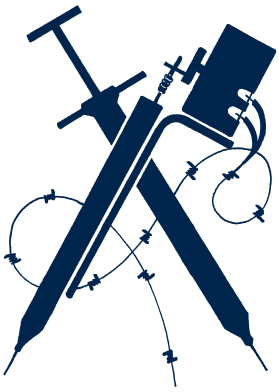
Strategic directions for action

This summary of strategic directions is based on the 2007 report *Hard Time: Promoting HIV and Hepatitis C Prevention Programming for Prisoners in Canada* by the Canadian HIV/AIDS Legal Network and Prisoners' HIV/AIDS Support Action Network (PASAN). The full report is available at www.aidslaw.ca/prisons or at www.pasan.org.

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

PASAN

Promoting HIV and Hepatitis C prevention programming for prisoners in Canada



Everyone in the prison environment — prisoners, prison staff, and service-providers — benefits from improving the health of prisoners and reducing the incidence of blood-borne diseases such as HIV and hepatitis C. More broadly, everyone also benefits in the communities to which prisoners return.

HIV and hepatitis C virus (HCV) are important public health problems in Canadian prisons. Most studies to date estimate the HIV prevalence rate in prisons to be at least 10 times the rate in the population outside prison,[1] and some studies found rates almost 20 times higher.[2] A 2007 study in Ontario found HCV prevalence among people entering prison to be 22 times higher than in the general population.[3] There is compelling evidence that HIV and HCV are spread in Canadian prisons. Among people who use drugs, incarceration itself represents additional risk of HIV transmission. For example, in Vancouver it was found among a group of people who injected drugs that those who had recently been incarcerated were 2.7 times more likely to be HIV-positive than those who had not been to prison.[4] Many studies have documented injection drug use and syringe-sharing, as well as unsafe tattooing, inside prisons. The cost of treating HIV and HCV are significant — hundreds of thousands of dollars per person over a lifetime; lost productivity entails other costs for society.

To a significant extent, prisons are home to people who have been socially marginalized — people who suffer from addictions and mental illness, who have lived with high levels of poverty and low levels of literacy, and who have suffered physical, emotional and psychological abuse, including the effects of colonization in the case of many Aboriginal prisoners. Moreover, overreliance on criminal law as a response to drug use and addiction means that many people who use illicit drugs are incarcerated. Prior to being imprisoned, many of these people engaged in behaviours that put them at risk for HIV and HCV, and some were infected with HIV, HCV or both. These risky behaviours continue in prison. Thus, it is not surprising that the HIV and HCV prevalence rates among prisoners far exceed rates in the general population.

HIV and HCV risk behaviours in prisons are fuelled by activities that the criminal law makes illegal (e.g., possession of controlled substances) or that prison policies make the subject of disciplinary charges (possession of needles for injecting, possession of equipment for tattooing, and engaging in consensual sex or tattooing). The threat of punishment, combined with the fact that prisoners are subject to extensive security measures, drives such activities underground and makes prevention in prisons more difficult than outside of them. Yet, it is the very concentration of people who engage in risky behaviours that makes prisons ideal settings in which to respond to these behaviours using proven public health measures. Prison-system responses grounded in a rational policy environment based on human rights, combined with best practice-driven programming, will

have the greatest chance of reducing the potential for transmission and promoting health and safety in the prison environment.

Prisoners do not surrender their rights upon incarceration; rather, they retain all rights subject to the restrictions that are unavoidable in a prison environment. Prisoners are entitled to enjoy the highest attainable standard of health, as guaranteed under international law. Prison health care, including measures for the prevention of disease, should be equivalent to that available in the community at large. Together, human rights guarantees and international guidelines can steer the development of HIV and HCV prevention and harm reduction policy and programming in prisons; they can also serve as a framework within which to examine the responses of governments and prison authorities to the threat posed to prisoners by blood-borne viruses such HIV and hepatitis.

Conclusions of our review

The Legal Network and PASAN reviewed over 30 programs related to prevention of HIV and HCV in Canadian prisons, including visiting most of these programs within prisons. Among the conclusions of our review are the following:

Collaboration between prison and public health authorities: Prison HIV and HCV prevention policies and programs can be strengthened by collaboration between public health authorities (based outside the prison system), and prison administration and staff. In a number of successful collaborations of this kind that we reviewed, public health personnel were able to act autonomously within the corrections environment. Although public health authorities in Canada have a different organizational structure and define geographical regions differently from prison authorities (among other challenges), this collaboration is very important for good programs.

Role of community-based organizations and prisoners themselves: Many programs have had some measure of success because community-based educators and service-providers have been given the opportunity to design and implement programs. Programs are also enriched and improved by meaningful participation of prisoners as peer educators. The success of peer programs depends to a great extent on the experience of the peer educator or researcher, and the relationship of trust and respect he or she has established over time with other prisoners and prison staff. When peer educators and researchers are released from prison, others should be encouraged to come forward to be trained, and resources should be found to ensure that programs can continue.

Sterile syringe programs lacking: Harm reduction programs in prisons in Canada differ from programs in the community in one fundamental way. Prison legislation and policy prohibit prisoners from possessing needles for injecting or tattooing, and there is no policy in place to permit the distribution of sterile needles. As a result, no Canadian jurisdiction offers comprehensive HIV and HCV prevention and harm reduction programming for prisoners, nor could they do so in the current legal and policy framework. Outside prisons, people who inject drugs can obtain clean needles through government-financed programs or by purchasing them in pharmacies. People in the community have access to tattoo parlours that follow universal precautions to prevent the transmission of infections. Many countries have implemented well-controlled syringe exchange in prison with dramatic results in HIV and HCV prevention.[5] We will continue to advocate for the provision of sterile injecting equipment in prisons in Canada.

Attention to MMT: Methadone maintenance therapy (MMT) has proven effective, safe and cost-effective in prisons. In Canada, MMT is the standard of care for treating opioid dependence. Yet access to MMT does not exist in some provincial and territorial prisons for reasons sometimes more related to ill-founded security concerns than to health concerns, an indication of the extent to which prison health care falls short of equivalence with community-based services. Moreover, lack of MMT in the community does not excuse prisons from meeting their legal obligations to provide prisoners with the means to protect their health. In some parts of Canada, both community and prison MMT provision is hampered by a lack of physicians licensed to prescribe methadone. Prison authorities, provincial and territorial ministries of health, and provincial colleges of physicians must work together to find ways to increase the number of physicians licensed to prescribe this treatment.

Dedicated staff needed: Resource constraints may often limit HCV and HIV prevention programs in prisons. Community-based organizations with expertise in providing prison programs are also often greatly constrained by a lack of resources. There are plainly many competing demands on prison health care staff, given the significant health care needs of the prison population. Unless there is a dedicated staff position, it is difficult for prison health care staff to find time to work on HIV and HCV prevention programs, either as the primary program provider or as a support to peer groups or NGOs.

Security and comprehensive services: Institutional prison culture is heavily focused on security and drug interdiction. In some prison systems, this focus has been tempered somewhat by an appreciation of the government's legal obligation to protect the health of prisoners, as well as the public health rationales for doing so. As a result, many prisoners in Canada have access to information about HIV and HCV prevention and harm reduction, and access to condoms, dental dams, lubricant, bleach, and MMT. Yet, many prisoners still lack this access. For example, in some prisons in Canada, condoms are still considered "contraband," and prisoners can be punished for possessing them, whereas no such impediment exists in the community. Prevention of HIV transmission in prisons in Canada will not succeed without serious and systematic attention to universal condom access.

Gaps between policy and practice: There are unfortunate gaps between policy and practice in some jurisdictions. Sometimes good policies exist as a framework for HIV and HCV prevention, but too often the applicable policy is not followed, thereby impeding prisoners' ability to protect their health. Conversely, there were some instances where, in the absence of specific policy, a service was nonetheless being provided to prisoners. In addition, more sharing of good policies and programs between jurisdictions would be useful. Officials in some provinces are not always aware of good practices in other parts of the country.

Specific populations: We documented significant gaps in coverage (of both policy and programs) for specific prison populations: women prisoners, Aboriginal prisoners, youth in prison, prisoners from ethno-cultural minorities, and transsexual and transgender prisoners. The HIV and HCV prevention and harm reduction needs of specific prison populations require greater attention from prison authorities. It appears that only CSC has programs specific to Aboriginal and women prisoners; CSC continues to work to improve those programs to meet the needs of these populations. We believe that CSC should ensure greater input from Aboriginal and women prisoners, and from community-based Aboriginal and women's organizations, in the design and delivery of programs for these populations so that the programs can better reflect the complex factors that make many Aboriginal people and women vulnerable to HIV and HCV infection.

Strategic directions for action

Enabling policy should be in place in every prison system in Canada, and HIV and HCV prevention and harm reduction programs should be made available to all prisoners in Canada regardless of their gender, ethnicity, culture, gender identity, sentence, or province where they are imprisoned. Based on our research and observations, we suggest six strategic directions for action to promote best practices in HIV and HCV prevention and harm reduction in prison:

1. Identify leaders from among people with legal responsibility for prisoners' well-being or for public health (elected officials, prison authorities, prison health staff, prison security staff, and provincial and local public health authorities) who are willing to work together to promote HIV and HCV prevention and harm reduction in prisons across Canada. Some of these people are already engaged in federal/provincial/territorial bodies.

2. Engage responsible organizations and people (from among elected officials, prison authorities, prison health staff, prison security staff, public health professionals, non-governmental and community-based organizations, and prisoners) with a mandate to protect and promote the health of prisoners and community health. Engagement involves communication; communication involves contact. Opportunities for organizations and people to meet, share information, and develop collaborative partnerships should be fostered.

3. Agree on Canadian best policy and practice for HIV and HCV prevention and harm reduction in prisons. It is essential that those people responsible for HIV and HCV prevention and harm reduction for prisoners and occupational safety for staff have a shared vision of Canadian best policy and practice for HIV and HCV prevention and harm reduction in prisons. A shared vision based on best policy and practice sets the goal or standard that all Canadian jurisdictions should strive to meet, taking into account their particular circumstances.

4. Identify barriers to HIV and HCV prevention and harm reduction in prison and develop strategies to overcome these barriers. Recommendations for prison HIV and HCV prevention and harm reduction policy and programs have existed for years. Some Canadian jurisdictions and prisons have been able to put in place policies and programs, others have not. No jurisdiction in Canada has comprehensive HIV and HCV prevention and harm reduction policy and programming for prisoners. The barriers to HIV and HCV prevention and harm reduction in prison must be identified in order to develop strategies to overcome them.

5. Undertake policy and program reviews and evaluation and, where needed, design and implement enhanced or new policies and programs, based on cooperation among prison authorities, prison health authorities, prison staff, public health authorities, non-governmental and community-based organizations, and prisoners. This will help to ensure that various perspectives, experiences and skills are reflected in policies and programs. This report documents many "best and promising" programs in prison HIV and HCV and harm reduction, and enabling policies that support such programs. Significant expertise and human resources already exist and should be shared. There is no need to "reinvent the wheel."

6. Externally monitor and evaluate policies and programs on an ongoing basis to determine whether HIV and HCV prevention and harm reduction polices are being followed and whether programs are meeting the needs they were intended to meet. Publicize the results as a way of increasing transparency and accountability of both governmental and non-governmental organizations. Without monitoring and evaluation, it is difficult to determine whether HIV and HCV prevention and harm reduction polices are being followed and whether programs are meeting the needs they were intended to meet. Prisoners need to be included in the monitoring and evaluation process. Sharing results of monitoring and evaluation is essential to collaboration and cooperation, and to constantly improving and building on HIV and HCV prevention and harm reduction policy and programs already in place in prisons in Canada and internationally.

References

[1] Centre for Infectious Disease Prevention and Control, Health Canada, and CSC, *Infectious Disease Prevention and Control in Canadian Federal Penitentiaries 2000-01*, Ottawa: CSC, 2003, p. 6.

[2] C. Poulin et al., "Prevalence of HIV and Hepatitis C Virus Infections Among Inmates of Quebec Provincial Prisons," *Canadian Medical Association Journal* 177(3) (2007): 252–256.

[3] L Calzavara et al., "Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities," *Canadian Medical Association Journal* 177(3) (2007): 257-261.

[4] M.W. Tyndall et al., "Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic," *AIDS* 17(6) (2003): 887–93.

[5] R Lines et al. *Prison needle exchange: lessons from a comprehensive review of international evidence and experience* (2nd edition). Canadian HIV/AIDS Legal Network, 2006.

Funding for this publication was provided by the Public Health Agency of Canada. The opinions expressed in this publication are those of the authors/researchers and do not necessarily reflect the official views of the Public Health Agency of Canada.