HIV/AIDS IN PRISON SYSTEMS: A COMPREHENSIVE STRATEGY

A Brief from the

Prisoners with HIV/AIDS Support Action Network (PASAN)

to the Minister of Correctional Services
and the Minister of Health

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EXECUTIVE SUMMARY

The Prisoners with HIV/AIDS Support Action Network (PASAN) is a coalition formed to advocate for the development and implementation of suitable provincial and federal policies on HIV/AIDS in prisons. PASAN's members include ex-prisoners and representatives from a variety of community-based organizations involved with prison issues and/or HIV/AIDS.

The AIDS crisis is devastating Canadian prisoners. Inmates are becoming infected with HIV during their incarceration because they do not have the information and resources to protect themselves. Once infected, their lives are endangered by a lack of access both to doctors specializing in HIV/AIDS and to non-approved treatments and alternative therapies. And prisoners with HIV/AIDS are maltreated. For example, they are often needlessly forced into isolation and their confidentiality is routinely violated because both guards and fellow prisoners are under the false impression that if they know who is infected then they do not need to take precautions to avoid HIV infection.

The AIDS crisis in prison systems is a product of **government inaction**. HIV transmission could be prevented and the health of prisoners with HIV/AIDS could be improved by the implementation of a **comprehensive HIV/AIDS policy**, encompassing **education and prevention programs**, and **support and medical services**.

PASAN urges both the provincial and federal governments to formulate and to implement such comprehensive HIV/AIDS policies. Our **recommendations** for the content of these policies are summarized below.

At the provincial level, we propose that a **joint ministerial task force**, including members from the **Ministries of Correctional Services** and **of Health**, be formed to consult with prisoners, community groups, and prison staff unions while implementing our recommendations.

We also propose that the **same process** be undertaken at the federal level with **Correctional Services Canada** (CSC) and the **Ministry of Health and Welfare**. We urge these federal agencies to **co-ordinate** their response to our recommendations with the provincial task force.

Guiding Principles

Five principles inform our approach to the questions concerning HIV/AIDS in prison systems:

- **Prisoners with HIV/AIDS have a basic right to maintain their health.**
- **Prisoners have a right to protect themselves against HIV infection.**
- **Prisoners have a right to keep their health status private. This means that (i) HIV-**

antibody testing should only be done anonymously, and (ii) prisoners with HIV/AIDS should be able to keep their status confidential.

- **Prisoners have a right to informed consent with respect to HIV-antibody testing and HIV/AIDS treatment.**

- **HIV/AIDS support, education, and treatment programs should be run by 'outside' community-based organizations brought into the prisons rather than by correctional staff.**

Furthermore, we recognize that the diversity of the prison population requires that all HIV/AIDS programs should be sensitive to differences of race, culture, gender, sexual orientation, and mental and physical ability. Programs should be available in many languages and at varying literacy levels.

OVERVIEW OF RECOMMENDATIONS

An HIV/AIDS policy for the prisons must address two primary issues: the prevention of new HIV infection, and the care and support for those who are already infected with HIV or have AIDS. The following 36 recommendations addressing these two issues apply to the whole of the correctional system, both the men's and women's prisons. But because HIV/AIDS affects women differently than men, both physically and socially, we have also made the last four recommendations in order to address the HIV/AIDS-related needs specific to women prisoners.

We are advocating for changes in the correctional systems. This does not mean that we want to lessen the safety and security of prisons; we recognize the concerns of guards and correctional services' administrators around these issues. We believe that the promotion of health in the prison population and the education of both prisoners and staff are the best ways to create safety and security. When the points outlined in our brief are taken into consideration, there is no real conflict between the needs of prisoners and the needs of prison staff with respect to HIV/AIDS.

PREVENTING HIV/AIDS IN THE PRISONS

HIV is transmitted through unsafe needle use and unsafe sex. Prisoners are engaging in these activities and putting themselves at risk for HIV infection because either they do not know these activities are unsafe, they do not know how to engage in them safely, or they do not have the means to engage in them safely. Comprehensive **education** is the first step to preventing HIV infection in the prisons.

But not only inmates need to be educated. Stopping the discrimination against those with HIV/AIDS and those engaging in behaviours associated with HIV/AIDS requires that HIV/AIDS education be directed at everyone involved with correctional systems. Therefore:

1. **HIV/AIDS education should be compulsory for all inmates (male and female) and all staff providing services for incarcerated individuals (workers at the Ministry of Correctional Services and CSC such as guards, Case Management Officers, and Classification Officers; members of Correctional Officers' unions, e.g. OPSEU; Clinical Support staff; etc.).**

2. **Education must be *comprehensive* for both inmates and staff.**

3. **All educational presentations and materials must recognize and respond to the needs of prisoners with disabilities, from different ethnic and linguistic backgrounds, with varying language skills, and of different races, sexes, and sexual orientations.**

4. **In addition to group HIV/AIDS-educational sessions, information should be made available to inmates individually upon entering and exiting the correctional facility.**

In order to guarantee that information is current and to ensure that the prisoners trust those providing the education:

5. **External, community-based AIDS and health organizations should lead educational sessions. Peer education should also be promoted.**

Education will only be effective if prisoners have the means to act on their knowledge. The federal government has recently, if belatedly, recognized the truth of this proposition by starting a condom distribution program. Such programs must be started in provincial institutions, and all such programs must be expanded to improve distribution methods and to include other safer sex materials. Therefore:

6. **Condoms, dental dams, latex gloves, appropriate lubricants, and other safer sex materials must be made available to all prisoners.**

With the advent of its condom distribution plan, the federal government has acknowledged that consensual sexual activity takes place in prisons. This is not an illegal activity 'outside'. But because it is an institutional offense, prisoners, when having sex, are less likely to have safer sex: the extra time required is time in which they might be discovered and penalized. Accordingly:

7. **Consensual sex between prisoners should not be an institutional offense.**

Injection drug use is the second primary mode of HIV infection. And injection drug use is a fact of prison life that cannot be ignored. Just as safer sex education requires the distribution of safer sex materials, safer injection drug use education requires that prisoners have the means to use drugs safely. Denying inmates access to clean needles and bleach condemns them to preventable infection and illness. Thus:

8. **A confidential needle exchange program should be implemented.**

9. Bleach kits should be distributed in a non-identifying manner.

Needle exchange and bleach kit distribution programs outside of prisons no longer have many opponents. When people are aware that such programs make HIV easily preventable for injection drug users without, at the same time, increasing the amount of drug use, opposition usually evaporates. To ensure that these programs do not meet opposition when implemented 'inside':

10. A public relations campaign should be initiated to combat anticipated resistance by staff or the public to a needle exchange program.

Needle exchange and bleach kit distribution programs are most successful when they form part of a health model for understanding drug use. In such a model, prisoners are given information about the health consequences of continued drug use. Stopping using is identified as the healthiest option. Clean needle use is recommended for those who cannot or will not stop using. To facilitate the development of this health model:

11. Community-based workers should educate prisoners about substance use as a health issue.

12. Treatment programs for inmates with substance use concerns should be developed.

The use of unclean needles in tattooing is a third mode of HIV transmission in prisons. We suggest that:

13. Tattoo equipment and supplies should be covered under 'hobby-craft'; extra safety precautions should be established.

CARE AND SUPPORT FOR PRISONERS WITH HIV/AIDS

Prisoners with HIV/AIDS die faster than those with HIV/AIDS 'outside'. This fact is partly the result of inadequate **support services** for these prisoners. They are entitled to all of the medical and support services available to people with HIV/AIDS outside of prisons. Specifically:

14. Prisoners with HIV/AIDS must be guaranteed access to medical and dental workers of their choice. In particular, they must have access to experienced and expert HIV primary care physicians.

15. The services of community-based workers serving prisoners with HIV/AIDS must be made available to all prisoners who desire them.

16. **Prisoners with HIV/AIDS must have access to alternative therapies and non-approved treatments.**

A prisoner with HIV/AIDS also faces situations quite unlike those someone with HIV/AIDS on the 'outside' might have to confront. For example, a prisoner does not have control of her or his diet; or she or he might be forced to share a cell, increasing her or his exposure to opportunistic infections. To meet the special needs of a prisoner with HIV/AIDS:

17. **The special dietary needs of prisoners with HIV/AIDS (because of either illness or therapeutic programs) must be met.**

18. **The comfort needs of prisoners with HIV/AIDS (e.g. extra clothing or blankets) must be met.**

19. **Prisoners with HIV/AIDS should be given sensitive, humane, and compassionate treatment when being escorted outside the prison.**

Some prisoners with HIV/AIDS will be in need of practical assistance, without being so ill as to require hospitalization. In such cases:

20. **Special programs must be established for prisoners with HIV/AIDS who are suffering from AIDS-related illnesses and who are ineligible for medical parole/probation.**

Of course, it is best for people who have HIV/AIDS to spend as little time as possible in prison. They have better access to medical and social services on the 'outside' and they are more likely to maintain their health if they remain in their communities. A sentence for someone with a life-threatening illness is qualitatively harsher than the same sentence given to a healthy person. Reduced sentences and early releases are justifiable on humanitarian grounds. Thus:

21. **Sentencing guidelines for judges and prosecutors regarding people living with HIV/AIDS need to be developed.**

22. **A compassionate release and/or medical parole/probation program should be developed for prisoners with HIV/AIDS.**

As HIV infection is legally recognized as a disability, it is a violation of **human rights** codes to discriminate on the basis of HIV status. Discrimination will decrease with adequate education, but it is most easily avoided if a prisoner can keep her or his HIV status **confidential**. In order to maintain confidentiality:

23. **HIV-related information in the possession of medical providers should be released to prison authorities only under extraordinary circumstances and only with the consent of the prisoner.**

24. **The confidentiality of all prisoners' HIV-antibody status (whether positive or negative) must be respected. Staff members who break the confidentiality of prisoners should be disciplined and/or fired.**

25. **The distribution of medications should not require a breach of the confidentiality of prisoners with HIV/AIDS.**

26. **Prisoners who want access to supportive counselling, medical treatment, etc., must be guaranteed that their confidentiality will be respected.**

Currently it is all too common for prisoners who are known to have HIV/AIDS to be forcibly isolated. Guards, administrators, and other inmates are often under the illusion that they are safe from possible infection if all those known to be HIV positive are segregated. Education is the best method for addressing these irrational fears.

27. **Prisoners with HIV/AIDS should not be involuntarily isolated or segregated.**

People outside of the prison system are able to keep their HIV status confidential because they can use the **anonymous HIV-antibody testing** program recently implemented by the Ontario government. This program must be expanded to include prisoners:

28. **HIV-antibody testing of inmates must be done voluntarily and anonymously.**
29. **Testing should be carried out by 'outside' community-based agencies.**

When someone knows her or his HIV status, she or his is able to make decisions regarding possible medical interventions to prevent and/or delay the onset of serious illness. Prisoners will more likely choose to be tested if they know they have options should they test positive:

30. **HIV-antibody testing must be accompanied by access to medical monitoring and treatment (when necessary).**

A spectrum of support services should be available to prisoners with HIV/AIDS, starting at intake, throughout incarceration, and after release. Thus, HIV/AIDS issues need to be integrated into existing **aftercare** programs:

31. **Parole Officers, Probation Officers, workers in halfway houses, and other aftercare workers must be educated about HIV/AIDS.**

32. **Exit kits with HIV/AIDS information, contacts with community-based organizations, condoms, bleach kits, etc. must be made available to prisoners when they are released from correctional facilities.**

Any programs for prisoners with HIV/AIDS while incarcerated must continue to be available to them upon release:

33. **Programs providing continuity of care after release must be established for prisoners with HIV/AIDS.**

34. **Any special programs used by a prisoner with HIV/AIDS must remain available to her or him outside of prison.**

35. **Community-based groups must be involved with the development and implementation of aftercare strategies.**

36. **The Ministry of Correctional Services and CSC should work with community-based HIV/AIDS housing programs and service organizations to ensure that they meet the needs of ex-prisoners.**

WOMEN PRISONERS AND HIV/AIDS

The special HIV/AIDS-related needs of women prisoners must be met:

37. **Education and prevention information must be culturally sensitive and gender specific.**

38. **A broad range of prevention materials, addressed specifically to women, must be made available in such a way as to protect prisoners' confidentiality.**

39. **Women with HIV/AIDS must have access to appropriate treatments and hospital care.**

40. **Women with HIV/AIDS must have access to 'outside' resources such as counsellors and facilitators who are culturally and ethnically appropriate.**

FURTHER ISSUES

The following prison populations must be included in the HIV/AIDS policy outlined above: **young offenders**, **psychiatric inmates**, and **refugees** and **immigrants** who are detained while awaiting hearings or deportation. The special HIV/AIDS-related needs of each of these populations also must be met.

PASAN will be helping to write a brief on young offenders and HIV/AIDS in the near future. We will also be contributing to a project focussing on HIV/AIDS and immigrants. Some PASAN members plan to investigate HIV/AIDS issues concerning psychiatric inmates.

PASAN will also be examining HIV/AIDS issues relating to **security and detainment within the criminal justice system**. Police officers and court personnel must be educated about HIV/AIDS.

INTRODUCTION

The Prisoners with HIV/AIDS Support Action Network (PASAN) is a coalition formed to advocate for the development and implementation of suitable provincial and federal policies on HIV/AIDS[1] in prisons. After more than ten years of the AIDS crisis, there has yet to be an adequate governmental response to the effects of the crisis in prisons. Because of this neglect, inmates are being infected with HIV during their incarceration and prisoners with HIV/AIDS are suffering from worsening health and are needlessly dying.

Currently, the treatment of prisoners with HIV/AIDS varies from institution to institution. Guards and supervisory staff are often ignorant of the realities of HIV/AIDS, forcibly isolating inmates with HIV/AIDS solely because of their HIV status. The confidentiality of HIV-positive inmates is routinely violated because both guards and fellow prisoners are under the false impression that if they know who is infected then they do not need to take precautions to avoid HIV infection. Because of a lack of support services, education, and access to treatment, prisoners with AIDS have a **shorter lifespan** than those with AIDS on the 'outside'.

The HIV epidemic is increasing in the prisons because the behaviours which transmit the virus (unsafe sex and unsafe needle use) are common. **This increase could be avoided**. Transmission of the virus would be prevented with the implementation of a suitable HIV/AIDS policy for the prison systems.

PASAN proposes that a **comprehensive** AIDS policy be developed, one that acknowledges the interconnections between HIV/AIDS education, distribution of prevention materials (condoms, needles, and bleach), and services for prisoners with HIV/AIDS. It is impossible to address any one facet of the AIDS crisis adequately unless the other facets are also addressed. For example, Solicitor General Douglas Lewis, the minister responsible for Correctional Services Canada (CSC), recently announced that condoms would be distributed in the federal prisons. But without proper education, and while consensual sex remains an institutional offense, safer sex will remain the exception rather than the rule.

Guiding Principles

In formulating our recommendations, we have followed the lead of the prisoners who, despite a lack of administrative support and in the face of considerable hostility and discrimination, educated themselves and created HIV/AIDS education and prevention campaigns on their own. Five basic

[1] HIV, the Human Immunodeficiency Virus, is thought to be the cause of the immunosupression that allows for the opportunistic infections which define AIDS (Acquired Immune Deficiency Syndrome) to flourish.

tenets inform our recommendations. We believe:

- Prisoners with HIV/AIDS have a **basic right to maintain their health**. Prisoners are in jail and their freedom is being sacrificed as a penalty for a crime; their health should not also have to be sacrificed. This right can best be satisfied through the development of medical parole/probation and compassionate release programs. At the very least, all the medical and social supports available to people with HIV/AIDS outside of the prison system must also be available to those 'inside'.

- Prisoners have a **right to protect themselves** against HIV infection, through education and access to proper protective materials (such as condoms and clean needles).

- Prisoners have a **right to keep their health status private**. This means that HIV-antibody testing should be done anonymously and that prisoners with HIV/AIDS should be able to keep their status confidential.

- Prisoners have a **right to informed consent** with respect to HIV-antibody testing and HIV/AIDS treatment. In order for consent to be informed, a prisoner must have **received** all the information about the procedure, its possible effects, and alternatives to it, necessary to make a decision. Information can only be received if it is provided in a manner suited to the prisoner's literacy and language skills.

- HIV/AIDS support, education, and treatment programs should be **run by 'outside' community-based organizations brought into the prisons** rather than by correctional staff; prisoners are more trusting of and receptive to 'outside' workers.

We recognize the concerns of guards and correctional services' administrators around safety and security issues. But we believe that the promotion of health in the prison populations and the education of both prisoners and staff are the best ways to create safety and security. When the points outlined in our brief are taken into consideration, there is no real conflict between the needs of prisoners and the needs of prison staff with respect to HIV/AIDS.

Communities Call for a Response

PASAN members include ex-prisoners, both HIV positive and negative, and representatives from a variety of community-based organizations involved with prison issues and/or HIV/AIDS (see Appendix 2). The diversity of PASAN's membership has helped us to recognize that a viable strategy for confronting HIV/AIDS in the prisons must address the various communities in prison. Throughout the brief, we stress that HIV/AIDS programs must be sensitive to culture, race, gender, sexual orientation, and disability. Prisoners speak many languages and have various levels of literacy skills; a mental or physical disability may restrict a person's ability to communicate. These differences must be acknowledged and valued in the design of all HIV/AIDS programs.

Our recommendations for the development of a comprehensive prison HIV/AIDS policy are aimed at both the provincial and federal governments because we believe that the length of a prison sentence is not relevant to either the prevention of HIV infection or the needs of prisoners with HIV/AIDS: HIV transmission, discrimination on the basis of HIV status, and AIDS-related health problems can happen in only a short period of time.

At the provincial level, we propose that a **joint ministerial task force**, including members from the **Ministries of Correctional Services** and **of Health**, be formed to consult with prisoners, community groups, and prison staff unions while implementing our recommendations.

We also propose that the **same process** be undertaken at the federal level with **Correctional Services Canada** (CSC) and the **Ministry of Health and Welfare**. We urge these federal agencies to **co-ordinate** their response to our recommendations with the provincial task force.
HIV/AIDS in the prisons cannot be wished away. Implementing our recommendations will help to control the AIDS crisis in the prisons and the costs associated with it -- not only the monetary costs of increased health care, but the costs in needlessly sacrificed human lives.

HIV/AIDS EDUCATION AND PREVENTION

The first decade of the AIDS crisis has, among other things, taught us the lesson that education is the best means of preventing HIV infection. This lesson applies as much inside prisons as it does 'outside'. Prisoners often engage in behaviours putting them at high risk for HIV infection prior to and during incarceration. And though prisoners may be difficult to reach with prevention messages outside the correctional institutions, they are literally a captive audience while inside. This coalition is concerned about enabling inmates to protect themselves through a comprehensive AIDS strategy that includes mandatory HIV/AIDS educational programming for both inmates and staff. With education, inmates can help to limit the spread of HIV infection; without it, they are put in a situation where they may only help to spread HIV.

Recommendations for educational programs in prisons have been made by the Royal Society of Canada, the National Advisory Committee on AIDS, and the World Health Organization. In June 1990, the report of the Parliamentary Ad Hoc Committee on AIDS expressed "concerns about the effectiveness of the information programs on HIV to which inmates and staff are exposed."

> There was evidence that they are not likely to be effective in changing behaviour, and that they are not mandatory or even pressed upon the inmates, although the prison setting would allow for this. Dr. Hankins [an epidemiologist studying HIV/AIDS in prisons] suggested that those who attended optional programs might fear that other inmates would assume that they were infected. In any case, in terms of anything but abstention from all high risk behaviours, which is surely unlikely, information probably will not be of much use if inmates do not have the means to act on it. Inmates have told Dr. Hankins that education sessions are simply frustrating. "We get them all keen to protect themselves, and then there are no means by which they can do so."[2]

These comments serve to reinforce the need for a **comprehensive** prison AIDS strategy: education in isolation is not useful. Education must be accompanied by programs which provide prevention materials.

Recommendations

1. **HIV/AIDS education should be compulsory for all inmates (male and female) and all staff providing services for incarcerated individuals (workers at the Ministry of Correctional Services and CSC such as guards, Case Management Officers, and Classification Officers; members of Correctional Officers' unions, e.g. OPSEU;**

[2] Hon. David MacDonald (chair), "Confronting a Crisis: Report of a Parliamentary Ad Hoc Committee on AIDS" (1990).

Clinical Support staff; etc.).

Education for inmates should begin at the time of admission, at the medical unit or as part of the general orientation process. Since the transmission of HIV requires only a few minutes, prison officials will have to consider how to deliver this service so that all offenders, even those admitted for only a few days, are able to participate. Inmates should also have access to staff who are able to answer questions, provide additional information, and respond to personal HIV/AIDS issues in a competent and confidential manner.

To enable Ministry of Correctional Services and CSC staff to address HIV/AIDS issues comfortably, staff education should be a distinct and separate part of their orientation program at the beginning of employment. Ongoing mandatory updating sessions should be offered yearly.

2. Education must be *comprehensive* for both inmates and staff.

The coalition recommends that the following topics be included in AIDS educational programming for both inmates and correctional services staff:

1. Definitions of HIV and AIDS, discussion of how they differ, and and the possibilities of **living** with HIV and AIDS.

2. A review of how HIV is transmitted, focussing on unprotected sexual intercourse and needle sharing for injecting drugs and tattooing.

3. How HIV is not transmitted.

4. The means of protection against HIV infection, identifying safer sex options and advocating for inmates' access to condoms, needles, and bleach.

5. Clarification that it is the behaviours in which a person participates, rather than the groups to which a person belongs that place someone at risk for HIV infection (risk behaviour vs. risk group model).

6. Sexual assault and the risks of HIV transmission, advocating for improvements in the prison system to reduce the incidence of sexual assault.

7. Issues concerning homophobia, heterosexism, and oppression.

8. Testing options (anonymous, confidential), issues of pre- and post-test counselling, confidentiality, the necessity of informed consent.

9. Treatment options for those with HIV/AIDS.

10. Community resources (such as community-based AIDS organizations and local health clinics) available to people with HIV/AIDS within the institutions and upon release.
11. Universal precautions, reinforcing for staff and inmates that if these precautions are followed by everyone, there is no need to know a person's HIV status.

12. The availability of additional educational resources such as audio tape, video tape, and pictorial materials (comics and cartoons).

In addition to group HIV/AIDS-education sessions, individual HIV/AIDS counselling should be available to prisoners and staff whenever they request it.

3. All educational presentations and materials must recognize and respond to the needs of prisoners with disabilities, from different ethnic and linguistic backgrounds, with varying language skills, and of different races, sexes, and sexual orientations.

Education can be useful only if it is actively received by prisoners. But prisoners are hardly a homogeneous group. The differences among prisoners must be acknowledged in the creation of educational programs.

It is important not to overlook the education of disabled prisoners. A mental or physical disability may restrict a person's ability to speak in a manner which is readily understood. People who are non-verbal sometimes learn alternative means of communication, such as Bliss symbolics. The deaf and hard-of-hearing communicate in a variety of ways: sign language (ASL and signed English), speech, lip reading, and/or very basic gestures.

4. In addition to group HIV/AIDS-educational sessions, information should be made available to inmates individually upon entering and exiting the correctional facility.

At the beginning of incarceration, each inmate should be given kits at the point of entry which would include condoms, bleach kits, information about the topics mentioned above (items 1-12), and information regarding the HIV/AIDS services available in the prison system.

Exit kits (containing condoms, bleach, written information about HIV/AIDS) are recommended for distribution at the time of release. Again the written material should cover the topics listed above with added emphasis on community resources (e.g. John Howard Society, agencies providing HIV/AIDS information and support, where to get condoms, locations of needle exchanges, etc.). The kits should also include information about obtaining identification, Welfare, SIN and OHIP; options for safe and affordable housing; information about accessing HIV-knowledgeable counselling, addiction counselling, and support groups.

Exit kits should be distributed privately and inmates should be free to choose whether or not to take one. For example, the kits could be available in the changing stall at the discharge area in every prison. If they are designed appropriately, prisoners could have the option of discretely slipping one

into their pockets when they are changing into their own clothes. In order to avoid rejection of these kits, it is recommended that written materials come from agencies external to the correctional facility and ministry.

5. External, community-based AIDS and health organizations should lead educational sessions. Peer education should also be promoted.

Education is better received by inmates when provided by health- and HIV/AIDS-education workers from agencies outside of the Ministry of Correctional Services and CSC. The input of inmates should be sought when developing HIV/AIDS education programs with the intent of implementing peer training. In this way, inmates could educate fellow inmates.

Training of staff, as well, should be done through these external organizations and community groups to ensure that the program and information both remain current, unbiased, and accurate, and discourage phobias and misinformation. The Ministry of Correctional Services and CSC should also recognize and make use of the educational expertise of agencies outside the corrections field on a consultative basis when planning any HIV/AIDS programs.

Not all local communities will have adequate resources to facilitate HIV/AIDS education in the prisons. To deal with these cases, we recommend the development of a mobile HIV/AIDS education unit, which would allow community-based workers to travel to the prisons in under-served areas and to deliver consistent AIDS education throughout the prison system. Already-existing AIDS hotlines should be promoted for inmates and staff to use between visits.

6. Condoms, dental dams, latex gloves, appropriate lubricants, and other safer sex materials must be made available to all prisoners.

As we have already stressed, education is only successful if prisoners are enabled to use the information they are given. Safer sex education must be accompanied by safer sex materials. In late 1991, Douglas Lewis, the minister responsible for Correctional Services Canada, announced that condoms would be distributed in federal prisons. The provincial Ministry of Correctional Services must follow suit immediately and make condoms available in provincial prisons.

Even where condoms are available, we are concerned with the method of distribution. Condoms should not only be distributed through health care services, they should also be available in showers and on ranges. The locations of condom sources should be safe and allow for confidentiality. Condoms must be available free of charge and must be available in both men's and women's prisons.

But condoms alone are not enough. Dental dams (latex barriers used for protection in oral-vaginal and oral-anal contacts) must also be easily available and free of charge to both men and women. Prisoners also need water-based lubricant (such as K-Y) to use with condoms. Condoms used without lubricant (even so-called 'lubricated' condoms) can tear and break, and can cause harm to

their users. At the moment, some prisoners are using food products or hand creams as lubricants. But such oil-based products damage latex and cause condoms to break, increasing the riskiness of sexual activity.

7. Consensual sex between prisoners should not be an institutional offense.

Sexual activity between inmates is a fact of prison life, a fact which CSC, with their condom distribution plan, has finally acknowledged. But consensual sex between prisoners remains prohibited. This means that when prisoners are having sex they will be less likely to have safer sex; the extra time required is time in which they may be discovered and penalized. In order to fight the transmission of HIV most effectively, there must be no penalties for consensual sex between prisoners.

We recommend that consensual sex be allowed not only because this change will increase the effectiveness of HIV prevention. We see sexuality as an integral part of human nature: disallowing sexual activity between prisoners is a violation of human rights. Sex can be a source of comfort, contact, and companionship for prisoners.

The argument that sex must be prohibited in order to maintain order in the prison is unsound. Sexual activity continues to take place in prisons, despite being banned, and there is no loss of order and control. In fact, the need to be furtive while engaging in sexual activity is more a source of disorder than the sex itself. Of course, non-consensual sex is unacceptable; it is a crime and should be treated as such.

Consensual sex should be allowed for all prisoners, whether HIV positive or negative. Safer sex practices should be encouraged for all sexually active prisoners. Prisoners known to be HIV positive must not have their confidentiality breached in an attempt to 'protect' his or her sexual partners. It is every individual's responsibility to protect him- or herself from HIV infection. With proper education and access to prevention materials, prisoners will be able to make informed choices to protect themselves and each other.

INJECTION DRUG USE AND HIV

HIV transmission through injection drug use is a growing problem in Canada and an area which must be addressed in correctional settings. Current research on injection drug users has concluded that: "Incarceration is an important risk fact for exposure to HIV through needle sharing in this population. Over 80% had been in jail overnight or longer since beginning to inject drugs, with 25% of those sharing injecting equipment while in custody."[3] And while the current Canadian 'war on drugs' is being fought from a criminal perspective -- defining substance use as a criminal problem -- the emergence of an HIV epidemic among drug users show that substance use is better understood as a health issue. We propose that Canada and the criminal system re-address their failing efforts regarding substance use and develop a new health model in their attempts to deal with the situation.

A first step towards constructing this new model must be a consideration of the linkages between drugs and crime: Why do people use drugs? Why do some drug users commit crimes? Dr. Diane Riley, a senior policy analyst at the Canadian Council on Substance Abuse, has suggested that those involved in crime need the support that drugs can give -- drugs provide a means of coping.

Similarly, those in our overcrowded correctional facilities often turn to substance use as a means to cope with the harsh reality of prison life. They end up being more concerned with their daily struggles than with health issues regarding HIV. A health model for treating drug use is an attempt to help people find alternative ways of coping. In such a model there is also a recognition that until such alternative ways have been found, healthier drug use must be promoted. If someone is going to use drugs regardless, she or he should be encouraged not to share needles. And if that person is going to share needles, she or he should be encouraged to clean them with bleach.

We advocate a multifaceted approach to dealing with substance use in the prisons, injection drug users, and their risk of HIV infection. This approach should include a needle exchange program, bleach kit distribution, education on drug use as a health issue, and treatment for addictions.

Note, however, that the need for a comprehensive and multifaceted approach should not be an excuse for delayed action: the immediacy of the situation requires the earliest possible intervention. For example, a needle exchange program and bleach kit distribution can be implemented at once, and can be integrated into the larger health model as it is developed.

CSC, Health and Welfare, and various other government agencies are finally admitting what many community-based groups have known for years -- that there exists unsafe drug use in correctional facilities. With the attention that the problem has received recently, and in view of the health risks involved, it is now time for action.

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[3] P. Millson, "Evaluation of a Programme to Prevent HIV Transmission in Injection Drug Users in Toronto," (1991).

Recommendations

8. A confidential needle exchange program should be implemented.

Clean needles (and needle-cleaning equipment) are essential in stopping the growing risk of HIV infection in correctional settings:

> In order to further reduce HIV transmission ... the feasibility should be explored of providing inmates with confidential access to clean needles and syringes through a one-for-one needle exchange intended to reduce HIV transmission while not prompting drug use.[4]

Already the Commissioners' Directives of Correctional Services Canada provide infection-control guidelines which allow for the possibility of needle exchanges in the correctional setting. In fact, section 821-1 of these directives insists that "the program should address precaution techniques and the prevention of disease transmission within the institution and to family and friends." We recommend that these precautionary techniques also include methods which have been proved effective in efforts to stop HIV infection, such as needle exchange programs and bleach kit distribution.

Needle exchanges and bleach kit distribution programs have been successfully employed outside of the prison setting throughout the world: they have been essential in combating HIV transmission. "No new cases of HIV infection among [injection drug users] have been found in the area during the three years experience from needle exchange programs in Sweden, despite frequent testing for HIV antibodies."[5] It should also be noted that "findings dispute the argument that needle exchange programs create a new generation of drug users."[6]

A prison needle exchange program should be modelled after existing outside exchange programs while simultaneously protecting prisoners from harassment from prison staff and fellow prisoners. Therefore, the program must guarantee confidentiality, especially from guards. Without such a guarantee, prisoners will not make use of the exchange and the intervention will fail. We suggest that needles be exchanged through the health service at the correctional setting; prisoners should not be accountable to non-medical prison staff (including guards) when obtaining needles. The health

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[4] Health and Welfare Canada, Canada Diseases Weekly Report 17 (October 26, 1991), p. 234.

[5] Journal of AIDS (September 1991), p. 893.

[6] Kaplan, AIDS and Public Health Journal 6 (1991), p. 114.

service department of the prison should treat the exchanges in a confidential one-for-one manner.

We do not recommend the provision of a needle-exchange machine. As has been noted in some European prisons, such machines can be faulty and are easily vandalized. Also, using machine poses problems for prisoners who wish to maintain their confidentiality.

Arguments have been made that needles pose a security threat, that they can be used as weapons. However, a prisoner wishing to use violence against a guard or another prisoner will likely utilize other already available methods, such as pencils, pens, razors, utensils, toothbrushes, etc. Moreover, a needle exchange program does not increase the number of needles in the institution. Only those who already have a needle can get a new one through the exchange.

9. Bleach kits should be distributed in a non-identifying manner.

Such kits should be distributed universally, possibly during the weekly provision of supplies. Prisoners who do not need a kit can simply return it or later dispose of it.

10. A public relations campaign should be initiated to combat anticipated resistance by staff or the public to a needle exchange program.

Needle exchange programs on the 'outside' are becoming more common. Experience has shown us that the few opponents they encounter in the community can be overcome through consultation and education. Harm reduction is the framework in which we promote needle exchanges to the outside community. A similar strategy should be pursued in supporting a prison exchange program.

Information regarding drug use in the prisons and the health risks it involves should be made public. The success of needle exchanges in halting the transmission of HIV should also be conveyed. It should be noted that keeping a prisoner free of HIV and AIDS is a massive cost savings.

11. Community-based workers should educate prisoners about substance use as a health issue.

An educational component regarding drug use is an essential part of the health care model we are proposing. Studies have shown that education is better received by inmates when it is provided through outside sources and through an inmate peer support program. Therefore, we suggest that an educational program be developed by an appropriate pool of community resources.

12. Treatment programs for inmates with substance use concerns should be developed.

Treatment programs should be administered separately from the correctional institution, possibly within the health services of the prison. Staff should consist of individuals hired outside the prison system who are appropriate to the population. These staff would be accountable to external

organizations and community groups to ensure that the program remains current, unbiased, accurate, and confidential, and discourages stigmatization and misinformation.

In the case of those in maximum security facilities who wish to access treatment, provisions should be made for guarded safe rooms where the prisoner could consult with the care worker in confidence.

Although we advocate the development of health services within the prison that are confidential and appropriate, we realize that alternatives should be presented. Therefore, we suggest that a system be established whereby prisoners could access outside services and treatment confidentially and without compromising security concerns.

13. Tattoo equipment and supplies should be covered under 'hobby-craft'; extra safety precautions should be established.

Even though the risk for HIV infection in this practice can be high, tattooing is an art form in which many inmates engage. It can be practiced safely if new needles are used for each tattoo and if safety guidelines are followed. Expert tattoo artists should be brought into the prisons to help inmates learn to tattoo safely.

SUPPORT SERVICES

Prisoners with HIV/AIDS are, like all prisoners, serving a sentence during which they are forced to sacrifice their freedom; there is no justification for their also being forced to sacrifice their health and well-being. Accordingly, all support services available to people with HIV/AIDS outside of prisons must be made accessible to inmates.

Counselling, medical care, and access to the full range of therapies are minimal requirements for all people with HIV/AIDS, including inmates. The comfort requirements of prisoners with HIV/AIDS also must be addressed. For example, special dietary needs must be met and comfortable bedding must be provided. Currently, a prisoner with AIDS has a survival rate one half of that of a person 'outside'. Only if inmates have access to a variety of health and support services, such as those suggested below, will this statistic improve.

Recommendations

14. Prisoners with HIV/AIDS must be guaranteed access to medical and dental workers of their choice. In particular, they must have access to experienced and expert HIV primary care physicians.

Decent health care is a fundamental right of all Canadians inside or out of prison. To ensure this right is respected for prisoners with HIV/AIDS, the correction system's "Management of Inmates with Human Immunodeficiency Virus (HIV) Infections" must be amended to include a guarantee that inmates have access to HIV primary care physicians and dentists. Any required therapies or vaccines must be available free of charge.

15. The services of community-based workers serving prisoners with HIV/AIDS must be made available to all prisoners who desire them.

In particular, medical and psycho-social support services should be available to HIV-positive inmates. These services need to be coordinated and integrated with service on the 'outside' where follow-up can be continued after release. Community AIDS workers take an active role in the inmates' concerns by considering their HIV status to be the top priority. Given the proper monitoring, information, and the means, prisoners with HIV/AIDS are able to take care of themselves.

16. Prisoners with HIV/AIDS must have access to alternative therapies and non-

approved treatments.

It has become standard for the medical care of people with HIV/AIDS on the 'outside' to include alternative therapies and non-approved treatments. These options must also be available to prisoners. This means that they must have access to information about such therapies and medications. Contacts with community-based groups such as Toronto's Community AIDS Treatment Information Exchange (CATIE) must be facilitated.

17. The special dietary needs of prisoners with HIV/AIDS (because of either illness therapeutic programs) must be met.

Nutrition is fundamental to the health and well-being of a person living with HIV/AIDS. Prison food is often high in calories and fat; prisoners with HIV/AIDS wishing to eat more healthily should be allowed to do so. Vitamin and diet supplements, currently unavailable in prisons, should be made available on a regular and continuing basis.

Food is usually served at designated times only. Thus, if an inmate does not have an appetite at those times, she or he has no choice but to wait until the next meal. Removing food from the dining room for eating later is an offense and there are no provisions for alternate eating times. As people with HIV/AIDS often have suppressed or erratic appetites, prisoners with HIV/AIDS must have food available to them when they have are hungry.

Steps taken to meet the food needs of prisoners with HIV/AIDS must not compromise the confidentiality of their HIV status.

18. The comfort needs of prisoners with HIV/AIDS (e.g. extra clothing or blankets) must be met.

Prisoners with HIV/AIDS must be provided with warm cells, enough clothing, and adequate bedding. Their privacy must be respected. Given the susceptibility of an immuno-compromised person to illnesses others would easily fight off, a single occupancy cell should be made available to prisoners with HIV/AIDS upon their request.

19. Prisoners with HIV/AIDS should be given sensitive, humane, and compassionate treatment when being escorted outside the prison.

Handcuffs should be avoided. Escorts should not wear undue protective clothing or gear such as gloves and masks. Any fears about infection should be alleviated through education. The HIV status of the prisoner, if known, should not be revealed: her or his confidentiality must be respected.

20. Special programs must be established for prisoners with HIV/AIDS who are suffering from AIDS-related illnesses and who are ineligible for medical parole/probation.

People with AIDS often are in need of practical assistance, but are not sick enough to require ospitalization. Elsewhere, we have recommended that most prisoners with HIV/AIDS be given medical parole/probation so that they can have access to the various levels of support available in the community 'outside' (see Recommendation 22). But the needs of prisoners ineligible for medical parole/probation must also be met. A special area should be set aside where prisoners with medical needs could have the support they require (such as help with bathing and meals, reminders to take medications). Of course, such participation is such a program must be optional to prisoners.[7]

We recognize that when the medical needs of a prisoner with HIV/AIDS become more demanding, it seems difficult both to provide the necessary services and to maintain the confidentiality of the prisoner's health status. This difficulty can be avoided if support services are provided on the basis of the prisoner's needs as they manifest themselves, not on the basis of her or his medical diagnosis. If support workers do need to know medical information, it should only be released with the prisoner's consent. Workers should be required to keep any such information confidential (see Recommendations 23-6).

[7] New York State's Walsh Medical Centre, a long-term care centre for inmates is an example of such a program (James Dao, "New York's Prisoners with AIDS Ask for Dignity During Last Days," New York Times (March 22, 1992)).

HUMAN RIGHTS, COMPASSIONATE RELEASE, AND CONFIDENTIALITY

HIV infection is legally recognized as a disability. Accordingly, the human rights codes protecting the disabled from discrimination also apply to people with HIV/AIDS. Nonetheless these people continue to face discrimination, especially if they happen also to be prisoners. Prisoners with HIV/AIDS are experiencing human rights violations in our correctional systems.

Discrimination against prisoners with HIV/AIDS takes several forms. First, judges sometimes view the HIV status of a convict as a reason to incarcerate or to lengthen prison terms. Given that a sentence for someone with a life-threatening illness is qualitatively harsher than the same sentence given to a healthy person, we recommend that a compassionate release program for HIV-positive prisoners be developed.

Second, when an HIV-positive person is in prison, her or his health status is usually circulated among both the guards and the prisoners. Indeed, an HIV-positive status is sometimes viewed as a sufficient reason for the forced isolation of a prisoner. By being denied the right to keep their health status private, a prisoner with HIV/AIDS is often also denied the supportive environment (insofar as this is possible inside prisons) she or he requires to maintain her or his health.

Prisoners have written to PASAN members detailing the abuses they have suffered 'inside'. One prisoner writes: "I've been isolated for no reason for seven months.... The penal system seems more interested in persecuting me for my HIV-positive status than in attempting to reduce the spread of AIDS." Another comments: "I was put in the hole because I have AIDS. When I complained in writing, they threw my complaints away. Then they threatened me with further abuse if I didn't shut up." An inmate from another institution describes how "one isolated HIV-positive prisoner is often told by a security staff: 'I'll be back in four hours to see if you are still alive.'" In order to avoid future situations such as these, we call for the recognition of a prisoner's right to keep her or his health status private, and for rules disallowing the involuntary isolation of prisoners with HIV/AIDS.

Recommendations

21. Sentencing guidelines for judges and prosecutors regarding people living with HIV/AIDS need to be developed.

Imprisonment, coupled with the poor diet and living conditions of the prison, are much more detrimental to the health of a person living with HIV/AIDS than they are to prisoners whose immune systems are not compromised. A five year sentence given to a person already living with AIDS is comparable to a death sentence. For prisoners, the greatest fear often is dying alone and in jail.

The quality of 'time served' for someone living with a fatal disease is more psychologically stressful and more physically detrimental than for the healthy. Sentences can justly be shortened for people in

such situations, and alternatives to imprisonment should be investigated and developed.

It is unacceptable to sentence HIV-positive people to prison solely in order to "protect the public health" (a 'public' which somehow excludes people with HIV/AIDS). The criminal system must not try to do the job of public health authorities. In one recent case, a woman who normally would have been given a suspended sentence was sent to jail because the judge knew she was HIV positive and sexually active.[8] Education rather than incarceration is the best way to reduce HIV transmission and increase safer sex practices.

The Ministry of Correctional Services and Correctional Services Canada should urge the Office of the Attorney General and the Ministry of Justice to develop educational programs around HIV/AIDS for judges and attorneys. The development of alternatives to incarceration for convicts who have HIV/AIDS helps to reduce the number of prisoners with HIV/AIDS.

22. A compassionate release and/or medical parole/probation program should be developed for prisoners with HIV/AIDS.

Currently, compassionate release is only considered for terminally ill prisoners whose sickness is so advanced that they are near death. Release, at this point, means little other than a transfer from prison institutions to another form of institutionalization -- the hospital. New guidelines need to be developed to allow for early parole and probation for medical reasons, 'medical parole/probation'.[9] If possible, prisoners living with HIV/AIDS should be released from the penal system as early into their sentences as is thought possible (remembering security concerns). Living with HIV requires a positive and healing environment, not the punishment, violence, and powerlessness that is the norm in prisons.

23. HIV-related information in the possession of medical providers should be released to prison authorities only under extraordinary circumstances and only with the consent of the prisoner.

Staff must be trained to protect the privacy of inmates' medical data. Work rules prohibiting release of HIV-related information must be strictly enforced. An HIV-positive prisoner should be consulted and his or her consent must be obtained before medical information is given to prison authorities or

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[8] Kingston Whig-Standard (Feb. 7, 1991).

[9] There is currently a bill before the New York State Assembly which would allow for medical parole (James Dao, "New York's Prisoners with AIDS Ask for Dignity During Last Days," New York Times (March 22, 1992)).

support workers.

24. The confidentiality of all prisoners' HIV-antibody status (whether positive or negative) must be respected. Staff members who break the confidentiality of prisoners should be disciplined and/or fired.

Prison administrators and staff should have access to the HIV-antibody status of prisoners only when it is absolutely necessary and with consent. When this information is shared, it must be held in the strictest confidence. This policy and the penalties for breaking it must be made widely known in the prison community, among both staff and inmates.

25. The distribution of medications should not require a breach of the confidentiality of prisoners with HIV/AIDS.

Guards (and other non-medical staff) should not have any knowledge of the medications prisoners are taking. This means that guards should not be distributing medications (as is currently the case in Ontario prisons). We recommend the distribution method used in federal prisons, where medications are usually distributed by medical staff to inmates, who then keep their supplies in their private lockers; this allows for prisoners' confidentiality to be maintained.

26. Prisoners who want access to supportive counselling, medical treatment, etc., must be guaranteed that their confidentiality will be respected.

Requests for access to counselling, medical treatment and other services should be made through the health service. Guards should not be told the reason for a prisoner's meeting with an outside worker, nor should they be present at such meetings.

27. Prisoners with HIV/AIDS should not be involuntarily isolated or segregated.

Involuntary isolation of prisoners with HIV/AIDS is not justifiable nor in the best interest of either that person or the general population of prisoners. The isolation of HIV-positive prisoners has been an all-too-frequent reality, if not official policy, of both provincial and federal prisons. Usually the reasons given for the punishment of isolation vary, but have a constant theme: the HIV-positive prisoner somehow jeopardizes the "good order of the institution," either by the fact of infection or because her or his behaviour (when coupled with the knowledge that she or he is HIV infected) is deemed a threat to either staff or other prisoners. Sometimes it is thought by prison authorities that segregation, if not isolation, is in the best interest of the HIV-infected prisoner, who may otherwise be subjected to threats or violence by guards or other inmates.

Isolation heaps depression and anxiety onto the person isolated. The resulting stress, depression, and anxiety, actively suppress the immune system, hastening illness in the person living with HIV/AIDS.

It must be made clear that involuntary isolation serves no one's interests. Rather it presents to the prison population a false sense of security -- that infectious people are removed from their lives and that therefore they need not take proper safer sex and safer drug use precautions.

If special housing requirements do present themselves, such as when an individual living with HIV/AIDS is jeopardized by viruses or opportunistic infections transmitted by others in the population, the choice to pursue special housing arrangements ought to be the choice of the individual. "Special housing" ought to translate into supportive medical care, and not punishment or hardship.

ANONYMOUS HIV-ANTIBODY TESTING

On January 1, 1992, the provincial government of Ontario began implementing a program whereby people who are not in prison can be anonymously tested for antibodies to HIV. Prisoners should also have access to this service.

The identification of people with HIV within prisons is often suggested as a means of infection control. But this suggestion rests on several myths. It is an illusion to think that staff and inmates would be protected from AIDS by knowing every inmate's HIV status. In fact, it would be practically impossible to be certain of everyone's status, because the results of the HIV-antibody test are not always 100% accurate. Tests must be repeated after a period of approximately six months, during which time the individual must not have participated in any high risk activities (such as having sexual intercourse without using a condom, or sharing injection equipment with someone who has been exposed to the virus). The test measures the presence of antibodies to HIV, not the presence of the virus itself. People who have recently been infected (within the past six months) may not have developed antibodies to the virus yet, and thus may test negative. There can be false negative and false positive results to the test.

Because of this, public health campaigns argue that we can only assume that **everyone**, including staff, could be HIV positive. The proper use of universal precautions when dealing with anyone's potentially infectious bodily fluids is the only way to meet the concern of work place safety effectively. Universal precautions include the wearing of latex gloves when cleaning up blood spills (for example). This does **not** mean that staff need to be covered from head to foot in protective clothing when they come in contact with someone who is HIV positive. Proper education for staff and inmates regarding HIV transmissibility and universal precautions would reduce unnecessary fears or reactions.

There are some legitimate reasons for HIV testing. HIV sero-prevalence studies examine the presence of HIV in a given population. However, especially in these times of economic restraint, HIV sero-prevalence studies may not be the wisest use of severely limited funds. Thorough HIV testing of inmates would be a very time-consuming and expensive procedure, using money that would be better spent improving the care of and services to prisoners with HIV/AIDS. In any case, established ethical guidelines for HIV sero-prevalence studies[10] require that there be universal access to confidential HIV-antibody testing in place before a sero-prevalence study can be undertaken. Given the problems with current testing programs in prisons, until our recommendations are

[10] Federal Centre for AIDS Working Group on Anonymous Unlinked HIV Seroprevalence, "Guidelines on Ethical and Legal Considerations in Anonymous Unlinked HIV Seroprevalence Research," Canadian Medical Association Journal 143 (1990), pp. 625-7. See also: Gilbert Sharpe, "HIV Seroprevalence Studies Report," Legal Services Ontario Ministry of Health (1991).

followed, most sero-prevalence studies would be unethical.

An individual may choose to be tested in order to seek preventive treatments or therapies before they develop any of the opportunistic infections associated with AIDS. "Early diagnosis is essential in the effective treatment of HIV disease."[11] Knowing one's own HIV status also allows the individual to consider some lifestyle changes (e.g. sexual behaviour, drug use, nutrition, rest).

> [S]ome individuals at risk of HIV infection are reluctant to be tested. They are concerned that their names will be reported to the public health system, and they fear discrimination and loss of privacy. Anonymous HIV testing is intended to remove these barriers and encourage people at risk of HIV infection to come forward for testing and receive the medical and social services they require.[12]

Recommendations

28. HIV-antibody testing of inmates must be done voluntarily and anonymously.

> With anonymous testing, no personal identifiers are used. There is no link between the person's name and the test. Individuals book their own appointments using a first name only. The HIV test itself is ordered and conducted using a number code rather than a name. Those ordering or conducting the tests cannot match the test results to the person's name. No names are reported.
>
> Working with experienced health care providers, the Ministry of Health has established rigorous guidelines for anonymous HIV testing including pre- and post-test counselling and evaluation.[13]

Inmates must be provided with information about high risk behaviour, symptoms, and available treatments, in order to judge for themselves whether or not to test. Proper pre-test counselling is absolutely necessary. This allows the individual to prepare in advance for the possibility of a positive test result. Post-test counselling should include a discussion of the meaning of the test result (whether positive or negative), possible sources of error, and ways in which to make behaviour changes concerning health, sexual practices, and drug use techniques. Proper counselling regarding precautions (e.g. the use of condoms, bleach to clean injection equipment) and availability of necessary prevention materials would have an impact on transmissions both within the prison population and 'outside' when prisoners are released.

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[11] College of Physicians and Surgeons of Ontario, College Notices 24 (1992).

[12] Ibid.

[13] Ibid.

Hassle Free Clinic, a Toronto agency specializing in sexually transmitted diseases, birth control, and HIV testing, has produced a document on anonymous testing procedures for the Ministry of Health. This document as well as material for staff training regarding anonymous testing are available through the AIDS Bureau of the Ministry of Health.

29. Testing should be carried out by 'outside' community-based agencies.

Having testing done by an outside agency better protects inmates' confidentiality. Inmates would also be more likely to trust a counsellor from a community-based agency, with whom they would not have to worry about a breach of confidentiality (which could lead to discrimination from fellow inmates or prison staff). A 'safe' testing environment would likely lead to more inmates choosing to be tested and would therefore allow inmates to avail themselves of information, counselling, and treatment to delay the onset of HIV-related illnesses.

Given that 'outside' workers coming 'inside' are well received by inmates, permitting them also to offer counselling and anonymous testing would increase prison security. Staff would feel protected by an informed population who begin to change their behaviour voluntarily.

Toronto's Hassle Free Clinic has been in the Toronto Jail providing education programs and screening for sexually transmitted diseases (STD's). Counsellors at Hassle Free have stated that they are prepared to conduct anonymous HIV testing inside Toronto area jails. They suggest that 'outside' workers go in to schedule appointments, to provide counselling, and to take blood samples.

30. HIV-antibody testing must be accompanied by access to medical monitoring and treatment (when necessary).

When someone knows her or his HIV status, she or his is able to make decisions regarding possible medical interventions to prevent and/or delay the onset of serious illness. Prisoners will more likely choose to be tested if they know they have options should they test positive.

See the Support Services section of this brief for further recommendations concerning medical treatment.

AFTERCARE

This brief has recommended that numerous services, supports, and treatment be available in correctional settings. Currently, these services and supports are only offered outside prisons. In order to ensure the success of the Ministry of Correctional Services' and CSC's efforts to provide such services and care, mechanisms must be implemented to ensure that these programs can be continued upon a prisoner's release. It is essential that the Ministries provide the links necessary to facilitate a continuation of care and support.

Recommendations

31. Parole Officers, Probation Officers, workers in halfway houses, and other aftercare workers must be educated about HIV/AIDS.

As has been recommended in the Education and Prevention section of this brief (see Recommendation 1), aftercare workers should attend mandatory and comprehensive educational sessions on HIV/AIDS, community resources for people with HIV/AIDS, and the special needs of people with HIV/AIDS.

32. Exit kits with HIV/AIDS information, contacts with community-based organizations, condoms, bleach kits, etc. must be made available to prisoners when they are released from correctional facilities.

See Recommendation 4 for details.

33. Programs providing continuity of care after release must be established for prisoners with HIV/AIDS.

Inmates with HIV/AIDS who are receiving health care during their prison stay, should be supported in continuing the care they require after release. To maintain continuity of care during the transition from prison to community, every inmate with HIV/AIDS should be assisted in finding medical care and support services in the community. This should include helping prisoners to register with related community-based services prior to release where such services are available and if the prisoner so desires.

34. Any special programs used by a prisoner with HIV/AIDS must remain available to her or him outside of prison.

The Ministry of Correctional Services and CSC must provide special programs (counselling, support, education) to meet the needs of inmates who are HIV-positive or living with AIDS. These agencies

should collaborate with community service agencies which serve released prisoners (youth service organizations, Elizabeth Fry Societies, John Howard Societies, etc.) in order that programs accessed in prison are also available outside of prison.

35. Community-based groups must be involved with the development and implementation of aftercare strategies.

In order to facilitate the continuity of HIV/AIDS programs in the transition from prison to community, the Ministry of Correctional Services and CSC should consult with community groups and agencies which provide services and education to people with HIV/AIDS, and current and former prisoners, in an attempt to provide a comprehensive aftercare strategy. These agencies and groups must be allowed access to provide such services in prison, in order that a link can be established for the inmate prior to release into the community.

36. The Ministry of Correctional Services and CSC should work with community-based HIV/AIDS housing programs and service organizations to ensure that they meet the needs of ex-prisoners.

Community-based housing programs (such as, in Toronto, McEwan House, Fife House, Barrett House, Casey House) and service organizations should be helped to adapt their services to the needs of recently released prisoners with HIV/AIDS. Special halfway houses for ex-prisoners with HIV/AIDS could also be developed. Housing in all parts of the province must be developed.

WOMEN PRISONERS AND HIV/AIDS

Women now constitute the fastest-growing group of new HIV cases in Canada. World-wide, there are three million women infected with the virus, one third of all reported cases. It is estimated that by the year 2000, the number of women infected will exceed that of men.[14] Despite the rising statistics, the deficiency of services for HIV-positive women remains acute.

Women experience HIV/AIDS differently than men, both socially and physically. Women are diagnosed with HIV infection later, reach an AIDS diagnosis faster, and die sooner. One Philadelphia study indicated that the average woman with AIDS survives 15 and one half weeks from diagnosis to death, while the average white gay man with AIDS lives 39 months.[15]

The majority of women in prisons are members of social groups marginalized not only on the basis of gender, but also on the basis of race, class, sexual orientation, disability, substance use, and/or occupations as sex workers. The Centers for Disease Control reports that the incidence of AIDS is 13 times higher among Black women than white women, and eight times higher among Latina women. While in general there is a lack of female peer counsellors, there are especially too few AIDS counsellors who are sensitive to the issues of, and can relate to, the already-marginalized women confined within the Canadian prison system.

As a group, women prisoners have more health problems than male prisoners. Many of the former have chronic conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care. Within our society, women have traditionally been the caregivers, often subordinating their own health and well-being to that of others.

A study conducted in Massachusetts in 1990 found that 20% of the state's HIV-infected individuals were in correctional facilities and a disproportionately high number were women. About 35% of more than 400 women who chose to be tested at MCI-Framingham were HIV-positive, compared to 13% of male prisoners.[16]

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[14] World Health Organization, Global Program on AIDS (January 1992).

[15] Quoted in the Toronto Star (Feb. 11, 1991).

[16] N. Waring and B. Smith, Women and Criminal Justice 2 (1991), pp. 117-43.

In Canada, a 1989 Montreal study in a medium security prison for women found that 14.6% of 130 injection drug users (half of those surveyed) were seropositive. 83.7% had loaned or borrowed needles, 51.9% had done so with strangers.[17]

To date, AIDS research and studies have largely excluded women. Many HIV-related infections occur only in women but are not included in medical standards for an AIDS diagnosis. Many physicians do not realize that women's symptoms are unique. The first signs of female infection, for instance, include common medical conditions such as persistent vaginal yeast infections, irregular menstrual cycles, skin problems, swollen lymph glands, recurrent herpes, mouth sores, and fevers. Women are more likely than men to suffer from bacterial pneumonia or wasting syndrome. They rarely get Kaposi's Sarcoma, but commonly die of cervical cancer.

In addition, prison doctors are often unaware of current treatment options for women, who tend to have less access to treatments in general. Necessary educational and preventive information and materials specific to women are often not at their disposal. Besides lack of medical care, women prisoners are often subject to emotional deprivation such as isolation and lack of support and basic comforts. When receiving treatment or support outside the prisons, they are subjected to the unnecessary indignity of handcuffs.

We are aware that several community-based organizations (Kingston AIDS Project, some sexually transmitted disease clinics) have been providing HIV/AIDS education and counselling for prisoners and staff. While we welcome these initiatives by community-based agencies and consider them a step in the right direction, we feel they do not constitute a sufficient response to the crisis. A comprehensive AIDS strategy must be adopted to rectify the conditions that make women prisoners with HIV/AIDS among the most marginalized and ignored of all people with HIV/AIDS.

Recommendations

37. Education and prevention information must be culturally sensitive and gender specific.

Such information should include pamphlets, posters, videos, speakers, and counsellors which target readers and audiences with diverse cultural backgrounds and literacy skills. As well, there should be information about pregnant HIV-positive women and HIV-positive mothers with both HIV-positive and HIV-negative children.

38. A broad range of prevention materials, addressed specifically to women, must be

[17] C. Hankins, "HIV-1 Infection in a Medium Security Prison for Women," Canada Diseases Weekly Report 15 (1989), pp. 168-70.

made available in such a way as to protect prisoners' confidentiality.

The following prevention materials must be made available: dental dams, condoms, thin latex gloves, water-soluble lubricants, bleach kits, and clean needles. See Recommendation 6 for details.

39. Women with HIV/AIDS must have access to appropriate treatments and hospital care.

Often current levels of medical care and expertise within the prison system are insufficient to meet the needs of women living with HIV/AIDS. Women must have HIV primary-care physicians who are knowledgeable about women's symptoms; prisoners should be free to choose the physician they believe is appropriate for their needs.

40. Women with HIV/AIDS must have access to 'outside' resources such as female counsellors and facilitators who are culturally and ethnically appropriate.

Not only can community-based AIDS workers support women prisoners to live with HIV/AIDS, they can assist in the development of peer support groups within and outside the prison.

FURTHER ISSUES

I. Young Offenders

A comprehensive HIV/AIDS policy must apply to institutions for young offenders. HIV/AIDS education must be provided, prevention materials for safer sex and safer drug use must be available, and health care must be accessible. Given that the HIV epidemic is spreading rapidly among teenagers, it is critical that the HIV/AIDS-related needs of young offenders be met.

PASAN plans to help write a brief on young offenders and HIV/AIDS in the near future. We will continue to advocate for young offenders around HIV/AIDS issues.

II. Refugees and Immigrants

Refugees awaiting hearings and immigrants awaiting deportation are held in detention centres. The recommendations we have made for the prison system also apply to these detention centres. In this context, it is particularly important that all written materials and services are available in many languages.

PASAN will continue to follow HIV/AIDS issues relating to detained immigrants and refugees. We will also be contributing to a project focussing on HIV/AIDS and immigration.

III. Psychiatric Inmates

The HIV/AIDS-related needs of psychiatric inmates must be met. Workers at psychiatric institutions must be educated about HIV/AIDS and inmates with HIV/AIDS must have access to treatment and counselling.

PASAN members will be examining the response of psychiatric institutions to HIV/AIDS.

IV. Security and Detainment within the Criminal Justice System

Between arrest and imprisonment, detainees encounter not only staff from the prison system, but also police officers, prisoner escorts, and other court security personnel. All of these people must be educated about HIV/AIDS and the needs of detainees with HIV/AIDS. Police forces, in particular, need to be more aware of the specific needs of suspects with HIV/AIDS.

Some PASAN members have begun investigating the complexities involving policing, the criminal justice system, and HIV/AIDS. PASAN will continue investigating these issues.

APPENDIX 1

BACKGROUND INFORMATION

Who is in prison?

Currently there are approximately 14,700 people who have been federally sentenced (a sentence of more than two years) to Canadian prisons. A fair number of these people are 'long term' prisoners, which could mean life sentences with no chance of parole eligibility for up to 25 years. In Ontario, there are an additional 7,600 people held in provincial jails (serving sentences of less than two years). There are nearly 120,000 people sentenced to provincial and territorial institutions each year. Overall, the Canadian prison population has increased by 40% since 1984. And sentences are getting longer, largely as a result of the so-called 'war on drugs'.

On average, there are nearly 30,000 adults imprisoned on any given day in Canada. And this does not include those less than 18 years of age, the young offenders. Canada trails only the United States among all Western nations in its rate of imprisoning its own citizens. There are 230 federal, provincial, and territorial prisons in this country.[18]

Prisoners are often young, unemployed, and from working class backgrounds. While a clear majority of prisoners are listed as Caucasian, a disproportionate number of the prison population are people of colour -- primarily Aboriginal, Black, Asian, or Latino-Latina. Federally sentenced Native women account for about 20% of the federal female prisoner population, while Native women account for less than 2% of the Canadian population. It is thought that 85-90% of federally sentenced women and a clear majority of federally sentenced males are survivors of some form of childhood abuse (sexual, physical, or emotional).

Why are they in prison?

The people being incarcerated are, in the majority, being convicted of non-violent, property- or drug-related crimes. In two Quebec provincial jails, 70% of the men and 50% of the women prisoners were found to be serving sentences on drug-related convictions.[19]

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[18] Ibid.

[19] C. Hankins, "HIV-1 Infection Among Incarcerated Men -- Quebec," Canada Diseases Weekly Report 17 (1991), pp. 233-35. C. Hankins, "HIV-1 Infection in a Medium Security Prison for Women," Canada Diseases Weekly Report 15 (1989), pp. 168-70.

Prisoners are at risk for HIV.

HIV is primarily transmitted through unprotected sexual intercourse and through unsafe injection drug use. And drugs and sex are alive and well inside our jails and prisons, despite the legal prohibitions on these activities. Because inmates do not have access to the information and equipment necessary to use drugs and to have sex safely, they are engaging in behaviours that put them at high risk for contracting HIV.

It is thought that at least 20% of the total prison population is engaging in same-sex sexual activity; we can assume because of the ban on condoms in Ontario jails that a significant amount of this sexual activity is occurring in unsafe, high-risk manners. Even in the federal institutions where condoms have recently become available, problems in condom distribution, the lack of other protective materials (lubricant, gloves, etc.), and the fact that consensual sex remains an institutional offence, all help to create a situation in which safer sex is practiced only intermittently.

Researchers at the Canadian Council on Substance Abuse, have found that "58.7% of all federal inmates were classified as having a serious substance abuse problem".[20] And it is estimated that 50% of prisoners in Canada have tried or used injection drugs inside prisons. One study found that 20-30% of new admissions to a provincial jail bore visible marks of injection drug use.

It is clear that drugs get into the institutions (very often with the co-operation of the guards) and are widely used. Despite high levels of injection drug use, the presence of syringes used to inject illegal drugs is severely limited. Only a handful of needles will circulate in a population of 400-600 people. Accordingly, once incarcerated, with no access to clean needles or bleach, yet ongoing access to injectable drugs, inmates using injection drugs must share needles even though they may not have shared on the outside.[21] Needle sharing usually occurs in bathrooms, cells, and hidden areas. Home-made and unsafe sharps (needle substitutes) are fashioned out of hardened plastic and ball-point pens, often causing damage to veins, scarring, infections, and blood poisoning.

Because of tight security and the repressive penal environment, both sex and drug use go on in hidden, closeted ways inside the prisons. This causes an increase in high-risk behaviour, because the activities cannot be well-planned and usually involve elements of fear and stress. For instance, it has been found that bleach provision to prisoners (in isolation from other programs around injection drug use, such as a needle exchange) is not highly successful because prisoners who are injecting drugs

[20] Coates, "Coming to Grips with Substance Abuse in the Federal System," Canadian Council on Substance Abuse 11 (1991).

[21] Peggy Millson, "Evaluation of a Programme to Prevent HIV Transmission in Injecting Drug Users in Toronto," (1991).

usually feel the time and activity it takes to clean a syringe or home-made sharp could be time in which guards would detect the activity. The possession of a syringe will result in institutional charges, time in 'the hole', loss of the syringe, and damaged parole possibilities.

The HIV/AIDS epidemic is known to be raging in prisons elsewhere.

Authorities cannot say they have not been warned about the possibility of an AIDS epidemic among Canadian prisoners. Presently, in the state of New York, at least 10,000 of the state's 55,000 prisoners -- close to 20% -- are living with HIV/AIDS. AIDS-related illnesses are the leading causes of death for prisoners in New York: two out of every three prison deaths are AIDS related. New York State prisoners with AIDS have a life expectancy of one-half to one-third of that for people living with AIDS outside of prisons. Across the European Economic Community, it is thought that there are 20,000 to 30,000 prisoners living with HIV/AIDS.[22]

We are ignorant of the prevalence of HIV/AIDS in Canadian prisons.

In Canada to date, there has been no widespread screening for HIV among prisoners' blood samples. We have no way of knowing how many prisoners are HIV infected. Officially, the figure is less than 50 -- but this number emerges out of a near-total vacuum of information. Prisoners are by and large hesitant to go for HIV-antibody testing because they fear segregation due to the threat of possible violence from guards or inmates.

Studies performed by leading epidemiologist Catherine Hankins in two provincial jails on 1,100 female and male prisoners in Quebec give us some evidence of a widespread problem. She found an overall infection rate of about 5%. In one of the jails she examined, 50% of the prisoners were injection drug users, of whom 15% were HIV positive.[23]

We do not need HIV sero-prevalence studies to know that HIV/AIDS is threatening prisoners' lives.

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[22] James Dao, "New York's Prisoners with AIDS Ask for Dignity During Last Days," New York Times (March 22, 1992). Karen Birchard, "Prisons on AIDS/Drug Use Alert," The Journal (Aug.-Sept. 1991), p. 12.

[23] C. Hankins, "HIV-1 Infection Among Incarcerated Men -- Quebec," Canada Diseases Weekly Report 17 (1991), pp. 233-35. C. Hankins, "HIV-1 Infection in a Medium Security Prison for Women," Canada Diseases Weekly Report 15 (1989), pp. 168-70.

We do know that inmates tend to suffer from poorer conditions of health and wellness than does the 'outside' population. One sample of provincial incarcerees in British Columbia found that 40% of the inmates had orthopaedic problems, 30% had respiratory tract infections, and 20% suffered from sexually transmitted diseases. The suicide rate for prisoners in Canada is six to sixteen times higher than that of the overall population.[24] But medical care constitutes a small amount of the federal correctional budget. Only $48.4 million of the total federal correctional expenditure of $768.8 million was directed towards health care in 1989, and only 515 of a total of 10,000 employees work in health-care related areas.[25]

Poor levels of health among prisoners are partly caused by present penal conditions. But inmates also tend to enter prisons with poor health histories; often they are members of social classes and communities already marginalized from health and social services. Not only is there a clear link between unemployment and incarceration rates, there is also a direct link between conditions of poverty, powerlessness, and the prevalence of disease.

It has been well established that HIV/AIDS has disproportionately affected marginalized people whose living conditions are frequently unhealthy, and those who are effectively excluded from society's health care services -- people like injection drug users, the urban poor, street youth, women, gay men, natives, people of colour, and prisoners. In the United States, for example, while Blacks and Latinos/Latinas comprise only 20% of the total population, they make up 40% of Americans living with AIDS.[26]

Prisons contain a large concentration of people whose past and current behaviours put them at risk for HIV infection. They are also the people previously missed by traditional and mainstream educational campaigns. Because they are usually out of school and may have low levels of literacy, the education and prevention campaigns mounted by the state prove ineffective in reaching such marginalized groups.

HIV/AIDS has already reached into Canadian prisons. The epidemic in the prisons will only worsen unless action is taken immediately.

The status quo in the prisons is part of the AIDS crisis. We have shown that prisoners are often in a situation where they are either ignorant of the means or unable to change the behaviours putting them

[24] Coates, "Coming to Grips with Substance Abuse in the Federal System," Canadian Council on Substance Abuse 11 (1991).

[25] Correctional Services Canada, "Basic Facts about Corrections in Canada" (1990).

[26] Even though the epidemiology of HIV/AIDS in the United States has significant differences from its epidemiology in Canada, the statistics do make it clear that those living in unhealthy situations are more likely to become infected with HIV. The differences in epidemiology between the two countries arise because of differences in patterns of poverty and marginalization, the presence of national medical insurance in Canada, and the relatively more advanced stage of the epidemic in the US.

at risk for HIV.

Calls for a governmental response to the HIV/AIDS crisis in the prisons have already come from groups such as the Parliamentary Ad Hoc Committee on AIDS, the Royal Society of Canada, and the National AIDS Advisory Committee (NAC-AIDS). Although prisoners are identified as a priority target in the National AIDS Strategy, there has not been any commitment to action.

The provincial and federal governments have yet to develop comprehensive policies regarding HIV/AIDS in correctional settings. Only if Canadian governments take immediate action will the AIDS crisis in the prisons be prevented from worsening.

Appendix 2

PASAN MEMBER ORGANIZATIONS

AIDS Action Now!

AIDS Committee of Toronto

Alexandra Park AIDS Prevention Program

Anishnawbe Health Toronto

Black Coalition for AIDS Prevention

Canadian Organization for the Rights of Prostitutes

Elizabeth Fry Society of Toronto

Hassle Free Clinic

John Howard Society of Metropolitan Toronto

Kingston AIDS Project

Maggie's

Street Outreach Services

Toronto People with AIDS Foundation

Two-spirited People of the First Nations -- Native AIDS Awareness Project

Youth Link -- Inner City

Legal Counsel: Advocacy Resource Centre for the Handicapped