requirements regulated in the General Health Act and the Prison Rules on the protection of the clinical data and health information.

Article 215 of the Prison Rules states that: “The data included in the personal clinical history are confidential, they must be stored in a safe location under adequate security, and may only be accessed by authorized personnel”.

Article 8 of the Prison Rules states that: “Personal data of inmates on political opinions, religious or philosophical beliefs, ethnic or racial origin, health or sexual life, collected to complete individualized forms on program execution or prison treatment programs, may only be transferred or disclosed to other persons with the express written consent of the inmate involved or when, for reasons of general interest, it is provided for by a Law”.

Inmates must be adequately informed of the confidential nature of their participation in exchange. The credibility of the guarantees of confidentiality for the IDU inmate is a key factor for his participation and adherence, and therefore for the success of the program.

X. INFORMATION AND TRAINING OF PRISON WORKERS

Prison workers should be fully informed about the program before it is started. Regarding this, it is advisable to conduct courses to train, motivate and increase awareness on the benefits of harm reduction programs, and in particular of NEPs. The reasons for starting up the program, its objectives, the importance of maintaining confidentiality and the rules established for its operation should also be explained.

As was previously mentioned in the rationale section, fear of improper functioning of the program as a result of the particularities of the prison setting is a frequent concern, and, in fact, it has dissuaded generalized implementation of the program in the past until experience on its use was available. The results in prisons where the program is already operating have not confirmed these fears. In this regard and with reference to the potential increased risk for prison workers when a NEP is implemented, the Directorate General for Labour Inspection and Social Security in its directive 101/2002 considers that “implementation of a NEP does not pose serious risks for the performance of prison officer activities, but rather reduces them and minimizes the risks derived from the clandestine syringe use”. However, a series of measures for protection and prevention should be taken to eliminate or reduce the risks, including among others:

- Needles or other sharp instruments should be handled with adequate precaution when they are collected or manipulated for any reason.
- If the needles are not contained in their rigid case, they should not be recapped or manipulated in any other way.
- Piercing or cutting equipment should never be discarded into the plastic bags of conventional disposal bins; but rather into the rigid puncture-resistant containers available in all prisons.

- In the event of needlestick injury, whether accidental or not, the incident should be reported as soon as possible to the appropriate occupational health unit, which will specify the measures to be taken in each case.

With respect to the risk of occupational accidents, prison workers should know that the risk to health care personnel of acquiring HIV infection from a needle-stick injury is very low (0.3% with a recently used needle in a seropositive person). The start-up of a NEP should not increase the risk, but rather, as previously stated, result in greater safety. First of all, illicit syringes, which are usually hidden and unprotected, are replaced by program syringes equipped with a rigid protective case. Secondly, in the event of an accident, it is less likely that the syringe has been used because the inmate can and should exchange it for a new one at the first opportunity after use. Thirdly, in the event that the syringe has been used, it is less likely that it has been shared by various inmates, thus reducing the probability of it being infected and enabling the user to be identified with greater certainty, which allows preventive actions to be taken if necessary. Finally, in the long term, reduction of parentally transmitted diseases will make prisons a healthier and less risky environment.

Although the risk of accidental needlestick injury in a prison is very remote and much less likely than in a health care center, it is important to adopt the required measures to offer the maximum protection to workers. A key element for this is to ensure that the syringe is always kept in its case. A syringe in a closed case is not dangerous even if it is hidden, while an accident is always possible with an exposed needle, even if it is visible. Therefore, program rules should stress particularly that it is compulsory to keep the syringe in its case. It should also be taken into account that is unadvisable to establish a large number of rules, since an excessive number of rules dilutes the importance of the basic rules. It is easier to ensure compliance with a minimum number of basic rules that have real impact on maintaining the safety of the program than to implement a program with many accessory rules may cause effective preventive measures to be neglected, and therefore lead to an increased risk of accidents.

XI. EVALUATION OF THE PROGRAM

Quantitative data on program activities is obtained automatically from the SANIT program: number of users, number of syringes supplied and returned, enrollments and withdrawals from the program, and reasons for withdrawal.

The incidence of diseases associated with drug use (HIV, HCV, HBV) will be compiled by the usual means (SANIT, Notifiable Diseases). It is recommendable to collect information on both incidents and penalties related to the NEP.

In addition to these data, it is necessary to know the impact of the program on risk practices and the opinions of inmates participating in the exchange and other inmates on the program, as well as those of warden officers and the team implementing the program. In the case of inmates, it is useful to collect information on the changes in the frequency of injection and sexual risk practices, as well as their attitudes and opinions about the NEP. In the case of prison workers, a survey of their attitudes and opinions about the NEP should be conducted.

Collection of the information by means of questionnaires can be performed in each prison at the intervals considered appropriate. It is recommended that this information be collected at least on a yearly basis. This information for overall evaluation of the NEP will be collected at the intervals determined by the managing board. The simplest way to do so is by selecting a sample of inmates and another sample of prison officers.

In annexes 3 and 4, forms are provided for recording the opinions, attitudes, etc. of inmates and prison workers, respectively, in order to obtain a minimum set of common data for evaluation. The information in the questionnaires will be collected on an anonymous basis. The data collected will allow the following indicators to be obtained:

a) Attitudes and opinions (inmates and prison workers)

- Level of information on the NEP
- Level of acceptance of the NEP
- Level of satisfaction with the functioning of the NEP (hours, personnel, rules...)
- Impact of the NEP on prison security
- Impact on relations between inmates and prison workers

b) Behaviors (inmates)

- Percentage of inmates who have consumed heroin in the last 30 days
- Percentage of inmates who have consumed IV heroin in the last 30 days
- Percentage of inmates who have consumed cocaine in the last 30 days
- Percentage of inmates who have consumed IV cocaine in the last 30 days
- Percentage of IDUs who have borrowed syringes previously used by others in the last 30 days
- Percentage of IDUs who have lent their used syringes in the last 30 days

- Percentage of IDUs who have shared other injection instruments (spoons, filters, water, containers for dissolving drug...) in the last 30 days
- Percentage of inmates who have used a condom in their most recent sex relation.

A report on the NEP should be made at least on an yearly basis that includes information on the incidence of associated diseases, program activities, as well as any new needs or problems that may have been detected or any other pertinent information.