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HIV/AIDS
in
Prisons

2004/2005

HIV/AIDS and Hepatitis C in Prisons: The Facts

This info sheet reviews what is known about HIV/AIDS and hepatitis C in prisons.

This is one of a series of 13 info sheets on HIV/AIDS in prisons.

1. HIV/AIDS and Hepatitis C in Prisons: The Facts
2. High-Risk Behaviours behind Bars
3. HIV Transmission in Prison
4. Prevention: Condoms
5. Prevention: Bleach
6. Prevention: Sterile Needles
7. Prevention and Treatment: Methadone
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HIV Seroprevalence in Prisons

Canadian federal prisons

In Canada's federal prison system (which houses people sentenced to prison terms of two years or more), the number of reported cases of HIV/AIDS rose from 14 in January 1989 to 159 in March 1996 to 251 in 2002 (data for 2002 are preliminary). This means that 2.01 percent of all federal prisoners are *known* to be HIV positive. The actual numbers may be even higher: the reported cases, provided by the Correctional Service of Canada (CSC), include only cases of HIV infection and AIDS *known* to CSC, but many prisoners may not have disclosed their HIV status to CSC, or may not know themselves that they are HIV-positive.

Canadian provincial prisons

In provincial prisons (which house people sentenced to prison terms of less than two years), rates of HIV infection are also high. Studies undertaken in prisons in British Columbia, Ontario, and Québec have all shown that HIV seroprevalence rates in prisons are over 10 times higher than in the general population, ranging from 1.0 to 8.8 percent. For example:

- A study released in 2004 of 1,617 prisoners in 7 provincial institutions in Québec found an HIV seroprevalence rate of 2.3 percent among men and 8.8 percent among women.
- A 1993 study carried out among over 12,000 people entering Ontario prisons found HIV seroprevalence rates of 1.0 percent among adult men and 1.2 percent among adult women.

As in federal prisons, the number of prisoners living with HIV or AIDS in provincial prisons is on the rise. For example:

- In British Columbia, a study conducted in all adult BC provincial prisons in 1993 found an HIV seroprevalence rate of 1.1 percent. The study has not been repeated, but in 1996 a review of known cases alone revealed rates ranging from 2 to 20 percent in various prisons.

Worldwide

As in Canada, rates of HIV-infection in prison populations worldwide are much higher than in the general population. They are, in general, closely related to two factors: the proportion of prisoners who injected drugs prior to imprisonment, and the rate of HIV infection among injection drug users in the community.

Many of those who are HIV-positive in prison were already living with the virus on the outside. Indeed, the highest rates of HIV infection in

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prisons can be found in areas where rates of HIV infection are high among injection drug users in the community. Commenting on the situation in the United States, the US National Commission on AIDS stated that “by choosing mass imprisonment as the ... governments’ response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection.”

HIV infection rates are high in many prison systems. In Western Europe, particularly high rates have been reported in Portuguese (20 percent) and Spanish prisons (16.6 percent). Rates are also high in countries such as Switzerland (4 to 12 percent) and Italy (7 percent). In Eastern Europe, 7 percent of Ukrainian prisoners and 15 percent of Lithuanian prisoners are HIV positive. Forty-one percent of South African prisoners are reported to be HIV positive. In Latin America, high rates of HIV infection have been found in Brazil (10.9 to 21.5 percent) and Honduras (7 percent).

In contrast, relatively low rates of HIV prevalence have been reported from Australia. In the United States, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. Many systems continue to have rates under one percent, while in a few rates approach 10 percent among men and 15 percent among women.

Hepatitis C Seroprevalence

Canada

Hepatitis C (HCV) prevalence rates in prisons are even higher than HIV prevalence rates. Studies undertaken in the early and mid 1990s in Canadian prisons revealed rates of between 28 and 40 percent.

Rates continue to rise. In one federal prison, 33 percent of study participants tested positive in 1998, compared to 27.9 percent in 1995. In 2002, 3,173 federal prisoners were known to be HCV positive: 25.2 percent of male and 33.7 percent of female prisoners.

Worldwide

A review of prevalence and incidence in incarcerated populations worldwide found HCV seroprevalence rates ranging from 4.8 percent in an Indian jail to 92 percent in two prisons in Northern Spain.

Potential for further spread

Most HCV-positive prisoners come to prison already infected, but the potential for further spread is high. HCV is much more easily transmitted than HIV, and transmission has been documented in prisons in several countries, including Canada.

Additional Reading

Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries 2000-01. A Report of the Correctional Service of Canada’s Infectious Diseases Surveillance System. Ottawa: CSC, 2003. Available at www.csc-scc.gc.ca/text/pblct/infectiousdiseases/index_e.shtml.

GE Macalino et al. Hepatitis C infection and incarcerated populations. *International Journal of Drug Policy* 2004; 15: 103-114. A review of prevalence and incidence of HCV in prisons worldwide.

R Elliott. Prisoners’ Constitutional Right to Sterile Needles and Bleach. Appendix 2 of R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1996, at 3-4. Provides a summary of early Canadian seroprevalence studies in prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP2.html

C Hankins et al. HIV-1 infection in a medium security prison for women - Quebec. *Canada Diseases Weekly Report* 1989; 15(33): 168-170. The first HIV seroprevalence study in a Canadian prison.

S Landry et al. Étude de prévalence du VIH et du VHC chez les personnes incarcérées au Québec et pistes pour l’intervention. *Canadian Journal of Infectious Diseases* 2004; 15 (Suppl A): 50A (abstract 306). The most recent Canadian study.

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidsida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d’information est également disponible en français.**

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High-Risk Behaviours behind Bars

This info sheet presents some of the evidence of the prevalence of high-risk behaviours – in particular, injection drug use – behind bars.

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Drug Use

Despite the sustained efforts of prison systems to prevent drug use by prisoners — by doing what they can to prevent the entry of drugs into prisons — the reality is that drugs can and do enter. A number of studies have provided evidence of the extent of injection and other drug use in prisons.

Canada

In a survey carried out by the Correctional Service of Canada (CSC) in 1995, 40 percent of 4285 federal prisoners self-reported having used drugs since arriving at their current institution.

Injection drug use is also prevalent, and the scarcity of needles often leads to needle sharing. Members of the Expert Committee on AIDS and Prisons were told by prisoners that injection drug use and needle sharing are frequent and that sometimes 15 to 20 people will use one needle. Many staff also acknowledge that drug use is a reality, admitting that “drugs are part of prison culture and reality” and that “there does not seem to be a way to ensure that there will be no use of drugs.”

Such anecdotal evidence of the prevalence of injection drug use is confirmed by many studies:

- In a study released in 2004, 76 percent of 1,475 injection drug users enrolled into the Vancouver Injection Drug Users Study reported a history of incarceration since they first began injecting drugs. Of these, 31 percent reported injecting in prison.
- In a 2003 study of federally incarcerated women, 19 percent reported injection drug use in prison.
- In a 1998 study, 24.3 percent of prisoners at Joyceville Penitentiary in Kingston, Ontario reported using injection drugs in prison, compared to 12 percent in a similar study at the same prison in 1995.
- In a study among incarcerated men and women in provincial prisons in Montréal, 73.3 percent of men and 15 percent of women reported drug use while incarcerated. Of these, 6.2 percent of men and 1.5 percent of women injected drugs.
- In a study among prisoners of a provincial prison in Québec City, twelve of 499 admitted injecting drugs during imprisonment, of whom 11 shared needles and three were HIV- positive.
- In CSC’s 1995 inmate survey, 11 percent of 4285 federal prisoners reported having injected since arriving in their current institution. Injection drug use was particularly high in the Pacific Region, with 23 percent reporting injection drug use.

Worldwide

Many other countries report high rates of injection drug use behind bars. Typically, injection drug use decreases in prisons among prisoners who were users on the outside. However, prisoners are more likely to

HIGH-RISK BEHAVIOURS BEHIND BARS

inject in an unsafe manner when they do inject, and a significant number of people start injecting while in prison. Studies have therefore concluded that imprisonment increases the risk of contracting HIV infection. The following are data from some recent studies:

- A 2002 report prepared for the European Union found that between 0.3 and 34 percent of prisoners in the European Union and Norway injected while incarcerated; that between 0.4 and 21 percent of injection drug users started injecting in prison, and that a high proportion of injection drug users in prison share injection equipment.
- In Russia, a study among 1,087 prisoners found that 43 percent had injected a drug ever in their lives, and that 20 percent had injected while incarcerated. Of these, 64 percent used injection equipment that had already been used by somebody else, and 13.5 percent started injecting in prison.
- In Mexico, a study in two jails found rates of IDU of 37 percent and 24 percent respectively.

Sexual Activity

In prisons, sexual activity is considered to be a less significant risk factor for HIV and hepatitis C transmission than sharing of injection equipment. Nevertheless, it does occur and puts prisoners at risk of contracting HIV infection.

Homosexual activity occurs inside prisons, as it does outside, as a consequence of sexual orientation. In addition, prison life produces conditions that encourage homosexual activity and the establishment of homosexual relationships between prisoners who do not identify themselves as homosexuals. The prevalence of sexual activity in prison is based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification, and the extent to which conjugal visits are permitted. Studies of sexual contact in prison have shown “inmate involvement to vary greatly.” In a study in state prisons and city jails in New York, prisoners reported frequent instances of unprotected sex behind bars. One woman summarized the prevalence and range of sexual activity:

Male CO’s [correctional officers] are having sex with females. Female CO’s are having sex with female inmates, and the male inmates are having sex with male inmates. Male inmates are having sex with female inmates.

In a survey conducted among 1100 male prisoners in Russia, only 10 to 15 percent of the prisoners reported having had no sexual contacts while serving their term. Non-consensual sexual activity was prevalent.

In Canada, according to CSC’s 1995 survey, six percent of federal prisoners reported having had sex with another prisoner. This is consistent with the results of studies in provincial prisons. More recently, in a 2002 study of federal women prisoners, 37 percent reported being sexually active in prison.

Tattooing

In prison, tattooing is a social activity and involves sharing needles, which makes it risky. In Canada, 45 percent of federal prisoners reported having had a tattoo done in prison. In 2004, the Correctional Service of Canada announced that it will conduct a pilot “safer tattooing practices initiative.”

Additional Reading

R Lines et al. *Prison Needle Exchange: A Review of International Evidence and Experience*. Montreal: Canadian HIV/AIDS Legal Network, 2004. Contains an overview of research on injection drug use in prison. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm

A DiCenso, G Dias, J Gahagan. *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C*. Toronto: PASAN, 2003. Contains info on risk behaviours among federally incarcerated women in Canada. Available at www.pasan.org.

Correctional Service Canada. *1995 National Inmate Survey: Final Report*. Ottawa: The Service (Correctional Research and Development), 1996, No SR-02. The results of CSC’s 1995 inmate survey. Available at www.csc-scc.gc.ca.

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HIV/AIDS in Prisons

2004/2005

HIV Transmission in Prison

This info sheet presents some of the evidence of the extent of HIV transmission behind bars. It shows that outbreaks of HIV infection have and will continue to occur in prisons unless HIV prevention is taken seriously. This raises important questions about the moral and legal obligations of prison systems to prevent the further spread of HIV in prisons (see info sheet 12).

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Until recently, few data were available on how many prisoners become infected in prison. The data that were available suggested that “transmission does occur in correctional facilities, but at quite low rates.” This was sometimes used to argue that HIV transmission in prisons is rare and that there is no need for increased prevention efforts.

However, most of the studies that have reported relatively low levels of HIV transmission in prison were conducted early in the HIV epidemic and sampled long-term prisoners who would have been at less risk of infection than short-term prisoners. The extent of HIV infection occurring in prisons may have been underestimated. In recent years, a growing number of studies undertaken in Scotland, Australia, Lithuania, and Russia have shown how frighteningly quickly HIV can spread behind bars. Two of these studies are summarized in more detail here.

Outbreak of HIV Infection in a Scottish Prison

Taylor investigated an outbreak of HIV in Glenochil prison in 1993. Before the investigation began, 263 of the prisoners who had been at Glenochil at the time of the outbreak had either been released or transferred to another prison. Of the remaining 378, 227 were recruited into the study. Recruitment ranged from 26 to 51 percent across 11 subunits at Glenochil. Anecdotal reports suggest that many prisoners who were not recruited were injectors from one subunit where injection was prevalent. Of the 227 prisoners recruited, 76 reported a history of injection and 33 reported injecting in Glenochil. Twenty-nine of the latter were tested for HIV, with 14 testing positive. Thirteen had a common strain of HIV, proving that they became infected in prison. All those infected in prison reported extensive periods of syringe sharing.

Outbreak in a Lithuanian Prison

During random checks undertaken in 2002 by the state-run AIDS Center, 263 prisoners at Alytus prison tested positive for HIV. Tests at Lithuania’s other 14 prisons found only 18 cases. Before the tests at Alytus prison, Lithuanian officials had listed just 300 cases of HIV in the whole country, or less than 0.01 percent of the population, the lowest rate in Europe. It is believed that the outbreak at Alytus was due to sharing of drug injection equipment.

HIV TRANSMISSION IN PRISON

Canadian Prisons

Springhill, Nova Scotia

In 1996 two HIV- and HCV-positive prisoners at Springhill Institution, a federal institution in Nova Scotia, informed health-care staff that they had shared needles and injection equipment with a significant number of other prisoners. A disease outbreak containment intervention was initiated, and 17 contacts of the two men were tested. However, no attempt was made to prove that, as a result of sharing needles and injection equipment with the known positive inmates, the contacts had contracted HIV or HCV while in prison.

Joyceville, Ontario

In 1997 a prisoner who had been sharing injection equipment with fellow drug users at Joyceville Penitentiary, a medium-security federal prison for men, revealed that he was HIV-positive. This caused concern among the large number of prisoners who had shared injection equipment with him. The prisoners were reluctant to seek HIV testing from the prison's health-care staff for fear of self-identifying as injection drug users. The prison's inmate committee therefore requested that an HIV-seroprevalence study be carried out as a way of providing prisoners with access to anonymous testing.

The study showed that risk behaviours and rates of infection in the prison had increased substantially since a previous study that had been undertaken at the same prison in 1995. In addition, the researchers who undertook the study "saw individuals with equivocal test results who were likely in the process of seroconverting." Since the study was completed, they became aware of one individual, negative for HIV in March 1998, who is now positive, and one individual who has contracted HCV.

Additional Reading

Correctional Service Canada. *Springhill Project Report*. Ottawa: CSC, May 1999. A report on the outbreak intervention at Springhill Institution.

K Dolan. Evidence about HIV transmission in prisons. *Canadian HIV/AIDS Policy & Law Newsletter* 1997/98; 3(4)/4(1): 32-35. An excellent summary of the evidence as of 1997, at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/Winter9798/26DOLANE.html.

PM Ford et al. HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 52-54. A summary of the study at Joyceville Institution. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/prisons.htm.

A Taylor et al. Outbreak of HIV infection in a Scottish prison. *British Medical Journal* 1995; 310: 289-292. The first documented outbreak of HIV infection in prison. See also A Taylor, D Goldberg. Outbreak of HIV infection in a Scottish prison: why did it happen? *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(3): 13-14. The account of why the outbreak of HIV infection occurred. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/April1996/14avrilE.html.

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Prevention: Condoms

Info sheets 1-3 in this series showed how prevalent HIV infection and hepatitis C are in prisons; that the behaviours through which these infections can be transmitted are also prevalent; and that outbreaks of infection have and will continue to occur unless efforts to prevent the spread of infections are stepped up. Info sheets 4-7 discuss what can be done to reduce the spread of HIV and other infections in prison.

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Providing Condoms

According to the World Health Organization, 23 of 52 prison systems surveyed allowed condom distribution as early as late 1991. Significantly, no system that has adopted a policy of making condoms available in prisons has reversed the policy, and the number of systems that make condoms available has continued to grow every year. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made condoms available rose from 53 percent in 1989 to 75 percent in 1992 and 81 percent in 1997. In the most recent survey, condoms were available in all but four systems.

In 1995 in Australia, 50 prisoners launched a legal action against the state of New South Wales (NSW) for non-provision of condoms, arguing that “[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded.” Since then, at least in part because of the legal action, the NSW government has decided to make condoms available. Other Australian systems have also made condoms available. Only in the United States does only a small minority of prison systems make condoms available.

Canadian Federal Prisons

In Canada’s federal prisons, condoms were made available on 1 January 1992. After some initial opposition, the decision to make them available has been well accepted and has not created any problems. However, in some prisons access to condoms remained limited. In particular, where access was restricted to distribution in health-care services, prisoners said they were afraid to pick up condoms for fear of being identified as engaging in homosexual activity and of being discriminated against. In response, and as a result of a recommendation by the Expert Committee on AIDS and Prisons, the federal prison system announced in 1994 that condoms, dental dams, and water-based lubricant would become more easily and discreetly available.

Canadian Provincial Prisons

On 1 October 1989 the Northwest Territories adopted the first prison policy in Canada to allow for the distribution of condoms to inmates. Most other prison systems followed. However, even today, in some provincial prisons condoms, dental dams, and lubricant are not available, and in many provincial prisons they are not easily and discreetly available:

- British Columbia is an exception. In its provincial prison system, condoms have been easily and discreetly accessible for years.
- In Québec, a working group established by the Québec ministry of public security released a report in 1997 recommending wider and more

PREVENTION: CONDOMS

discreet access to condoms. At present, distribution methods vary between prisons.

- Some jurisdictions such as Ontario, Alberta, and Nova Scotia, among others, continue their policy of making condoms available only through prison health services. Others, such as Saskatchewan and Manitoba, use different methods of distribution in different prisons, some necessitating a request to the health unit and some not.
- In four prison systems (New Brunswick, Newfoundland, Nunavut, and Prince Edward Island), condoms and dental dams are still not made available.

Not making condoms, dental dams, and lubricant available, or making them available only through prison medical services, runs against all Canadian and international recommendations. Because prisoners, on average, spend only 30 to 40 days in provincial prisons, the prevalence of sexual activity may be lower than in federal prisons, but sexual activity nevertheless occurs. In addition, studies have shown that, when prisoners have to ask for condoms at health-care services, few will do so. Making condoms available is not enough. They must be easily and discreetly accessible.

Recommendation

Without any further delay, condoms, dental dams, and water-based lubricant need to be made easily and discreetly accessible to inmates in all prisons, in various locations throughout the institutions, and without prisoners having to ask for them.

Denial of HIV prevention measures such as condoms to prisoners exposes prisoners and the general community to disease. The potential liability of correctional authorities to civil action was recently illustrated by an out-of-court financial settlement achieved by a South African former prisoner who claimed that he had contracted HIV through sex while in prison

between 1993 and 1994. Condoms were introduced in South African prisons in 1996.

Additional Reading

K Dolan, D Lowe, J Shearer. Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine & Ethics* 2004; 32: 124-128. The most recent of only a few evaluations of prison condom distribution programs.

R Lines. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Montreal: Canadian HIV/AIDS Legal Network, 2002. Contains information about provision of safer sex measures in all Canadian prison systems. Available at www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm

A DiCenso, G Dias, J Gahagan. *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C*. Toronto: PASAN, 2003. Examines access to safer sex measures among women in Canadian federal prisons. Available at www.pasan.org.

Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994. Recommends easy access to condoms and that consensual sexual activity “be removed from the category of institutional offences”; and deals with prevention of non-consensual sexual activity.

Joint United Nations Programme on HIV/AIDS. *Prisons and AIDS: UNAIDS Point of View*. Geneva: UNAIDS, 1997. States that “UNAIDS believes it vital that condoms, together with lubricant, should be readily available to prisoners.”

R Jürgens. Results of the Staff Questionnaire. In: Correctional Service of Canada. *HIV/AIDS in Prisons: Background Materials*. Minister of Supply and Services Canada, 1994, at 85-109. An overwhelming majority of 462 prison staff responding to a questionnaire said that making condoms available had created no problems.

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Prevention: Bleach

This info sheet discusses one way of reducing the spread of HIV and other infections in prisons through injection drug use: providing bleach, together with instructions on correct use, to sterilize needles and syringes. Info sheets 6 and 7 will discuss two other ways: making needles available, and methadone maintenance treatment.

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Experience has shown that drugs, needles, and syringes will find their way through the thickest and most secure of prison walls. While continuing and often stepping up drug interdiction efforts, prison systems around the world have therefore taken steps to reduce the risk of the spread of HIV and other diseases through injection drug use. These include provision of bleach to sterilize needles and syringes, making sterile needles available (info sheet 6), and methadone maintenance treatment (info sheet 7).

Providing Bleach

According to the World Health Organization's network on HIV/AIDS in prison, 16 of 52 prison systems surveyed made bleach available to prisoners as early as 1991. Bleach was available in some prison systems in Germany, France, and Australia, in prisons in Spain, Switzerland, Belgium, Luxembourg, and the Netherlands, and in some African and at least one Central American prison system.

Significantly, no system that has adopted a policy of making bleach available in prisons has ever reversed the policy, and the number of systems that make bleach available continues to grow. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made bleach available rose from 28 percent in 1992 to 50 percent in 1997. In the most recent survey, bleach was available in 11 of 23 systems. Of the respondents who did not make it available, three said that it should be made available and five said that both needles and bleach should be made available.

Canadian Federal Prisons

In its 1994 Report, the Expert Committee on AIDS and Prisons (ECAP) recommended that bleach be made available to prisoners. The Committee emphasized that this "in no way condones drug use, but rather emphasizes that in correctional facilities as elsewhere, the overriding concern in any effort to deal with drug use needs to be the health of the persons involved and of the community as a whole."

Initially, the Correctional Service of Canada (CSC) rejected ECAP's recommendation, agreeing only to pilot-test a bleach-distribution program in one institution. However, in the spring of 1995 the Commissioner of CSC instructed CSC to initiate the implementation of bleach distribution in all institutions. As a result, bleach became available in all institutions in the fall of 1996.

Provincial Prisons

In a small number of provincial prison systems bleach has also become available or has continued to be informally available.

PREVENTION: BLEACH

A model to follow

In 1992, the BC provincial system issued a policy directing that bleach be made available to prisoners. Adoption of the policy did not lead to any “incidents of misuse ... or any evidence to indicate an increase in needle use.” In April 1995 a revised policy was approved, requiring that bleach be freely available, readily accessible, and distributed in a way that ensures anonymity and minimizes risk of injury.

Not making bleach available runs counter to all Canadian and international recommendations, which agree that full-strength liquid bleach, together with instructions on how to sterilize needles and syringes, should be provided to prisoners.

Recommendation

Full-strength liquid bleach, together with instructions on how to sterilize needles and syringes, needs to be made easily and discreetly accessible to prisoners in all institutions.

Limitations

Making bleach available is important, but not enough:

- Based on research, bleach disinfection should be considered as a method to reduce the risk of *HIV infection* from the re-use or sharing of needles and syringes only when *no other safer options are available*. Sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and syringes. With regard to *HCV infection*, a new study suggests that bleach may reduce its spread. However, the authors emphasized that bleach “is not a substitute for clean needles each and every time.”
- Research has shown that even outside of prison many injection drug users – as many as half or more in some studies – do not know, or do not practice, the proper method of using bleach for disinfecting needles. The probability of effective decontamination is decreased further in prison. Injecting is an illicit activity. Because prisoners can be accosted at any moment by prison staff, injecting and cleaning is a hurried affair. Studies have shown that bleach disinfection takes more time than most prisoners can take.

Additional Reading

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Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidssida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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6

HIV/AIDS in Prisons

2004/2005

Prevention: Sterile Needles

This info sheet provides important information about needle-distribution programs in prisons. It shows that needles can be made available in prisons safely with good results.

This is one of a series of 13 info sheets on HIV/AIDS in prisons.

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4. Prevention: Condoms
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Particularly because of the questionable efficacy of bleach in destroying HIV and other viruses (see info sheet 5), providing sterile needles to prisoners has been widely recommended. In its 1994 report, the Expert Committee on AIDS and Prisons (ECAP) observed that the scarcity of injection equipment in prisons almost guarantees that prisoners who persist in drug-injecting behaviour will share their equipment:

Some injection drug users have stated that the only time they ever shared needles was during imprisonment and that they would not otherwise have done so. Access to clean drug-injection equipment would ensure that inmates would not have to share their equipment.

The Committee concluded that making injection equipment available in prisons would be “inevitable.”

International Developments

Recently, an increasing number of prisons have established needle exchange or distribution programs.

Switzerland

In Switzerland, distribution of sterile injection equipment has been a reality in some prisons since the early 1990s. Sterile injection equipment first became available to inmates in 1992, at Oberschöngrün prison for men. Dr Probst, a part-time medical officer working at Oberschöngrün, was faced with the ethical dilemma of as many as 15 of 70 prisoners regularly injecting drugs, with no adequate preventive measures. Probst began distributing sterile injection equipment without informing the warden. When the warden discovered this, instead of firing Probst he listened to Probst’s arguments and sought approval to sanction the distribution of needles and syringes. As of 2004 distribution is ongoing, has never resulted in any negative consequences, and is supported by prisoners, staff, and the prison administration. Initial scepticism by staff has been replaced by their full support:

Staff have realized that distribution of sterile injection equipment is in their own interest. They feel safer now than before the distribution started. Three years ago, they were always afraid of sticking themselves with a hidden needle during cell searches. Now, inmates are allowed to keep needles, but only in a glass in their medical cabinet over their sink. No staff has suffered needle-stick injuries since 1993.

In June 1994 another Swiss prison – Hindelbank institution for women – started a one-year pilot

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AIDS prevention program including needle distribution. Hindelbank's program has been evaluated by external experts, with very positive results: the health status of prisoners improved; no new cases of infection with HIV or hepatitis occurred; a significant decrease in needle sharing was observed; there was no increase in drug consumption; needles were not used as weapons; and only about 20 percent of staff did not agree with the project. Following the first evaluation, a decision was taken to continue the program. The prison has also experienced a drastic reduction in fatal overdoses since the program started.

Other Swiss prisons have since started their own programs, and in 2004, distribution of sterile needles was being undertaken in seven prisons in different parts of the country.

Germany

In Germany, a green light to the development and implementation of the first two pilot schemes was given in 1995, and the first pilot project started on 15 April 1996 in Lower Saxony. An evaluation undertaken after two years showed positive results, and recommended not only to continue the two existing pilot projects but to expand them to all prisons in Lower Saxony. At the end of 2000, needle exchange schemes had been successfully introduced in seven prisons in Berlin, Hamburg, and Lower Saxony, and others were looking at how to implement them. However, since then six of the programs were closed down, not because of any problems with the programs, but as a result of political decisions by newly elected centre-right wing state governments. In each of these cases, the decision to cancel the programs was made without consultation with prison staff, and without an opportunity to prepare prisoners for the impending loss of access to the programs. It has been reported that since the programs closed, prisoners have gone back to sharing needles and to hiding them, increasing the likelihood of transmission of HIV and HCV, as well as the risk of accidental needle stick injuries for staff. Staff have been among the most vocal critics of the governments' decision to close down the programs, and have lobbied the governments to reinstate the programs.

Spain

In Spain, the first pilot project started in August 1997. An evaluation undertaken after 22 months showed positive results and, as a result, in June 2001, the Directorate General for Prisons ordered that needle exchange programs be implemented in all prisons. As of early 2004, exchanges were operating in more than 30 prisons, and a pilot program had also been established in a prison in the autonomous region of Catalonia.

Eastern Europe

In recent years, countries in Eastern Europe and the former Soviet Union have also begun implementing prison needle exchange programs.

The *Republic of Moldova* started a pilot project in one prison in 1999. Based on its success, the program has been expanded to two other prisons, with further expansion planned.

Kyrgyzstan started a pilot project in one prison in October 2002. In 2003, approval was given to expand the program to all 11 prisons in the country. By April 2004, all prisons had needle distribution programs.

The *Republic of Belarus* started a pilot project in one prison in April 2003. In 2004, needle exchange programs will be introduced in two other prisons, and the Ministry of Internal Affairs has stated that it is prepared to establish them in all prisons in the country.

Canadian Situation

As of 2004, no Canadian prison system had started a needle-exchange program. However, a few systems, including the federal prison system, are studying the issue. A 1999 committee established by the Correctional Service of Canada (CSC) to examine the feasibility of establishing needle exchange programs in Canadian federal institutions recommended that pilot programs be initiated across Canada.

People opposed to making needles available have said that distributing sterile needles in Canadian prisons would be seen as condoning drug use. In reality, it is not an endorsement of illicit drug use by prisoners. Rather, it is a pragmatic public health measure that recognizes that drugs get into prisons, prisoners inject drugs, and that efforts to eliminate drugs from prisons are doomed to fail. Not undertaking pilot needle-distribution projects, in the knowledge that HIV and other infections are being transmitted in prisons, could be seen as condoning the spread of infections among prisoners and ultimately to the general public.

What Can We Learn?

The experience of prisons in which needles have been made available, including scientific evaluation of the pilot phases carried out in 11 projects, provides many lessons. Among the most important are:

1. *Prison needle exchange programs are safe*
Needles can be made available in prisons in a manner that is non-threatening to staff and that increases staff safety. Since the first prison needle exchange program started in 1992, there are no reported cases of a needle being used as a weapon

PREVENTION: STERILE NEEDLES

either against prison staff or other prisoners. In addition, prisoners are usually required to keep their kit in a pre-determined location in their cells. This assists staff when they enter the cell to conduct searches and has decreased accidental needle stick injuries to staff.

2. Prison needle exchange programs do not lead to increased drug use

Evaluations of existing programs have consistently found that the availability of needles does not result in an increased number of drug injectors, an increase in overall drug use, or an increase in the amount of drugs in the institutions.

3. Prison needle exchange programs do not condone illegal drug use and do not undermine abstinence-based programs

Drugs remain prohibited within institutions where needle exchange programs are in place. Security staff remain responsible for locating and confiscating illegal drugs. However, it is recognized that if and when drugs find their way into the prison and are used by prisoners, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, needles that are part of the official needle exchange program are not.

In most cases, prison needle exchange programs have been introduced as only one component of a more comprehensive approach to dealing with drug-related harms, including abstinence-based programs, drug treatment, drug-free units, and harm reduction measures. Evaluations have found that needle exchange programs in prisons actually facilitate referral of drug users to drug treatment programs, and have led to an increase in the number of prisoners accessing such programs.

4. Prison needle exchange programs have been successfully introduced in various prison environments

While programs were first introduced in small Swiss prisons, they have since been successfully implemented in prisons for men and for women, in small, medium, and large institutions, as well as in prisons of all security classifications. Finally, after having been introduced in well resourced prison systems, programs have been established in systems with very limited resources. There are several models of distribution of sterile injection equipment, including automatic dispensing machines, distribution by medical staff or counsellors, and distribution by prisoners trained as peer outreach workers. What is appropriate in a particular institution depends on

many factors: the size of the institution, the extent of injection drug use, the security level, whether it is a prison for men or for women, the commitment of health-care staff, and the “stability” of the relations between staff and prisoners.

5. Prison needle exchange programs reduce risk behaviour and prevent disease transmission

Most importantly, evaluations of existing programs have shown that reports of syringe sharing declined dramatically, and that no new cases of HIV, hepatitis B, or hepatitis C transmission were reported. In addition, other positive health outcomes have been documented in some prisons, such as a decrease in fatal and non-fatal overdoses and a decrease in abscesses and other injection-related infections.

6. Prison needle exchange programs function best when prison administration, staff, and prisoners support them

The support of the prison administration and staff is important, and educational workshops and consultations with prison staff should be undertaken. This is not to say, however, that staff in prisons in which such programs have been introduced have been universally supportive from the start. In several cases, as shown by the evaluations, they were reluctant at first, but supported the program after they experienced its benefits.

7. Prison needle exchange programs are best introduced as pilot projects

Experience has shown that a good way for a prison system to start a needle-distribution program, and to overcome objections, is to operate a program as a pilot project and to evaluate it after the first year of operation.

Recommendation

Sterile injection equipment should be made available in prisons where prisoners inject illegal drugs. In prison systems where distribution has not yet started, pilot projects should be undertaken immediately.

Additional Reading

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PREVENTION: STERILE NEEDLES

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H Stöver. *Study on Assistance to Drug Users in Prisons*. Lisbon, European Monitoring Centre for Drugs and Drug Addiction, 2001 (EMCDDA/2001). A now out-dated, but still relevant overview of needle exchange programs in prison. Available at www.emcdda.org.

T Kerr, R Jürgens. *Syringe Exchange Programs in Prisons: Reviewing the Evidence*. Montreal: Canadian HIV/AIDS Legal Network, 2004. A 10-page review of the evidence. Available via www.aidslaw.ca/Maincontent/issues/prisons.htm.

Canadian Human Rights Commission. *Protecting Their Rights. A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*. Ottawa: The Commission, December 2003. Available at www.chrc-ccdp.ca/Legis&Poli/IndexFSW_FSF.asp?l=e. In its report, the Canadian Human Rights Commission recommended that the Correctional Service of Canada implement a pilot needle exchange program in three or more correctional facilities, at least one of them a women's facility, by June 2004.

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidsida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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HIV/AIDS
in
Prisons

2004/2005

Prevention and Treatment: Methadone

This info sheet provides important information about methadone maintenance treatment (MMT) in prisons. It explains that providing MMT is an HIV-prevention strategy that provides people dependent on drugs with an additional option for getting away from needle use and sharing; and points out that, since it is a medically indicated form of treatment, it should be available to opiate-dependent people regardless of whether they are outside or inside prison.

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Why MMT?

Methadone is a long-acting synthetic narcotic that is taken orally to effectively block craving or withdrawal symptoms from opioids such as heroin. Many have recommended the introduction or expansion of MMT in prisons as an HIV-prevention strategy that provides people dependent on drugs with an additional option for getting away from needle use and sharing. The main aim of MMT is to help people get off injecting, not off drugs. Methadone dose reduction - with the ultimate goal of helping the client to get off drugs - is a longer-term objective.

Community MMT programs have rapidly expanded since the mid 1990s. There are ample data supporting their effectiveness in reducing high-risk injecting behaviour and in reducing the risk of contracting HIV. There is also evidence that MMT is the most effective treatment available for heroin-dependent injection drug users in terms of reducing mortality, heroin consumption, and criminality. Further, MMT attracts and retains more heroin injectors than any other form of treatment. Finally, there is evidence that people who are on MMT and who are forced to withdraw from methadone because they are incarcerated often "return to narcotic use, often within the prison system, and often via injection." It has therefore been widely recommended that prisoners who were on MMT outside prison be allowed to continue it in prison.

Further, with the advent of HIV/AIDS, the arguments for offering MMT to those who were not following such a treatment outside are compelling. Prisoners who are injection drug users are likely to continue injecting in prison and are more likely to share injection equipment, creating a high risk of HIV transmission (see info sheets 2 and 3). As in the community, MMT, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons.

Where Is It Being Offered?

Worldwide, an increasing number of prison systems are offering MMT to prisoners, including most Western European systems (with the exception of Greece, Sweden, and two jurisdictions in Germany). Programs also exist in Australia and in the United States (at Rikers Island, New York City). Finally, an increasing number of Eastern European systems is starting MMT programs or planning to do so in the next years.

In Canada, methadone was rarely prescribed to anyone in prison until quite recently. However, this has changed, partly because of the recommendations urging prisons systems to provide MMT, partly because of legal action. One such case was in BC. An HIV-positive woman undertook action against the provincial prison system for failing to provide her

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with methadone. The woman had been refused continuation of MMT. She argued that, under the circumstances she found herself in, her detention was illegal. The prison system arranged for a doctor to examine the woman, and he prescribed methadone for her. After this, she withdrew her petition. In another case, a man with a longstanding, “serious heroin problem” was sentenced to two years less one day in prison - and thus to imprisonment in a provincial prison in Québec - because that prison had agreed to provide him with MMT. The defence had submitted that it was necessary to deal with the root causes of the man’s crimes, namely his heroin addiction, and that treatment with methadone was essential to overcoming that addiction.

In September 1996 the BC Corrections Branch adopted a policy of continuing methadone for incarcerated adults who were already on MMT in the community, becoming the first correctional system in Canada to make MMT available in a uniform way. On 1 December 1997 the federal prison system followed suit. Today, in the federal and in most provincial and territorial systems, prisoners who were already on MMT outside can continue such treatment in prison. However, few systems allow prisoners to initiate MMT while incarcerated. Only the federal system and the BC provincial system have formal methadone initiation programs, while Quebec, Saskatchewan, and Yukon allow MMT initiation under “exceptional circumstances”.

Are There Other Alternatives?

Some prison systems are still reluctant to make MMT available, or to extend availability to those prisoners who were not receiving it prior to incarceration. Some consider methadone as just another mood-altering drug, the provision of which delays the necessary personal growth required to move beyond a drug-centred existence. Some also object to MMT on moral grounds, arguing that it merely replaces one drug with another. If there were reliably effective alternative methods of achieving enduring abstinence, this would be a meagre achievement.

However, as Dolan and Wodak have explained, there are no such alternatives:

[T]he majority of heroin-dependent patients relapse to heroin use after detoxification; and few are attracted into, and retained in drug-free treatment long enough to achieve abstinence. Any treatment [such as MMT] which retains half of those who enrol in treatment, substantially reduces their illicit opioid use and involvement in criminal activity, and improves their health and well-being is accomplishing more than “merely” substituting one drug of dependence for another.

In recent years, evaluations of prison MMT programs in Canada, Australia, and the US have provided clear evidence of their benefits.

Recommendation

MMT is a medically indicated form of treatment that should be available to opiate-dependent people regardless of whether they are outside or inside prison.

Additional Reading

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T Kerr, R Jürgens. Methadone Maintenance Therapy in Prisons: Reviewing the Evidence. Montreal: Canadian HIV/AIDS Legal Network, 2004. Available via www.aidslaw.ca/Maincontent/issues/prisons.htm.

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8

HIV/AIDS in Prisons

2004/2005

Care and Treatment

Info sheets 4-7 in this series emphasize the importance of preventing the further spread of HIV and other infections in prisons. This info sheet deals with an equally important issue: providing prisoners with HIV/AIDS with care and treatment equivalent to that available to other members of the community.

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The Equivalence Principle

The 1993 World Health Organization *Guidelines on HIV infection and AIDS in prisons* state, as a general principle, that prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination. Most Canadian prison health-care services do their best to provide prisoners with HIV or AIDS with good care, and often refer prisoners to outside specialists for HIV-related care. However, prisoners report that they sometimes receive care and treatment that is not up to the standard that they received in the community, or even in other prisons they have been in.

Other issues include: the increase in the number of sick prisoners; prisons not being equipped to deal with prisoners who require long-term, ongoing care and treatment (including palliative care); and the difficulty of accessing investigational drugs and alternative therapies.

Antiretroviral Therapies

Left untreated, most people infected with HIV will eventually go on to develop HIV-related illnesses (morbidity) and die (mortality). The standard for treating HIV infection involves a combination of antiretroviral medications known as Highly Active Antiretroviral Therapy (HAART). Throughout Canada, prisoners with HIV/AIDS are prescribed HAART medications. Many HAART regimes are complex. Some medications must be taken with food, some on an empty stomach, some once a day, some twice, many at specific, fixed times of day every day. Taking HAART medications as prescribed is crucial to good health. Several studies have shown that 90 to 95 percent of doses must be taken as prescribed in order to achieve optimal suppression of HIV in the body. Non-medically indicated interruptions in HAART can have serious detrimental consequences for individual prisoner's health and for public health.

Non-medically indicated (and non consensual) interruptions in HAART occur in prisons, both federally and provincially. We know this from anecdotal evidence and from epidemiological studies. Prisoners report going without their HAART medications for days, not getting their dose at the prescribed time of day, or the correct dose. Doses are missed because medications are not reordered, prisoners are too ill to get their medications from health services, lock-downs, and lack of access to medications in segregation. Prisoners also report missing doses of HAART when they are arrested and incarcerated, make court appearances, or transferred between provincial and federal systems or even between institutions in the same system.

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Prisoners also report being released from custody without HAART or without sufficient medication to hold them until they are able to get a supply in the community.

Adequate Medication for Pain

Prisoners with HIV/AIDS also report they do not receive adequate medication for pain. Many prisons are reluctant to provide narcotic pain relief as it conflicts with the “zero-tolerance” to drugs ethos of the prison system. This is compounded by attitudes toward drug users, who typically require higher doses of pain medication than non-users because of their high tolerance for narcotics. Prisoners requesting higher doses of pain medication may be perceived as wanting to “get high” in prison. Without appropriate pain medication, prisoners may resort to illicit drugs, and unsafe injecting, to manage their pain.

Coroners Inquests

Many of the failings of prison systems were brought to light in a 1997 inquest into the care of Billy Bell, a prisoner who died of AIDS-related causes at Kingston Penitentiary. At the inquest into Billy Bell’s death, a specialist from the HIV clinic at the Kingston General Hospital, Dr Sally Ford, testified about how the prison failed to provide Billy the quality care that her patients outside the prison receive. The prison pharmacy would run out of doses of AZT and Billy would miss his dose days at a time. Billy also experienced difficulty accessing proper pain management medication. Many of the same issues were raised again at an inquest in 2001. Michael Joseph LeBlanc probably became infected with HIV and HCV while incarcerated. In November 1999, he died at the Regional Hospital in Kingston Penitentiary, in extreme physical, psychological, and emotional distress.

Recommendations

Prisons must ensure that prisoners receive care, support, and treatment equivalent to that available to people living with HIV/AIDS in the community. At a minimum, prisoners must have equivalent access to:

- pain control, including narcotics where medically indicated;
- investigational drugs, and complementary and alternative therapies;
- information on treatment options;
- uninterrupted HAART;
- health promotion strategies in order to slow the progression of their disease, including proper nutrition, vaccination, and programs to treat addictions.

In the longer term, prison health care should evolve from a reactive sick-call system to a proactive system emphasizing early detection, health promotion, and prevention.

Additional Reading

T Kerr et al. Determinants of highly active anti-retroviral discontinuation among injection drug users. *Canadian Journal of Infectious Diseases* 2004; 15(suppl A): 86A. Canadian Association for AIDS Research Conference. Montreal: May 13-17, 2004. A study showing that incarceration is independently associated with discontinuation of HAART.

R Lines. Death exposes treatment of prisoners living with HIV/AIDS. *Canadian HIV/AIDS Policy & Law Newsletter* 1997/98; 3(4)/4(1): 29-30 at 29. At www.aidslaw.ca/Maincontent/otherdocs/Newsletter/Winter9798/24LINES1E.html. See also G Betteridge. Inquest into the death of a prisoner co-infected with HIV and hepatitis C: how many more will there be? *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1): Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/prisons2.htm.

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidsida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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HIV/AIDS in Prisons

2004/2005

A Comprehensive Strategy

Measures directed at preventing HIV/AIDS (see info sheets 4-7) and at ensuring that prisoners with HIV/AIDS receive adequate care, treatment, and support (see info sheet 8) are arguably the cornerstones of a comprehensive strategy on HIV/AIDS in prisons. However, other, additional measures are also required.

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A Rare Case of Consensus

Since the late 1980s, a large number of national and international organizations – including community-based groups in many countries, Canada’s Expert Committee on AIDS and Prisons (ECAP), the World Health Organization, and the United Nations Joint Programme on HIV/AIDS (UNAIDS) – have analyzed the issues raised by HIV/AIDS in prisons and *have all reached the same conclusions and made the same recommendations.*

What Has Been Recommended?

All organizations and committees have recommended that a *comprehensive strategy* be adopted to deal with HIV/AIDS in prisons. Probably the most inclusive list of recommendations (88) was issued in 1994 by ECAP – a list that was updated in the 1996 report on HIV/AIDS in prisons of the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society.

What are the elements of a comprehensive strategy? Many have already been mentioned in info sheets 4-8. Not all others can be mentioned here, but some of the most important include:

A long-term, strategic approach

Prison systems need to take a proactive rather than reactive approach to the issues raised by HIV/AIDS, hepatitis, tuberculosis, and drug use in prisons; engage in a long-term, coordinated, strategic planning process; coordinate their efforts and collaborate closely; staff and resource their AIDS and infectious diseases programs adequately; involve prisoners, staff, and external experts, including AIDS-service organizations, in the development of all initiatives taken to reduce the spread of HIV and other infectious diseases; ensure uniform implementation of initiatives by releasing clear guidelines and enforceable standards, by monitoring implementation, and by holding prison administrations responsible for timely and consistent implementation; and evaluate all initiatives with the help of external experts.

A health issue

Because prisoners come from the community and return to it, and because what is done – or is not done – in prisons with regard to HIV/AIDS, hepatitis, and drug use has an impact on the health of all, health ministries need to take an active role and work in close collaboration with correctional systems to ensure that the health of all, including prisoners, is protected and promoted. Another option, which has been widely recommended, is to transfer control over prison health to public health authorities. Some countries have already introduced such a change. Norway was one of the first. In France, where prison health was transferred to the Ministry of Health in 1994, a positive impact is already evident. Each prison in France is twinned with a public hospital and, according to UNAIDS, “conditions have improved noticeably since the transfer of responsibility for health.”

A COMPREHENSIVE STRATEGY

HIV testing

There is no public health or security justification for compulsory or mandatory HIV testing of prisoners, or for denying prisoners with HIV/AIDS access to all activities available to the rest of the population. Rather, prisoners should be encouraged to voluntarily test for HIV, with their informed, specific consent, with pre- and post-test counseling, and with assurance of the confidentiality of test results. As people outside prison do, they should have access to a variety of voluntary, high-quality, bias-free testing options.

Educational programs for prisoners

Education of prisoners remains one of the most important efforts to promote and protect their health. It should not be limited to written information or the showing of a video, but include ongoing educational sessions and be delivered or supplemented by external, community-based AIDS, health, or prisoner organizations. Wherever possible, prisoners should be encouraged and assisted in delivering peer education, counseling, and support programs.

Educational programs for staff

Educational programs for staff are also a priority. Training about HIV/AIDS, hepatitis, and other infectious diseases must be part of the core training of all prison staff, including correctional officers. In particular, staff need to learn about how to deal with prisoners with HIV/AIDS and to respect their rights and dignity, the absence of risk of HIV transmission from most contact with prisoners, and the need to respect medical confidentiality. Community groups and people with HIV should be delivering part of the training.

Protective measures for staff

Making sure that staff's workplace is safe is crucial. In this context, staff are rightly concerned about overcrowding in the institutions, and understaffing, which – rather than measures taken to prevent the spread of HIV in prisons – constitute the real threats to their safety. Prison systems have to address staff's concerns in these areas.

Drug policy

Reducing the number of drug users who are incarcerated needs to become an immediate priority.

Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available.

Additional Reading

Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994. Contains 88 recommendations.

R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996. Updates the recommendations in the above report. Available at www.aidslaw.ca/Maincontent/issues/prisons/download1.html.

R Lines. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Montreal: Canadian HIV/AIDS Legal Network, 2002. Updates the recommendations of the above report. Available at www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm.

Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. *HIV/AIDS and Human Rights: International Guidelines*. New York and Geneva: United Nations, 1998 (HR/PUB/98/1). Contains an important recommendation regarding HIV/AIDS in prisons (recommendation 29(e)). Everyone should have a copy and use it. Available at www.unaids.org.

Prisoners with HIV/AIDS Support Action Network. *HIV/AIDS in Prisons Systems: A Comprehensive Strategy*. Toronto: PASAN, 1992. Available at www.pasan.org.

World Health Organization. *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva: WHO, 1993 (WHO/GPA/DIR/93.3). Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html.

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidsida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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Aboriginal Prisoners and HIV/AIDS

Aboriginal people are vastly overrepresented among prisoners in both federal and provincial prisons in Canada. At the same time, the HIV epidemic among Aboriginal people shows no sign of abating. All the measures described in info sheets 4-9 will help address the issues Aboriginal prisoners face in the context of HIV/AIDS, but the additional measures described in this sheet are also necessary.

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The Numbers

In a judgment rendered on 23 April 1999, the Supreme Court of Canada said that prison has replaced residential schools as the likely fate of all too many modern-day Aboriginal Canadians. The Court pointed out that:

- While less than three percent of the national population is Aboriginal, Aboriginal people represent 15 percent of the federal prisoner population.
- In the Prairie Region of the Correctional Service of Canada (CSC), Aboriginal people account for 64 percent of the prisoner population.
- A male treaty Indian is 25 times more likely to be incarcerated in provincial jail than a non-Native.
- A female treaty Indian is 131 times more likely to be incarcerated in provincial jail than a non-Native.
- While Aboriginal people make up only six to seven percent of the general population in Manitoba and Saskatchewan, they comprise 72 percent of the provincial jail admissions in Manitoba and 55 percent in Saskatchewan.

At the same time, available evidence suggests that Aboriginal communities are at increased risk for HIV infection. Aboriginal people are infected at a younger age than non-Aboriginal people; they are overrepresented in groups at high risk for HIV infection, in particular among injection drug users; and the high degree of movement of Aboriginal people between inner cities and rural areas may bring the risk of HIV to even the most remote Aboriginal community.

What Must Be Done?

Aboriginal prisoners need the same preventive measures (see info sheets 4-7), and the same level of care, treatment, and support (see info sheet 8) as other prisoners.

In addition, however, there is a need for initiatives, by and for Aboriginal prisoners, that recognize their special needs and cultural values and promote opportunities for them to improve their health. In its 1994 report, the Expert Committee on AIDS and Prisons (ECAP) proposed the following initiatives:

- Development of information and prevention programs that will respond to the specific needs of Aboriginal prisoners.
- Inclusion of community and peer input into these programs.
- Increased efforts, for and by Aboriginal prisoners, their communities, and elders, with the assistance of CSC and others, to improve the health status of Aboriginal prisoners.

ABORIGINAL PRISONERS AND HIV/AIDS

- Increased efforts to decrease the vulnerability of Aboriginal prisoners to exposure to infectious diseases, in particular HIV infection, to drug use and its harms, and to imprisonment.

The Committee made a series of recommendations:

- CSC should ensure that Aboriginal prisoners have access to traditional healers, healing ceremonies, and medicines.
- Education and prevention programs should be developed that will respond to the specific needs of Aboriginal prisoners.
- Aboriginal groups and elders/healers should be encouraged to deliver these programs.
- CSC in collaboration with Health Canada and others should fund Aboriginal groups and elders/healers to provide this education.
- Aboriginal prisoners should be encouraged and assisted in developing peer education, counseling, and support programs.
- CSC in collaboration with Health Canada and others should fund such programs.

In recent years, the Correctional Service of Canada has undertaken a variety of initiatives aimed at providing education specific to the needs of Aboriginal prisoners, and a strategy and action plan for Aboriginal people and HIV/AIDS in corrections has been developed. However, this has been a slow process, and everybody agrees that much more needs to be done.

Finally, implementing the recommendations of the Expert Committee on AIDS and Prisons and adopting strategies and actions for Aboriginal people and HIV/AIDS *in prison*, while essential, will not be enough. Various government inquiries have concluded that the justice system is failing Aboriginal people on a crushing scale. As the Supreme Court of Canada said, “[t]hese findings cry out for recognition of the magnitude and gravity of the problem, and for responses to alleviate it.” Every attempt should be made to divert Aboriginal people away from prison and toward alternatives.

Additional Reading

JK Barlow, J Serkiz, A Fulton. *Circle of Knowledge Keepers: Training Kit for Inuit, Metis and First Nations Offenders as Peer Educators & Counsellors*. Ottawa: Canadian Aboriginal AIDS Network, 2001. National training program for Aboriginal Peer Education in prison. Prepared by the Canadian Aboriginal AIDS Network for CSC. Available at www.linkup-connexion.ca/catalog/index.cfm?fuseaction=viewProducts&SubExpandList=&ExpandList=9.

R Lines. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Montreal: Canadian HIV/AIDS Legal Network, 2002. Reviews Aboriginal HIV/AIDS programs in Canadian prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm.

R v Gladue, SCC, 23 April 1999, File no 26300. A must-read. Available at www.lexum.umontreal.ca/csc-scc/en/pub/1999/vol1/html/1999scr1_0688.html.

Aboriginal People and HIV/AIDS: Legal Issues. Montréal: Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 1999. A series of info sheets on issues of discrimination, jurisdiction and funding, and testing and confidentiality. Available at www.aidslaw.ca/Maincontent/issues/aboriginalcomm.htm.

Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994. See pages 114-118 for a discussion of issues of relevance to Aboriginal offenders.

Health Canada. HIV/AIDS Epi Update: *HIV and AIDS Among Aboriginal People in Canada*. Ottawa, April 2003. Available via www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aepi/.

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidsida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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HIV/AIDS in Prisons

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Women prisoners and HIV/AIDS

Studies have shown that the prevalence of HIV among incarcerated women is even higher than among incarcerated men. At the same time, the proportion of women among new HIV infections in Canada is increasing steadily. The measures described in info sheets 4-9 will help address the issues women prisoners face in the context of HIV/AIDS, but the additional measures described in this sheet are also necessary.

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The Numbers

Seroprevalence studies undertaken in Canadian prisons, as well as a series of studies undertaken in prison systems in other countries, have shown that HIV infection is prevalent among women prisoners, in particular among those who have a history of injection drug use. Indeed, HIV seroprevalence among women prisoners generally exceeds that of male prisoners. For example, in a recent study in provincial prisons in Québec, the HIV seroprevalence rate among women was 8.8 percent, while it was 2.3 percent among male prisoners. Similarly, in 2002, 3.71 percent of prisoners in federal women's institutions, compared to 1.96 percent of male prisoners in the Canadian federal prison system, were known to be HIV-positive. At the same time, Canadian women - not just women prisoners - are increasingly becoming infected with HIV, especially those who use injection drugs and whose sexual partners are at increased risk for HIV:

- The proportion of AIDS cases among adult women has increased from 5.6 percent of all AIDS cases before 1990 to 8.3 percent in 1995 and 16 percent in 2001.
- The proportion of AIDS cases among adult women attributed to injection drug use has increased dramatically from 7.3 percent before 1990 to 26.6 percent in 1994 and 45.5 percent in the first half of 2002.
- It is estimated that by the end of 1999, 6,800 women in Canada were living with HIV, out of an estimated total of 49,800 people with HIV.
- Women accounted for 25.8 percent of all HIV-positive test reports in the first half of 2002 that included information on gender. Injection drug use was a risk factor for 35.5 percent of these HIV-positive women.

What Must Be Done?

Women prisoners need the same preventive measures (see info sheets 4-7), and the same level of care, treatment, and support (see info sheet 8) as male prisoners.

In addition, however, there is a need for initiatives that acknowledge that the problems encountered by women in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. The task of protecting women prisoners from HIV transmission therefore presents different - and sometimes greater - challenges than that of preventing HIV infection in male prisoners.

WOMEN PRISONERS AND HIV/AIDS

Underlying issues

Underlying many of the problems that women in prison encounter is the fact that “[t]he 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 occupation as sex workers.” Women prisoners often have more health problems than male prisoners. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care.

Many HIV-positive women do not receive the diagnostic and treatment services that could benefit them as early as do HIV-positive men. Among the reasons for this is that women are often unaware of having been exposed to HIV by their sexual or drug-using partners and as a result do not seek counseling, HIV testing, and care and treatment. Second, the needs of HIV-positive women differ from those of men, and social and community support are often less frequently available and less accessible. As a consequence, women are often less educated than men about HIV infection and AIDS and do not have the support structures they need. Third, disease manifestations attributable to HIV infection or AIDS are often different in women, which has led to underrecognition or delays in diagnosis. Thus, women who are infected have often been diagnosed as infected or having AIDS later than men.

For all these reasons, the educational needs of women prisoners regarding HIV/AIDS are different from the needs of male prisoners and the need for HIV prevention programs in women’s prisons may be even more pressing than in male prisons.

Recommendation

Prison systems need to take immediate action to develop and implement effective education and prevention programs targeted specifically to female prisoners.

Additional Reading

A DiCenso, G Dias, J Gahagan. *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C*. Toronto: PASAN, 2003. The most comprehensive Canadian report on HIV and incarcerated women. A must read. Available at www.pasan.org.

R Lines. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Montreal: Canadian HIV/AIDS Legal Network, 2002. Reviews HIV/AIDS programs for women in Canadian prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm

Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994. Pages 109-113 discuss issues of particular relevance to women in Canadian prisons.

Health Canada. *HIV/AIDS Epi Update: HIV and AIDS among Women in Canada*. Ottawa, April 2003. Information on the status of HIV and AIDS among women in Canada. Available via www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aeipi/.

World Health Organization. *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva: WHO, 1993 (WHO/GPA/DIR/93.3). Recommendations 44-46 concern incarcerated women. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html.

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidssida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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A Moral and Legal Obligation to Act

Prison systems have a moral and legal responsibility to do whatever they can to prevent the spread of infectious diseases among prisoners, and to provide care, treatment, and support equivalent to those available outside. Good prevention and care in prisons are in the interest of everyone – prisoners, prison staff, and the public.

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The State's Duty with Respect to Health

By its very nature, imprisonment involves the loss of the right to liberty. However, prisoners retain their other rights and privileges "except those necessarily removed or restricted by the fact of their incarceration." In particular, prisoners, as every other person, have "a right to the highest attainable level of physical and mental health": the state's duty with respect to health does not end at the gates of prisons.

Recommendations on HIV/AIDS and drug use in prisons have all stressed the importance of prevention in prisons, and have suggested that condoms, bleach, sterile needles, and methadone maintenance treatment be available to prisoners; and have stressed the importance of providing inmates with care, treatment, and support equivalent to those available outside. According to the 1993 World Health Organization (WHO) Guidelines on HIV/AIDS in Prisons, "[a]ll prisoners have the right to receive health care, *including preventive measures*, equivalent to that available in the community without discrimination." WHO states that prison administrations have a responsibility to put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike. This is consistent with the *Mission of the Correctional Service of Canada*, according to which the provision of a "safe, secure and clean environment that promotes health and well-being" is a "strategic objective."

Legal Action by Prisoners

The law could be used to force prison systems to introduce preventive measures or to hold prison systems liable for not providing them and for the resulting transmission of infections in prison.

In a number of cases, prisoners have already initiated legal action in order to obtain access to condoms and to methadone treatment. In such cases, this has provided the catalyst necessary for the institution of long-recommended changes. Courts have not even had to rule on the substantive issues raised: governments and correctional authorities, at least in part because of these cases, have acted before the courts forced them to do so, and made condoms and methadone treatment available.

Further, in at least two cases, Australian prisoners initiated legal action to secure damages for having contracted HIV in prison. The first prisoner seroconverted while in a maximum-security institution in Queensland and launched an action for damages for negligence against the prison system. The second prisoner testified from his hospital bed that he had contracted HIV while under the control and custody of the New South Wales prison authorities, and instituted a negligence claim against the authorities for failing to provide him with access to condoms and sterile needles while he was incarcerated. Because he

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died shortly after the commencement of the pre-trial hearing and left no estate or dependants, the case ended with his passing.

Finally, in Canada, a prisoner claims that he contracted HIV in prison because of the prison system's negligence, and that, once infected, he did not receive proper care. He is currently suing the Correctional Service of Canada for damages.

These legal cases have been important, but it would be a shame if prisoners were obliged to continue to have recourse to the courts in order to claim and have recognized their rights to access preventive means. There can be no question that the issue of providing protective means to prisoners would be more appropriately dealt with by swift action by correctional systems than by court action.

Why Should We Care?

Prisoners, even though they live behind bars, are part of our communities. Most prisoners leave prison at some point to return to their community, some after only a short time inside. Some prisoners enter and leave prison many times. Prisoners deserve the same level of care and protection that people outside prison get. They are sentenced to prison, not to be infected:

[B]y entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities (United Nations Commission on Human Rights, 1996).

Introduction of preventive measures in prisons, and providing prisoners with medical care equivalent to that available outside, is in the interest of all concerned. Any measure undertaken to prevent the spread of HIV and other infections will benefit prisoners, staff, and the public. It will protect the health of prisoners, who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. It

will protect staff: lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered. It will protect the public. Most prisoners are in prison only for short periods of time and are then released into their communities. In order to protect the general population, prevention measures need to be available in prisons, as they are outside.

Additional Reading

G Betteridge, R Jürgens. *Prisoners, HIV/AIDS, and Human Rights*. Montréal: Canadian HIV/AIDS Legal Network, 2004. Discusses the legal responsibilities of prison systems. Via www.aidslaw.ca/Maincontent/issues/prisons.htm.

D Kloeze. Inmate sues the Correctional Service of Canada. In R Jürgens (ed). *HIV/AIDS in prisons: New developments. Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 13-19, at 13-15. At www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6no3-2002/prisons.htm.

Correctional Service Canada. *Mission of the Correctional Service of Canada*. Ottawa: Ministry of Supply and Services Canada, 1997. At www.csc-scc.gc.ca/text/pblct/mission/index_e.shtml.

Joint United Nations Programme on HIV/AIDS. United Nations Commission on Human Rights (Fifty-second Session, item 8 of the agenda). *HIV/AIDS in Prisons – Statement by UNAIDS*. Geneva, April 1996. Argues that the treatment of prisoners in many countries constitutes a violation of the prisoners' human rights. Via www.unaids.org.

H Krever, The Honourable Mr Justice. *Commission of Inquiry on the Blood System in Canada: Final Report*. Volumes 1-3. Ottawa: Minister of Public Works and Government Services Canada, 1997. After this report, governments should know better than to continue fragmented, reactive approaches to the public health crisis occurring in prisons.

J Skirrow. Lessons from Krever – a personal perspective. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 35-41. Discusses nine lessons that emerge from the Krever Report. At www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/krever.htm.

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidssida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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Essential Resources

There is a vast amount of literature on HIV/AIDS in prisons. This info sheet provides information about a number of selected, essential resources – articles, books, reports, and newsletters that provide crucial information and/or recommendations on HIV/AIDS in prisons.

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9. A Comprehensive Strategy
10. Aboriginal Prisoners and HIV/AIDS
11. Women Prisoners and HIV/AIDS
12. A Moral and Legal Obligation to Act
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Canadian Resources

P Collins et al. *Driving the Point Home: A Strategy for Safer Tattooing in Canadian Prisons*. Toronto: PASAN, Canadian HIV/AIDS Legal Network, HIV/AIDS Regional Services, 2003.

The most comprehensive policy document on tattooing in prisons. Developed in consultation with inmate committees across the country. At www.pasan.org.

Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994.

One of the most comprehensive reports on issues raised by HIV/AIDS and by drug use in prisons. It contains 88 recommendations on how to prevent HIV transmission in prisons and on care for prisoners with HIV/AIDS. Still extremely relevant, but must be read together with Jürgens, 1996, and Lines, 2002, *infra*. Also available: *HIV/AIDS in Prisons: Summary Report and Recommendations*; and *HIV/AIDS in Prisons: Background Materials* (includes a review of Canadian legal cases dealing with issues raised by HIV/AIDS in prison, a summary of the prison policies of Canadian provinces and territories and of selected foreign countries, and an analysis of the legal and ethical issues raised by protecting confidential medical information pertaining to prisoners).

Correctional Service Canada. *1995 National Inmate Survey: Final Report*. Ottawa: CSC (Correctional Research and Development), 1996, No SR-02.

The results of a CSC survey of 4285 inmates, confirming that a high proportion of inmates engage in high-risk behaviours.

Correctional Service Canada. *Research Report: Institutional Methadone Maintenance Treatment: Impact on Release Outcome and Institutional Behaviour*. Ottawa: CSC Research Branch, 2002 (No R-119).

Study documenting the positive impact of the introduction of MMT on release outcome and institutional behaviour. Available via www.csc-scc.gc.ca/text/rsrch/reports/reports_e.shtml.

Correctional Service Canada. *Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries 2000-01. A Report of the Correctional Service of Canada's Infectious Diseases Surveillance System*. Ottawa: CSC, 2003. At www.csc-scc.gc.ca/text/pblct/infectiousdiseases/index_e.shtml.

Correctional Service Canada. A health care needs assessment of federal inmates in Canada. *Canadian Journal of Public Health* 2004; 95(suppl 1): S1-S63.

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A DiCenso, G Dias, J Gahagan. *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C.* Toronto: PASAN, 2003.

The most comprehensive Canadian report on HIV, HCV, and incarcerated women. At www.pasan.org.

R Elliott. Prisoners' Constitutional Right to Sterile Needles and Bleach. Appendix 2 in **R Jürgens.** *HIV/AIDS in Prisons: Final Report.* Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996.

Do prisoners have a right to the means that would allow them to protect themselves against contracting HIV and other diseases in prisons? Can prison systems be forced to provide condoms, bleach, and sterile needles? Can and should the law be used to achieve change in prison HIV/AIDS policies? The article discusses these questions. In particular, it analyzes whether denying prisoners access to sterile needles is a violation of their constitutional rights. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP2.html.

R Jürgens. *HIV/AIDS in Prisons: Final Report.* Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996.

A comprehensive 150-page report, summarizing the history of HIV/AIDS in prisons in Canada and internationally. Includes sections on prevalence of risk behaviours in prisons, HIV transmission behind bars, needle-exchange programs, methadone maintenance treatment, and more. Argues that prison systems have a moral and legal obligation to act to reduce the risk of further spread of HIV behind bars, and to provide appropriate care, treatment, and support. Includes hundreds of references and a substantial bibliography. Still extremely relevant, but should be read together with Lines, 2002, *infra*. Available at www.aidslaw.ca/Maincontent/issues/prisons/download1.html

R Lines. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card.* Montreal: Canadian HIV/AIDS Legal Network, 2002.

Provides a detailed review of the provision of HIV/AIDS programs and services in Canadian prison systems. Includes a "Harm Reduction Report Card" for each jurisdiction rating its provision of HIV prevention measures. Available at www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm.

R Lines. *Pros & Cons: A Guide to Creating Successful Community-based HIV/AIDS Programs for Prisoners.* Toronto: PASAN, 2002.

The most comprehensive Canadian resource on developing HIV/AIDS prevention and support services for prisoners. Available at www.pasan.org.

International Resources

American College of Physicians, National Commission on Correctional Health Care, and American Correctional Health Services Association. The crisis in correctional health care: the impact of the national drug control strategy on correctional health services. *Annals of Internal Medicine* 1992; 117(1): 72-77.

A joint position paper pointing out how existing problems in prisons in the US have been exacerbated by the war on drugs. The paper recommends that the drug-control strategy, with its emphasis on incarceration, be reconsidered; that correctional health-care budgets reflect the growing needs of the inmate population; that correctional health care be recognized as an integral part of the public health sector; that correctional care evolve from its present reactive "sick call" model into a proactive system that emphasizes early disease detection and treatment, health promotion, and disease prevention.

P Bollini (ed). *HIV in Prison. A Manual for the Newly Independent States.* Médecins sans frontières, Prison Reform International, World Health Organization, 2001 (Russian edition, 2003).

A manual for prison staff in the countries of the former Soviet Union. Extremely useful for other prison systems as well. In English and Russian.

K Dolan, D Lowe, J Shearer. Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine & Ethics* 2004; 32: 124-128.

The most recent of only a few evaluations of prison condom distribution programs.

K Dolan et al. A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence* 2003; 72: 59-65.

The first-of-its kind trial found that prison-based MMT reduced heroin injecting.

K Dolan, S Rutter, A Wodak. *Prison-based syringe exchange programmes: a review of international research and development in Addiction* 2003, 98, 153-158.

Good summary of evaluations of prison needle exchange programs in Switzerland, Germany, and Spain.

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K Dolan, A Wodak. An international review of methadone provision in prisons. *Addiction Research* 1996; 4(1): 85-97.

Few papers have appeared documenting the provision of methadone in prison systems. This is a good early review.

NN Dubler, VW Sidel. On research on HIV Infection and AIDS in correctional institutions. *The Milbank Quarterly* 1989; 67(2): 171-207.

The article discusses the problems involved in conducting research on prisoners. It concludes that, although a prison setting precludes voluntary and uncoerced choice, prisoners should be permitted to choose to participate in research, including therapeutic trials with no placebo arm that hold out the possibility of benefit.

European Network on HIV/AIDS and Hepatitis Prevention in Prisons. *Final Report on the EU Project European Network on HIV/AIDS Prevention in Prisons*. Bonn and Marseille: The Network, 1997.

The proceedings of the first seminar of the European Network for HIV/AIDS and Hepatitis Prevention in Prison, held in Marseille on 20 June 1996, contain a review of literature on HIV risk behaviours in prisons and an overview of the situation in six European countries: Germany, Scotland, France, Italy, the Netherlands, and Sweden. See also: **European Network on HIV/AIDS and Hepatitis Prevention in Prisons. 2. Annual Report – European Network on HIV/AIDS Prevention in Prisons. Bonn and Marseille: The Network, 1998** (the second report by the European Network, with detailed information regarding HIV/AIDS and hepatitis in prisons in 16 European countries and an updated European bibliography on HIV/AIDS in prison).

LM Maruschak. HIV in Prisons, 2001. Washington, DC: US Dept of Justice, Bureau of Justice Statistics Bulletin, 2004.

Summarizes the situation with regard to HIV/AIDS in prisons in the US. Available at www.ojp.usdoj.gov/bjs/pub/pdf/hivp01.pdf.

Joint United Nations Programme on AIDS. *Prisons and AIDS: UNAIDS Technical Update*. Geneva: UNAIDS, 1997; and *Prisons and AIDS: UNAIDS Point of View*. Geneva: UNAIDS, 1997.

An extremely useful pair of documents on HIV/AIDS and drug use in prisons around the world, with basic information about the issues, challenges, responses, resources, and UNAIDS' point of view. This is probably the best summary available on HIV/AIDS and drug use in prisons. Available via www.unaids.org.

Joint United Nations Programme on HIV/AIDS. United Nations Commission on Human Rights (Fifty-second Session, item 8 of the agenda). *HIV/AIDS in Prisons – Statement by the Joint United Nations Programme on HIV/AIDS (UNAIDS)*. Geneva, April 1996.

This statement by UNAIDS to the Commission on Human Rights argues that the treatment of prisoners in many countries constitutes a violation of the prisoners' human rights. UNAIDS urges all governments to use the World Health Organization's guidelines on HIV/AIDS in prisons (see *infra*) in formulating their prison policies and offers assistance to any government wishing to implement the guidelines. Available via www.unaids.org.

F Kapadia et al. Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users? *Epidemiology* 2002; 13(6): 738-741.

The study showing that bleach disinfection may provide some protection against HCV.

T Kerr, R Jürgens. *Methadone Maintenance Therapy in Prisons: Reviewing the Evidence*. Montreal: Canadian HIV/AIDS Legal Network, 2004.

A 10-page review of the evidence. Available via www.aidslaw.ca/Maincontent/issues/prisons.htm.

T Kerr, R Jürgens. *Syringe Exchange Programs in Prisons: Reviewing the Evidence*. Montreal: Canadian HIV/AIDS Legal Network, 2004.

A 10-page review of the evidence. Available via www.aidslaw.ca/Maincontent/issues/prisons.htm.

GE Macalino et al. Hepatitis C infection and incarcerated populations. *International Journal of Drug Policy* 2004; 15: 103-114.

A review of prevalence and incidence of HCV in prisons worldwide.

R Lines, R Jürgens, H Stöver, D Latishevschi, J Nelles. *Prison Needle Exchange: A Review of International Evidence and Experience*. Montreal: Canadian HIV/AIDS Legal Network, 2004.

The most comprehensive and detailed report available on the international experience of prison syringe exchange programs in Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm

Ministerio Del Interior/Ministerio De Sanidad y Consumo. *Needle Exchange in Prison Framework Program*. Madrid: Ministerio Del Interior/Ministerio De Sanidad y Consumo, 2002.

ESSENTIAL RESOURCES

Detailed plan and guidelines used for the implementation of needle exchange programs in all Spanish prisons. Essential for anyone wishing to see how a successful needle exchange program is established in a prison. Available in Spanish and English.

J Nelles, T Harding. Preventing HIV transmission in prison: a tale of medical disobedience and Swiss pragmatism. *The Lancet* 1995; 346: 1507.

Describes how Dr Franz Probst, a part-time medical officer working at Oberschöngrün prison in the Swiss canton of Solothurn, began distributing sterile injection material without informing the prison director: the world's first distribution of injection material inside prison began as an act of medical disobedience.

D Shewan, JB Davies (eds). *Drug Use and Prisons: An International Perspective*. Amsterdam: Harwood Academic, 2000.

Provides a comprehensive account of patterns of drug use and risk behaviours in prisons, and of the different responses to this feature of prison life. Contains articles from Europe, North and South America, Africa, and Australia.

H Stöver, J Nelles. 10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies. *International Journal of Drug Policy* 2003; 14: 437-444.

H Stöver. *Study on Assistance to Drug Users in Prisons*. Lisbon, European Monitoring Centre for Drugs and Drug Addiction, 2001 (EMCDDA/2001).

A comprehensive study on HIV/AIDS and drug use in prisons. Available at www.emcdda.org

World Health Organization. WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: WHO, 1993 (WHO/GPA/DIR/93.3).

Proposes standards for prison authorities in efforts to prevent HIV transmission and provide care to those with HIV/AIDS in prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html.

Newsletters

AIDS Policy & Law

A US biweekly newsletter on legislation, regulation, and litigation concerning AIDS. Contains short summaries of US developments, mainly lawsuits.

Canadian HIV/Policy & Law Review

Required reading for all those working on, or interested in, HIV/AIDS in prisons. Provides regular updates and feature articles on policies and programs from around the world. Bilingual (English and French). Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm

Hepp Report

Provides HIV updates designed for practitioners in the correctional setting. Targets correctional administrators and HIV/AIDS care providers, with information on HIV treatment, efficient approaches to administering such treatments in the correctional environment, and US and international news. Published monthly. For info, see www.hivcorrections.org

Websites

www.aidslaw.ca

The website of the Canadian HIV/AIDS Legal Network. Nowhere will you find more info on HIV/AIDS in prisons than on this site.

www.pasan.org

The website of the Prisoners' HIV/AIDS Support Action Network (PASAN), with policy documents and reports, educational materials for use in prisons, and the quarterly bulletin *Cell Count*.

www.thebody.com/whatis/prison.html

The Body is one of the HIV/AIDS "super-sites." Their prison reference page provides links to a number of articles and publications.

www.atac-usa.org/Prisons.html

The website of the Access to Health Care for the Incarcerated initiative of the [US] AIDS Treatment Activists Coalition (ATAC) contains a list of 40 of "the best websites with information on HIV/AIDS, HCV, and prisons."

Third, revised and updated version, 2004. Copies of this info sheet are available on the Network website at <http://www.aidslaw.ca/Maincontent/issues/prisons.htm> and through the Canadian HIV/AIDS Information Centre (email: aidssida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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