



Hard Time:

Promoting HIV and
Hepatitis C Prevention
Programming for
Prisoners in Canada

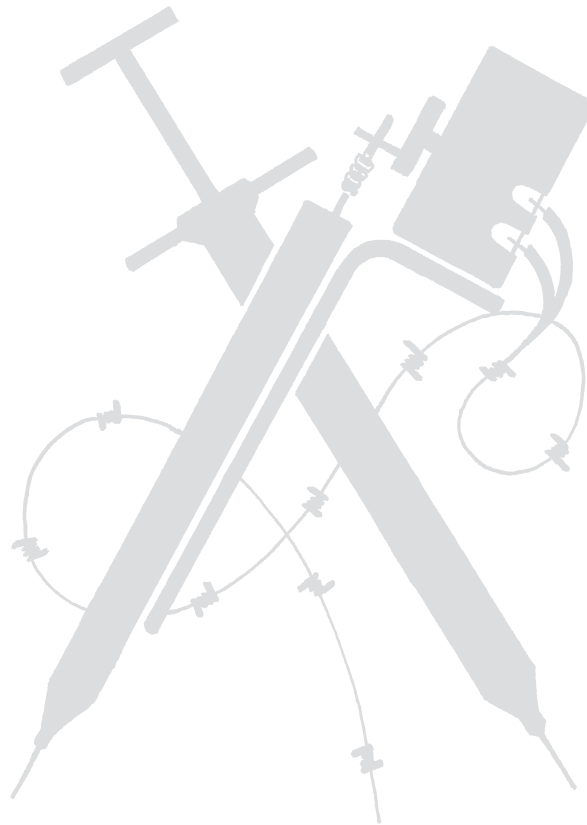


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Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada

Canadian HIV/AIDS Legal Network, PASAN
2007



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Authorship note

This report was written by Giselle Dias of PASAN and Glenn Betteridge of the Canadian HIV/AIDS Legal Network. It was reviewed by a number of outside reviewers (prisoners, prison staff, staff at community-based organizations, and provincial and federal prison authorities), by Anne Marie DiCenso on behalf of PASAN, and by Joanne Csete and Richard Elliott on behalf of the Legal Network.

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Dedication

This report is dedicated to Randy Charbonneau, who passed away while the project was underway, and to all the other prisoners who have worked and continue to work to promote prisoner health.

About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

Canadian HIV/AIDS Legal Network

1240 Bay Street, Suite 600

Toronto, Ontario, Canada M5R 2A7

Telephone: +1 416 595-1666

Fax: +1 416 595-0094

E-mail: info@aidslaw.ca

Website: www.aidslaw.ca

About the Prisoners' HIV/AIDS Support Action Network (PASAN)

PASAN (www.pasan.org) is a community-based prisoners' rights organization that strives to provide advocacy, education and support to prisoners and ex-prisoners in Ontario on HIV/AIDS, Hepatitis C and other harm reduction issues. Established in 1991,

PASAN is the only community-based organization in Canada exclusively providing HIV/AIDS and Hepatitis C prevention education and support services to prisoners, ex-prisoners, youth in custody and their families.

Prisoners' HIV/AIDS Support Action Network (PASAN)

489 College Street, Suite 500

Toronto, Ontario, Canada M6G 1A5

Telephone: +1 416 920-9567

Fax: +1 416 920-4314

E-mail: info@pasan.org

Website: www.pasan.org



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Executive summary

Everyone in the prison environment — prisoners, prison staff, and service-providers — benefits from enhancing the health of prisoners and reducing the incidence of blood-borne diseases such as HIV and hepatitis C virus (HCV). The health of prisoners is an issue of public health concern. Prisoners come from the community and the vast majority return to it.

To a great extent, prisons are home to people who have been socially marginalized — people who suffer from addictions and other mental health issues, people who are poor, people who have low levels of literacy, and people who have suffered physical, emotional and psychological abuse, including the effects of colonization in the case of many Aboriginal prisoners. Prior to being imprisoned, some 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 behaviours often continue or may be initiated in prison, with potential consequences for HIV and HCV transmission, particularly where access to information and prevention measures are limited or non-existent.

The goal of this report is to encourage and aid prison systems, other sectors of government, non-governmental and community organizations, and prisoners themselves in responding to the challenges of HIV and HCV, particularly with respect to prevention. This report is intended to fulfill this goal by increasing:

- knowledge and understanding of legal and human rights issues related to HIV and HCV prevention and harm reduction in prisons;
- awareness of the many enabling policies and the best and promising programs for prison HIV and HCV prevention and harm reduction that exist in Canada; and
- the capacity of governmental, non-governmental and community organizations, and prisoners and prison staff to participate in the formulation and implementation of HIV and HCV prevention and harm reduction policy and programs.

It is a well-established legal principle that prisoners do not surrender their rights upon incarceration, but instead 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. Together, human rights guarantees and international guidelines can steer the development of HIV and HCV prevention and harm reduction policy and programming in prisons, and 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 as HIV and hepatitis. We refer throughout this report to guidelines developed by the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), and Joint United Nations Programme on HIV/AIDS (UNAIDS).

Two basic methods were used to collect information about the policies and programs presented in the report: (1) a paper review of prison HIV and HCV prevention and harm reduction policies, programs and supporting

materials covering all 14 legislative jurisdictions in Canada; and (2) visits to federal and provincial prisons in eight provinces (**British Columbia, Alberta, Saskatchewan, Manitoba, Nova Scotia, New Brunswick, Quebec and Ontario**), including interviews with prisoners, prison staff, prison administration, and community organizations.

This report presents “enabling policies” and “best and promising programs” from prison systems and prisons in Canada in relation to:

- HIV infectious disease and sexual health counselling and testing
- condoms, dental dams, and lubricant
- cleaning injecting, tattooing, and piercing equipment
- methadone maintenance therapy (MMT)
- testing for illicit drugs
- education and information for prisoners and prison staff
- specific populations (women prisoners, Aboriginal prisoners, imprisoned youth, prisoners from ethno-cultural minorities, transsexual and transgendered prisoners)
- drug-free living units and therapeutic communities

The “**best and promising programs**” sections of the report include descriptions of **30 programs** that we judged might be worthy of consideration as models by other prisons and jurisdictions. We have also identified **20 “enabling policies”** — those that conform to international guidelines or otherwise support effective HIV and HCV prevention and harm reduction programming for prisoners and staff — which we consider worthy of consideration as models.

In some important respects, the HIV and HCV prevention and harm reduction programs provided in Canadian prison systems mirror such programs in communities across Canada. Community programs differ from province to province to territory, and from community to community within a province or territory. Where community programs are lacking, prisons should not be excused from meeting their legal obligations to provide prisoners with the means to protect their health. Prison authorities and authorities responsible for health care and public health in the community should work together to find solutions to common problems or to meet unmet needs. There are many examples of such effective cooperation described in the report.

Harm reduction program 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 (and other equipment) for injecting and tattooing, as there is in a growing number of other countries. As a result, no Canadian jurisdiction offers comprehensive HIV and HCV prevention and harm reduction programming for prisoners — which, in our view, includes access to sterile tattooing and injecting equipment — nor in the current legal and policy framework could it do so.

Our policy scan, coupled with visits to prisons and interviews with prisoners, prison staff and staff at community-based organizations, also revealed frequent gaps between policy and practice. There were many instances where, within a prison, the applicable policy was not being followed, thereby impeding the ability of prisoners to protect their health.

We documented significant gaps in coverage (of both policy and programs) for specific prison populations, notably 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.

We have found that prison HIV and HCV prevention and harm reduction policies and programming can be strengthened by collaboration between public health authorities and prison administration and staff. We have documented a number of such successful collaborations in which public health personnel act autonomously within the corrections environment. It is our observation that greater collaboration of this kind at both the policy and programmatic levels would ensure more far-reaching programming to meet prisoners' needs. One challenge to scaling up this collaboration is the organizational structure of public health authorities in Canada; in many provinces, decisions about public health resource allocation and programming are made at the level of local public health units. The challenge will be for prison systems and public health officials to engage at the provincial level — or the federal-provincial level in the case of Correctional Service of Canada (CSC) — to craft policy and agreements so that programs can be implemented in prisons throughout a province or territory.

We suggest for consideration six strategic directions for action:

1. Identify leaders from among people with legal responsibility for prisoners 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.
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.
3. Agree on Canadian best policy and practice for HIV and HCV prevention and harm reduction in prisons, thereby setting the 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 identify strategies to overcome these barriers.
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 cooperation will help to ensure that various perspectives, experiences and skills are reflected.
6. Monitor and evaluate policies and programs on an ongoing basis to determine whether HIV and HCV prevention and harm reduction policies 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.

Introduction

Prisoner health is public health

The health of prisoners is an issue of public health concern. Everyone in the prison environment — prisoners, prison staff, and service-providers — benefits from enhancing the health of prisoners and reducing the incidence of communicable disease. Programs to decrease the risk of HIV and hepatitis C virus (HCV) transmission, including programs to minimize accidental exposure to these blood-borne infections, make prisons a safer place to live and work. Prisoners come from the community and the vast majority return to it. When prisoners living with HIV and HCV are released from incarceration, prisoners' health issues necessarily become health issues in the community.

The costs of treating chronic infections such as HIV and HCV are significant. Lifetime care and treatment costs for HIV were estimated in 1998 to total about \$160,000 per person with HIV, while the indirect costs associated with lost productivity and premature death may be as high as \$600,000 per person.¹ A Canadian study showed that the mean direct cost of providing medical care (including pharmaceutical, inpatient, outpatient, and home care costs) for one patient living with HIV for one month in Alberta in 1997–1998 was \$1,036 (or \$12,432 annually), adjusted to 2001 dollars.² A study published in 2006 estimated the lifetime cost of treating a single case of HIV infection in the United States to be US\$618,900.³

The HIV and HCV epidemics have presented challenges for Canadian federal and provincial governments, including for prison officials. To a great extent, prisons are home to people who have been socially marginalized — people who suffer from addictions and other mental illness, who are poor, who have 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.⁴ Moreover, over-reliance on the criminal law as a response to drug use and addiction means that many people who use illicit drugs are incarcerated.⁵ 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. Once incarcerated, some of these people continue to engage in risk behaviours with the potential consequences of viral transmission. Thus, it is not surprising that the HIV and HCV prevalence rates among prisoners far exceed rates in the general population.

Harm reduction, including HIV and HCV prevention among people who inject drugs, is embodied in policy in several jurisdictions in Canada. At the federal level, until 2007, Canada's Drug Strategy was formally based on a "four-pillar" approach of which harm reduction was one pillar (along with prevention of drug use, treatment of drug dependence and law enforcement).⁶ At the provincial level, British Columbia has perhaps the strongest policies and formal guidance to health practitioners, including materials that explain clearly the policy

¹ Martin Spigelman Research Associates, *Getting Ahead of the Epidemic: The Federal Government Role in the Canadian Strategy on HIV/AIDS 1998-2008* (2003): 50.

² H. Krentz, M. Auld and M. Gill, "The changing direct costs of medical care for patients with HIV/AIDS, 1995-2001" *Canadian Medical Association Journal* 169(2) (2003): 106–110. Regarding the costs associated with treating HCV infection, see: M. Wright et al., "Health benefits of antiviral therapy for mild chronic hepatitis C: randomised control trial and economic evaluation" *Health Technology Assessment* 10(21) (2006), revealed that in 2006 in the United Kingdom the cost of the antiviral medication used to treat hepatitis C (and excluding associated treatment costs) was £7,141, while the total cost of a liver transplant necessitated by advanced hepatitis C was £50,313.

³ B. Schackman et al., "The lifetime cost of current Human Immunodeficiency Virus care in the United States" *Medical Care* 99(44) (2006): 11.

⁴ See, generally, "A Health Care Needs Assessment of Federal Inmates in Canada," *Canadian Journal of Public Health* 95(S1) (2004): S1–S63.

⁵ K. deBeck et al., "Canada's 2003 renewed drug strategy — an evidence-based review," *HIV/AIDS Policy & Law Review* 11(2/3) (2006): 1.

⁶ As of May 2007, the statement of the four pillars of Canada's Drug Strategy was removed from government web sites and replaced with a notice saying that a new National Anti-Drug Strategy is in development; see http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html. The federal budget presented to Parliament in March 2007 included no funding for harm reduction. See March 30, 2007 letter from the Canadian HIV/AIDS Legal Network to members of Parliament on this subject at <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=691>.

and programmatic importance of a wide range of harm reduction services.⁷ Nova Scotia has also formally endorsed harm reduction,⁸ and most other provinces and territories fund and issue guidelines on specific harm reduction measures such as needle exchange programs and methadone provision. These policy and program commitments should be reflected in prison health programs as well.

HIV and hepatitis C virus in Canadian prisons

The most comprehensive information readily available about HIV and HCV prevalence rates in the Canadian prison population comes from studies of provincial prisoners in Ontario.⁹ CSC collects data on HIV and HCV among inmates, but it is impossible to determine with certainty the percentage of prisoners in Canada living with HIV or HCV. This is partly because prisoners in Canada are not subject to routine, mandatory HIV or HCV testing, a policy that is consistent with international guidelines. In addition, there is a paucity of longitudinal research on HIV and HCV prevalence among prisoners and large-sample research on prisoners' health. With the exception of research in Ontario provincial prisons, the only available data are from small-scale, point-in-time, voluntary studies, resulting in poor generalizability of results. Self-selection bias may be at work in such voluntary studies in that prisoners who consider themselves at risk may come forward more readily for testing; conversely, some prisoners at risk may not wish to get tested in prison out of fear of the consequences of being known to be living with HIV.¹⁰ Finally, data on detected cases of infectious disease are collected and published by the federal prison system, but not by provincial and territorial prison systems. And while case reporting is important, it does not give an accurate overall picture, as it suffers from some of the same limitations as voluntary HIV and HCV testing studies.

Everyone in the prison environment — prisoners, prison staff, and service-providers — benefits from enhancing the health of prisoners and reducing the incidence of communicable disease.



Estimates of HIV prevalence in Canadian federal and provincial prisons range from two to eight percent, while studies of HIV prevalence in individual prisons report rates of between 1 and 11.94 percent.¹¹ In Ontario, one large-scale study published in 1995 reported results from HIV antibody tests of urine specimens obtained

⁷ See, e.g., Ministry of Health, British Columbia. *Harm reduction: A British Columbia community guide*. Vancouver, 2005. Available at www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf.

⁸ Nova Scotia Health. *Standards for Blood Borne Pathogens Prevention Services in Nova Scotia*. Halifax, May 2004, esp. pp 23-30. Available at http://www.gov.ns.ca/hpp/publichealth/content/pubs/BBP_Integrated_Standards.pdf.

⁹ See the following studies that provide data on HIV and HCV prevalence in Ontario provincial prisons: L. Calzavara et al., *Prevalence and Risk Factors for HIV and Hepatitis C in Ontario's Jails and Detention Centres (2003-2004)*, University of Toronto, 2006; L. Calzavara et al., "The prevalence of HIV-1 infection among inmates in Ontario, Canada," *Canadian Journal of Public Health* (1995) 86(5):335-339; and L. Calzavara et al., "Reducing Volunteer Bias: Using Left-over Specimens to Estimate Rates of HIV Infection Among Inmates in Ontario, Canada," *AIDS* 9 (1995): 631-637.

¹⁰ Regarding stigma, discrimination and the potential for violence against people living with HIV in prison in Canada, see W. Small et al., "The experiences of HIV-positive injection drug users receiving HAART within correctional environments in Canada" (2007, unpublished draft on file with the authors). Staff from PASAN and the HIV & AIDS Legal Clinic (Ontario) also report that their clients living with HIV have been subjected to discriminatory treatment by other prisoners and correctional staff within federal prisons. In commenting on the draft report, CSC staff at National Headquarters, Health Services wrote: "Many of CSC's nurses have excellent relationships with offenders that allow them to provide harm reduction counselling during all aspects of their health care treatment, not just through a specific program."

¹¹ R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, Canadian HIV/AIDS Legal Network, second edition, 2006, p. 6.

from people entering prison (9201 adult men, 1302 adult women, 1259 young male offenders, and 72 young female offenders).¹² Overall rates of HIV-1 infection were one percent for adult men, 1.2 percent for adult women, and zero percent for young offenders. One percent of entrants during the test period refused to have their urine used for research (which refusal was not associated with a history of injecting drug use). Another large-scale study of entrants to Ontario provincial prisons between February 2003 and July 2004 found that the HIV prevalence rate among the adult population was two percent.¹³ In Quebec, a study conducted between January and June 2003 found that HIV prevalence among those in Quebec's provincial prisons 2.3 percent among men and 8.8 percent among women.¹⁴ Conservatively, the studies to date put the HIV prevalence rate in prisons at roughly 10 times the prevalence rate in the general Canadian population,¹⁵ although some studies, such as the more recent 2003 study in Quebec provincial prisons, indicate an HIV prevalence among the study population that is almost 19 times higher than that in the general population. By further comparison, recent HIV prevalence data among people who inject drugs, gathered at surveillance sites, showed variable rates — from 1.2 percent (reported in Regina in 2005) to 23.8 percent (reported in Edmonton in 2005).¹⁶

Studies estimate the prevalence of HCV in the Canadian prison population to be between 19.2 and 39.8 percent.¹⁷ The 2003–04 study of entrants to Ontario provincial prisons found that HCV prevalence rate among the adult population was 17.6 percent, and that 1.2 percent of adult prisoners were co-infected with HIV and HCV.¹⁸ The 2003 study of Quebec provincial prisoners reported HCV prevalence of 16.6 percent among men and 29.2 percent among women, and that most of those prisoners with HIV were also co-infected with HCV.¹⁹ It has been estimated the HCV prevalence rate in the general population is 0.8 percent.²⁰ Among people who inject drugs in the community, data gathered at surveillance sites showed high HCV prevalence, ranging from 61.8 percent (reported in Winnipeg) to 68.6 percent (reported in Sudbury and Victoria).²¹ Studies show that the prevalence of both HIV and HCV is higher among women than men in prison.

There is evidence that cannot be ignored or discounted that HIV and HCV are spread in Canadian prisons. Among drug users, incarceration itself represents additional risk of HIV transmission. Participants in the Vancouver Injection Drug Users Study (VIDUS) who had recently been incarcerated were 2.7 times more likely to be HIV-positive than those who had not been to jail or prison.²² An external evaluation of the attributable risks reported in that study concluded that 21 percent of the HIV infections among injection drug users in Vancouver were likely acquired in prison.²³ The VIDUS researchers subsequently analyzed syringe

¹² L. Calzavara et al., "Reducing volunteer bias: using left-over specimens to estimate rates of HIV infection among inmates in Ontario, Canada," *AIDS* 9 (1995): 631–637; L. Calzavara et al., *The Study of HIV Prevalence in Ontario Jails, Detention and Youth Centres: Final Report*, University of Toronto, 1994.

¹³ L. Calzavara et al., *Prevalence and Risk Factors for HIV and Hepatitis C in Ontario's Jails and Detention Centres (2003-2004)*, University of Toronto, 2006, p. 12.

¹⁴ C. Poulin et al., "HIV and Hepatitis C Virus Infections Among Inmates of Quebec Provincial Prisons," *Canadian Medical Association Journal* 176 (2007) (forthcoming at time of publication).

¹⁵ 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.

¹⁶ Public Health Agency of Canada. *HIV/AIDS Epi Updates, August 2006*, Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006, Chapter 10, p. 77.

¹⁷ S. Skoretz, G. Zaniewski and N.J. Goedhuis, "Hepatitis C virus transmission in the prison/inmate population," *Canada Communicable Disease Report* 30(16) (2004): 141–148, specifically p. 142.

¹⁸ L. Calzavara et al., *Prevalence and Risk Factors for HIV and Hepatitis C in Ontario's Jails and Detention Centres (2003-2004)*, University of Toronto, 2006, p. 12.

¹⁹ Poulin et al.

²⁰ R. Remis et al., *Estimating the Number of Blood Transfusion Recipients Infected by Hepatitis C Virus in Canada*, Report to Health Canada, June 1998.

²¹ Public Health Agency of Canada. *HIV/AIDS Epi Updates, August 2006*, Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006, Chapter 10, pp. 77–78.

²² 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.

²³ H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17(6) (2003): 911–913.

sharing in prison.²⁴ They found that incarceration in the six months prior to being interviewed was associated with syringe lending by HIV-positive VIDUS study participants during that period. Similarly, among HIV-negative participants, incarceration in the six months prior to being interviewed was associated with syringe borrowing during that period. VIDUS researchers have also published qualitative evidence from a small-scale study of prisoners that “confirmed the previous reports that injecting within the prison environment is characterized by a pattern of syringe sharing among large networks composed of numerous individuals.”²⁵ The study also found that prisoners living with HIV conceal their status from injection partners for fear that others will not lend or share with them the rare syringe that may be available.

Risk behaviours associated with HIV and HCV transmission in prison are not confined to a particular demographic group — men or women, adults or youth — and are not the exclusive problem of federal or provincial/territorial prisons. Of the 104 female prisoners who participated in a study in a British Columbia prison in which both provincial and federal prisoners were incarcerated, 21 percent (22/104) reported injection drug use inside prison; of this number, 19 reported sharing a syringe with other prisoners, and three reported not cleaning used syringes with bleach.²⁶ Self-reported HIV and HCV infection rates among the prisoners were eight percent and 25 percent, respectively. In 2006, a group of Ontario researchers reported on prevalence and predictors of HIV and HCV in Ontario jails and detention centres.²⁷ Over 1900 adults and youth admitted to Ontario facilities during a 17-month period were screened for HIV and HCV and completed an interviewer-administered survey. Participants reported having engaged in the following risk behaviours during a previous period of incarceration: tattooing (21 percent of adults; 43 percent of youth); piercing (nine percent; five percent); and injecting drugs (16 percent; eight percent). Those in Quebec provincial prisons who participated in the 2003 study reported the following risk behaviours while incarcerated: receiving a tattoo (37.9 percent of men, 18.3 percent of whom reported that non-sterile equipment was used; 4.8 percent of women, 41.7 percent of whom reported the use of non-sterile equipment); injecting drugs (4.4 percent of men, of whom 63.3 percent reported sharing injection equipment; 0.8 percent of women, of whom 50 percent reported sharing); and piercing (2.1 percent of men, 20.7 percent of whom reported the use of non-sterile equipment; 4 percent of women, 30 percent of whom reported non-sterile equipment).²⁸

Risk behaviours in prisons are fuelled by activities that the criminal law makes illegal (e.g., possession of controlled drugs and 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 (either under the criminal law or prison disciplinary rules), combined with the fact that prisoners are subject to extensive security measures, drives such activities underground and makes prevention more difficult than in the community, both at a political and at a practical level. Yet, it is the very concentration of people who engage in risky behaviours that makes prison a prime opportunity 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 prisoner health and occupational health and safety.

²⁴ E Wood et al., “Recent incarceration independently predicts syringe sharing among injection drug users,” *Public Health Reports* 120(2) (2005): 150–156.

²⁵ W Small et al., “Incarceration, addiction and harm reduction: inmates’ experiences injecting drugs in prison,” *Substance Use and Misuse* 40(6) (2005): 831–843. See, also, J. Wylie, *A Pilot Study Assessing Risk Factors for Hepatitis C and HIV Transmission Within a Federal Correctional Institution*, Chadham (Mantioaba) Provincial Laboratory, 2004, a small scale (n=40) study of active and former injection drug users in a federal prison.

²⁶ R. Martin, “Drug use and risk of blood-borne infections,” *Canadian Journal of Public Health* 96(2) (2005): 97–101.

²⁷ L. Calzavara et al., *Prevalence and Risk Factors for HIV and Hepatitis C in Ontario’s Jails and Detention Centres (2003-2004)*, University of Toronto, 2006.

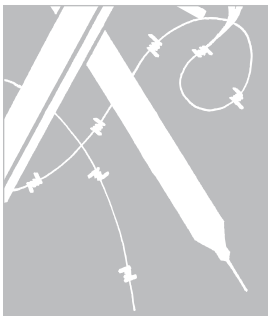
²⁸ Poulin et al.

Goals of this report

The challenge of HIV and HCV prevention and treatment in prison is shared by the 14 Canadian jurisdictions responsible for administering prison systems. The goal of this report is to encourage and aid prison systems, other sectors of government, non-governmental and community organizations, and prisoners themselves in responding to the challenges of HIV and HCV, particularly with respect to prevention. This report is intended to fulfill this goal by increasing:

- knowledge and understanding of legal, ethical and human rights issues related to HIV and HCV prevention and harm reduction in prisons;
- the capacity of government, non-governmental and community organizations, and prisoners to address these issues; and
- involvement of government, non-governmental and community organizations, and prisoners in discussion, information-sharing, and problem-solving regarding prison policy and programming on HIV and HCV prevention and harm reduction in prisons.

This report describes prison policies that enable HIV and HCV prevention and harm reduction, and documents best and promising prison HIV and HCV prevention and harm reduction programs. Health authorities and prison officials recognize the value of collaboration — the work of the Federal/Provincial/Territorial Advisory Committee on AIDS, the Federal/Provincial/Territorial Heads of Corrections, and the Heads of Corrections Working Group on Health all reflects this collaboration. This report seeks to promote greater collaboration at the federal/provincial/territorial (FPT) level and to expand the scope of collaboration to include parties beyond government, thus complementing FPT efforts already underway, in three ways.



[O]fficials responsible for prison systems [should] recognize the imperative of, and advantages that flow from, increasing consultation and collaboration with prisoners and “outside” organizations and individuals . . .

First, as far we know, this is the first attempt at a “national” survey of both policy and practice in relation to prison HIV and HCV prevention and harm reduction, and we hope it will provide a useful overview for FPT officials in both prisons and public health. We have attempted to engage federal and provincial prison officials, many of whom sit on the FPT bodies, in the project as advisory committee members as well as in our regular communications, and invited their suggestions about best and promising programs in their jurisdictions.

Second, we hope to encourage officials responsible for prison systems to recognize the imperative of, and advantages that flow from, increasing consultation and collaboration with prisoners and “outside” organizations and individuals, including public health authorities (local, regional and national); community-based AIDS service organizations; community-based harm reduction programs; methadone clinics and physicians licensed to prescribe methadone; prisoners’ support organizations; Aboriginal, women’s and ethno-cultural minorities’ organizations that work with prisoners; and universities.

Third, we hope to engage FPT representatives, non-governmental and community organizations, and prisoners in developing an action plan for HIV and HCV prevention and harm reduction in prison in Canada, based on the concluding observations and strategic directions for action set out in the final section of the report. One of the purposes of the strategic directions will be to propose ways for prison officials to more effectively share

information and expertise about HIV and HCV prevention and harm reduction policy and programming, and to encourage implementation of a supportive policy environment and best practice programs both within and across jurisdictions. We hope that prisoners and “outside” organizations will also be involved in developing and implementing an action plan to achieve those ends.

The Canadian HIV/AIDS Legal Network and the Prisoners’ HIV/AIDS Support Action Network (PASAN) are committed to advancing the health and human rights of prisoners, both in Canada and internationally. We hope that the report will be useful to prison systems, health and public health authorities, non-governmental and community-based organizations, and prisoners in other countries.

Methods

Two basic methods were used to collect the information presented in this report — a paper review; and prison visits and in-person interviews.

To collect information about existing HIV and HCV prevention and harm reduction policies and programs in federal and provincial/territorial prisons, the Legal Network filed “access to information” requests with all 14 legislative jurisdictions in Canada. We requested two types of documents: (1) policies, guidelines, directives, memoranda, and standing orders that set out procedures, practices, or standards; and (2) training and educational materials. We requested information in relation to a wide range of programs that have been relied upon to reduce the harms associated with behaviours that risk transmitting HIV and HCV in prison:

- HIV antibody testing and counselling
- condoms, dental dams and lubricant
- bleach to clean needles
- methadone maintenance therapy
- illicit drug testing
- drug-free living units
- education and information for prisoners
- education and training for staff
- special programs for women or Aboriginal prisoners

The bulk of the report is organized around these programs. Because provincial and territorial governments are responsible for providing both adult and youth detention services, we requested information from them about all such services and policies.

An advisory committee consisting of prisoners, ex-prisoners, community-based organizations, and provincial public health officials guided the project. There were representatives from British Columbia, Saskatchewan, Ontario, Quebec, and Nova Scotia. CSC National Headquarters (NHQ) was invited to participate on the advisory committee, but declined. The advisory committee included prisoner representatives from both federal and provincial corrections. It included community members representing women, people who use drugs, Aboriginal communities and Black communities. As well, we consulted informally with members of the transgendered/transsexual community. The advisory committee members are listed in Appendix A.

Due to funding constraints, prison visits and in-person interviews were limited.²⁹ Best and promising HIV and HCV prevention and harm reduction programs for adult prisoners were documented through interviews conducted in eight provinces: **British Columbia, Alberta, Saskatchewan, Manitoba, Nova Scotia, New Brunswick, Quebec** and **Ontario**. In order to document best and promising practices, PASAN and the Legal Network contacted prisoners, prisoner organizations, community organizations, federal and provincial officials responsible for prisoner health, and health care staff within prisons. We invited all of these groups to provide examples from their personal and work experience of programs they considered best or promising practices.³⁰ Many of the best and promising programs in the report were identified by prison authorities, and CSC identified almost all the programs described here in the federal system.

Giselle Dias of PASAN traveled to the aforementioned provinces between July and November of 2006 and visited both federal and provincial prisons and community-based organizations. Information about specific projects that had been identified as best or promising practices was gathered, including:

- background;
- objectives and main activities;
- start date;
- outcomes;
- lessons learned;
- limitations;
- how the project was funded; and
- evaluation of the project.

In total, she visited 20 prisons and interviewed 85 people. The prisons visited and the people and organizations consulted are listed in Appendix B. In Quebec, interviews were conducted in both French and English. A translator familiar with prisoner issues assisted with French interviews. Where required, phone and e-mail follow-up was conducted with people who had provided in-person interviews.

Based on the information gathered, the programs were evaluated to identify which ones would be included in the report. In seeking to examine promising programs, we attempted to identify programs that have been successful at reducing the risk of infection of HIV and hepatitis C virus for prisoners. Based on the notion of “best practices” developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS), we looked at programs that

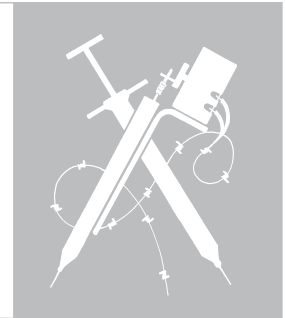
²⁹ Due to resource limitations, we were unable to travel to every province and territory in which a program had been identified. In consultation with the advisory committee, we identified the following priorities: We would visit both men’s and women’s adult prisons (both federal and provincial) and would visit sites in all five CSC administrative regions. Because the prisoner population in the Prairie Region is quite diverse, including a high proportion of Aboriginal prisoners from different nations, prisons in all three provinces (Alberta, Manitoba, and Saskatchewan) were visited. Prisons in two provinces in the Atlantic region (Nova Scotia and New Brunswick) were visited.

³⁰ Prisoners across Canada were reached through a letter (in both French and English) asking for examples of best and promising harm reduction programs being run by prisoners, community groups or prison services. The letter was sent to inmate committees, peer health groups, Native Brotherhoods and Sisterhoods, and Black Inmates and Friends Assemblies in all federal prisons across Canada. In addition, in an attempt to reach prisoners, an advertisement was placed in *Cell Count* (PASAN’s quarterly newsletter). A separate letter was sent to community groups through project advisory committee members and the Canadian AIDS Society. That letter was also sent to prison officials and staff (Federal/Provincial/Territorial Heads of The Corrections Working Group on Health; CSC NHQ Health Services, CSC Regional Infectious Disease Coordinators; heads of health care in each CSC prison; heads of health care in prisons in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick and Nova Scotia).

- worked in some demonstrable way either in full or in part, and
- illustrated usefully some lessons learned (what works, how and why).³¹

This report is necessarily methodologically constrained. Ideally, we would have liked to survey all corrections institutions in Canada and be able to report quantitative results on the extent and quality of HIV and HCV prevention programs across the country. We would have been glad to be able to visit more prisons in person, but this too was impossible in the face of limited resources. The selection of programs highlighted in this report is necessarily somewhat subjective, but that selection resulted from consultation with corrections authorities and others involved with programs. We nonetheless hope that the programs highlighted are illustrative of important lessons.

Best and promising HIV and HCV prevention and harm reduction programs for adult prisoners were documented through interviews conducted in eight provinces . . .



Outline of the report

The report is organized into 14 main sections. The next section establishes the conceptual framework of human rights norms and harm reduction principles.

Each of the third through twelfth sections examines a specific HIV and HCV prevention or harm reduction need of prisoners (HIV and STI testing; condoms, dental dams, lubricant; bleach; methadone maintenance therapy; education and information) or the needs of a specific prison population (women, Aboriginal prisoners, and youth), or the training needs of prison staff. Each section is divided into subheadings: a compilation of guidance, recommendations and international perspectives; observations; enabling policy; and best and promising programs.

The report presents each best or promising program according to a standard format:

- contact information for the responsible person or organization
- overview of the program
- lessons learned
- limitations
- funding source
- supporting documents
- evaluation results

³¹ See Joint United Nations Programme on HIV/AIDS (UNAIDS). Summary Booklet of Best Practices. Geneva, June 1999, p 5. Available at http://data.unaids.org/Publications/IRC-pub02/JC-SummBooklet-1_en.pdf

The thirteenth section explores HIV and HCV prevention and harm reduction needs of other specific prisoner populations (members of ethno-cultural minorities, transsexual and transgendered prisoners) and presents a relatively recent development in programming for prisoners (drug-free living units and therapeutic communities).

Finally, the fourteenth section offers concluding observations and strategic directions for action for promoting HIV and HCV prevention and harm reduction in prisons in Canada. The observations include a discussion regarding the need for comprehensive approaches to HIV and HCV prevention and harm reduction in prisons.

Appendix A lists the advisory committee members. Appendix B lists the people consulted and prisons visited. Appendices C and D provide references for two tables reviewing HIV and HCV prevention and harm reduction policies and programs.

Conceptual framework

Human rights principles

Human rights norms can guide the development of HIV and HCV prevention and harm reduction policy and programming in prisons. This section of the report provides an overview of the relevant international and Canadian human rights norms (treaties, legislation, guidelines), and other standards related to prison conditions. In the subsequent sections of the report that examine specific HIV and HCV prevention and harm reduction policies and practices, these human rights norms will be brought to bear on the analysis of the situation of prisoners at risk of HIV and HCV infection and of harm reductions programs designed to protect the health of prisoners. Taken together, these norms establish the legal and ethical obligations of government to respect, protect and fulfil the rights of prisoners. These norms represent a framework within which to examine the responses of governments and prison authorities to the threat posed to prisoners by blood-borne viruses such as HIV and hepatitis.

Prisoners' rights under international human rights law

It is a well-established legal principle that prisoners do not surrender their rights upon incarceration, but instead retain all rights “subject to the restrictions that are unavoidable in a closed environment.”³² Courts in Canada have recognized this principle.³³

The rule of law is another fundamental principle applicable to the situation of prisoners. Arguably, the rule of law should be adhered to more strictly in the prison context because prisoners are by and large deprived of the ability to affect their own circumstances — in ethical and human rights terms, their autonomy and agency are constrained. Prisoners are under the authority of prison officials upon whom they rely for the essentials of life as well as all other entitlements and privileges.

Together these two principles — prisoners retain rights and the rule of law — form a mutually reinforcing core and starting point for the analysis of the rights of prisoners.

Canada has signed numerous international laws relevant to the rights of prisoners in the context of the HIV/AIDS epidemic:

- International Covenant on Civil and Political Rights (ICCPR)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- American Declaration on the Rights and Duties of Man (OAS Declaration)
- American Convention on Human Rights (OAS Convention)
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (OAS Protocol)

³² UN Committee on Human Rights, General Comment No. 21, Article 10 (Humane treatment of persons deprived of their liberty), UN CHROR, 44th Sess. (1992), UN Doc.HRI/GEN/1/Rev.6(2003) at 153, para 3; *Standard Minimum Rules for the Treatment of Prisoners*, UN Doc. A/CONF/611 (1955), amended UN Doc. E/5988 (1977); Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111, UN Doc. A/45/49 (1990); World Health Organization, *WHO Guidelines on HIV Infection and AIDS in Prisons* (Geneva: WHO, 1993). See, also, domestic case law such as the judgment of the Indian Supreme Court in *Sobraj v. The Superintendent, Central Jail Tihar*, [1978] I.N.S.C. 153, [1979] 1 S.C.R. 512 stating (at 518) that “prisoners retain all rights enjoyed by free citizens except those that are lost necessarily as an incident of confinement.” See, also, statutory law, such as Canada’s *Corrections and Conditional Release Act*, S.C. 1992, c. 20, s. 4(e), which states “that offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence....”

³³ *Raymond v Honey* [1982]; *DBM Patnaik v State of AP* [1974] AIR SC 2092 (India); *Charles Sobraj v Superintendent, Central Jail, Tihar* [1978] AIR SC 1514 (India); *Sanjay Suri v Dehi Administration* [1980] AIR SC 1579 (India); *S v Makwanyane and Another* [1995] 3 SA 391 (CC) (South Africa).

Since most of these covenants are based on the UN Universal Declaration of Human Rights, there is a great deal of overlap in the human rights they guarantee. The Universal Declaration has the status of customary international law and, as such, is binding on all states. Moreover, states that have ratified or acceded to any one of the declarations, conventions or charters set out above have recognized that they are legally bound to respect, protect and fulfill the following human rights, which are common to all:

- right to equality and non-discrimination
- right to life
- right to security of the person
- right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment
- right to enjoyment of the highest attainable standard of physical and mental health
- right to privacy
- right to an effective remedy for violations of human rights

Prisoners, human rights and health

In the context of the HIV/AIDS and hepatitis C epidemics, a public health rationale also dictates that governments should fulfill their human rights obligations to prisoners. Programs undertaken to prevent the spread of HIV, HCV and other blood-borne 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 by virtue of the fact that most inmates are in prison only for short periods and are then released into their communities. In order to protect the general population, prevention programs need to be available in prisons, as they are outside. The *WHO (World Health Organization) Guidelines on HIV Infection and AIDS in Prisons*³⁴ recommend that the standard of health care provided to prisoners must be comparable to that available in the general community (i.e., the principle of “equivalence” of health services), including with respect to prevention programs. WHO recommends more specifically that general policies adopted under national AIDS programmes apply equally to prisoners and the community [WHO Guidelines 1, 2, 4]. Similarly, the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the Inter-Parliamentary Union recommend that prisoners be provided with “access equal to the outside community” in relation to HIV-related prevention and care services.³⁵

Access to HIV and HCV prevention and harm reduction programs engages a number of human rights — the right to life, the right to security of the person, and the right to enjoyment of the highest attainable standard of physical and mental health. The right to health in international law should be understood in the context of the broad concept of health set forth in the WHO Constitution, which defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Like all persons, prisoners are entitled to enjoy the highest attainable standard of health, as guaranteed under international law.

Key international instruments reveal a general consensus around the principle of equivalence of health services. In the context of HIV/AIDS, health services would include providing prisoners the means to protect themselves from exposure to HIV (and co-infection with HCV) and other forms of drug-related harm. Specific rules and principles apply to the situation of prisoners, and impose obligations on states to do certain things and not to

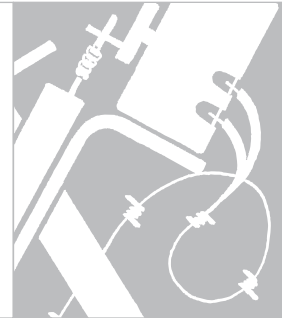
³⁴ WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993 WHO/GPA/DIR/93.3.

³⁵ UNAIDS, IPU, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*. UNAIDS: Geneva, 1999, pp. 61, 63.

do others in relation to prisoners and prison conditions.³⁶ Many of the principles and rules in these instruments flow from or are iterations of the fundamental right of prisoners not to be subjected to cruel, inhumane or degrading treatment or punishment. None of these instruments are law per se. The Basic Principles and the Body of Principles are resolutions of the UN General Assembly.

The Standard Minimum Rules (SMR) state that the rules and principles “set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions,” and represent “the minimum conditions which are accepted as suitable by the United Nations” [SMR 1, 2]. The SMR and four Council of Europe (COE) recommendations establish comprehensive and detailed rules for the treatment of prisoners and management of prisons, rather than high-level statements of principle.³⁷ While obviously not applicable in Canada, COE recommendations provide a concrete indication of the behaviour expected among European nations committed to the rule of law and other democratic principles, nations very similar to Canada in this and other respects. The COE Recommendations were adopted by the Committee of Ministers and, as their name suggests, are only recommendations and are not binding on COE member states. COE Recommendation 98(7) urges that “governments of member states take into account” the principles and recommendations and specifically addresses HIV and other infectious diseases [articles 36–42].

In order to protect the general population, [HIV and HCV] prevention programs need to be available in prisons, as they are outside.



The following international norms are also relevant to HIV and HCV prevention and harm reduction in prisons:

- right to non-discrimination, including the benefit of special rules for sick or handicapped persons [Basic Principles 2; Body of Principles 5(2); SMR 6]
- access to health services available in the country without discrimination on the grounds of their legal situation [Basic Principles 9; Principles of Medical Ethics 1; COE Recommendation R 98(7) 10, 11, 19]
- medical services organized in a close relationship to the general health administration of the community or nation [SMR 22(1); COE Recommendation R 98(7) 7]
- right to obtain from public sources reasonable quantities of educational, cultural and informational material, subject to reasonable conditions to secure security and good order [Body of Principles 28].

³⁶ See international instruments such as: Basic Principles for the Treatment of Prisoners [Basic Principles]; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment [Body of Principles]; Standard Minimum Rules for the Treatment of Prisoners [SMR]; Principles of Medical Ethics.

³⁷ Council of Europe, P.A. Standing Committee, Recommendation 1080 (1988) On a Co-ordinated European Health Policy to Prevent the Spread of AIDS in Prison; Council of Europe, Recommendation R (93)6 of the Committee of Ministers Concerning Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and Related Health Problems in Prison; Council of Europe, Recommendation No R (98)7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison; Council of Europe, Recommendation R (2006)2 of the Committee of Ministers on the European Prison Rules. Available via <http://assembly.coe.int/>.

Five additional international instruments — one declaration and three sets of guidelines — which seek to give content to international human rights guarantees are relevant to the situation of prisoners in the context of HIV/AIDS:

- *Declaration of Commitment on HIV/AIDS*, United Nations General Assembly Special Session on HIV/AIDS (UNGASS Declaration)³⁸
- *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS and Office of the United Nations High Commissioner for Human Rights (International Guidelines)³⁹
- *WHO guidelines on HIV infection and AIDS in prisons* (WHO Guidelines)
- *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, UNAIDS and Inter-Parliamentary Union (IPU Handbook)⁴⁰
- *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for and Effective National Response*, United Nations Office on Drugs and Crimes (UNODC Framework)⁴¹

None of these documents has the force of law. All are the result of consultation, collaboration or a special session of a United Nations body or bodies.

Guideline 4 of the International Guidelines specifically encourages states to “review and reform criminal law and prison systems to ensure that they are consistent with human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable populations.” The International Guidelines are intended to promote and protect respect for human rights in the context of HIV/AIDS, and were developed at the request of the UN Commission on Human Rights to benefit governments by “outlin[ing] clearly how human rights standards apply in the area of HIV/AIDS and indicat[ing] concrete, specific measures, both in terms of legislation and practice, that should be undertaken” to fulfill state obligations in relation to public health within their specific contexts [para 2, 15(d)]. The International Guidelines identify the following specific action in relation to prisons:

Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered [para 29(e)].

The WHO Guidelines “provide standards — from a public health perspective — which prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by HIV/AIDS. It is expected that the guidelines will be adapted by prison authorities to meet their local needs.” The WHO Guidelines outline general principles and cover issues such as HIV testing; prevention measures; management of HIV-infected prisoners; confidentiality; care and support of HIV-infected prisoners; tuberculosis; women prisoners; juvenile detention; semi-liberty, release and early release; community

³⁸ United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. Resolution A/Res/S-26/2, 27 June 2001.

³⁹ UNAIDS/OHCHR, *The International Guidelines on HIV/AIDS and Human Rights*, 2006 consolidation.

⁴⁰ UNAIDS and Inter-Parliamentary Union, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*. 1999.

⁴¹ UNODC, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for and Effective National Response*. 2006.

contacts; resources and evaluation and research. (References to the content of specific guidelines are found in subsequent sections of this report.)

The UNODC Framework “provide[s] a framework for mounting an effective national response to HIV/AIDS in prisons that meets international health and human rights standards, prioritizes public health, is grounded in best practices, and supports the management of custodial institutions.” The UNODC Framework includes 100 specific actions framed around 11 principles representing an “international consensus” on effective prison management in the context of HIV/AIDS.⁴² We make detailed reference to specific parts of this framework in the sections to follow.

Prisoners’ right to health in Canada

In Canada, the *Canadian Charter of Rights and Freedoms* and laws governing prison systems impose obligations on governments to safeguard the health and well-being of prisoners. Among Canadian jurisdictions, only the federal government has a statutory (i.e., written in a law) obligation to provide prisoners with essential health care akin to that available in the community.⁴³ The federal prison system is governed under the *Corrections and Conditional Release Act* (CCRA) and the accompanying regulations.⁴⁴ Under sections 85 to 88 of the CCRA, CSC is mandated to provide every prisoner with essential health care and reasonable access to non-essential mental health care that will contribute to his or her rehabilitation and reintegration into the community. While the principle of equivalence is not directly stated in the CCRA, the broad definition given to “health care,” including the requirement that medical care “shall conform to professionally accepted standards,” arguably implies that prisoners are entitled to equivalence of essential health services, including prevention programs.⁴⁵

CSC is in the process of attempting to get each prison’s health services accredited through the Canadian Council on Health Services Accreditation. However, as reported by the Correctional Investigator, as of the end of fiscal year 2005–2006, only 10 percent of the 29 prison health services that underwent the full accreditation process were fully accredited. For the Correctional Investigator, this “raises questions about the Correctional Service’s compliance with its legislative obligation to meet ‘professionally accepted standards.’”

Provincial and territorial prison systems are created under provincial laws. Overall provincial and territorial legislation does not incorporate international standards for the treatment of prisoners to the same extent as does the CCRA. Regarding health services, provincial and territorial laws are weaker than the CCRA in conferring on provincial and territorial prisoners a right to receive equivalent health care, or placing on prison staff the responsibility for providing such care. Nova Scotia is exceptional in this regard. Its prison legislation was amended in 2005 to transfer responsibility for prison health care from prison authorities to the minister of health, the minister responsible for health services to the general population in Nova Scotia. This is a strong indication of that province’s commitment to equivalent health care for prisoners.

HIV and HCV prevention and harm reduction programming has become central to the mandate of health care in the prison environment in Canada. HIV and HCV prevention and harm reduction-related policies are principally developed by staff responsible for health care, and programs are principally coordinated if not directly delivered by health care staff. At the intergovernmental level, the FPT group concerned with corrections has established a working group on health, which is primarily concerned with responding to infectious diseases, including HIV and HCV.

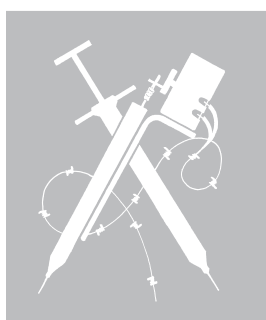
⁴² UNODC Framework, p. 8.

⁴³ Under the sentencing provisions of the Criminal Code, people who receive a sentence of incarceration of at least two years are incarcerated in a federal institution; those who receive sentences of less than two years are incarcerated in a provincial institution.

⁴⁴ *Corrections and Conditional Release Act* (CCRA), SC 1992, c 20; SOR/92-620.

⁴⁵ CCRA, s. 85 defines “health care” as “medical care, dental care and mental health care, provided by registered health care professionals.” Under s. 86(1), CSC “shall provide every inmate with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community.” Moreover, under 86(2), the provision of health care “shall conform to professional accepted standards.”

In Canada, it has been argued that both the Charter and the CCRA guarantee prisoners a standard of health services equivalent to that in the general community, which includes access to adequate HIV prevention programs.⁴⁶ Section 7 of the Charter protects against deprivation of the right to life, liberty, and security of the person; section 12 protects against cruel and unusual punishment; and section 15 guarantees the right to equality before and under the law and the right to equal protection and benefit of the law without discrimination. There is a strong argument that the constitutional rationale for applying Charter protections in the case of prisoners' access to sterile needles for injecting would apply equally in the case of other HIV and HCV prevention and harm reduction programs available in the community. Lines has recently argued that under international law, prisoners' right to health requires equivalence of *outcomes*, which may imply that prison authorities are obliged to provide more and better programs than what is available in the community.⁴⁷ Further, a number of domestic courts in other countries have determined that states owe greater obligations to prisoners than to the population at large because prisoners do not have control over their circumstances or access to prevention, care and treatment services that would be available to them if they were in the community.⁴⁸



“Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use, especially the risk of HIV infection.”

In the sections that follow, we examine specific HIV and HCV prevention and harm reduction needs of prisoners. In addition to the international perspectives, the “Guidance, recommendations and international perspectives” section is informed by analyses of the HIV and HCV prevention and harm reduction needs of Canadian prisoners. In particular, we make frequent reference to the recommendations of the CSC Expert Committee on AIDS and Prisons (ECAP)⁴⁹ and, to a lesser extent, reports by the Legal Network and PASAN.

HIV and HCV prevention and harm reduction

In this report, we have adopted the well-accepted description of harm reduction developed by the International Harm Reduction Development Program of the Open Society Institute:

Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use, especially the risk of HIV infection. It seeks to lessen the problems associated with drug use through methodologies that safeguard the dignity, humanity and human rights of people who use drugs.

⁴⁶ See for example, R Elliott, “Prisoners’ constitutional right to sterile needles and bleach,” Appendix 2 in R. Jürgens, *HIV/AIDS in Prisons: Final Report*. Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996.

⁴⁷ R. Lines, “From equivalence of standards to equivalence of objectives: the entitlement of prisoners to health standards higher than those outside prisons” *International Journal of Prisoner Health* 2(1) (2006): 269–280. Lines argues that given the extreme health problems evident in prisons worldwide, the legal obligations of the state to safeguard the lives and well-being of people it holds in custody and the implications of poor prison health on overall public health, standards of prison health care only equivalent to that in the community would in some cases fall short of human rights obligations and public health needs. He argues that it is time to move beyond the concept of equivalent standards of health care, and instead promote standards that achieve equivalent objectives. In some circumstances, meeting this new standard will require that the scope and accessibility of prison health services be higher than those outside of prisons.

⁴⁸ See, e.g., cases cited in R. Lines, “From equivalence of standards to equivalence of objectives: the entitlement of prisoners to health standards higher than those outside prisons” *International Journal of Prisoner Health* 2(1) (2006): 269–280, specifically pp.274–275.

⁴⁹ ECAP, *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*, February 1994.

This approach is based on the pragmatic acknowledgement that, despite years of trying, there are no known effective interventions for eliminating drug use or drug-related problems in any community, city, or country. In most cultures, adopting a harm reduction approach requires a shift in thinking away from deeply rooted, and understandable, long-term idealistic goals of eliminating drug use and getting all drug users to become drug free.

Harm reduction does not deny the value of helping people become drug free, or the desirability of abstinence as an eventual goal. It simply recognizes that for many drug users these are distant goals and that services to reduce the risk in the interim are therefore essential if personal and public health disasters are to be avoided. Recognizing the reality of drug use, harm reduction programs measure success in terms of individual and community quality of life and health and not in relation to levels of drug use.

Harm reduction entails a prioritization of goals. Given the high individual and social costs associated with AIDS, measures to prevent the spread of HIV are at the forefront of harm reduction priorities.⁵⁰

Measures to prevent the spread of HCV are also a high priority for the perspective of prisoners, given the high rates of HCV infection among prisoners in Canada, the fact that some prisoners engage in risk behaviours, and the individual and public health risks of HIV and HCV co-infection. (For purposes of this report, we also expand on the definition of harm reduction laid out above, which focuses specifically on harms associated with drug use, to also include measures aimed at preventing harms associated with unsafe sex, including not only HIV but also other sexually transmitted infections for which preventive measures can be taken if available.)

Among Canadian jurisdictions, a handful of prison policies make reference to “harm reduction.” However, only the CSC policy explicitly defines the term. Commissioner’s Directive 821 states:

Harm reduction is a policy, a program or a measure aimed at reducing the negative health, social and economic consequences of harmful behaviours such as injection drug use and unsafe sex. Harm reduction items such as condoms and bleach reduce the risk of transmission of disease and the harms consequent to infection.⁵¹

⁵⁰ Open Society Institute, *What is Harm Reduction?*, January 1, 2001. Available via: www.soros.org/initiatives/health/focus/ihrd. See, also, N. Hunt, *A Review of the Evidence-Base for Harm Reduction Approaches to Drug Use*, 2003.

⁵¹ CSC, Commissioner’s Directive, 821 *Management of Infectious Disease* (November 4, 2004).

Importance of comprehensive approaches to HIV and HCV prevention and harm reduction in prisons

Guidance, recommendations and international perspectives

Comprehensive approaches to harm reduction, health promotion, and disease prevention in prison are those that offer a range of programs to meet prisoners' needs, and that are developed and delivered in collaboration with prisoners, community health providers and non-governmental and community-based organizations. In our view, it is also evident that truly comprehensive approaches must be in keeping with human rights norms, as set out above. Thus, a comprehensive approach to harm reduction, health promotion, and disease prevention for prisoners must be equivalent with, and to the greatest extent possible integrated into, community policies, structures and programs.

The Body of Principles, Basic Principles and SMR emphasize that prisoners are members of the community and that efforts should be made to maintain and foster community contacts. The rationale behind this idea is that prisoner-community contact fosters rehabilitation and reintegration. According to the SMR, "community agencies should be enlisted wherever possible to assist the staff of the institution" and "steps should be taken to safeguard, to the maximum extent compatible with the law and the sentence, the rights relating to civil interests, social security rights and other social benefits of prisoners" [SMR 61; 80]. The contribution of the participation and help of social institutions to prisoner reintegration into society is recognized in article 10 of the Basic Principles. COE Recommendation R 98(7) contains numerous provisions urging cooperation and coordination with community and non-prison agencies. The WHO Guidelines recommend that cooperation with non-governmental and private organizations, such as those with expertise in HIV/AIDS prevention, counselling and social support, be encouraged [WHO Guidelines 53].

The UNODC Framework recognizes as one of its 11 general principles "equivalence in prison health care."⁵² Action 41 calls on prison systems to "ensure that all necessary care is provided to prisoners free of charge and without discrimination at a level equivalent to that in the community ... includ[ing] HIV prevention measures, voluntary HIV testing with pre-and post- test counselling (VCT), drug treatment services." Another UNODC Framework principle is "collaborative, inclusive, and intersectoral cooperation and action."⁵³ Prison authorities are called on to cooperate and collaborate with local, national and international stakeholders in implementing effective measures and strategies to address HIV/AIDS.⁵⁴ Action 11 calls on prison systems to implement policies that "integrate prison health service provisions into public health structures, and enhance collaboration between public health, social services, and drug services and prison health systems and staff." The UNODC Framework recommends that prison systems integrate prisoner health into wider community health structures, and assign responsibility for health care to the same ministries, departments and agencies that provide health care to people in the community [Action 44; p. 22]. At the very least, governments should actively promote collaboration and cooperation among prison health services and community health services responsible for health promotion and infectious disease prevention [Action 44; p. 22]. The UNODC Framework's collaborative approach also includes recognizing and providing opportunities for the meaningful participation of civil society organizations, staff, prisoners and former prisoners in the development and implementation of legislation, policy and programs.⁵⁵ Finally, as a general principle, the UNODC framework states that it is essential that programmes and services be responsive to the unique needs of vulnerable or minority populations within the prison system — including incarcerated women; children and young people; migrants; ethnic minorities; indigenous populations; men who have sex with men; lesbian, gay, bisexual, and transsexual and

⁵² UNODC Framework, p. 10.

⁵³ UNODC Framework, p. 13.

⁵⁴ UNODC Framework, pp. ix–x.

⁵⁵ UNODC Framework, p. 13.

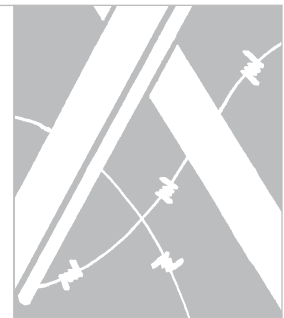
transgender prisoners; sex workers; and injecting and other drug users — who should therefore be given particular priority and focus when developing HIV/AIDS services.⁵⁶

In Canada, health care for prisoners is provided principally by the same ministry or department responsible for prison administration, not by the ministry or department responsible for providing health care to the general population. Yet the physical plant and policy infrastructure of prisons and their health services are generally not designed and are often poorly equipped to deal with prisoners infected with chronic, potentially fatal diseases such as HIV/AIDS, hepatitis and tuberculosis. Prisons may not have adequate staffing levels, staff training or equipment even to meet the health needs of prisoners suffering from these diseases, let alone to provide the comprehensive range of public health promotion and prevention activities that are central to reducing the spread of infectious diseases.

In 1994, ECAP recommended that CSC study the feasibility of prison health care services being provided by outside agencies [Recommendation 10, p. 104]. Comprehensive approaches to health promotion and infectious disease prevention have also been recommended in Canada by the Legal Network as a sound public health response to HIV/AIDS given the inter-relatedness of prison health and public health.

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, tuberculosis, and drug use has an impact on the health of all Canadians, Health Canada and provincial health ministries need to ... take a more active role and work in closer collaboration with the federal and provincial correctional systems to ensure that the health of all Canadians, including prisoners, is protected and promoted.⁵⁷

[T]he UNODC framework states that it is essential that programmes and services be responsive to the unique needs of vulnerable or minority populations within the prison system . . . who should therefore be given particular priority and focus when developing HIV/AIDS services.



CSC has studied the issue of greater collaboration between prison health services and community public health and developed a plan for enhanced collaboration.⁵⁸ The resulting concept paper, *Enhancing Collaboration Between Correctional Service of Canada and Public Health*, is “not so much a prescription for what needs to be done, as it is a reflection of initiatives and mechanisms already in place that need to be expanded, formalized and nurtured” — given that much of the collaboration between CSC and public health “has been ad hoc, sparked by particular events and/or by particular individuals with a commitment to collaboration and a belief in its potential to enhance the work of both parties.”⁵⁹ The question of whether provincial public health staff have the jurisdiction (i.e., legal authority) to work with CSC prisons and prisoners was identified as a barrier to collaboration by CSC and public health staff. However, those who attended the round table meeting concluded that both CSC and public health have legal jurisdiction within CSC facilities and, “[i]n addition,

⁵⁶ UNODC Framework, p. 13.

⁵⁷ R. Jürgens, *HIV/AIDS in Prisons: Final Report*. Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996, recommendation 1.8, at p. 100.

⁵⁸ M.A. Mulvihill, *Enhancing Collaboration Between Correctional Service of Canada and Public Health: A Concept Paper*, July 2000; M.A. Mulvihill, *An Action Plan to Enhance Collaboration Between Correctional Service of Canada and Public Health*, April 5, 2000.

⁵⁹ M.A. Mulvihill, *Enhancing Collaboration Between Correctional Service of Canada and Public Health*, p. 1.

they both have a moral and professional obligation to respond to infectious diseases within CSC prisons, and this requires collaboration and partnership.”⁶⁰

Enhancing Collaboration Between Correctional Service of Canada and Public Health reported the key components of collaboration as identified by participants at a CSC public health round table meeting in March of 2000 as follows:

- clear goal(s) and purpose for the collaboration
- effective and ongoing communication
- clear mandate, roles and responsibilities
- mutual respect and valuing of diversity
- clients and staff are involved
- planned and pro-active with a built-in evaluation process
- enhances sharing of resources (i.e. money, people, education, expertise, and knowledge).⁶¹

The concept paper recognizes that over time collaboration will be sustainable and effective only if formal structures, processes and mechanisms are “in place to ensure collaboration occurs in a consistent and systematic way.”⁶²

Enabling legislation and agreements

The following legislation and agreements support comprehensive approaches to HIV and HCV prevention and harm reduction in prison.

- In Nova Scotia, according to section 25 of the *Correctional Services Act*, S.N.S., 2005, c 37, the Minister of Health is responsible for the provision, administration and operation of health services for offenders in custody. This legislative authority is unique in Canada. Section 26 provides that the Minister may, in the case of adults in custody, delegate the delivery of health services to a district health authority or, in the case of youth in custody delegate the IWK Health Centre (IWK). Accordingly, medical care for prisoners in Nova Scotia is provided by the Capital District Health Authority (CDHA) and IWK for adults and youth, respectively.
- The federal *Corrections and Conditional Release Act* (CCRA) is unique among Canadian prison laws in that it explicitly recognizes that “prisoners retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of sentence” and that policies and programs must respect and respond to the needs of different prisoner populations [section 4]. It is also unique in that it accepts the principle of equivalence of services. It obliges CSC to provide prisoners with essential health care and reasonable access to non-essential health care that conforms to professionally accepted standards [section 86].
- Under a Memorandum of Agreement between Health Authority #9 Sexual Health Program of the Province of Saskatchewan and the Department of the Solicitor General of Canada, as

⁶⁰ M.A. Mulvihill, *Enhancing Collaboration Between Correctional Service of Canada and Public Health*, p. 3.

⁶¹ M.A. Mulvihill, *Enhancing Collaboration Between Correctional Service of Canada and Public Health*, p. 2.

⁶² M.A. Mulvihill, *Enhancing Collaboration Between Correctional Service of Canada and Public Health*, p. 6.

represented by the Correctional Service of Canada (October 31, 2002), a project nurse from the Health Authority provides anonymous HIV testing and counselling to prisoners and carries out contact tracing (see section 2.1, 2.2), the costs of which are paid by CSC.

- In New Brunswick, as part of a Memorandum of Understanding between the Minister of Health and Wellness (Public Health Management Service) and the federal Department of Public Safety and Emergency Preparedness Canada, a public health nurse provides anonymous, non-nominal or nominal HIV antibody testing and counselling, as well as contact tracing. A new memorandum, which would expand this to include other sexually transmitted infections, and hepatitis B and C, was being negotiated at the time of writing.⁶³

Survey of policy and programs at a glance

The tables on the following pages can be used not only to get a sense of which policies and programs exist, but also the basis for the policies and programs. The tables have been extensively referenced so that readers can find out the relevant policy documents or, in the case of programs, the resources relied upon when the program is operationalized (e.g., manuals, workbooks, videos).

⁶³ E-mail from Alan Sierolawski, National Infectious Diseases Program Coordinator, Correctional Service Canada (June 25, 2007).

Table 1: Survey of policy related to HIV and HCV

The table below was compiled from the information received as a result of “access-to-information” requests. How recent the information is differs for each jurisdiction, depending on the date when the response to the access-to-information request was provided. *Generally, the information is current to the first half of 2006.* The reference notes for the table are in Appendix C.

	CSC	AB	BC ^a	MN	NB	NL	NT	NS ^b	NU	ON	PE ^c	QC	SK	YK
HIV testing — adult	✓ ^d	✓ ^e	✓ ^f	✓ ^g	✓ ^h	✓ ⁱ	✓ ^j		✓ ^k				✓ ^l	✓ ^m
HIV testing — youth							✓ ⁿ						✓ ^o	
Condoms, dental dams, lubricant — adult	✓ ^p	✓ ^q	✓ ^r	✓ ^s		✓ ^t	✓ ^u			✓ ^v				
Condoms, dental dams, lubricant — youth				✓ ^w			✓ ^x						✓ ^y	
Bleach — adult	✓ ^z		✓ ^{aa}											
Bleach — youth														
MMT — adult continuation	✓ ^{ab}	✓ ^{ac}	✓ ^{ad}	✓ ^{ae}	✓ ^{af}					✓ ^{ag}		✓ ^{ah}	✓ ^{ai}	
MMT — adult initiation	✓ ^{aj}		✓ ^{ak}							✓ ^{al}			✓ ^{am}	
MMT — youth continuation													✓ ^{an}	
MMT — youth initiation														
Illicit Drug testing — adult	✓ ^{ao}	✓ ^{ap}	✓ ^{aq}	✓ ^{ar}	✓ ^{as}		✓ ^{at}							
Illicit Drug testing — youth				✓ ^{au}	✓ ^{av}		✓ ^{aw}							
Education & Information HIV/HCV — adult	✓ ^{ax}	✓ ^{ay}	✓ ^{az}	✓ ^{ba}	✓ ^{bb}	✓ ^{bc}	✓ ^{bd}		✓ ^{be}				✓ ^{bf}	
Education & Information HIV/HCV — youth		✓ ^{bg}		✓ ^{bh}			✓ ^{bi}			✓ ^{bj}			✓ ^{bk}	
Education & Information HIV/HCV — staff	✓ ^{bl}	✓ ^{bm}	✓ ^{bn}	✓ ^{bo}	✓ ^{bp}	✓ ^{bq}	✓ ^{br}		✓ ^{bs}	✓ ^{bt}			✓ ^{bu}	
Education & Information HIV/HCV — HC staff		✓ ^{bv}					✓ ^{bw}		✓ ^{bx}	✓				
Special programs — women	✓ ^{by}													
Special programs — Aboriginal	✓ ^{bz}													

Except in unusual cases, youth (persons under the age of 18) who receive a custodial sentence do not serve those sentences in federal penitentiaries; most young offenders given custodial sentences serve these sentences in a separate “youth custody facility”, as contemplated under the federal *Youth Criminal Justice Act*, S.C. 2002, c. 1

Table 2: Survey of selected programs related to HIV and HCV

The table below was compiled from the information received as a result of access-to-information requests and feedback on the draft report provided by prison officials. How recent the information is differs for each jurisdiction, depending on the date when the response to the access to information request or the feedback to the draft report was provided. *Generally, the information is current to the first half of 2006.* The reference notes for the table are in Appendix D.

	CSC	AB	BC	MN	NB	NL	NT	NS	NU	ON	PE ^a	QC	SK	YK
HIV testing — adult								✓ ^b		✓ ^c	✓			
HIV testing — youth			✓ ^d			✓ ^e		✓ ^f			✓			
Condoms, dental dams, lubricant — adult								✓ ^g				✓ ^h		
Condoms, dental dams, lubricant — youth			✓ ⁱ			✓ ^j		✓ ^k						
Bleach — adult						✓ ^l								
Bleach — youth														
MMT — adult continuation						✓ ^m					✓			
MMT — adult initiation											✓			
MMT — youth continuation			✓ ⁿ							✓ ^o				
MMT — youth initiation													✓ ^p	
Illicit Drug testing — adult						✓ ^q					✓			
Illicit Drug testing — youth								✓ ^r			✓ ^s			
Education & Information HIV/HCV — adult	✓ ^t	✓ ^u	✓ ^v		?		✓ ^x	✓ ^y				✓ ^z	✓ ^{aa}	✓ ^{ab}
Education & Information HIV/HCV — youth			✓ ^{ac}			✓ ^{ad}		✓ ^{ae}			✓			
Education & Information HIV/HCV — staff	✓ ^{af}				✓ ^{ag}		✓ ^{ah}			✓ ^{ai}	✓	✓ ^{aj}		
Education & Information HIV/HCV — HC staff	✓ ^{ak}				✓ ^{al}		✓ ^{am}				✓			✓ ^{an}
Special programs — women	✓ ^{ao}						✓ ^{ap}							
Special programs — Aboriginal	✓ ^{aq}						✓ ^{ar}						✓ ^{as}	✓ ^{at}

Except in unusual cases, youth (persons under the age of 18) who receive a custodial sentence do not serve those sentences in federal penitentiaries; most young offenders given custodial sentences serve these sentences in a separate “youth custody facility”, as contemplated under the federal *Youth Criminal Justice Act*, S.C. 2002, c. 1

HIV, infectious disease and sexual health counselling and testing

Guidance, recommendations and international perspectives

The WHO Guidelines on HIV and prisons recommend that voluntary HIV testing be available to prisoners where it is available in the community, undertaken only after informed consent, and accompanied by pre- and post-test counselling. As well, the guidelines recommend that health care staff ensure prisoner confidentiality [WHO Guidelines 11, 12]. ECAP recommended in relation to Canadian federal prisons that testing be available to all prisoners upon request, and always be accompanied by pre- and post-test education and counselling. ECAP also recommended that prison authorities make prisoners aware of the availability of HIV antibody testing on entry to prison and throughout their incarceration. Finally, ECAP recommended that prisoners have access to testing services provided by prison and community clinic health personnel, including anonymous HIV testing [recommendation 2, pp. 27, 28].

HIV testing in the prison setting raises the issue of confidentiality in relation to medical information, and specifically HIV status. The consequences of unauthorized disclosure in the prison setting can be extreme, including verbal abuse, stigma, discrimination in medical and other decision-making and treatment, threats of and actual physical violence and, in some cases, even death. Prison staff members who breach the duty of confidentiality owed to prisoners are in breach of prisoners' right to privacy. The WHO Guidelines state that "information on the health status and medical treatment of prisoners is confidential" and can only be disclosed by medical staff with the prisoner's consent or where "warranted to ensure the safety and well-being of prisoners and staff, applying to the disclosure the same principles as generally applied in the community" [WHO Guidelines 31, 32]. In the Canadian context, ECAP highlighted the need for protection of confidential medical information of prisoners, given the very real potential for discrimination against known HIV-positive prisoners [recommendation 3, pp. 36, 37].

The UNODC Framework sets out a number of recommendations regarding HIV testing. The underlying principle is equivalence: access to voluntary, confidential HIV testing with pre- and post- test counselling sufficient to meet standards of informed consent should be made available to prisoners where it is available in the community. This includes access to anonymous HIV testing where it is available outside of prison. The Framework calls upon prison systems to ensure the confidentiality of prisoners' test results [Actions 62–66; p. 25].

Observations

Outside health care services are an important component to prisoner health and can complement existing services. CSC has implemented this practice at Saskatchewan Penitentiary, Riverbend Institution and Westmorland Institution. Provincial corrections in Manitoba and Quebec also have outside agencies providing testing services to prisoners. These services have proven to be effective and complement existing prison health services. They allow prisoners to have a choice of services from different sources. They have an additional benefit: Often, upon their release, prisoners will visit the community health clinic providing these services. More programs like this should be offered across Canada.

Enabling policy

The following policies support HIV and HCV prevention and harm reduction in prison:

- New Brunswick, Public Safety Corrections, Adult Institutional Policy, *G-42 Universal Precautions — Blood-borne Pathogens* (March 2001) provides for voluntary HIV antibody testing with pre- and post-test counselling. Prisoners may approach health services to request testing if they are already aware of the service. Or, in the context of a health assessment, prison health care staff advise prisoners with a history of high-risk behaviour

that testing is available. As part of a memorandum of understanding (MOU) between the Minister of Health and Wellness (Public Health Management Service) and the Minister of Public Safety (June 30, 2003), a public health nurse provides anonymous, non-nominal or nominal HIV antibody testing and counselling, as well as contact tracing. At the time of writing, a new MOU which includes other sexually transmitted infections, as well as hepatitis B and C, was under negotiation.⁶⁴

- Northwest Territories, North Slave Correctional Facility – Standing Orders, *12.08, Infectious and Communicable Diseases* (November 6, 2001) ss. 3.2, 3.3, 3.6, together provide for voluntary HIV testing and pre- and post-test counselling. See similarly Northwest Territories, South Mackenzie Correctional Centre – Standing Orders, *1209, AIDS* (September 5, 1998) s. 4; Northwest Territories, Territorial Women’s Correctional Centre – Standing Orders, *12.08 AIDS* (February 8, 2006), s. 3; Northwest Territories, Corrections Service – Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) s. 4.9.

Best and promising programs

Sexual Health Clinic provides counselling and testing to federal prisoners

Contacts:

Tony de Padua
Prince Albert. Sexual Health Clinic
2nd Floor, McIntosh Mall
800 Central Avenue.
Prince Albert, SK S6V 7V6
Telephone: +1 306 765-6540
Fax: +1 306 765-6544
adepadua@firstnationsuniversity.ca
www.saskatoonhealthregion.ca

Chief of Health Services
Saskatchewan Penitentiary
15th Street West
P.O. Box 160
Prince Albert, SK S6V 5R6
Telephone: +1 306 765-8000
Fax: +1 306 765-8073

Chief of Health Services
Riverbend Institution
15th Street West
P.O. Box 850
Prince Albert, SK S6V 5S4
Telephone: +1 306 765-8200
Fax: +1 306 765-8220

⁶⁴ E-mail from Alan Sierolawski, National Infectious Diseases Program Coordinator, Correctional Service Canada (June 25, 2007).

Overview

In 1998, the Sexual Health Clinic in Prince Albert, Saskatchewan, in partnership with Correctional Services of Canada (CSC), began a pilot site for anonymous HIV/AIDS testing for prisoners at Saskatchewan Penitentiary and Riverbend Institution. CSC was following the advice of ECAP which recommended that anonymous HIV testing be made available to federal prisoners.

The sexual health nurse from the community (Tony de Padua) has an office located in the health care area of the Saskatchewan Penitentiary and of Riverbend Institution. The nurse offers anonymous HIV antibody testing, testing for hepatitis A, B, C, syphilis, gonorrhoea and chlamydia. He emphasizes the importance of building relationships in order to promote better prisoner health. Therefore, he will see prisoners about any health concerns prisoners may have. This allows the prisoner to get to know the nurse before they come to talk to him about highly personal issues such as HIV, hepatitis or other sexually transmitted infections (STIs). The results of HIV testing are anonymous; they are not reported to health care staff and are kept confidential between the public health nurse and the prisoner.

The nurse speaks to CSC health care staff regarding a client's case only with permission of the client. Guards do not escort prisoners to their appointments, and there is no staff present in the room while the nurse is with a client. According to CSC, the only exception to this rule exists when the nurse is taking blood; a guard must be present for security reasons. The nurse explains this to the client before blood is drawn and tells the prisoner that he does not have to talk while the guard is in the room. This helps build trust with the prisoner.

Appointments to see the nurse are facilitated in two ways: (a) prisoners put in a request form to see a public health nurse (they do not need to cite a reason for the request on the form); and (b) when health care staff receives requests related to HIV or sexual health, CSC health care staff will often forward these requests to the sexual health nurse.

A relationship of trust has developed between CSC health care staff and the nurse, which allows for greater scope for project activities. CSC health care staff trusts the nurse's judgement; therefore, if a prisoner does not want to wait for the prison health care services and wants liver function tests, for example, the community nurse is allowed to draw blood for testing. The nurse tries to act as a bridge between prisoners and prison health care staff.

After tests for HIV, HCV and STIs are completed, the community nurse follows up with prisoners regardless of test results. Because HIV tests are conducted anonymously, prisoners who test positive for HIV do not have this information entered into a patient file. All other STI tests are nominal; under public health law, positive results are required to be reported. If a prisoner tests positive for a STI, the nurse will meet with him or her regarding past partners and fill out public health forms. He brings partner contact information back to the Sexual Health Clinic and transmits it to the regional public health authorities responsible for contacting the partner. Results from all blood tests for HIV, STIs and HCV are stored at the Sexual Health Clinic.

To advertise the sexual health program in the prison, the community nurse distributed signs, posters and pamphlets. He may attend cultural events to talk informally about

the program and often visits the cultural centre to discuss the program. He tries to do outreach with elders, peer educators, the Lifers' Group and the Inmate Committee. In the beginning, he did a lot of education after hours and through the prison's education program so that prisoners knew about his program and what he was doing at the prison. He also took the time to create a video that could be played on the prison's Teldon (prison television program), explaining what he was doing.

The nurse estimates that there has been an increase in the number of high-risk prisoners testing for HIV as a result of the program. He believes that the program has been successful in reaching prisoners who would be reluctant to seek HIV testing from CSC health services.

Lessons learned

Prisoners are more likely to use services when they believe that their reasons for seeking services will be kept in confidence. The community nurse advocated with CSC health care staff and CSC health services at NHQ to ensure that this program was expanded to do more than anonymous testing. (When the program was initiated, CSC wanted the public health nurse to provide only anonymous HIV testing. The nurse recognized this would not work because everyone would know why prisoners were coming to see him.)

It is important to promote programs directly with prisoners. The nurse attended meetings of pre-existing, recognized prisoner groups (e.g., Native Brotherhood, Lifers' Groups, and Inmate Committee) to inform prisoners about the services he was offering. Involving prisoner-run groups was essential to the success of the program.

Human resources need to be flexibly managed. When the program started, the nurse was in the prison twice a week trying to see clients as well as to promote the program. However, since the program has stabilized he only needs to be at the prison once a week. The nurse has found that he needs to be flexible with his time depending on what is happening at the prison. If there are many HIV-positive prisoners in the prison, he may need to go into the prison two days a week.

Education of health care and other prison staff was essential to the success of the program. It was clear that education needed to be done with staff regarding the program to ensure the sexual health nurse would be supported. In 1998, when the program started, the head of prison health care services (Marlene Beal), was supportive of the new position and talked with prison staff about Tony's role as sexual health nurse. Initially there was a lack of support from guards; now Tony has guards asking questions regarding transmission of HIV, HCV and testing.

There need to be clear boundaries and guidelines about the sharing of information. Prison health care staff and prisoners need to have a clear understanding of what information the sexual health nurse will share with prison health care staff. The nurse developed guidelines for information sharing, and communicated these guidelines to prison health care staff and prisoners.

Confidentiality is essential to the program. Everything discussed between the public health nurse and the prisoner is kept confidential. The only exceptions are if the prisoner intends to hurt him or herself or someone else. This is explained to the prisoner during his first visit.

Secured funding is essential for the consistency of a program. Lack of consistency can lower prisoners' confidence in services. Initially, funding gaps were a significant problem; fortunately, stable funding has since been secured. Funding needs to be secured as it takes a couple of years for programs to be integrated into the life of the prison.

Limitations

Not all prisoners may be aware that anonymous HIV testing is available. Since the community nurse is in the prison only once a week, he finds it difficult to reach prisoners on a regular basis to let them know that he is available to do anonymous HIV testing, and to explain the important differences between anonymous and nominal testing.

Prisoners engaging in high-risk behaviours may not seek services from prison healthcare for fear of repercussions; the community nurse may be able to address these fears to some degree, but they are likely to be difficult to dispel completely. The community nurse finds that most prisoners who are using illicit drugs do not regularly seek access to prison health care services. This means that many prisoners engaged in high-risk behaviours for HIV and HCV transmission may not be getting tested or receiving other health care services. Even though the nurse tries to set up appointments every three to six months to meet with prisoners who are injecting drugs, he acknowledges that he is not able to make contact with everyone who is doing so.

There are three logistical limitations to the program. First, the processes for prisoners to come to the community nurse's office don't always work smoothly. Passes (appointment cards) are not always given to prisoners (this means they do not know they have an appointment). This is a CSC administrative issue; it is difficult for the nurse, as an outside person, to address it. Second, Saskatchewan Penitentiary is a multi-security level prison. For visits with maximum-security prisoners, the nurse has to make his initial contact with prisoners from the hallway outside of the prisoner's cell. This lack of confidentiality is a major limitation for providing outreach and services to maximum security prisoners. Third, the nurse's office is located within the prison health care area, which may discourage prisoners who do not want health care staff to know that they are seeing the sexual health nurse. Ideally, more should be done to promote the privacy of prisoners who seek the services offered by the sexual health nurse, so that the program can fulfill its potential to reach the greatest number of prisoners and those prisoners at greatest risk.

Prison health care staff have a great deal of authority with regards to which outside agencies are granted access. Personalities play a large role in the success or failure of a project. It is important to note that prison health officials acknowledge that if the prison nurses felt that they could not work with the community health nurse, his work at Saskatchewan Penitentiary may not have been as successful.

Funding

Correctional Services of Canada

Supporting documents

N/A

Evaluation

N/A

Provincial corrections partners with local public health

Contact:

Marilyn Sloane
Director of Health Services
Manitoba Corrections
329 Duke Ave
Portage la Prairie, MB R1N 0S4
Telephone: +1 204 239-3505
Fax: +1 204 239-3397
Marilyn.Sloane@gov.mb.ca

Overview

Currently, five of the nine provincial prisons in Manitoba have provincial public health nurses going into prisons to work. The public health nurses are responsible for providing a “needs assessment” of the facility through discussion with correctional staff and prisoners concerning sexual health. They also provide one-to-one or group education and counselling for prison staff and prisoners on a variety of sexual and reproductive health topics: STIs, HIV/AIDS, hepatitis A, B and C, birth control, parenting, reproductive health and related cancers. At Headingly Prison, the public health nurse provides education in the prisoner living units. During these sessions, the public health nurse and the unit manager will organize time to play health promotion games with the prisoners (trivia games, envelope games and HIV bingo). These games provide information about healthy sexuality, STIs, HIV, drug use and tattooing.

Public health nurses offer prisoners individual appointments for HIV, hepatitis A, B and C, gonorrhoea, chlamydia and syphilis testing, and offer hepatitis A and B immunization in conjunction with prison health care staff. They conduct STI contact tracing in the community, as required. A public health nurse may see a prisoner based on a referral from a prison nurse or correctional staff or by self-referral. Sometimes a prison guard will refer a prisoner caught tattooing. In the latter circumstance, there is no expectation on the part of the public health nurse that he or she needs to report back to a prison guard. All information that is given by the prisoner is considered confidential. Public health nurses also participate in release planning and provide condoms, pamphlets, community resources and referrals.

Lessons learned

When the pilot project began, the public health nurses were assigned to and located within one prison. After the first evaluation, it was decided that it would be better to use visiting nurses wearing “institutional” security tags, so that the nurses were distinguished from prison health care service providers. The visiting role allowed the nurses to offer more flexibility with respect to the timing of their visits.

Strong leadership and planning was essential to the program’s success. The original evaluation noted that each prison would need to have a very strong health manager in place to guide and make decisions about the program.

Education and participation of prison staff are essential to the success of the program. Manitoba Corrections and public health have found that the more education the prison staff have about infectious diseases, STIs and harm reduction, the more supportive

they are of new programs. Public health nurses provide staff with ongoing education sessions on blood-borne pathogens (BBPs), universal precautions and post-exposure procedures. As a result, prison staff are more at ease with the issues and better able to put in place the proper practices and procedures to reduce the risk associated with BBPs. The staff have a better understanding of the role of public health within the prison and this allows for mutual respect and understanding.

Prison health care staff need to be well informed of the scope of the public health program in order not to feel their roles and job security are threatened. Health care nurses inside the prisons were concerned that public health nurses would take over their jobs. When this issue came to light, greater attention was paid to fostering a shared understanding of roles and responsibilities among the visiting public health nurses and prison health care staff.

Building relationships with prisoners helps create a continuity of care when prisoners are released. Often prisoners, once released into the community will visit the public health nurses they became familiar with while imprisoned. This is especially true in smaller communities.

Limitations

Roles and responsibilities must be clearly defined. Initially, there was some misunderstanding among prison nurses about the scope of services they believed the public health nurse should be offering prisoners. This resulted in some strain between public health nurses and prison health-care staff. Therefore, greater attention was paid to fostering a shared understanding of roles and responsibilities among the visiting public health nurses and prison health-care staff.

Limitation on time and resources can affect prisoners' access to services. The programs need increased funding, space for offices within the prisons, additional medical and office equipment, and increased human resources. Some of the prisons could use a full-time, dedicated public health nurse. Prisoners are not able to get all the services that they are requesting because of this lack of resources.

Lack of space to provide services can limit the number of prisoners served. There may be no holding area in the health care unit for prisoners, so that only one prisoner can physically be in the unit at any one time. When that person leaves, the public health nurse has to wait until the next prisoner comes down to health care, affecting the number of prisoners a public health nurse can see each time he or she is at the prison.

Funding

Manitoba Health

Supporting documents

N/A

Evaluation

We were advised that an evaluation has been completed by Manitoba Public Health, but we were not provided with a copy.

Community health centre operates clinics inside provincial prisons

Contact:

Francine Prévost, Sexual Health Counsellor
CLSC Ahuntsic
1165 Henri-Bourassa Boulevard East
Montréal, QC H2C 3K2
Telephone: +1 514 920-3248
Fax: +1 514 389-1361
www.chez.com/clscahuntsic

Overview

The Ahuntsic local community health centre (known by the acronym “CLSC” in French) started visiting the Centre de Détention de Montréal (also known as Bordeaux Correctional Centre) in 1993, following a study by Dr. Catherine Hankins (now chief science advisor of UNAIDS) on the prevalence of HIV/AIDS in the Quebec prison system. The study indicated that there was a high prevalence of HIV in prisons, there was no follow-up for HIV testing, and no community referrals being made for prisoners. Since the Ahuntsic staff was already working in Tanguay (a female provincial prison) and they had the experience to run such a program, it made sense to have the Ahuntsic CLSC offer similar programming for the men in Bordeaux.

The Ahuntsic CLSC team in Bordeaux is comprised of two nurses, one social worker and one sexual health counsellor. The team at Bordeaux deal with health issues pertaining to drug use, HIV/AIDS and hepatitis C. They also provide hepatitis A and B vaccinations, and conduct education sessions with prisoners, during which they distribute condoms, bleach, gloves and alcohol swabs. The CLSC staff has an office separate from the health care unit where they meet with prisoners on an individual basis to do counselling and testing for HIV/AIDS, HCV and other STIs, and provide counselling and condoms to meet prisoners’ HIV and HCV prevention and harm reduction needs. They keep their own filing system and these files are not shared with prison health care staff. Prisoners can also follow up with the Ahuntsic CLSC once they are released from prison, which allows for greater continuity of care.

Lessons learned

Prisoners prefer having a choice in health care services. Having community health care service providers in prisons offers prisoners a choice in the care that they receive with regards to HIV, HCV, STIs and harm reduction. Prisoners are able to obtain services through prison health care or through CLSC, providing more possibilities for finding someone with whom they are comfortable to work.

The fact that all information provided to CLSC staff is kept confidential helps prisoners build trust with CLSC staff. Some prisoners may prefer obtaining services from a community health care professional, rather than prison health care staff.

Prisoners should have access to confidential testing. Prisoners have expressed satisfaction in the ability to have access to services that are private and confidential. They are particularly satisfied with access to anonymous HIV testing.

Limitations

A lack of funding leads to unmet needs among prisoners. With their current staffing levels, CLSC staff are unable to provide services to the large prison population in Bordeaux (approximately 1000 prisoners at one time; 15 500 admissions per year).

Some living units are completely inaccessible because of the extensive security measures in place. For example, in some living units, a prison guard will sit at the table with the sexual health expert while she gives information to a prisoner. This security-driven practice undermines the ability of prisoners to receive confidential services.

Often prisoners will ask CLSC staff for help in obtaining services from prison health care staff. This potentially puts CLSC staff in a position of advocating on behalf of prisoners within the prison and can make the working relationship between CLSC staff and prison health care staff difficult. CLSC has also at times found it difficult to get security staff to understand the importance of CLSC's work at Bordeaux.

Funding

Quebec Ministry of Health and Social Services

Supporting documents

N/A.

Evaluation

J. Beauchemin and J.-F. Labadie, *Évaluation de l'utilité et de l'accessibilité des services de counselling et de dépistage du VIH en milieu carcéral: Rapport final*, Montréal: Régie régionale de la santé et des services sociaux de Montréal-Centre et CLSC Ahuntsic, Août 1997. The evaluation was undertaken as a partnership between the local health centre, the regional public health authority, and the two prisons (Tanguay and Bordeaux). It was conducted from the perspective of the prisoners targeted by the program to determine the usefulness, appropriateness and adequacy of the counselling and testing services provided by the Ahuntsic local health centre. Quantitative and qualitative methods were used to gather information: questionnaires, individual interviews and focus groups among prisoners who had used the services and those who had not. The data revealed that the services were reaching prisoners at high risk of HIV infection, including those people who had a recent history of injection drug use, prostitution and sexual partners who injected drugs. The data permitted the identification of certain personal dynamics and other factors within the prison environment that affected the decision to test among prisoners who came forward for testing. Overall, the prisoners who used the service were very satisfied, and believed that their personal information remained confidential. The evaluation includes recommendations for maintaining and increasing access to the counselling and testing program, for increasing the scope of prevention, and for developing interventions to engage prisoners to reduce the harms associated with certain behaviours.

Community health centre educates prisoners about HIV and HCV prevention and harm reduction and provides supplies

Contact:

Thierry Pinet
CLSC de Sherbrooke
50 Camirand Street
Sherbrooke, QC J1H 4J5
Telephone: +1 819 565-5370 ext. 2330
Fax: +1 819 823-0415
tpinet.csss-iugs@ssss.gouv.qc.ca

Overview

In 1995, health care staff at Sherbrooke Correctional Centre invited the Sherbrooke local community health centre (CLSC in French) to do a presentation to prisoners on HIV/AIDS and offer HIV testing to prisoners. CLSC Sherbrooke has been working inside the prison since that time.

Currently, a worker from the CLSC (Thierry Pinet) visits Sherbrooke provincial jail two days a week. He is allowed in prisoners' cells to discuss health issues and distribute condoms, lubricant, bleach, steri-cups (i.e., small sterile cups which can be used to prepare drugs for injection or inks for tattooing), gloves, antibiotic cream and matches imprinted with the CLSC Sherbrooke logo and contact information. Every three weeks Thierry provides HIV, HCV and other STI testing, and offers hepatitis A and B vaccinations. There is no exchange of prisoners' health information or files between prison health care staff and CLSC, except where a prisoner wants this to happen and consents to it.

Lessons learned

Buy-in from staff contributes to the success of a program. CLSC Sherbrooke initially started with small projects in order to gain the confidence of prison staff at all levels. To ensure that prison staff also "buys in," the CLSC conducts HIV and HCV prevention and harm reduction education with staff, thus providing them with an opportunity to ask questions and get a sense of the content of the presentations offered to prisoners.

CLSC Sherbrooke staff are respectful of the rules and regulations of the prison and have learned that the best way to expand the services they offer to prisoners is by educating the prison administration about the HIV and HCV prevention and harm reduction needs of prisoners. An example of this is that when a CLSC nurse became aware of the extent of prisoner tattooing within the prison, he approached the head of prison health care with information about the risks associated with underground tattooing and strategies to help reduce the risks. As a result of his efforts, and with the approval of the prison administration, the nurse began to distribute steri-cups, gloves, alcohol swabs and antibiotic cream. In his experience, it is important to be pro-active and to approach the administration regarding the potential harms faced by prisoners and ways to reduce the risk.

Regular meetings with key players in the prison contribute to the success of the program. The CLSC nurse has learned that the program is more successful if everyone

at the prison is updated on what is happening with the project. Therefore, every second month, the nurse meets with the superintendent, head of security, and health care staff to update them and discuss any concerns or issues.

Limitations

The nurse raised one significant limitation: Despite some of the pro-active practices allowed within the prison, syringes are still not allowed to be distributed, and therefore sharing needles is still an issue.

Prisoners' ability to see the CLSC nurse is affected by the lack of an accessible, private and confidential space in which he can set up and provide services. Currently, the nurse has to share space with another community organization, which may compromise confidentiality. Also the location of the office makes it difficult for prisoners to get access to the space.

Funding

Quebec Minister of Health and Social Services

Supporting documents

N/A

Evaluation

J. Archambault, *Évaluation de l'efficacité d'un projet de prévention du VIH et des autres MTSS en milieu carcéral (projet S.A.P.)*, CLSC de la Région-Sherbrookoise, Mars 2001. The program evaluation focused on the underlying principles and characteristics of the program and the interactions between those involved in the program. A literature review was undertaken and semi-structured interviews were conducted with prisoners (18), prison staff (8), and support workers providing services to prisoners and ex-prisoners (5). A 173-page report was produced. Prisoner interviews revealed two themes among regular users of the program: the diversity of needs among prisoners and the ability of the program to respond to those diverse needs. The evaluation concluded that the program adhered to health prevention and promotion principles. Moreover, prisoners reported an intention to reduce risk behaviours, and an increase in their control over health-related behaviours. Of note, interviews with prison staff indicated that their support for the program played a significant role in the program's success.

Condoms, dental dams and lubricant

Guidance, recommendations and international perspectives

The WHO Guidelines recommend that condoms “be made available to prisoners throughout their period of detention” and “prior to any form of leave or release” [WHO Guidelines 20]. The UNODC Framework calls on prison systems to “[r]ecognize that consensual sexual activity occurs in prisons, and ensure that consensual sexual activity is not penalised as this will discourage prisoners accessing condoms” [Action 22; p. 19]. It also recommends that condoms be accessible to prisoners in a confidential and non-discriminatory fashion [Action 60; p. 24]. ECAP recommends that condoms, dental dams and water-based lubricant be made available to federal prisoners not only through the health services but also in other locations where prisoners meet. In addition, ECAP recommends that prisoners be given health kits containing condoms, dental dams and water-based lubricant on entry, for family visits and on release. Finally, as with the UNODC Framework, in order to discourage unsafe sexual activity, ECAP recommends that consensual sexual activity no longer be considered an offence under prison rules [recommendation 6.1.1, 6.1.2, pp. 58, 60].

Observations

Condom, dental dam and lubricant distribution was inconsistent in the federal and provincial prisons we visited. In some prisons, condom distribution was required by policy but condoms were not available in practice. In one prison where the policy stated that prisoners should be provided access to condoms without having to ask prison staff, condoms were kept in a staff member’s desk drawer. CSC’s *Management Control Framework* makes regional managers responsible for ensuring that, at regular intervals, CSC policies are being adhered to in within all institutions. Despite the *Framework*, condoms are still not being made available in some prisons according to the terms of the policy. Further efforts need to be made at the prison and regional levels to bridge the gap between policy and practice.

Most provincial prisons we visited had some form of condom distribution. However, many programs are not effective because prisoners must ask health care or other staff for condoms, dental dams and lubricant. All international guidelines and recommendations clearly outline that this is not an effective method of distribution. Some provincial prison guards are still concerned that condoms are a security risk (clogging septic systems, jamming locks). These concerns need to be addressed by prison administration through increased information and education for, and discussion with, prison guards. These problems have not materialized in prison systems that have implemented condom distribution.

Dental dam distribution in the prisons we visited is even less consistent than condom distribution. The dental dams that are distributed tend to be the kind used by dentists, which some prisoners said are too thick to allow enough sensation during sex and, in most cases, are not sterile (unless individually wrapped). Some of the federal prisons we visited made efforts to ensure that dental dams were individually wrapped, for sanitary reasons. There were often no printed instructions on how to use the dental dams, either posted near to where dental dams were distributed, or distributed with the dental dams. Based on interviews, it was clear that some prisoners do not know the function of dental dams or how to use them properly.

Prisoners’ safer-sex needs do not stop the moment they are released. Some jurisdictions have recognized this and have responded. For example, Manitoba provincial prisons offer release kits for prisoners, as did some other prisons we visited. These kits are one way of addressing prisoners’ need for safer-sex information and condoms and lubricant after their release. The kit includes an information card with phone numbers for local representatives of regional health authorities, Aboriginal organizations and other health services. This is a quick, inexpensive and effective method of helping prisoners protect their health upon release.

A review of policy and program documentation revealed imprisoned youth are not provided with adequate access to condoms, dental dams or lubricant.

Enabling policy

The following policies support HIV and HCV prevention in prison:

- B.C. Corrections Branch — Adult Custody Division, Health Care Service Manual, *Chapter 14 Blood and Body Fluid Borne Pathogens* (August 2002) s. 14.4, and B.C. Corrections Branch — Adult Custody Policy, *Chapter 9 Inmate Health Care Services* (April 2005) s. 9.19 provide that condoms, one-time use packages of lubricant, and printed material regarding the use of condoms are to be made freely available and readily accessible prisoners.
- Manitoba, Justice, Corrections Division, Custodial Policy, *Communicable Disease Control* (May 10, 2004) s. 9.2 and Appendix “B” provides for lubricated condoms, lubricant and/or dental dams during incarceration and for release packages containing at least six condoms. See also, Headingly Correctional Centre, Standing Orders, *Communicable Disease Control 50-10* (August 25, 2003) s. 12.2b.
- Correctional Service of Canada, Commissioner’s Directive, *821 Management of Infectious Disease* (November 4, 2004) s. 21 provides, in part, that “non-lubricated, non-spermicidal condoms, water-based lubricants, dental dams ... are discreetly available to inmates at a minimum of three locations, as well as in all private family visiting units.”

Best and promising programs

CSC distributes condoms, dental dams and lubricant in discreet and accessible locations throughout the prison

Contact:

Felix Parum
Peer Health Educator
Fenbrook Institution
P.O. Box 5000
Gravenhurst, ON P1P 1Y2

Chief of Health Services
Fenbrook Institution
P.O. Box 5000
Gravenhurst, ON P1P 1Y2
Telephone: +1 705 687-6641
Fax: +1 705 687-1896

Overview

In January 1992, CSC made condoms available to help prevent HIV transmission through sexual activity. Distribution varied from institution to institution including; distribution by healthcare only, distributing condoms to all prisoners, and leaving supplies of condoms in living units. Dental dams were available to female prisons only and lubricant availability varied across institutions. As of November 4, 2004, Commissioner’s Directive 821 states: “Approved harm reduction items shall be readily and discreetly accessible to inmates in CSC operational units so that no inmate is

required to make a request to a staff member for any item. The Institutional Head shall ensure that non-lubricated, non-spermicidal condoms, water-based lubricants, dental dams and bleach are discreetly available to inmates at a minimum of three locations, as well as in all private family visiting units.”

Fenbrook ensures that both lubricated and non-lubricated condoms and lubricant are available on each living unit in the laundry rooms (eight locations in total). Condoms and lubricant are also available in all private family visiting (PFV) units and in the Peer Education and Counselling (PEC) office. PEC workers are responsible for stocking condoms and lubricant.

Dental dams are individually wrapped by PEC workers in packages which include an instruction sheet and are distributed to prisoners exclusively through the PEC office. Prison health services put in a work order in August 2006 to have dental dam dispensers installed beside condom dispensers in unit laundry rooms, as of June 2007; the dispensers had still not been installed.

Lessons learned

Condoms, dental dams and lubricant can be made easily and discreetly available, with a minimum of staff resources.

Involving peers in delivering condoms, dental dams and lubricant contributes to the program’s success. Currently, all new prisoners go through the CSC Reception Awareness Program, which informs them about all harm reduction practices available in the prison. Immediately following the Program, peers health counsellors engage prisoners and teach them how to use condoms and dental dams effectively.

Limitations

The peer educator finds that most people do not know what dental dams are or how to use them. Instructions on the use of dental dams would be helpful for prisoners.

Dental dams should be made available in the same way as condoms, as required under Commissioner’s Directive 821.

Funding

Correctional Service of Canada

Supporting documents

Commissioner’s Directive 821, Correctional Service of Canada.

Evaluation

Performance Assurance Sector, *Evaluation of HIV/AIDS Harm Reduction Measures in the Correctional Service of Canada*. Correctional Service of Canada, April 1999. This evaluation reviewed condom distribution in federal prisons through a literature review, site visits and a review of CSC incident reports. **Note that this evaluation was conducted prior to 1999. Many of the observations and findings do not reflect current CSC policy and programs.** According to CSC, many of the recommendations made have been incorporated into policy or programs.

Release packages distributed by Manitoba corrections

Contact:

Marilyn Sloane
Director of Health Services
Manitoba Corrections
329 Duke Avenue
Portage la Prairie, MB R1N 0S4
Telephone: +1 204 239-3503
Fax: +1 204 239-3397
Marilyn.Sloane@gov.mb.ca

Overview

Manitoba Corrections asked for permission from prison superintendents to distribute release packages to prisoners to help reduce their risk of contracting sexually transmitted infections in the community. The packages include: six condoms, two lubricant packages, STI information, and a card that includes all Regional Health Authorities with toll free numbers and First Nations resources. The information is put into a plain envelope (so its contents are kept confidential) and given to every prisoner upon release.

Lessons learned

Access to health kits is important for prisoners upon release. Prison health care staff will often find the envelope in the garbage with the contents removed. Prisoners do not always have the resources or time to find sources of condoms when they are initially released, so these packages address a demonstrated need.

Limitations

N/A

Funding

Manitoba Corrections

Evaluation

N/A

Cleaning injecting and tattooing or piercing equipment

NOTE: *Cleaning syringes with disinfectant such as bleach does not reduce the risk of HIV and HCV infection sufficiently among people who share drug injecting equipment to rely on this measure exclusively. In a comprehensive review of the available evidence as of 2004, WHO concluded: “Bleach and other forms of disinfection are not supported by good evidence of effectiveness for reducing HIV infection.”⁶⁵ Bleach is not fully effective in reducing HCV transmission,⁶⁶ a finding recently confirmed by a study examining the incidence of HCV among Scottish prisoners, to whom disinfecting tables have been available since 1993.⁶⁷ In addition, while research has demonstrated that thorough, repeated applications of bleach may eliminate HIV in syringes,⁶⁸ some field studies also indicate that people who inject drugs may have trouble following the correct procedure to disinfect syringes (of HIV) using bleach, and have concluded that disinfection with bleach appeared to offer little or no protection against HIV infection.⁶⁹ In numerous studies, half or more of injecting drug users did not know or did not practise an effective method of disinfecting needles using bleach.⁷⁰ Furthermore, evidence from Australia indicates that, for various reasons, a substantial proportion of prisoners may not avail themselves of bleach even when it is made available.⁷¹ The probability of effective decontamination of needles using bleach is further decreased in prison because cleaning is a time-consuming procedure; some prisoners are reticent to engage in any activity that increases the risk of alerting prison staff to their illicit drug use, given the penal consequences that follow, a point that has been noted by WHO Europe in recommending access to sterile syringes for prisoners.⁷² Thus, the available evidence indicates that bleach disinfection of syringes is not a substitute for the use of sterile needles. However, **numerous experts, guidelines, and reports have recommended that in the absence of access to sterile needles and syringes, prisoners should be provided with access to bleach as a means of reducing transmission of HIV.***

Guidance, recommendations and international perspectives

The WHO Guidelines recommend that where bleach is available in the community, bleach or another viricidal agent should be made available to prisoners with specific detailed instructions on cleaning injecting, tattooing and piercing equipment. Significantly, WHO further recommends that in countries where clean syringes are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment to prisoners during detention and on release [WHO Guidelines 24]. The UNODC

⁶⁵ WHO, *Effectiveness of Sterile Needle and Syringe in Reducing HIV/AIDS Among Injecting Drug Users*, Evidence for Action Technical Papers (Geneva: WHO, 2004) at 28.

⁶⁶ H. Hagan and H. Thiede, “Does bleach disinfection of syringes help prevent hepatitis C virus transmission?” *Epidemiology* 14(5) (2003): 628; author reply by F. Kapadia et al., *ibid.* at 629.

⁶⁷ J.K. Champion et al., “Instance of hepatitis C virus infection and associated risk factors among Scottish prison inmates: a cohort study” *American Journal of Epidemiology* 159 (2204): 514–519.

⁶⁸ N. Abdala et al., “Can HIV-1-contaminated syringes be disinfected? Implications for transmission among injection drug users” *Journal of Acquired Immune Deficiency Syndromes* 28(5) (2001): 487.

⁶⁹ R.E. Chaisson et al., “HIV, bleach, and needle-sharing,” *Lancet* 1(8547): 1430; D Vlahov et al., “HIV seroconversion and disinfection of injection equipment among intravenous drug users,” *Epidemiology* 2(6) (1991): 444–446; S Titus et al., “Bleach use and HIV seroconversion among New York City injection drug users,” *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 700–704; D Vlahov et al., “Field effectiveness of needle disinfection among injecting drug users,” *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 760–766; C.B. McCoy et al., “Compliance to bleach disinfection protocols among injecting drug users in Miami,” *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 773.

⁷⁰ C.B. McCoy et al., “Compliance to bleach disinfection protocols among injecting drug users in Miami,” *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 773; A.A. Gleghorn et al., “Inadequate bleach contact times during syringe cleaning among injection drug users,” *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 767; R.G. Carlson et al., “A preliminary evaluation of a modified needle-cleaning intervention using bleach among injection drug users,” *AIDS Education and Prevention* 10(6) (1998): 523.

⁷¹ K.A. Dolan et al., “A bleach program for inmates in NSW: an HIV prevention strategy,” *Australian and New Zealand Journal of Public Health* 22(7) (1998): 838.

⁷² WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, noting: “Serious problems are related to the use of bleach in prisons. For example, prisoners are highly to unlikely to spend 45 minutes shaking the syringes to clean them while waiting to inject in some hidden corner of the prison. Bleach can therefore create a false sense of security between prisoners sharing paraphernalia.”

Framework recommends that prison systems ensure that HIV prevention measures available outside prisons, including sterile needles and syringes, razor blades, and tattooing equipment, be provided to prisoners in a confidential and non-discriminatory fashion [Action 60; p. 24].

ECAP recommended that full-strength household bleach be made easily and discretely available to federal prisoners, including providing small containers of bleach in a health kit given to every prisoner on entry and release. ECAP recommended that CSC research methods to further reduce the risk of HIV transmission associated with shared injection equipment, including access to sterile injection equipment. Regarding tattooing and piercing in federal prisons, ECAP recommended that equipment and supplies be authorized for use in the prisons, and educational materials and training on safer tattooing and piercing be made available to prisoners to develop proficiency, failing which CSC should consider giving prisoners access to outside tattooists and piercers [recommendation 6.3(2), 6.3(6), 6.4, 6.5; pp. 78–81].

Observations

CSC's Safer Tattooing Initiative Pilot project was the only initiative in Canadian prisons that significantly addressed the potential transmission of HIV and HCV through tattooing. The project was terminated by the government in late 2006. The evaluations conducted by CSC indicated that the program may have reduced the risk of transmission and resulted in cost saving in the long run.⁷³ Prisoners and some community AIDS organizations expressed concerns with some aspects of the program and noted that many of the project sites started too late and did not have enough "buy-in" from correctional staff. However, this should not take away from the creative and innovative role that CSC played in initiating this project, and the useful co-operation between the Public Health Agency of Canada and CSC in developing the pilot program.

During our visits, we found that a limited number of prisons recognized the inevitability of tattooing and provided "tattoo kits" (bleach, antibiotic ointment, tongue depressor, gloves, alcohol swab and an empty container) to reduce the harm associated with underground tattooing. Peer education has been an important component in conveying understanding of the risks of tattooing. In prisons where peer health groups are running effectively, peers often educate other prisoners about risks associated with tattooing and strategies to avoid such risks. Other options for decreasing risks of tattooing in prison would be to officially permit the activity (i.e., tattooing and possessing tattooing equipment would no longer be disciplinary offences) and provide ink, needles, and education for tattooists; or to allow tattoo artists from the community to provide tattoos in prison. Permitting prisoners to undertake tattoos as part of official prisoner hobby craft programs (including leather work, glass work, wood work) and permitting tattoo artists from the community to work in prison have been recommended by ECAP and many community organizations for over a decade. Recently, CSC's draft evaluation of the pilot tattooing initiative suggested permitting community tattoo artists to work in prison as one option for decreasing underground, unhygienic tattooing.

Community organizations have been conducting education on tattooing and the risks associated with tattooing in prison. A group in Quebec brought in a respected tattooist from the community into a prison to talk about safe tattooing. Having community members come into the prison to conduct education allows prisoners to ask questions that they may not ask of prison staff.

Overall, existing policies and programs are ineffective at preventing the spread of HIV and HCV through tattooing.

⁷³ M. Nakef, *Draft Evaluation Report: Correctional Service Canada's Safer Tattooing Practices Pilot Initiative*, CSC, undated. On file with the authors.

Enabling policy

The following policies support HIV and HCV prevention and needle-related harm reduction in prison:

- Correctional Service of Canada, Commissioner's Directive, *821-2 Bleach Distribution* (November 4, 2004) is comprehensive and detailed. The policy objective is “[t]o promote public health and a safe and healthy environment through the provision of bleach kits to inmates, as a harm reduction measure against the transmission of HIV and other infectious diseases.” The policy makes the warden responsible for appointing a staff person as coordinator of bleach distribution, details the responsibilities of the coordinator, specifies that full-strength bleach is to be made available, and details the contents of bleach kits and the distribution of the kits. The policy also addresses replacement of bleach, education about using bleach to reduce infectious disease transmission, the application of rules regarding contraband, safety precautions, and first-aid measures.
- B.C. Corrections Branch — Adult Custody Division, Health Care Service Manual, *Chapter 14 Blood and Body Fluid Borne Pathogens* (August 2002) section 14.5 sets out policy to “ensure that filtered household bleach is available and accessible” to prisoners. The policy specifies that the bleach must be full-strength, addresses central supply of bleach, and details principles and standards for distribution. Health care staff are assigned an educational role and written information about using bleach is to be posted. In addition, the policy states clearly that possession of bleach bottles should not be used to establish drug use or other activities that contravene prison rules. Finally, the policy includes first-aid measures. See also B.C. Corrections Branch — Adult Custody Policy, *Chapter 9 Inmate Health Care Services* (April 2005) s. 9.20.

Best and promising programs

Tattooing pilot project in federal prisons

Correctional Service of Canada
National Headquarters, Health Services
340 Laurier Avenue West
Ottawa, ON K1A 0P9
Telephone: +1 613 943-9574
Fax: +1 613 995-6277

Overview

The Correctional Service of Canada (CSC) conducted a pilot project in six prisons on safer tattooing practices in 2005–2006. The pilot was introduced to reduce the risk of infectious disease transmission among prisoners and the community.

According to CSC, the pilot project had two components: (1) provide education to all prisoners about safer tattooing practices; and (2) provide safer tattooing services in a secure and supervised environment.

Pilot sites were introduced at the following prisons:

- Matsqui (medium-security level), Pacific Region
- Fraser Valley (multi-security level), Pacific Region

- Rockwood (minimum-security level), Prairie Region
- Bath (medium-security level), Ontario Region
- Cowansville (medium-security level), Quebec Region
- Atlantic (maximum-security level), Atlantic Region

These prisons represent the five CSC regions, different security levels and diversity in the prison population (both men and women; both Aboriginals and non-Aboriginals).

On August 1, 2005, the tattoo shop in Cowansville opened. Michel Cloutier, the Social Programs Officer (SPO), was responsible for overseeing the tattoo shop. Before the pilot site opened, one of the best-known tattoo artists in the prison (Louis Mirandette) handed in his tattooing equipment to the SPO to show his commitment to the project. Because SPO was new to tattooing, he asked Mirandette and other prisoners to get involved in setting up the shop. Together they found a place where an office could be built that met both the needs of the two prison tattooists and the need for security in the prison.

From the beginning, the SPO worked with the experienced tattoo artist, and they agreed that there would be no privileges given to any prisoners — i.e., tattoo sessions would be scheduled based on when the request was handed in. When a request was received, it was stamped with the date. The prisoner would then submit a drawing that he wanted tattooed. The rules and regulations were clear, and everyone agreed with them and respected them.

In one year, the shop provided 492 tattoo sessions during which 146 tattoos were completed. When the pilot project ended on September 29, 2006, there were still 78 outstanding prisoner requests for tattoos.

Lessons learned

Engagement of prisoners from implementation to delivery is important to the success of a project. The SPO included prisoners in the set-up of the tattoo shop and asked for direction from prisoners on the way the room should be laid out. Having buy-in from one of the most respected tattoo artists in the prison was particularly important for the project.

Support from management and education of staff were keys to the success of the tattoo shop. The superintendent at Cowansville supported the project and, before the pilot opened, an information session was conducted at every shift change for all staff. The session included information on the tattoo shop's importance for the safety of prisoners and staff. The SPO also had an open house for the prison staff and for members of the community to come and view the site when it opened.

Consistency and commitment of staffing (prisoner and SPO) were essential to the success of the project. Recognizing that having a turnover in staffing of the tattoo shop could affect the success of the pilot project and because he believed in the project, Mirandette refused a transfer to a lower-security prison part-way through the pilot. He took pride in saying he was one of the first prisoners to do a legal tattoo in Canada. Michel Cloutier was the SPO throughout the life of the project.

Limitations

The short life of the program affected its success. Both Cloutier and Mirandette felt that the project started too late and that there was not enough time to get a sense of its full impact before it was stopped by ministerial order.

Resources were another limitation. The waiting list, and thus the waiting time, for tattooing were long.

Restrictive policies on acceptable tattoo designs may have limited some prisoners' use of the shop. For example, Mirandette said that one prisoner was not allowed to get his daughter's name tattooed on his arm.⁷⁴

Funding

Government of Canada, Federal Initiative to Address HIV/AIDS in Canada

Supporting documents

Safer Tattooing Practices Initiative — Pilot Project Questions and Answers, Correctional Service of Canada

Guidelines for CSC Safer Tattooing Practices Initiative Pilot. January 14, 2005, Correctional Service of Canada

Evaluation

M. Nakef, *Draft Evaluation Report: Correctional Service Canada's Safer Tattooing Practices Pilot Initiative*, Correctional Service Canada, undated. The evaluation examined the initiative's operational component (tattoo rooms in six federal prisons) and educational component (information regarding unsafe tattooing provided to prisoners at regional reception centres and at the six prisons with tattoo rooms). It reported that between August 1, 2005 and August 31, 2006, 324 prisoners were tattooed through the initiative; and that 60 were on waiting lists. There were three overarching findings: First, the initiative demonstrated potential to reduce harm, reduce exposure to health risks, and enhance the safety of staff members, prisoners and the general public, which potential varies according to a number of site-specific factors. Specifically, the evaluation results suggested that illicit tattooing is most prevalent in medium-security institutions and that during the course of the initiative there was a reduction in illicit tattooing in such institutions. Second, the initiative resulted in an enhanced level of knowledge and awareness amongst staff and prisoners regarding blood-borne disease prevention and control practices. Third, the initiative was consistent with the federal government's strategy to address HIV/AIDS. Other findings relate to implementation shortcomings that impeded the effectiveness and efficiency of the initiative. Tattooing activities at most sites were constrained by a lack of trained tattoo artists, and sporadic hours of operation at some sites had an impact on the number of tattoos provided. The evaluation found that while the cost of the initiative was low relative to the potential benefits, a more cost-effective model

⁷⁴ This may have been the result of a misunderstanding of the CSC policy on tattoo designs, which forbade tattoos that advocated or promoted hatred or genocide of any identifiable group distinguished by colour, race, religion, ethnic origin, sex, sexual orientation or other specific traits. The policy also excluded tattoos that involved violence, coercion, compulsion, force bodily harm or threats or fear of bodily harm, and sexually oriented tattoos involving children. See: Guidelines for CSC Safer Tattooing Practices Initiative Pilot. January 14, 2005, Correctional Service of Canada.

could be implemented to yield the same or better results without compromising safety. Finally, the evaluation suggested a number of ways to address the implementation-related shortcomings and make the initiative more cost-effective and efficient. Notable among these enhancements was the suggestion that CSC consider using community tattoo services. The evaluation recommended that “[t]o maintain an enhanced level of knowledge and awareness of infection prevention and control practices, CSC should continue the education component of the Safer Practices Tattooing Initiative” (p. 22).

“Tattoo Kits” distributed in federal prison

Contact:

Correctional Service of Canada, Regional Administration
3, Place Laval, bureau 200
Laval, QC H7N 1A2
Telephone: +1 450 967-3386
Fax: +1 450 967-3460

Overview

In a number of CSC prisons in Quebec, peer health counsellors and health care staff distribute what is called a “prevention kit,” also known as a “tattoo kit.” These kits contain bleach, gloves, tongue depressors, alcohol swab, a topical antibiotic ointment and an empty container for preparing ink or cleaning equipment. These are given to prisoners upon request to help prevent the risk of HIV and HCV transmission associated tattooing, as well as to prisoners who have recently been tattooed to prevent infection.

Lessons learned

Peer-based groups can be effectively relied upon to distribute HIV and HCV prevention and harm reduction information and “kits”. Prisoners engaging in tattooing are more likely to ask one of their peers for a “tattoo kit” than to ask a health care staff member. In addition, because tattooing is prohibited in prisons, some prisoners may hesitate to ask staff questions about how to tattoo safely. Having peers with whom to discuss tattooing is essential in helping prisoners use safer practices.

Limitations

The distribution of “tattoo kits” is not mandatory under CSC policy (i.e., it is not included in a Commissioner’s Directive).

Tattooing remains illegal in prisons and therefore the activity remains underground and unsafe for both prisoners and staff. People have to work quickly before prison guards do “rounds” (i.e., check on prisoners) and cannot keep their equipment in plain view. Hidden needles (and other equipment) pose a danger of needle-stick injuries to prisoners and to guards conducting cell searches.

Bleach does not completely kill HCV and is therefore an ineffective way of dealing with risks in tattooing.

Funding

Correctional Service of Canada

Evaluation

While there was no evaluation specific to this program, CSC has conducted an evaluation of its bleach program. See Correctional Service of Canada, Performance Assurance Sector, *Evaluation of HIV/AIDS Harm Reduction Measures in the Correctional Service of Canada*. Correctional Service of Canada, April 1999. This evaluation comprised a literature review, site visits, and a review of CSC incident reports. *Note that this evaluation was conducted prior to 1999. Therefore, many of the observations and findings do not reflect current CSC policy and programs. In fact, the bleach program was substantially modified to respond to the recommendations made in the evaluation.*

Bleach distribution in federal women's prison made easy

Contact:

Chief of Health Care Services
Nova Institution for Women
180 James Street
Truro, NS B2N 6R8
Telephone: +1 902 897-1774
Fax: +1 902 893-6765

Overview

As per Commissioner's Directive 821, bleach must be located in three discreet locations in each prison. In most prisons, CSC has bleach dispensers in three locations. Occasionally, bleach will be distributed by peer health counsellors or by other, selected prisoners.

The Nova women's prison has bleach bottles available in each house (living units for women). Every two weeks when the house representative or house cleaner goes to get household items, (toilet paper, cleaning supplies, etc.) she also picks up a bottle of bleach. If the bleach runs out before the two weeks is up then the house representative or house cleaner will go to the prison supply store to get more bleach from a prison guard.

Lessons learned

Programs that are developed taking into account the purpose and spirit of the bleach policy create easy access to bleach for prisoners. The prison does not need to worry about the dispensing machines breaking down or having to pour bleach into small containers for distribution. Letting women have access to bleach in their houses

is an easy way to meet the policy that is in place. This is the most discreet way of distributing bleach and it makes it very accessible to all women without any worry about running out.

Limitations

Bleach does not completely kill the hepatitis C virus.

Funding

Correctional Services of Canada

Supporting documents

N/A

Evaluation

N/A

Opiate substitution therapy using methadone

Methadone is a narcotic medication licensed for use in Canada to treat opiate addiction. Substitution therapy has been described by in a joint WHO, UNODC and UNAIDS report in the following terms:

Medicines used in substitution therapy can be prescribed either in decreasing doses over short periods of time (usually less than one month) for treatment of withdrawal or for detoxification, or in relatively stable doses over a long period of time (usually more than six months) for substitution maintenance therapy, which allows stabilization of brain functions and prevention of craving and withdrawal. Substitution maintenance therapy is one of the most effective types of pharmacological therapy of opioid dependence. There is consistent evidence from numerous controlled trials, large longitudinal studies and programme evaluations, that substitution maintenance treatment for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviours with a high risk of HIV transmission.⁷⁵

Guidance, recommendations and international perspectives

The WHO Guidelines recommend that “prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment” and that in countries where MMT is available in the community it should be available in prisons [WHO Guidelines 23]. The UNODC Framework recommends that prison systems “[e]nsure that prisoners have access to the same drug treatment and counselling programs available to the population outside prison, including drug-free options, drug-free living areas, pharmacologically-supported drug treatment, and options to reduce the harm of drug use.” Methadone and other opiate substitution therapies are specifically mentioned, including both continuation and initiation of treatment for prisoners, based on the same criteria applicable in the community. UNODC calls for development and support of self-help and peer-support groups and NGO and expert participation in the development and provisions of drug treatment services [Action 77–79; p. 26]. ECAP recommended that federal prisoners who use drugs should have access to methadone [recommendation 6.3(7); p. 79].

Observations

Prison is a challenging environment in which to provide drug treatment programs because of the zero tolerance of drug use and emphasis on drug interdiction. In the prison setting, many prisoners cannot ask for help from the same people who are responsible for imprisoning them. Prisoners can’t disclose struggles with their recovery from drug addiction because of the zero tolerance drug policy. Consequences for a positive urine test can include: increased security, loss of escorted temporary absences (ETA’s) and, unescorted temporary absences (UTA’s), loss of contact visits with family, not getting released on parole, etc.

While continuation of MMT for people imprisoned in Canada is becoming more common, MMT initiation is still exceptional at the provincial/territorial level. While a majority of provinces have policies that permit people who enter prison to continue MMT if they were receiving it in the community, provincial policies vary. One of the most exciting and innovative programs that we saw was one of the Nova Scotia provincial prison that relies on an experienced community methadone provider, Direction 180, to initiate MMT in the local prison, taking advantage of expertise that does not exist among prison health care staff. CSC and British Columbia have the most comprehensive methadone programs running in prisons, which has directly benefited many prisoners over the years.

⁷⁵ WHO, UNODC and UNAIDS, *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention: Position Paper*. 2004, at pp. 12, 13.

Enabling policy

The following policies support HIV and HCV prevention and harm reduction in prison:

- Saskatchewan Corrections and Public Safety, Corrections Division Policy, *Methadone Maintenance Treatment for Offenders* (October 5, 1998; revised June 2003). The policy provides important direction to staff on both the overall program and individual case management. The policy is based on cooperation between prison medical services and community medical authorities and adherence to community standards. The policy permits prisoners who were receiving methadone in the community to continue to do so, and permits prisoners to initiate methadone while imprisoned. It specifies guidelines for supply and control of methadone, administration of methadone and capacity for treatment, as well as rules for case review and intermittent prisoners. A copy of the agreement that each prisoner must sign in order to receive methadone is included as an appendix.
- Correctional Service of Canada, Commissioner's Directive *800 Health Services* (September 30, 2004) s. 41; Correctional Service of Canada, Commissioner's Directive, *800-1 Methadone Treatment Guidelines* (May 2, 2002); Correctional Service of Canada, *Correctional Service of Canada: Specific Guidelines for Methadone Maintenance Treatment* (November 2003). The methadone policy is very well articulated and is situated within broader health services policies. Commissioner's Directive *800-1* sets out criteria for admission and priority admission to the program and for determining the number of prisoners that can receive MMT at a time in a given prison; and the agreements required of prisoners wanting to receive methadone. The *Specific Guidelines* include a general background on prisons and substance use; describe methadone maintenance in CSC and the roles of the various members of the methadone intervention team; address methadone dosing issues and drug screening; and incorporate information on substance abuse intervention.
- B.C. Corrections Branch — Adult Custody Division, Health Care Service Manual, *Chapter 10 Methadone* (August 2002; revised March 2007) ss. 10.1(4), 10.4. B.C.'s methadone policy permits both continuation and initiation. The policy specifically incorporates the community standard — the British Columbia College of Physicians' *Methadone Maintenance Handbook*. Issues addressed include physician communication, methadone orders and documentation, initiation, distribution, addiction counselling, withdrawal, disposal, and discharge from corrections. The initiation criteria are detailed and explicit, yet incorporate significant flexibility; significant decisions regarding specific cases and complex cases are reviewed by prison medical staff in consultation with the Director of Health Services.
- Ministry of Correctional Services, Health Care Policy and Procedures, *HCS 01 21 Emergency Treatment of Opioid Overdose and Medical Directive: Narcan (Naloxone HCL)* (November 1999); Memorandum from Karen McNeely, Chair, Provincial Nursing Advisory Committee to Health Care Coordinators, *Medical Directive: Narcan (Naloxone HCL)* (November 26, 1999). When introducing methadone in prison, the Ministry of Correctional Services in Ontario also developed a medical directive for the use of Narcan (naloxone HCL) for use in emergency situations where a prisoner overdoses on methadone or other opiates. Naloxone is a drug used to counter the effects of opioid overdose.

Best and promising programs

CSC committed to MMT

Contact:

Correctional Service of Canada
National Headquarters, Health Services
340 Laurier Avenue West
Ottawa, ON K1A 0P9
Telephone: +1 613 943-9574
Fax: +1 613 995-6277

Overview

MMT within CSC prisons operates on the same principles and standards as MMT in the community. The MMT program was introduced on World AIDS Day (December 1) 1997. In Phase 1 of MMT, if a prisoner using methadone entered a CSC prison, he or she was allowed to remain on treatment. In February 1999, a policy was introduced to enable those prisoners who hadn't previously undergone MMT outside prison and who met "exceptional circumstances criteria" to initiate methadone therapy within CSC. The two criteria were: (1) all other available treatments and programs had failed; and (2) the health of a prisoner continued to be seriously affected by drug use, and there was dire need for intervention.

In May 2002, as a result of a settlement in a lawsuit, CSC introduced Phase 2 of the MMT program to expand the initiation criteria to reflect community standards. As part of the settlement, CSC recognized that MMT is an essential part of the health services to which prisoners have a right. In November 2003, the CSC Specific Guidelines for Methadone Maintenance Treatment were updated. In 2005, CSC maintained over 1100 prisoners on methadone.

The goal of MMT is harm reduction, not abstinence. In the Specific Guidelines for Methadone Maintenance Treatment, CSC states MMT is prescribed "in order to minimize the adverse physical, psychological, social, and criminal effects associated with opioid use, including the spread of HIV and other infectious diseases in CSC prisons and in the community."

A Methadone Intervention Team (MIT) is responsible for enrolling prisoners in MMT at the prison level. Each prisoner on the MMT program has an MIT, which consists of an institutional parole officer, a correctional program officer, a prison nurse, and a physician.

Lessons learned

As noted below, CSC's methadone program has been evaluated very positively. The program has been the object of study tours by prison officials from countries seeking examples of good practices in MMT in prison.

Providing appropriate counselling and support to prisoners is essential to the success of the MMT program. CSC wanted a team approach, including drug counsellors on-site. CSC staff indicated that they found this to be helpful for the prisoner and provided all team members with more information about the patient. CSC believes that the

team approach makes it more likely that a prisoner will find at least one person with whom he or she can develop a good rapport. It also gives the patient some variety in provision of care.

Training and information for staff facilitating the program are vital. Staff working with methadone need information to feel comfortable and safe with the therapy. Nursing staff must be able to respond to issues associated with dispensing MMT, such as the potential for overdose, diversion and side-effects.

Understanding of addiction, its impact on people's lives, and harm reduction is essential to the program's success. Understanding a patient's circumstances can allow staff to have realistic expectations of prisoners taking MMT — it is not a solution for every psycho-social problem that an individual may face. Unrealistic expectations are frustrating for both the prisoner and the MIT.

Developing non-judgmental relationships with the prisoner is of paramount importance to a successful program. Practitioners need to be able to develop a therapeutic (rather than a punitive) relationship with the prisoner, create a safe environment in which the prisoner can be honest without fear of judgment or punishment, be able to recognize and praise the successes (no matter how big or small), and speak frankly and openly about set-backs (such as the use of illicit drugs while taking MMT).

Limitations

The restriction on the number of MMT patients permitted in each prison's caseload means that some prisons — though not most — have waiting lists. From the HIV and HCV prevention and harm reduction perspective, every prisoner who wants to be on MMT who meets the program's clinical criteria should ideally be provided with this proven opiate addiction treatment. Waiting lists are unfortunately not unique to the prison setting as many communities in Canada also are unable to serve everyone who seeks methadone therapy.

A lack of community methadone providers has created a serious constraint on the MMT program. This is an issue beyond the control and budgets of prison authorities. Community physicians licensed to prescribe MMT are in short supply throughout Canada, and those who are licensed are in demand in the community and may not be available or willing to work with prisoners. It is of grave concern that in some places, because there are not enough community providers, CSC has to try to taper prisoners off methadone before they are released into the community — a practice inconsistent with the well-established principle that patients should be able to remain on methadone therapy for as long as they need it — but the shortage of community-based methadone providers may necessitate this unfortunate departure from best practice.

At the prison level, there may be problems with confidentiality at the health care unit if MMT patients have to wait twenty minutes in an open room when there is not a more discreet waiting area. This is because anyone walking by the health care unit knows why they are waiting there. Prison health units should strive within the space limitations they have to ensure that this waiting happens in as discreet as possible a location.

Funding

Correctional Services of Canada

Canadian Drug Strategy

Supporting documents

Correctional Service of Canada, Commissioner's Directive, *800 Health Services* (September 30, 2004).

Correctional Service of Canada, Commissioner's Directive, *800-1 Methadone Treatment Guidelines* (May 2, 2002).

Correctional Service of Canada, *Correctional Service of Canada: Specific Guidelines for Methadone Maintenance Treatment* (November 2003).

Evaluation

There have been two formal evaluations of CSC's MMT program:

S. Johnson, J. van de Ven and B. Gant, *Institutional Methadone Maintenance Treatment: Impact on Release Outcome and Institutional Behaviour* [No R-119], Ottawa: Correctional Service of Canada, 2001. The study compared behaviour in prison and post-release outcomes of two groups: prisoners receiving MMT versus prisoners who tested positive for heroin use and were assessed as having a substance abuse problem, but were not receiving MMT. Overall, prisoners receiving MMT had lower readmission rates and were readmitted at a slower rate. In terms of behaviour, the MMT group had a reduced rate of serious drug-related prison charges following initiation of MMT. This likely indicates a decrease in drug-seeking and drug-taking behaviour among prisoners on MMT in comparison to prisoners not receiving MMT. The report is available at www.csc-scc.gc.ca/text/rsrch/reports/r119/r119_e.shtml.

Performance Assurance Sector, *Report on the Evaluation of CSC's Methadone Maintenance Treatment Program*. Correctional Service of Canada, August 2003. This comprehensive and detailed evaluation reviewed the expanded CSC MMT program. Four regional headquarters, fifteen CSC prisons and five community offices were visited as part of the evaluation. Staff (over 120) and prisoners (65) were interviewed. Overall, the evaluation shows that CSC's MMT program is functioning effectively. It found that although limits on the number of prisoners that could safely be provided with MMT had been established for each institution, 80 percent of prisons visited had exceeded the limits. Another finding was that although methadone intervention teams had been established in each prison visited, team member roles varied from site to site and there was uncertainty among members as to roles and responsibilities. The evaluation found that participation in MMT had been increasing faster than anticipated. One set of recommendations relates to approaches to address capacity of the program to respond to demand; another centres on clarifying roles and responsibilities. Recommendations were also made to increase training opportunities and resources for staff, and to ensure that staff fulfill reporting and record-keeping responsibilities. The evaluation report also contains a section on good practices. It is available at http://198.103.98.138/text/PA/methadone_eval_e.pdf.

Provincial prison works with community methadone clinic to initiate prisoners on MMT

Contact:

Cindy MacIsaac
Direction 180
2158 Gottingen Street
Halifax, NS B3K 3B4
Telephone: +1 902 420-0566
Fax: +1 902 423-6130
cynthmacisaac@aol.com

Overview

Direction 180 is a community MMT clinic that started in Halifax in 2001. On a number of occasions, Direction 180 staff have initiated MMT for prisoners in a near-by provincial prison. This activity was undertaken in response to potential risks prisoners were facing as a result of ongoing illicit drug use — i.e., when a prisoner was pregnant, was newly diagnosed with HIV, experienced a recent overdose or other severe health problems, or repeatedly missed appointments at community health facilities.

The assistance of Direction 180 in initiating methadone therapy for a prison is triggered by a call from either a prison health care staff member or prisoner. From there, a Direction 180 staff member does a pre-assessment with the prisoner. After the pre-assessment is completed and reviewed, Direction 180's physician visits and evaluates the prisoner and prescribes methadone if indicated. After the period of initiation, prison health care assumes responsibility for ongoing monitoring of the prisoner's care.

When the person gets out of prison, he or she can receive methadone from the Direction 180 clinic if he or she remains in the clinic's catchment area.

Lessons learned

In Nova Scotia, in 2005 the transfer of responsibility for health services from prison authorities to the Minister of Health placed increased emphasis on integrating community and prisoner health care services. The current provider, the Capital District Health Authority, has expressed a desire to create relationships between a range of community services and the prison population in order to meet prisoners' needs. Because Direction 180 had a pre-existing relationship with the Capital District Health Authority, they were able to work together to initiate MMT even in the absence of a specific prison policy framework.

Community health clinics should consider initiating methadone in provincial prisons where methadone is not being initiated. Direction 180 has shown that this practice can assist prisoners while incarcerated. People who were street-involved people before incarceration may have found it difficult to get to community-based services while they were actively using drugs, and bringing such services to the prison may be their first opportunity to utilize them. This practice should be seriously considered to promote community health-care standards in prison.

Limitation

There is no official, written policy or procedure in place to initiate methadone in prison.

Like many methadone clinics, Direction 180 suffers from chronic funding shortfalls. Direction 180 has provided services to prisoners in the past as part of their regular program, which is funded for 80 people, but in the fall of 2006 the clinic had 130 patients in their regular MMT caseload, leaving little room for services outside the clinic.

Funding

Direction 180, funded by Nova Scotia Department of Health.

Supporting documents

N/A

Evaluation

N/A

Provincial prisons initiate methadone maintenance therapy**Contact:**

Dr. Diane A. Rothern, M.D.
Medical Director
British Columbia Corrections
185-911 Yates Street
Victoria, BC V8V 4Y9
Telephone: +1 250 995-0009
Fax: +1 250 995-0010
diane.rothon@gov.bc.ca

Overview

In 1996, a policy was put into place to allow provincial prisoners in B.C. to continue and initiate MMT. British Columbia Corrections employs a team approach, involving health care staff (nurses and physicians), sentence management staff, drug and alcohol counsellors, and the Director of Health Services. Prisoners are identified for MMT at intake and throughout their sentence either by the team or through self-referral. To obtain MMT, a prisoner is assessed based on the criteria outlined in the British Columbia College of Physicians and Surgeons' *Methadone Maintenance Handbook*.

The BC program explicitly takes into account the fact that prisoners might only be in a provincial prison for a limited period of time. Thus, in order to qualify for MMT, the patient should be serving a sentence and the anticipated remaining time to be served should be long enough to complete the MMT initiation process and reach a stable dose

prior to release. Prisoners with short sentences may not start MMT. Exceptionally, prisoners on long-term remand (e.g., awaiting trial) may be started on MMT.

In practice, prisoners put in a request for MMT at the health care unit and are then interviewed by a health care staff member. Prisoners have to sign a methadone patient agreement to be accepted by the program, part of which requires them to agree to regular urine testing. The Medical Director reviews every request for MMT (and participates in significant decisions thereafter, especially in complex cases) in consultation with the MMT team. On average, it takes one week from the time the *Methadone Initiation Treatment Plan* form is submitted to the Medical Director for a decision to be made and, if approved, for the prisoner to receive the first dose of MMT.

While MMT procedures vary from prison to prison, the treatment process is usually supervised by health care staff with the support of a methadone observation officer. Prisoners are required to sit in the post-observation room for up to twenty minutes after receiving their dose, during which time they drink water, eat and talk. Prisoners are also subject to frisk searches during the dispensing process to ensure that the methadone is not diverted to an illicit market.

Once a prisoner is on MMT, a medical practitioner may declare the prisoner medically unfit for transfer until his or her condition is stable and the maintenance dose of methadone has been established. Upon release, prison health care staff and the Medical Director work to find a methadone-prescribing physician in the community for every prisoner on MMT.

Lessons learned

Collaboration between health care staff and security staff is essential to the success of the program. To address security concerns, a designated staff position — the methadone observation officer — observes the prisoners swallow MMT and during the required waiting period. This officer is responsible for ensuring that during the dispensing and observation period prisoners are not diverting their dose of methadone.

Limitations

One of the main limitations, identified by the Chief of Health care at Alouette Correctional Centre for Women in Maple Ridge, B.C., is that MMT initiation is very time-consuming. It takes a lot of staff time to do urine screening, adjust and dispense doses, and find community referrals and community physicians. At this institution in particular, it was noted that methadone initiation could take up to six months.

Supporting documents

B.C. Corrections Branch — Adult Custody Division, Health Care Service Manual, *Chapter 10 Methadone* (August 2002; revised March 2007).

Calibre Health Services Inc., *Methadone Initiation Treatment Plan* (Form), revised January 2007.

Evaluation

N/A

Testing for illicit drugs

Guidance, recommendations and international perspectives

The UNODC Framework calls on prison systems to implement rules that “[e]nsure that prisoners are not subject to mandatory or random drug testing, as such testing has been shown to encourage drug injecting (often using unsafe injecting practices)” [Action 14; p. 18]. The Legal Network’s *HIV/AIDS in Prisons: Final Report* recommends in relation to urinalysis that federal and provincial prison systems need to allow for external evaluation of urinalysis programs to determine their impact on drug use and HIV prevention efforts and their cost-effectiveness [Recommendation 6, p. 110].

Observations

CSC engages in random urine testing for illicit drugs, including THC (one of the active ingredient in cannabis), as part of its drug interdiction strategy. Most provinces and territories do not conduct random drug testing in prison. Rather, urine samples are required where there is cause (reasonable and probable grounds) to believe that a prisoner has consumed an illicit substance, or as a requirement for participating in programs (e.g., MMT or programs where prisoners are permitted to go into the community).

There is a concern that random urine testing for THC may, indirectly, have a negative impact on the health of prisoners who use illicit drugs.⁷⁶ THC from smoked cannabis is detectable in a person’s urine for a much longer period than drugs like heroin, other opiates, and cocaine, which are often consumed by injection. If there are random urine tests in a prison, some prisoners may thus make the calculation that it is better to inject drugs that won’t show up on the test, rather than smoking cannabis — a decision that can be disastrous with respect to HIV and HCV transmission. For this reason, random urine screening for THC is a practice that should be rigorously and independently evaluated. Pending such an evaluation, prisons should consider suspending random THC urine screening, consistent with an evidence-based harm reduction approach to drug use.

⁷⁶ For a list of studies and reports evaluating mandatory drug testing in prison, see R. Jürgens, *HIV/AIDS and HCV in Prisons: A Select Annotated Bibliography*, International Affairs Directorate, Health Canada, 2005, p. 147 and following. Available on-line via www.hc-sc.gc.ca/ahc-asc/pubs/index_e.html.

Education and information for prisoners

Guidance, recommendations and international perspectives

The WHO Guidelines recommend that prisoners receive information about HIV/AIDS and ways to prevent transmission, with special reference to risks of transmission within the prison environment. Prisoners should be specifically informed about the dangers of drug use, including the high risk of sharing injection drug equipment. Prisoners should also have access to both information intended for the general public and plain-language information that may be more appropriate to the linguistic needs of many prisoners. Prisoners should receive HIV/AIDS education on entry, during their term of imprisonment and in pre-release programming, with the opportunity for face-to-face communication with peers and qualified people. The WHO Guidelines recommend that prisoners be involved in the development of educational materials and, in light of the importance of peer education, that prisoners be involved in disseminating information [WHO Guidelines 14, 16, 17, 18, 22].

The UNODC Framework makes detailed recommendations for action for HIV prevention education. It calls on prison systems to deliver HIV/AIDS education as part of broader comprehensive program of health education, and to support and encourage peer-based HIV prevention, education and counselling initiatives [Actions 36, 54, 59; pp. 21, 24]. Information should be accurate, non-judgmental, accessible, and relevant to the prison environment (especially regarding routes of HIV transmission and risk behaviours), and the materials should respect, and be relevant to, differences in gender, age, race, ethnicity, culture, religion, language, literacy level, sexual orientation and gender identity [Actions 53, 56; p. 24]. The UNODC Framework calls on prison systems to give prisoners access to “national preventive mechanisms, non-governmental organizations and other professionals from the outside the prison system to assist in the provision of educational interventions” [Action 58; p. 24]. The Framework says that education programs should combat AIDS-related discrimination, including discrimination against same-sex relationships, sex workers and people who use drugs [Action 57; p. 24].

ECAP made recommendations for education regarding both HIV/AIDS and drug use, noting that “education about HIV infection and AIDS is the most important effort to promote and protect the health of inmates and prevent the transmission of HIV and other infectious agents.” ECAP recommended that:

- all prisoners receive written information about HIV/AIDS;
- HIV/AIDS education be part of mandatory reception programming;
- thereafter, voluntary education sessions be made available on a regular basis with the participation of external community-based AIDS, health or prisoner organizations, assisted by government funding;
- prisoners be encouraged to develop peer-based education, counselling and support programs, including by the creation of a paid peer counsellor position at each prison; and
- education programs take into account needs of prisoners with disabilities, from different ethnic and cultural backgrounds, and different levels of literacy [recommendation 5.1; p. 50].

ECAP’s recommendations regarding drug use education focused on revising programs that existed at the time (Drug and Alcohol Reception Induction Model, Alcohol and Drug Education Program) to include input by, and participation from, external community-based organizations and prisoners [recommendation 5.2; p. 54].

Observations

There are only a few community organizations participating in developing and providing harm reduction and safer sex education programs in prisons. PASAN is the only organization we are aware of in Canada that provides training to other community-based organizations to do programming inside prisons. As a result, it appears that many prison systems rely on educational materials and programs designed for the non-prison

population. It is imperative that more community agencies be funded to develop and deliver HIV and HCV prevention and harm reduction programming inside prison in order to meet the needs of the increasingly diverse prison population. As it stands, there are few programs designed and implemented for women, Aboriginals, and prisoners representing ethno-cultural minorities. It is also difficult to get an accurate picture of whether the specific educational and programming needs of youth are being met.

For the most part, we found that prisoners in Canada are not involved to the extent they ought to be in the development of educational materials and the delivery of educational programs. The involvement of prisoners (or former prisoners) in developing educational programs is virtually non-existent. There are several successful peer-delivered programs in the prisons we visited, mostly in CSC prisons. Each CSC prison (not including mental health and reception units) is required to have a Peer Education Counselling (PEC) program, but not all prisons do. Several of the PEC programs we visited were being successfully run — at Westmorland Institution (New Brunswick), Federal Training Center (Quebec), and La Macaza Institution (Quebec). Some common features of these PEC programs included: the PEC counsellor had the respect of other prisoners; the counsellor had an office located in an accessible location and not in view of security; the counsellor had access to a computer and printer to produce educational materials and correspond with organizations in the community; prison health care staff provided significant support to the counsellor and program; and the counsellor was provided with adequate supplies of HIV and HCV prevention and harm reduction materials (condoms, lubricant, dental dams, bleach and “tattoo kits”) which he was responsible for distributing to prisoners. **These features are essential for the success of a peer program.**

Programming provided by community-based NGOs varied from prison to prison. It was evident that community organizations do a great deal of work with limited resources, a common and significant limitation. The Ontario Aboriginal HIV/AIDS Strategy (OAHAS), All Nations Hope, Direction 180, Stella, the Centre Option-Prévention Toxicomanie-Violence-Délinquance-Sida (TVDS), Prisoners HIV/AIDS Support Action Network (PASAN), British Columbia People with AIDS Prison Outreach Project (BC PWA POP), and Streetworks all stated that limited funds made it difficult to run programs inside prisons. Most community-initiated programming engaged prisoners and was successful at disseminating HIV and HCV prevention and harm reduction information, but organizations expressed frustration at their limited ability to provide prisoners with HIV and HCV prevention measures that numerous prisoners at high risk of infection require, such as sterile needles for injecting and tattooing.

The use of games appeared to be one of the most effective ways to engage prisoners in education.

Enabling policy

No policies were identified.

Best and promising programs

Peer educator focuses on harm reduction in federal prison

Contact:

Alex Calvin Chartier
Peer Education Counsellor
La Macaza Institution
321 Chemin de l'Aéroport
La Macaza, QC J0T 1R0
Telephone: +1 819 275-2315
Fax: +1 819 275-3079

Overview

In 1994, ECAP made two recommendations concerning peer education designed to encourage peer education and training, and to urge that paid peer educator positions be established at each CSC prison. The recommendations were based on the premise that peer health counsellors can be particularly effective in advocating for programs to meet the HIV prevention and harm reduction needs of fellow prisoners. Also, it was believed that prisoners would be more comfortable speaking with a fellow prisoner about high-risk activities that are considered illegal in the prison setting. In response to the ECAP recommendations, CSC funded a proposal by SIDA/AIDS New Brunswick for a national pilot peer education program for prisoners. This pilot program (Con AIDS Network Peer Education Program) proved successful. Subsequently, the program's facilitation manual was revised and the name of the program was changed to Peer Education and Counselling (PEC). In 1997, CSC committed to implementing the PEC program in all of its institutions.

La Macaza is a medium-security prison with a relatively small population (250 prisoners). At La Macaza, the PEC office is shared with the Circle of Knowledge Keepers (the Aboriginal PEC program in CSC prisons) and is located in the gym area where prisoners can have easy access to the office. There is considerable prisoner traffic in this area during the evening when prisoners are not in school or at work. The PEC counsellor is a paid position within the prison.

PEC counsellor Alex Calvin Chartier answers questions about HIV/AIDS, hepatitis C, relationships, and proper nutrition. Because La Macaza has both a PEC counsellor and a Knowledge Keeper (Morris Bowen), they are able to do more outreach into the prison. They often go from cell to cell to advertise workshops and seminars. They are very proactive and work well together. Both the PEC counsellor and the Knowledge Keeper give out what is called a "prevention kit", also known as a "tattoo kit." The kit contains a tube of ointment, gloves, spatula, alcohol swabs and bleach. The kits are easily accessible through the PEC and the Knowledge Keeper office.

Lessons learned

Having a well respected, trained and paid peer is important for prisoner education on HIV/AIDS, HCV and harm reduction. Prisoners may feel more comfortable talking about high-risk activities with a peer than they do with prison health care staff.

Support from prison health care staff is important to the project. The health care staff are respected by prisoners and participate in the workshops and seminars being offered. Both the PEC and Knowledge Keeper mentioned that the head of health care (Solange Cyr) is very supportive of the programs.

Peer education programs must take into account different cultures and languages. PEC runs workshops in French and there is a high turnout of prisoners at the events. PEC has a close working relationship with the Knowledge Keeper, which assists in meeting the needs of Aboriginal and Métis prisoners.

Limitations

Prison health care staff are at times too busy to provide adequate support and training to the counsellors. The nurses are very busy and may often not have time for in-depth training of the PEC counsellor and the Knowledge Keeper. The counsellors have requested training in mediation, HIV and HCV treatment.

Lack of access to safer tattooing equipment causes health risks that counsellors are not able to address fully. Both the PEC counsellor and the Knowledge Keeper would like to have access to beading needles and ink for the tattoo kits. They strongly believe that the tattoo kits are not enough to stop the spread of HIV and HCV via tattooing.

Privacy and confidentiality are essential for prisoners visiting PEC and the Knowledge Keeper, but they are compromised in the current facilities. The PEC counsellor would like to have blinds in the PEC office so that people cannot see prisoners there. The office is also shared with an organization that supports prisoners serving life sentences, which can also compromise the confidentiality of prisoners.

Lack of funding has created a problem for the general office administration. They need additional funding to purchase a better computer, printer and coffee maker.

The PEC counsellor noted that activities are sometimes cut short because of counts, lock-ups, shift changes and other security requirements.

Funding

Correctional Service of Canada

Supporting documents

Correctional Service of Canada, *National HIV/AIDS Peer Education and Counselling Program*, Resource Manual, December 1998, revised March 2001.

Evaluation

J. Belliveau and O. Leblanc Pellerin, *Review of the National HIV/AIDS Peer Education and Counseling Program*. Correctional Services of Canada, June 2002. The evaluation concluded that: “All staff persons and inmates interviewed were unanimous in their support of a peer education and counselling program to prevent the spread of infectious disease in prison” (p. 29). At the time of the evaluation, of 52 CSC prisons, 23 had PEC programs running. However, there was a lack of consistency in those programs that were running. The evaluation identified that the training and resource manuals needed to be updated and that responsibility for the PEC program within each prison should rest with the head of health services. It also found that PEC training needed to be standardized, that a nurse should be providing the bulk of training, and that the certificates awarded to PEC counsellors should be displayed in the PEC office or the counsellor’s cell. Further, the evaluation recommended that the PEC facilitator and the PEC coordinator be responsible for the implementation of the program; and therefore, that the PEC facilitator be a nurse and the PEC coordinator be a prisoner who has completed the PEC training. The evaluation also recommended that a minimum of \$2,000 per prison be allotted in addition to “seed” money for prisons that had not yet initiated the program; and that an adequate and accessible office space that allows for privacy and confidentiality be provided in each prison.

In 2007, Health Services, CSC National Headquarters, provided additional information regarding the PEC program. For the first and second quarters (April–September) of fiscal year 2006, 86 percent of CSC institutions reported an active PEC Program. (CSC defines an “active” program as one in which there is at least one coordinator or

volunteer who is actively involved in peer education and support.)⁷⁷ This figure reflects data from institutions that are required to have PEC; it does not include those institutions that have Aboriginal PEC programs. Some of the reasons why institutions are unable to have an active PEC program at all times are: turnover in inmate population is high; inmates are sometimes diverted from participation in PEC to attend their Correctional Plan's mandatory programs; difficulties are sometimes encountered in finding inmates who are interested in being PEC coordinators or volunteers; and staff sometimes have difficulty finding time to organize and deliver training. The PEC program is currently being updated. Currently, CSC compiles monthly reports on the delivery of PEC and the Circle of Knowledge Keepers programs. These reports are sent to the Regional Infectious Disease Coordinators and the Regional Administrators of Health, who are required to respond to any problems with PEC or Circle of Knowledge Keeper programming.

⁷⁷ E-mail from Alan Sierolawski, National Infectious Diseases Program Coordinator, Correctional Service Canada (June 25, 2007).

Peer health counsellors work independently of the PEC Program

Contact:

John Bellosillo
Chairman, Peer Health Counselling
Warkworth Institution
P.O. Box 760
Campbellford, ON K0L 1L0

Overview of program

Independent (i.e., not associated with the CSC PEC program) peer health counselling was started by prisoners in Warkworth Institution in 1998, using a core group of peer counsellors who had served time at Kingston Penitentiary. The peer health counsellors work independently of CSC health services and the PEC program. Instead, they carry out their work as part of the social development programming for prisoners in Warkworth and work with a CSC Social Development Officer. Peer health counsellors rely on community resources for their ongoing training and education on crisis intervention, suicide prevention, HIV/AIDS, hepatitis C and palliative care. The peer health counselling group has also received support from agencies working with ethnocultural groups — including the Asian Coalition for HIV/AIDS Prevention (ACAP), the Black Coalition for HIV/AIDS Prevention (Black CAP), the Katarokwi Native Friendship Center, and 2-Spirited People of the 1st Nations — to address prisoners' HIV/AIDS and hepatitis C education and information needs. In addition, the Canadian AIDS Treatment Information Exchange (CATIE) and the HIV & AIDS Legal Clinic (Ontario) have been brought in by the peer health counsellors to provide information to prisoners. Many of these sessions have been facilitated with the assistance of PASAN and the support the Social Development Officer (Larry Chrysler) at Warkworth. Currently, the peer health group is working closely with the prison outreach

worker from the Peterborough HIV/AIDS Resource Network (PARN), who visits the prison once a month to counsel prisoners on HIV/AIDS prevention and treatment.

Peer health counsellors are active in the support and advocacy of the chronically ill prisoners in the prison, and they conduct educational programs about palliative care. Their work with chronically and terminally ill prisoners includes co-operation with the Warkworth prison chaplaincy to assist prisoners applying for parole on medical grounds. The peer health counsellors also work closely with the John Howard Society of Peterborough to assist prisoners to plan for release, and to ensure access to community resources upon release.

Lessons learned

HIV/AIDS, hepatitis C and harm reduction education can be undertaken by prisoners for prisoners, with support from entities other than prison health units. The peer health counsellors decided to work with social development programs so that they could have greater flexibility in the programs they offer and could receive information from the community rather than prison authorities.

Support of the prison's Social Programs Officer has been essential to the success of the program. He acts as a liaison for the peer health counsellors, and he contacts community organizations and facilitates their entry into the prison on behalf of the counsellors.

Having peer health counsellors independent of CSC health care and the CSC PEC program serves the needs of any prisoners who may not have complete confidence in CSC staff or CSC-run programs and would not access information and counselling provided by CSC staff or peer counsellors selected by CSC.

Limitations

Because the program is not part of CSC's organization-wide HIV/AIDS and infectious disease programming (i.e., PEC), the peer health counsellors do not get paid for the peer health work they do. Therefore, these prisoners do the peer counselling work for free on top of the paid work or schooling programs that form part of their daily routine.

High turnover of peer health counsellors means that the number of counsellors involved in the program at any one time is small, and there is an ongoing need to train new counsellors.

Warkworth Institution is located almost two hours from Toronto, which makes it difficult for Toronto-based community organizations to visit on a regular basis. Despite the high number of HIV/AIDS organizations in the Toronto area, very few of them are funded to do prison work, so they are unable to afford the travel and staff costs to go out to the prison.

Funding

N/A

Supporting documents

N/A

Evaluation

N/A

Federal prisoners start Health Awareness Group

Contact:

Health Awareness Group
Stony Mountain Institution
P.O Box 4500
Winnipeg, MB R3C 3W8

Overview

The Health Awareness Group (HAG) is a prisoner-driven initiative. It was started by prisoners in CSC's Stony Mountain prison in 1995 to address the alienation of their HIV infected peers after the suicide of a prisoner living with HIV. The group was formally recognized by the administration at Stony Mountain in October 1997. Group membership is open to all prisoners. In its initial phase, the group was assisted by the John Howard Society of Manitoba. HAG is now considered a social group within Stony Mountain, and is governed by an executive committee that decides what issues to work on.

HAG contributes to the maintenance and improvement of prisoners' individual and collective health. They do this by working with community support agencies and staff to educate prisoners about infectious diseases and emerging health concerns, monitor HIV and HCV prevention and harm reduction initiatives, and advocate for prisoner health and safety.

HAG's primary activities are: monitoring the availability of condoms, lubricant, and bleach and other HIV and HCV prevention and harm reduction programs available in prison; coordinating education programs on health issues one evening a week; working cooperatively with CSC health services and community organizations on emerging health issues; advocating for individual and collective health and safety; compiling a resource library of videos, posters, and pamphlets on health issues; and publishing a newsletter to inform the inmate population of the need for harm reduction programs and to update prisoners on health awareness events. HAG also makes referrals to existing prison and community services to address a wide range of prisoner health needs.

HAG's secondary activities include: lobbying prison authorities and politicians for safer tattooing and prison needle exchange; responding to media enquiries; acting as peer presenters for the Choosing Health in Prisons (CHIPS) program; and networking with community agencies to support initiatives in the community and the prison system.

HAG has obtained funding from the CSC National Infectious Diseases Program's Special Initiatives Program "HIV Prevention Strategies By Inmates for Inmates" (Special Initiatives Program) to run a poster contest and design a new interactive learning tool for use within the prison.

HAG would like to encourage the establishment of similar groups within each federal and provincial prison. It believes that its approach encourages prisoners and staff to work in partnership to provide safer and healthier environments for prisoners. HAG also asserts that this kind of peer service delivery and peer advocacy are examples of behaviours that should be encouraged and nurtured by corrections.

Lessons learned

Peer health groups are an asset to health services. Stony Mountain administration has found that HAG has helped cut down on health grievances by almost 90 percent. HAG is able to advocate effectively on behalf of prisoners by acting as a mediator between prisoners and health care regarding prisoner complaints about health services.

Peer health groups are highly effective in delivering HIV and HCV prevention and harm reduction training. Due to HAG's work, Stony Mountain has found that skin infections have declined because prisoners are being taught safer techniques for tattooing and injecting. Informally, health care staff are hearing that tattoo artists are more knowledgeable about health, including the use of clean ink and needles.

Peer-driven awareness regarding HIV has resulted in greater acceptance of prisoners living with HIV. HAG members have the respect of prisoners, and as a result, prisoners follow their example in treating HIV-positive prisoners in a non-judgmental and non-discriminatory manner.

Prisoners appreciate having options in peer programs. Stony Mountain has both PEC and HAG. "Official" educators (i.e., prisoners selected by the prison administration to receive the PEC training, and to provide PEC-based training) see all new prisoners at admission and offer them advice about how to stay healthy and safe in prison. Some prisoners get along better with PEC counsellors, some with HAG volunteers. In this way, the HAG complements prison-initiated, peer-health-based initiatives.

Limitations

Funding limitations mean that the continuity of prison staff support for the program is constrained. Funding for the prison staff support person has to be applied for every year.

Although HAG is recognized and accepted by the prison administration, it does not receive resources in the same way as the PEC program or some other official programs and groups. Health care staff and HAG members believe that HAG could benefit from a paid HAG coordinator position and an office.

Funding

Originally funded by John Howard Society of Manitoba. Currently HAG does not receive ongoing funding, but has been able to access money for specific, limited initiatives through the Special Initiatives Program.

Supporting documents

N/A

Evaluation

N/A

CSC funds prisoner HIV initiatives

Contact:

Correctional Service of Canada
National Headquarters, Health Services
340 Laurier Avenue West
Ottawa, ON K1A 0P9
Telephone: +1 613 943-9574
Fax: +1 613 995-6277

Overview

The Special Initiatives Program began in 2003. CSC recognized the need for peer health initiatives beyond the PEC program. The Special Initiatives Program funds peer-based HIV/AIDS prevention education programs for prisoners, providing an opportunity for prisoners to develop educational materials or organize activities dealing with HIV and hepatitis C prevention and harm reduction for other prisoners.

During the past three years, prisoners have been funded to design t-shirts, calendars and posters with HIV and hepatitis C prevention and education messages. Prisoners have also organized symposiums, health fairs and other awareness activities. To be funded for the project, prisoners must complete an application form (available through health care units) describing the project, its objectives and timelines; and must provide an itemized budget. Since the inception of the program, CSC has funded over 30 projects and activities. Decisions with respect to funding projects are made jointly by the Regional Infectious Diseases Coordinator in the region where the application originates and the National Infectious Diseases Program Coordinator.

Lessons learned

Peer initiatives are essential to health education in prisons. CSC has found that prisoner-led HIV and hepatitis C educational initiatives are very successful and can complement existing peer health programs within the prison.

Various approaches and strategies should be used to promote the program. The Special Initiatives Program would like to see an increase in applications. To that end, it has enlisted the help of community organizations, especially those with an interest in HIV/AIDS and harm reduction, to talk up the program with prisoners. Making contact with prisoner groups to promote the program can also help with the program's visibility within the prisons.

Limitations

Reliance on overworked prison staff means that prisoner applications may take time to complete and submit. Prison nursing staff may not always have time to seek several bids from companies for services, a standard practice in federal government contracting.

Many prisoners, including those prisoners already involved in delivering HIV and HCV prevention and harm reduction programming, were unaware of the Special Initiatives Program.

Funding

Government of Canada, Federal Initiative to Address HIV/AIDS in Canada

Supporting documents

Special Initiatives 2006/2007 Application Form

Evaluation

N/A

Community organization provides HIV and HCV prevention and harm reduction education to provincial prisoners**Contact:**

Eveline Allen
Prisoners HIV/AIDS Support Action Network
#500-489 College Street
Toronto, ON M6G 1A5
Telephone: +1 416 920-9567
Fax: +1 416 920-4314
eveline@pasan.org
www.pasan.org

Overview

The Prisoners HIV/AIDS Support Action Network (PASAN) is an Ontario community-based organization working to provide advocacy, education and support to prisoners on HIV/AIDS and hepatitis C-related issues. PASAN's Regional Outreach and Education Coordinator (Eveline Allen) annually provides 60 HIV/AIDS and hepatitis C group workshops in the three Toronto-area provincial prisons (Toronto Jail, Metro East Detention Centre and Metro West Detention Centre). Previously, PASAN outreach coordinator was able to meet one-on-one, on an impromptu basis, with prisoners who did not want to attend a group session, and prisoners with specific, personal questions, while doing "walk-arounds" in these facilities. These one-on-one sessions were cancelled effective October 2006 because of restrictions imposed by prison administration on PASAN's access to individual prisoners. One-on-one support for prisoners living with HIV is available upon request, if arranged ahead of time.

The objectives of the PASAN initiative are to decrease behaviours that put people at risk for HIV and hepatitis C infection, enhance access to HIV, hepatitis C and STI prevention materials, and promote sexual health. In addition, the program content addresses social and economic factors related to discrimination, poverty, race, sexual orientation, culture, gender, language skills, age, physical or mental ability and HIV seropositivity.

Lessons learned

Programs delivered by community-based organizations are essential component of HIV/AIDS, HCV and harm reduction education for prisoners. Many prisoners have expressed to PASAN that they do not fully trust prison health care staff because they do not see them as independent of prison security and administration. Some prisoners

said that they do not feel comfortable asking questions to health care staff about activities which are illegal or contravene prison rules — for example, questions about sexual intercourse, illicit drug use and tattooing.

Education of prisoners is an important first step to assist them in protecting their health. Most prisoners who attended the information sessions stated that they would be willing to try to utilize harm reduction strategies that they learned in the program.

Detention centres, which house prisoners awaiting court appearance, have a high turnover of detainees and thus present a prime opportunity to reach a large number of prisoners with education programs.

Education sessions on HIV and HCV should be delivered to prisoners on a regular basis. PASAN provides ongoing weekly programming inside the Toronto-based prisons. This consistency allows prisoners to get to know the facilitator, develop comfort and trust in her, and be able to ask questions that they might not normally ask. The facilitator has been doing programming in prisons for over 10 years and is highly respected by prisoners and staff.

There are different ways to get information to prisoners where it is not possible to meet every prisoner in person. The facilitator leaves pamphlets, brochures and newsletters. PASAN publishes Cell Count, a quarterly newsletter written for prisoners by prisoners and ex-prisoners. Every issue of the newsletter provides some information on HIV, HCV, safer tattooing, safer crack use, how to clean needles and other HIV and HCV prevention and harm reduction information relevant to prisoners. Prisoners and ex-prisoners contribute articles, poetry and drawings.

Limitations

PASAN staff are advised by prisoners that prison staff do not always tell prisoners that an education session will be taking place, and that sometimes prison staff are not available to escort prisoners to the education sessions.

Lack of sterile needles for injecting and tattooing (and other materials required to prevent the transmission of HIV and HCV during these injecting and tattooing) makes it impossible for prisoners engaged in risky activities to stay safe in Ontario prisons. There is limited access to condoms — they must be requested from staff, and a maximum of two are provided per request. There is no methadone initiation, no needle exchange, no tattooing equipment and no access to bleach.

Funding

City of Toronto, Toronto Public Health, AIDS Prevention Community Investment Program

Supporting Documents

R. Lines, *Pros and Cons. A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners*, PASAN, 2002.

Evaluation

Evaluation forms are handed out to prisoners after each education session; where prisoners are unable to complete written evaluations because of literacy or language barriers, oral feedback is solicited. Evaluations demonstrate that 80 percent of participants left the program with more knowledge of HIV/AIDS and hepatitis than

when they arrived; and that 84 percent of participants said they would try some of the things that they learned from the workshop (e.g., use of condoms and dental dams, and harm reduction practices both inside prison and in the community). Questionnaire responses to “what was good about the workshop” included: “Straightforwardness of program,” “informative,” “open-minded,” “instructor was easy to follow,” “made me less afraid” and a “good space to talk openly.”

Prison Outreach Program goes into in federal and provincial prisons

Contact:

Terry Howard
British Columbia Persons with AIDS Society
Prison Outreach Project
1107 Seymour Street, 2nd Floor
Vancouver, BC V6B 5S8
Telephone: +1 604 893-2281
Fax: +1 604 893-2251
terry@bcpwa.org
www.bcpwa.org

Overview

The Prison Outreach Program (POP) was started in 1994 by a prisoner at Mission Institution. Michael Linhart, a man serving a life sentence at Mission, was being discriminated against because of his HIV status. He contacted the British Columbia Persons with AIDS Society (BCPWA) and volunteers in the community who supported his efforts and began offering support to other prisoners in CSC prisons throughout British Columbia. When Linhart was paroled into the community, he continued his work from the newly founded POP at BCPWA.

POP provides services both to individual prisoners and to groups of prisoners. It has a toll-free line that operates daily from 10 am to 10 pm, allowing HIV-positive prisoners to speak with volunteers should they need support or assistance. The outreach coordinator and volunteers provide individual HIV/AIDS prevention information, education on harm reduction in prison, advocacy, and one-on-one support (both over the telephone and in person) to male and female prisoners living with or at risk of HIV/AIDS. The outreach coordinator, who is an employee of the BCPWA, and the volunteers organize monthly visits to CSC prisons and bi-weekly visits in provincial prisons. During visits the coordinator and volunteers provide individual support, advice on advocacy in response to human rights violations, and assistance with obtaining health care services. They also engage in release planning.

POP also delivers educational workshops on harm reduction, HIV and HCV prevention, hepatitis, STIs and health promotion.

Since 2003, POP has served prisoners in nine CSC prisons and four provincial prisons. POP began offering support services to women prisoners in 2004 with the opening

of the Fraser Valley Institution for federally-sentenced female prisoners, and the refurbishing of Alouette Correctional Center for Women (ACCW) to house provincial female prisoners.

POP involves prisoners in all aspects of programming whenever possible.

Lessons learned

It is essential to involve prisoners in all aspects of programming. POP has developed strong relationships with prisoners by involving prisoners in the development and delivery phases of all support programs.

By developing a working relationship with prison administration, POP has been able to increase prisoners' access to services and develop greater cooperation of prison administration to deliver prisoner-identified programs.

Having a strong framework for the delivery of programs is important. POP has found that consistency, integrity, respect and, above all, remembering for whom they work (prisoners living with and at risk of HIV/AIDS), are the key elements of the framework within which programs and services are delivered.

POP varies the educational content depending on the population they are working with. POP has identified the importance of the culture and gender issues in education with the prisoner population. These specific population needs are incorporated into the framework in which POP works.

Limitations

Insufficient funding limits community-based programs. POP lacks adequate program funding for staffing, transportation costs, and training materials. POP is not able to fully meet prisoners' demand for services.

While POP staff can educate prisoners about the risks associated with sharing injection drug equipment and unhygienic tattooing, they cannot provide prisoners with sterile syringes for injecting or needles for tattooing.

Funding

Until 2005, POP was funded under BCPWA's operational funding. Since that time, POP has received a AIDS Community Action Program (ACAP) grant from PHAC. POP has also received several smaller foundation grants and a grant from Roche Pharmaceutical.

Supporting documents

N/A

Evaluation

An evaluation of the ACAP-funded "Entry to Exit" project, is currently underway; to be completed in March 2007. Quarterly project reporting has demonstrated that POP has exceeded targeted objectives and outcome measures through the six completed reportable "quarters" of the two-year project. Longitudinal data and qualitative and statistical information have been collected since 2003 on all aspects of the POP services provided. No formal compilation of this data has been undertaken.

Community organization delivers drug and harm reduction education to provincial prisoners

Contact:

Sandra Johnson
Streetworks
Boyle Street Co-op
10116-105 Ave
Edmonton, AB T5H 0K2
Telephone: +1 780 422-7333 ext. 1
Fax: +1 780 425-2205

Overview

Front-line prison program staff at the Edmonton Remand Centre identified the need for more education for prisoners on drug use and harm reduction-related issues. Beginning in 2002, Streetworks was invited into the prison to offer education on HIV/AIDS, hepatitis and STIs. A Streetworks staff member (Sandra Johnson), accompanied by a community STI nurse, started to come into the prison on a weekly basis. The STI nurse did testing for HIV and hepatitis C, while the Streetworks staff member provided education to prisoners on their living units. Although the STI nurse no longer goes into the prison, Johnson visits the prison once a week to conduct an hour-long program. She discusses hepatitis A, B and C, HIV/AIDS and harm reduction. She usually has 10 participants for each education session and sometimes conducts two sessions per visit.

Front-line prison program staff act as a liaison for Streetworks and facilitate all visits into the prison, including coordinating security clearance and visits to the units. In addition, Unit Managers announce the program, which facilitates prisoners' attendance on a voluntary basis. Streetworks brings pamphlets regarding harm reduction, HIV/AIDS and hepatitis C and leaves leftover pamphlets for prisoners who did not attend the workshop. While a front-line prison staff person is present throughout the hour-long session, prisoners accept this presence because the staff member is not a guard. Streetworks staff make clear that prisoners can contact the Streetworks office for further, confidential information and advice.

Streetworks' prison program also assists individual prisoners in trying to stay safer and healthier both in prison and when they are released. It does this through advocacy on both an individual and systemic basis, to ensure that prisoners have access to whatever they reasonably need to stay healthy. Streetworks will often make phone calls and write letters in an effort to enhance prisoners' access to services.

Lessons learned

Streetworks and its staff have a good reputation with prisoners in part because of the work they undertake in the community, of which many prisoners are aware.

Demonstrated and visible prison system involvement in the program addresses prison staff concerns about outside agencies working in prison. The fact that a front-line prison program staff person accompanies the Streetworks' staff member addresses prison security staff members' security concerns. It is also significant that the front-line prison program staff member enjoys a good working relationship with security

staff, one based on respect for the security staff and prison rules. Finally, the front-line prison program staff member fosters a cooperative and trusting relationship with security staff by making them aware of the information being brought into the prison by Streetworks.

Education of prison staff, especially security staff, is an important factor in paving the way for prisoner educational programs. The more information the security staff have about harm reduction, the more supportive they have been of the Streetworks' program. This allows for easier access onto the units and greater support for the program overall.

Limitations

Lack of funding and resources is a significant limitation for Streetworks. With current funding, Streetworks can attend Edmonton Remand once a week for an hour. With approximately 700 prisoners and a high rate of turnover, Streetworks is unable to reach a large portion of the population.

Limited access to sterile injection equipment and clean needles for tattooing makes it difficult for prisoners to stay healthy and safe while in prison. Streetworks staff reports that prisoners have no access to bleach and no access to sterile needles for injecting.

A remand centre is a high-security environment, which makes programming difficult. There may be long waiting time to bring prisoners to locations where programming is offered, and the ability of community program staff to move about the units where prisoners live may be restricted.

Supporting documents

N/A

Evaluation

N/A

Community organization engages prisoners in education using specially-designed games

Contact:

Sylvain Turgeon / Manon Lacroix
Le Centre Option-Prévention Toxicomanie-Violence-Délinquance-Sida (TVDS)
615 Provost Street, apt. 1
Lachine, QC H8S 1M5
Telephone: +1 514 634-7899
Fax: +1 514 634-8521
tvds@bellnet.ca
www.tvds.ca/html/mainnav.swf

Overview

In 1993, an outreach worker (Sylvain Turgeon) at le Centre Option-Prévention Toxicomanie-Violence-Délinquance-Sida (TVDS) created a game based on “Snakes and Ladders” to teach HIV prevention ideas. He pilot-tested the game in schools, and it was very successful. In 1997, TVDS presented the game to Health Canada in Quebec and received funding to go into federal prisons and conduct an education program based on the game. In the first three months the program was run, 100 prisoners from 10 prisons participated. Over the past five years, a total of 2500 prisoners have participated in the program. The same outreach worker has also used a harm reduction version of bingo. He encourages participation in these games by giving out small prizes, such as chocolate bars. In addition, TVDS has trained numerous volunteers to go into the prisons weekly to give information sessions on HIV/AIDS, sexual health, piercing and tattooing.

Turgeon has also done work on educating prisoners on tattooing and the risks of tattooing in prison. In this training he was accompanied by a tattoo artist from a local shop (Tatouage Artistique). TVDS reports that this initiative was very well received by both prisoners and staff.

Lessons learned

Education on harm reduction is one of the most important efforts to help promote the health of prisoners. TVDS found that after some education sessions prisoners have turned in materials that they learned were hazardous (dirty needles, tattoo guns, etc.).

Creative education and small incentives engage prisoners. Going into prisons and educating prisoners through games is an effective method of teaching prisoners about HIV and HCV prevention and harm reduction. People learn through different methods, and this practice promises to be an effective way of working with prisoners. Small “prizes” such as chocolate bars have been a good incentive for increased prisoner participation.

Proper training of TVDS volunteers and staff has been essential to the longevity and success of a program. Sylvain has learned that it is very important for him to share within TVDS the knowledge that he has acquired in working on this program. This includes training volunteers about how to behave in prison (respect rules, dress code, limits, etc.). Strong mentorship means that when he leaves the agency, others will know how to run the program effectively.

Once developed, a good working relationship between a community-based organization and CSC (i.e., federal) prisons does not necessarily make it easier for the community-based organization to start work within provincial prisons. TVDS quickly realized that the provincial prison system in Quebec was organized very differently from CSC prisons; he found that it was more complicated to work within the Quebec provincial system.

Limitations

TVDS reports that in the early years of the program (1993 to 1997) it took a great deal of effort for a small community agency to develop a partnership with the CSC prisons. At that time, there were few if any community-based organizations going into prisons in the Quebec region to provide HIV/AIDS, HCV and harm reduction programming. CSC staff members in the prisons TVDS visited were reluctant to acknowledge that

prisoners were engaging in risk behaviours, some of which behaviours are criminal or go against prison rules. Thus prison staff could not fully acknowledge the need for education to reduce these risk behaviours and associated harms, and there was no accepted practice or model for community-CSC partnership around HIV and HCV prevention and harm reduction programming. This early limitation has been overcome.

Lack of sufficient and stable funding creates a strain on programs and staff. For example, TVDS reports that the funding for the program was cut in 2004 despite the fact that in 2003 TVDS provided the training in 11 prisons and 18 halfway houses (and 25 detox centres). It continues to be difficult to run such an ambitious program with only one dedicated staff member and no funding for additional staff, travel expenses and other associated costs.

Funding

Correctional Services of Canada

Supporting documents

N/A

Federal prison dedicates resources to health education for incoming prisoners

Contact:

Chief of Health Services
Stony Mountain Institution
P.O. Box 4500
Winnipeg, MB R3C 3W8
Telephone: +1 204 344-5111
Fax: +1 204 344-7100

Overview

Choosing Health in Prisons (CHIPS) is a voluntary program offered by CSC. Every prisoner entering a federal prison is eligible to be in the program. Prison health care at Stony Mountain has made the CHIPS program a priority at intake. The program is run every two weeks by a designated facilitator (Andrea Rees-Bergan), and it takes a full five days to complete, during which time prisoners receive their regular pay. Ninety-four percent of the population goes through the program. For prisoners who are not able to attend CHIPS (because they cannot mix with the population), they are given a Reception Awareness Package (RAP) in segregation and told that they can ask questions at any time.

The program covers information on HIV/AIDS, hepatitis C, STIs, harm reduction and other health-related concerns. The current facilitator recognizes that every group is different, and she adjusts to the group she is working with. She uses all modalities of learning (audio, visual, verbal, kinaesthetic and writing), plays games and shows videos to keep the group engaged in the learning. Some of the content focuses on the prison environment, and peers (i.e., other prisoners) come in to talk about how to stay

“safe” in the prison environment. Guards never ask the facilitator what she talks about in the program, and she tells prisoners clearly that the role of health education is not security.

Lessons learned

Thorough and intensive education about HIV and HCV prevention can encourage prisoners to test for HIV and HCV, and to protect their health. As a result of the CHIPS program, about 85 percent of the population has sought testing for HIV/AIDS, and there is an equally high rate of immunization for hepatitis A and B.

Using peers to educate other prisoners is an effective method of teaching. The facilitator engages peers during CHIPS to talk to prisoners on how to stay safe in prison. As a result, new prisoners coming into the prison system have a better understanding of the risk involved in particular activities.

Buy-in from prison staff creates a more successful program. Stony Mountain health care manages its budget to ensure that the prison has a full time nurse-educator. No other CSC prison has this position. Having a full-time nurse-educator allows for the time needed to focus on the education of prisoners. The prison staff person responsible for intake views the program as a priority, which contributes to the program’s high completion rate. The intake officer makes sure that CHIPS is included in the intake process as are other programs.

Limitations

N/A

Funding

Correctional Service of Canada

Supporting Documents

N/A

Evaluation

N/A

Community initiative

Mooky Cherian
Provincial Program Coordinator
Prisoners HIV/AIDS Support Action Network
#500-489 College Street
Toronto, ON M6G 1A5
Telephone: +1 416 920-9567
Fax: +1 416 920-4314
mooky@pasan.org
www.pasan.org

Overview

PASAN is the only organization in Canada exclusively providing HIV/AIDS and hepatitis C education and support services to prisoners, ex-prisoners, young offenders, and their families.

The Provincial In-Reach Coordinator (Mooky Cherian) is responsible for increasing the number of AIDS service organizations (ASOs) and community-based organizations providing services for prisoners and ex-prisoners. This is principally achieved through partnerships and training programs. Training for community-based organizations includes information on the differences between provincial and federal corrections; racism; Aboriginal prisoners; women in prison; transgender/transsexual people in prison; HIV and HCV in prison; harm reduction in prison; methadone; drug use; tattooing and piercing; sexual activity; health promotion; advocacy; building trust with prisoners; communication; barriers; allies; and other issues related to doing education in prisons or starting programs for prisoners.

Peers are also an important component of the training program. The coordinator brings a peer (prisoner or former prisoner) to each of his education sessions so that people can hear from a first-hand perspective the needs of prisoners. This component of the project helps put the information into perspective.

The coordinator also provides prison training and acts as a resource for ASOs and community-based organizations on issues related to prison work.

Lessons learned

It is important for community organizations to understand how the prison system operates. Many organizations are unfamiliar with the prison environment and will try to start programs without really understanding all of the dynamics at play.

There are specific policies that need to be in place, and decisions that need to be made internally, before an organization can start implementing programs for prisoners.

The participation of peers in education is essential to the success of a program. The coordinator has found engaging peers in this work has helped community organizations understand the impact of prison on someone's life.

Limitations

A lack of funding limits the success of the program. The coordinator is funded to do the initial training, but then there is no funding to do follow-up with organizations. He is also not able to provide programs to organizations in geographically isolated regions in Ontario or to provide ongoing training and support.

Community organizations need to be funded to meet the needs of prisoners. The coordinator finds that many organizations would be willing to work with prisoners but do not have the funding to initiate programs. For example, most organizations cannot afford the cost of collect phone calls or the travel expenses to visit the prisons.

Funding

Ontario Ministry of Health and Long-Term Care, AIDS Bureau

Supporting Documents

R. Lines, *Pros and Cons. A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners*, PASAN, 2002.

Anne Marie DiCenso, Giselle Dias, and Jacqueline Gahagan, *Unlocking Our Futures : A National Study on Women, Prisons, HIV, and Hepatitis C*, PASAN, 2003.

Training, education and professional development for prison staff

Guidance, recommendations and international perspectives

The WHO Guidelines recommend that prison staff should receive information about HIV/AIDS and ways to prevent transmission, with special reference to risks of transmission within the prison environment. The Guidelines recommend that staff receive such information during their initial training and thereafter on a regular basis, be consulted about and encouraged to participate in the development of educational materials, and be involved in the dissemination of information to their peers. Finally, the WHO Guidelines specify that education on infection control should emphasize universal precautions [WHO Guidelines 14, 15, 17, 18, 19].

The UNODC Framework recommends 10 wide-ranging actions regarding staff training and support on HIV/AIDS. Action 81 [p. 27], the first of these recommendations, reads:

Provide education on HIV/AIDS and other communicable diseases, routes of transmission in the workplace, confidentiality, drug use, HIV prevention measures, HIV testing and treatment opportunities, drug dependence treatment, universal precautions and use of protective equipment, and the rationale and content of prison rules and policies related to HIV/AIDS to all prison staff as part of their initial training, and update this training on a regular basis during the course of employment. Ensure that all staff receive regular training.

The Framework also recommends that staff be consulted on development and methods of delivery of educational materials and programs [Action 82; p. 27]. On a practical note, it is recommended that prison authorities ensure that all prison staff be provided hepatitis B vaccinations at no cost [Action 88; p. 28].

ECAP recommended that CSC staff be given written information, in addition to educational sessions involving the participation of external experts and organizations, about HIV/AIDS and universal precautions [recommendation 7; pp. 89–90].

Observations

Educating prison staff — health care staff, security staff, and program staff — about blood-borne infections, drug use and harm reduction is an important component in building a successful foundation for harm reduction programs for prisoners. It is also a vital component of occupational health and safety training for prison staff. It was our observation that, at present, both in policy and programs, the vast majority of staff education focuses on occupational health and safety related to HIV/AIDS and other BBPs. While such education is vital to protecting prison staff from occupational hazards, staff should also be provided with education about harm reduction for prisoners to promote their understanding and acceptance of harm reduction programs.

Informal, often one-on-one harm reduction education for prison staff is conducted in many different prisons by prisoners, community organizations and prison health care staff. Yet, overall, in policy and in the jurisdictions we visited, more could be done to provide programs that comprehensively address blood-borne infections, drug use, harm reduction, occupational health and safety, and the links among all of these. Exceptionally, HIV Edmonton has taken an active role in trying to educate provincial prison staff on issues of HIV/AIDS, HCV and harm reduction. They have conducted two conferences for prison staff. The trainings were supported by the Alberta Solicitor General's office, which highlighted to prison staff the importance of the programs and the high-level support they enjoyed. Throughout our interviews, we found that the more educated the prison staff were on issues related to blood-borne infections, drug use, harm reduction, and occupational health and safety, the less prison staff were likely to allow security concerns to dominate all health issues. Prison staff became much more likely to engage in dialogue and were generally less afraid.

CSC also developed extensive training materials and conducted training sessions across Canada to support the implementation of the methadone maintenance policy (Commissioner's Directive, *800-1 Methadone Treatment*

Guidelines, May 2, 2002). These materials were updated in 2005 for national methadone training of as many regional and prison staff as possible. Topics covered included general background on prisoners and substance abuse, including harm reduction, a comprehensive review of methadone, methadone in the prison environment, a review of staff roles and responsibilities, problem solving, management of prisoners with mental health issues, and a model for successful methadone intervention. Supplementing the “live” training sessions, VHS and DVD recordings of these sessions were made available to staff. (For more details regarding these training materials, please see the tables “Survey of policy” and “Survey of programs.”)

Currently, prison staff members are provided with a range of training opportunities about blood-borne infections, drug use, harm reduction and occupational health and safety. CSC offers a computer-based learning module on infectious diseases for non-health care staff, which module is mandatory for all correctional officer recruits.⁷⁸ Health-care staff benefit from the widest range of training opportunities, both training specific to the prison environment and general training through professional development programs and relevant national and international conferences. Staff training opportunities seem to differ from jurisdiction to jurisdiction, and there is no national conference on prisoner health, infectious disease or harm reduction for prisoners. Yet, there are important points of cooperation and coordination among jurisdictions. Numerous jurisdictions open up their trainings to prison staff from other jurisdictions, and such training opportunities appear to be publicized, in part, through the prison FPT mechanism.

For example, the 2005 CSC national methadone training was open to members of the FPT Heads of Corrections Working Group on Health as well as local provincial prison staff.⁷⁹ Another example of coordination is British Columbia Corrections’ Annual Corrections Health Care Conference to which front-line prison staff and management from all Canadian jurisdictions are invited. This multi-day conference is the only regularly occurring prison health care conference in Canada. It attracts a range of prison health care professionals and others (including nurses, physicians, psychologists, alcohol and drug counsellors, dentists, firefighters and paramedics, prison management, officials responsible for corrections and health, and people from community-based organizations). Each year the conference provides training on various aspects of prevention, care, treatment and support in relation to BBPs, including HIV/AIDS and other STIs and hepatitis. In 2007, women prisoners from B.C.’s Alouette Correctional Center for Women will participate in the conference and give presentations on their own participatory health research study (described below).

Enabling policy

The following policy supports HIV and HCV prevention in prison:

- Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Health Services, *Infectious / Communicable Disease – AIDS and HIV 20.15.03* (January 26, 2004). This policy makes each prison director “responsible to ensure that all staff are oriented to the procedures of infectious disease control and the prevention of HIV and other infectious diseases, that training is updated as necessary....”

⁷⁸ Ibid.

⁷⁹ Personal correspondence with Dr Diane A. Rethon, Medical Director, British Columbia Corrections.

Best and promising programs

AIDS service organization delivers HIV and HCV prevention and harm reduction training for prison guards

Contact:

Debra Jakubec
HIV Edmonton
#300–11456 Jasper Avenue
Edmonton, AB T5K 0M1
Telephone: +1 780 488-5742
Fax: +1 780 488-3735
director@hivedmonton.com
www.hivedmonton.com

Overview

In 2005–2006, HIV Edmonton in conjunction with Public Health Awareness Task Group of Non-Prescription Needle Use (NPNU) Consortium held a conference entitled: *Corrections Conference: Taking Care of Ourselves: A Seminar About HIV, AIDS, and Hepatitis Prevention in Prison.*

The purpose of the conference was to promote awareness of infectious disease prevention and harm reduction and to further related programming in prisons in partnership with Alberta Correctional Services. Prison guards were concerned about their risk of exposure to blood-borne pathogens (BBPs). Prison guards and other prison staff have an important role to play in implementing harm reduction strategies in their workplace. Short and intermediate objectives of the workshop were to increase awareness, understanding and acceptance of (and address myths about) BBPs and harm reduction among prison employees. The *Corrections Conference* was a full-day training workshop attended by 24 Alberta Correctional Services officers. Several speakers with expertise in BBPs, harm reduction, Aboriginal populations and front-line work with high-risk populations presented lectures. Topics included BBPs (HIV, HBV, and HCV), routine practices, post-exposure prophylaxis, Aboriginal populations, methadone maintenance and harm reduction.

Lessons learned

Support from the highest levels of management is essential to engage prison staff in the program. The *Corrections Conference* was effectively able to bring together prison staff from a number of facilities across Alberta because the conference was supported by the Solicitor General's office. This meant that the officers were paid to attend, the venue was paid for, and a staff member from the Solicitor General's office opened the conference. HIV Edmonton believed that "buy-in" from the highest level of Alberta Correctional Services was essential to the success of the project.

Limitations

Funding constraints can limit training opportunities. With additional funding, HIV Edmonton may have been able to train more prison staff using the same conference format.

Funding

Health Canada, Hepatitis C Regional Project Funding

Supporting documents

N/A

Evaluation

An evaluation form was distributed to each participant at the end the workshop. The majority of participants felt that they got what they needed from the workshop, that the objectives of the workshop were clear, that the material was presented in a clear logical manner, and that the instructors had a clear knowledge of their topic area and encouraged questions. The majority of participants were satisfied with the information they received and had an increased understanding of HIV and hepatitis. Participants reported that they had a better understanding of ways to protect themselves and had a better understanding of harm reduction. Over half of the participants felt that they would like to apply harm reduction strategies in their workplaces and that it was important to do so.

Population-specific needs: women prisoners

Guidance, recommendations and international perspectives

The WHO Guidelines state that “special attention should be given to the needs of women prisoners,” and specify that staff “should be trained to deal with the psychosocial and medical problems associated with HIV infection in women.” [Guideline 44]. Some of the particular services that should be made available to women prisoners include regular gynaecological consultations, with particular attention to STIs, as well as family planning counselling, appropriate care during pregnancy, care for children, and condoms and other contraceptives [WHO Guidelines 44–46]. As a general principle, the UNODC Framework states that is essential that programs and services be responsive to the unique needs of vulnerable or minority populations within the prison system; including incarcerated women, who should therefore be given particular priority and focus when developing HIV/AIDS services.⁸⁰ Specific to women prisoners, the Framework calls for initiatives that “reflect the fact that in many countries women face increased vulnerability to HIV infection, have higher rates of HIV infection in prisons than men, engage in risk behaviours differently than male prisoners, and generally serve shorter sentences than men” [Action 56; p. 24].

ECAP recommended that CSC provide women in federal prisons with educational and prevention programs specifically designed for women; ensure that there are programs that help to empower women in prison and decrease their vulnerability to abuse, HIV infection and drug use; and ensure that these programs are developed with community and peer input. ECAP also recommended that adequate information, counselling and support for pregnant women in prison be provided [recommendation 13; p. 113].

In 2003, PASAN published *Unlocking Our Futures: A National Study on Women, Prisons, HIV and Hepatitis C*.⁸¹ The report presents findings and recommendations from a qualitative evaluative study of 156 women in federal prison (approximately 40 percent of all women in federal prisons at the time) housed in nine prisons across Canada. The research investigated the women’s perceptions and lived experiences of HIV/AIDS and HCV, and documented the specific needs of the women regarding HIV and HCV prevention, care, treatment and support. Among other topics, the report made recommendations for prevention education, harm reduction programs and HIV and HCV testing. The report found that 1 in 4 women was having unprotected sex, 1 in 4 women were engaging in tattooing, and 1 in 5 was engaging in injection drug use.⁸² Some of the recommendations in *Unlocking Our Futures* are specific to women’s particular needs with respect to HIV and HCV prevention and harm reduction:

- Access to women-specific HIV and HCV prevention education programs must be expanded and made consistent throughout the system. Both correctional and community-based programs must be offered on an ongoing basis.
- Condoms, dental dams, and water-based lubricants must be made equally and consistently accessible across the system. In particular, dental dams and lubricants must be provided and made easily accessible. Access to safer sex measures must meet the guidelines of CSC Commissioner’s Directive 821, and not necessitate making a request to staff.
- CSC should monitor the implementation of Phase II of its methadone policy to ensure equitable access to the program for women across the system. Efforts should be made to

⁸⁰ UNODC Framework, p. 13.

⁸¹ A. Dicenso, J. Gahagan and G. Dias, *Unlocking Our Futures: A National Study on Women, Prisons, HIV and Hepatitis C*, PASAN, 2003. See also L. Rehman et al, “Harm reduction and women in the Canadian national prison system: policy or practice?,” *Women Health* 40(4) (2004): 57–73.

⁸² *Unlocking Our Futures*, *ibid.*, p. 4.

educate women on the selection criteria for the program, and the process for entering the program.

- Information on safer slashing/cutting, as well as safer alternatives to slashing, should be developed and made available. (Slashing is a form of self-injury that involves using blades or sharp objects to cut the skin.⁸³) Non-punitive responses to women who slash must be implemented in practice, not simply in policy.

Observations

Prisons for women are generally smaller than men's prisons and usually have multi-level security (i.e., maximum-, medium- and minimum-security all in one facility). Many of the federal prisons for women are outside of major cities, thus reducing the number of community-based organizations available to provide programs. Those community groups that are committed to serving women in prison may have to travel great distances to deliver programs and are usually not funded for costs associated with travel. When there is more than one level of security in a prison, it can be difficult to reach women in the higher-security living units. Women in the maximum security units are segregated from the rest of the women, living in virtual isolation. They are not allowed to be with women in the lower-security settings. As a result, community agencies either have to run multiple, separate groups in one day or visit the prison more often. Smaller populations in the prison may also mean that not as many women may come out to programs. If community groups feel that they are not getting women to the workshops, then they believe it may not be worth running group sessions. Funding agencies often want to see greater numbers before they will approve additional funding; prison programming doesn't always provide those numbers. These factors affect women's access to programming.

CSC's HIV/AIDS Peer Educational and Counselling Program has a women's component which addresses women-specific needs. However, many of the federal prisons for women that we surveyed did not have an active PEC program running. Furthermore, in federal prisons, access to dental dams and bleach was inconsistent. At one federal prison for women, two out of three bleach machines were not working and condoms were unavailable. In some federal prisons, there were highly skilled women who could conduct programming for their peers, but there was a lack of staff support and no training to replace peer educators who were released.

Overall, in the provincial prisons we visited, women were receiving little educational programming because the numbers of women are so low in some prisons. To give but one example, in one remand facility women were receiving one education session a year, and access to condoms and bleach was inconsistent.

A number of women interviewed spoke about making and using sex toys (i.e., dildos). Infections that can be transmitted by direct sexual contact between people and can also be transmitted by sharing sex toys. Prisons should respond to this risk through education and by providing women with the means to clean sex toys and providing condoms to cover sex toys. Prisons should also consider making sex toys available for purchase.

Enabling policy

Correctional Service of Canada, Commissioner's Directive 821, section 10: "The gender and cultural requirements of individuals and groups shall be respected and reflected in all activities aimed at addressing infectious diseases in the inmate population." In addition, the *Corrections and Conditional Release Act* requires that CSC provide programs designed particularly to address the needs of women and Aboriginal people in prison (sections 77 and 80).

⁸³ For more information on self-harm among federally sentenced women, see C. Wichmann, R. Serin and J. Abracen, *Women Offenders Who Engage in Self-harm: A Comparative Investigation*, Research Branch, CSC, February 2002.

Best and promising programs

Prisoners at federal prison for women run HIV/AIDS education and support group

Contact:

Correctional Service of Canada
National Headquarters, Health Services
340 Laurier Avenue West
Ottawa, ON K1A 0P9
Telephone: +1 613 943-9574
Fax: +1 613 995-6277

Overview

The support group was started in February 2006 at Edmonton Institution for Women (EIFW) by Carla Durocher who recognized the need for support around HIV/AIDS, hepatitis C and harm reduction for women in prison. The start-up funding for the program was obtained through CSC's Special Initiatives Program: HIV Prevention Strategies By Inmates for Inmates. She enlisted the support of another woman (Siofean Codderre) to help facilitate the group.

The group ran every Saturday for an hour. Codderre would book the room and put the schedule on a monthly calendar that would be posted in an area visible to all of the women classified as minimum and medium security prisoners. She would come to the meetings early to open the door, get the room set up and make coffee. The prison staff would make an announcement when the meeting was about to begin to inform the women that the program was starting. No staff attended the program sessions.

An average of fifteen women attended the support group where they spoke about what was going on in their lives. They would have a general discussion, play educational games (related to HIV/AIDS, hepatitis C or harm reduction), and sometimes women who were HIV-positive would share their experiences. Unfortunately, the group stopped meeting when the women who initiated the group were released.

Lessons learned

Peer-initiated support groups provide a safe and accepting learning environment for women prisoners who have experienced marginalization to share, support and learn from one another. The women who initiated this program were able to identify a gap in services and then meet that need. The high turnout of women at each session indicates that women were interested in learning more about HIV and HCV prevention and harm reduction.

Limitations

Lack of stable, ongoing funding was an impediment to running the program on an ongoing basis. The first year the facilitator received \$300 from CSC's Special Initiatives Program for a contest for best short story, poetry and poster.

It is important in social gatherings to provide women with items such as coffee or other beverages as well as small snacks. Unfortunately, the application for the Special Initiatives Program asks for "items such as food, drinks and/or prizes" to be kept to a minimum. No further application for funding was made.

Funding

Correctional Service of Canada, Special Initiatives Program: HIV Prevention Strategies By Inmates for Inmates

Supporting documents

N/A

Evaluation

N/A

University partners with provincial prison for women — participatory action research empowers prisoners**Contact:**

Ruth Elwood Martin, MD, FCFP
Clinical Professor, UBC Department of Family Practice
Suite 300, 5950 University Boulevard
Vancouver, BC V6T 1Z3
Telephone: +1 604 822-1891
Fax: +1 604 822-6950
ruth.martin@familymed.ubc.ca
www.accwwomenresearch.org

Overview

In June 2005, Dr Ruth Elwood Martin invited the women and staff at the Alouette Correctional Center for Women (ACCW), located in Maple Ridge, British Columbia, to participate in a study to explore ways that participatory action research might be conducted in prison to improve health. Dr Martin intended to submit a proposal for the Canadian Institutes for Health Research fund for vulnerable populations. In October 2005, the first ACCW health research forum took place, at which Dr Martin, community-based health researchers, staff and prisoners brainstormed ideas for the proposal that was subsequently written up and submitted. The application was not successful; but the prisoners who helped write the proposal requested that they be allowed to continue their work on the ACCW prisoner health research team because they found the work meaningful. They did not want to have to wait until they secured research funding.

Since then, women of the ACCW prisoner health research team have met daily, identifying their unmet physical and mental health needs; brainstorming questions to be researched; developing educational PowerPoint presentations; describing ideas for possible interventions; and holding monthly health research forums to which they invite all ACCW prisoners and staff, community organizations, university researchers and policy makers. This project is unique; the women have found no published reports of any similar health promotion or participatory action research in a prison setting.

The ACCW prisoner health research team has identified pressing health issues within the prison system, including access to health care in prison, and also issues affecting transition to life in the community post-release. Some of the issues include addiction; cultural and spiritual health; emotional and psychological health; exercise, sleep and nutrition; family life and relationships; housing and safety; infectious diseases, such as HIV and hepatitis; physical health; and acquisition of job skills and employment. The prisoners guide all aspects of the research from asking questions, gathering data, analyzing data, presenting new knowledge and designing new policies for change.

In March 2006, Dr Martin, on behalf of the research team, signed a five-year research agreement with the British Columbia Ministry of Public Safety and Solicitor General, Corrections Branch, to conduct community-based participatory action research aimed at improving the health of women in ACCW. The research has been approved by a UBC research ethics board.

In May 2006, the project received funding through the University of British Columbia Development Office. This funding was used to hire a university graduate for four months to act as research coordinator. In addition, in January 2007, the Vancouver Foundation awarded the project twelve months of funding, which will enable the women to develop and run a webpage, to hire a research assistant; and to evaluate the short- and long-term outcomes of this project. The women of the ACCW research team designed the web page to be a community resource for all women who are released from prison, and as a site for updated information about participatory research activities.

Lessons learned

Peer-driven projects can increase well-being and contribute to personal empowerment. Among the lessons learned is that women on the research team have reported increased self-esteem, interpersonal skills, computer skills and knowledge about their health. Women who attended the monthly forums report increased understanding of the health and social needs of women who are in prison.

Peer involvement in new projects creates a sense of ownership and, with it, a desire to increase knowledge and skills. The women at ACCW expressed excitement about the project. They have indicated how much they have learned about women's health and about HIV, HCV, drug use and harm reduction.

Collaboration among outside groups, corrections and prisoners can create a visionary, respectful program. Having the women, prison staff and an outside university partner work together on such an innovative project has helped educate all involved on issues that are important for a greater understanding of women in prison.

Because initially the project had little direct funding, the women shaped the research project themselves and gave it their own priorities. This might not have been possible had the project received large initial grants, given how many strings would likely have been attached.

The membership of the ACCW research team turns over frequently, because women receive short sentences, which results in unique strengths: (1) continual source of new ideas and fresh enthusiasms as newly admitted women join the team; (2) a natural momentum for the research priorities, because women who are soon to be released

from prison see the need for immediate improvement in health and education; and (3) natural links to the outside community, because some women wish to stay involved with the research project after their release.

Limitations

The frequent turn-over in the prisoner membership of the research team results in difficulty in maintaining project continuity.

In addition, lack of funding has severely limited actual research the project is able to undertake. The project has twice unsuccessfully applied for funding from the Canadian Institutes of Health Research.

Funding

Ministry of Public Safety and Solicitor General, Corrections Branch

University of British Columbia, Development Office

Vancouver Foundation

Supporting documents

For more information about this project, please visit the ACCW Health and Education Participatory Research Project webpage at www.accwwomenresearch.org.

A Summary of the Alouette Correctional Centre for Women (ACCW) Participatory Health Research Project, October 13, 2006.

Sex worker and HIV-prevention organization engages women prisoners through creative writing and art

Contact:

Stella

2065 Parthenais, Suite 404

Montréal, QC H2K 3T1

Telephone: +1 514 285-8889

Fax: +1 514 285-2465

info@chezstella.org

www.chezstella.org

Overview

From August 2005 to March 2006, Stella, a sex worker organization, engaged women at Joliette Institution (CSC prison for women in Quebec) and Tanguay Correctional Centre (provincial women's prison) in creative writing workshops. The goal was to produce a special issue of *ConStellation Magazine* specifically on women in prison. The women at Joliette and Tanguay participated in three creative writing classes and one art class conducted by staff at Stella, and they participated in an additional workshop on hepatitis C delivered by prison health care staff. The women in the

workshops helped one another in their writing. The magazine was launched in March 2006 at Joliette.

Lessons learned

Building relationships with prisoners was a key to the program's success. The workshops allowed the Stella workers to create ongoing relationships with the women at Joliette so that they could discuss sensitive personal issues. After the workshop, the women taking the course would call Stella regularly, providing an opportunity to continue to support the women from Joliette.

It is important to have facilitators who have varied life experiences. The workshops were particularly successful because one of the facilitators was an ex-prisoner and sex trade worker.

Support from prison staff is needed for programs to succeed. Stella had strong support from administration at both women's prisons while doing the workshops. This helped with getting access to the prisons, having a room to run workshops and maintaining confidentiality by not having staff in the room while facilitating workshop.

Limitations

Resource and time shortages limited the success of the program. Stella found that there was not enough funding to cover all of the expenses for the project. Prison security procedures can affect the time needed to conduct programs in prisons. Timelines were generally too short.

Language barriers created challenges. It was particularly difficult to do the workshops in both languages (English and French), and getting the information across became complicated.

Credibility of community organizations takes time to build and affects programming. Stella found that security staff was difficult to deal with at times. Because Stella was not well known at first within the prison by staff or prisoners, it had to build credibility.

Funding

Hepatitis C Prevention Project Funding, Quebec Regional Office, Public Health Agency of Canada

Documents

ConStellation Magazine. Volume 9, No. 1 (Winter 2005).
Available at www.chezstella.org/stella/?q=en/constellation.

Evaluation

N/A

Population-specific needs: Aboriginal prisoners

Guidance, recommendations and international perspectives

The UNODC Framework states that it is essential that programs and services be responsive to the unique needs of vulnerable or minority populations within the prison system, including incarcerated indigenous populations, whose needs should therefore be given particular priority and focus when developing HIV/AIDS services (p. 13). ECAP recommended that CSC ensure Aboriginal prisoners have education and prevention programs that respond to their specific needs, and that such programs be developed in concert with, and delivered by, peers, Aboriginal groups and elders or healers [recommendation 14; p. 118].

Observations

The rate of incarceration of Aboriginal prisoners is much greater than that of the general population. Based on an age-adjusted comparison with the Canadian population as a whole, one would expect about 2.5 percent of federal prisoners to be Aboriginal; in fact, 17 percent of male and 26 percent of female prisoners are Aboriginal.⁸⁴ The over-representation of Aboriginal prisoners varies considerable across Canada. (The over-incarceration of Aboriginal people is a serious systemic issue beyond the scope of this report.)

Programming for Aboriginal prisoners must address their specific needs in a culturally sensitive way. Procedures of the penal system (policing, courts and prisons) are most often not in keeping with the traditional values or customs of Aboriginal people. Overall, programming for Aboriginal prisoners is inconsistent and under-funded. At present, there are few programs being provided in prisons in Canada that meet the HIV and HCV prevention and harm reduction needs of Aboriginal prisoners. There are many reasons for this insufficiency. One Aboriginal organization, Ontario Aboriginal HIV/AIDS Strategy (OAHAS), identified racism as a factor based on its struggle to run effective programming in Ontario prisons. OAHAS also noted that there is a lack of funding for Aboriginal groups to do effective programming for prisoners. LaVerne Monette, Executive Director of OAHAS, said the organization will not take money from Corrections or CSC because she believes that it does not make sense to take money from the people who are imprisoning the people you work with. Such as practice would make it more difficult to build trusting relationships with prisoners and make it easier for groups to be co-opted by the system. She added that some Aboriginal prisoners have perceived Native Liaisons and even Elders as being “bought off” when they are paid by CSC.

Monette said that to do any education in prison for Aboriginal people, groups must talk about the history of Aboriginal people and the effects of colonization, residential schools, mobility, addiction, etc. *before* it is possible to start discussing HIV/AIDS and harm reduction. This offers Aboriginal prisoners some context and affirmation of their experience before they begin to talk about their health. Unfortunately, in her view, this is not something that is recognized by funding agencies and therefore is not funded.

More Aboriginal programs need to be supported, funded and encouraged in prisons. For example, when training Knowledge Keepers at CSC prisons in Saskatchewan, staff from All Nations Hope AIDS Network was called upon to help participants deal with issues of physical and sexual abuse. It is very difficult to deal with these sensitive issues in a peer-run train-the-trainer workshop of limited duration. Additional programming for Aboriginal prisoners would allow for ongoing support and education beyond what this training was able to provide. Issues of systemic racism, the history of Aboriginal people, residential schools and addiction all came up during the training and could not be addressed in depth. Unfortunately, many Aboriginal prisoners do not have an opportunity to deal with these issues during their incarceration because there are so few resources

⁸⁴ “A health care needs assessment of federal inmates in Canada,” *Canadian Journal of Public Health* 95(S1) (2004): S1–S63, p. s15.

available to them. In some instances, Elders are available; however, in many prisons it has been reported that prisons can go months before someone is hired into that position. Psychologists are rarely available to any prisoner, and many who are available do not have the experience in dealing with issues that are specific to Aboriginal prisoners.

Enabling policy

The following policy supports HIV and HCV prevention and harm reduction in prison:

- Correctional Service of Canada, Commissioner's Directive, *702 Aboriginal Programming* (September 6, 1995) section 5 provides as one of five policy objectives: "To ensure that the needs of all Aboriginal offenders are identified and that programs and services are developed and maintained to meet those needs."

Best and promising programs

Circle of Knowledge Keepers: Peer HIV/AIDS programming for federal Aboriginal prisoners

Contact:

Morris Bowen, Knowledge Keeper
La Macaza Institution
321 Chemin de l'Aéroport
La Macaza, QC J0T 1R0

Overview

As outlined in the CSC *Circle of Knowledge Keepers Training Manual*, many Aboriginal communities traditionally had storytellers who recounted legends, teachings and history. The purpose of this training manual is to educate Aboriginal peer health educators to work within the prisons in a manner that is in keeping with this aspect of Aboriginal history and culture. According to the Circle of Knowledge Keepers manual, the goals of Knowledge Keepers are to help prevent and reduce the spread of HIV/AIDS among Aboriginal prisoners in federal prisons. Knowledge Keepers seek to create a climate whereby Aboriginal Prisoners living with HIV/AIDS receive the best care, treatment and support; and to encourage and empower Aboriginal prisoners to sustain behavioural and lifestyle changes in the community.

Aboriginal peer educators who take the training are called "Knowledge Keepers" and fulfill the role of a traditional storyteller. Knowledge Keepers are trusted with important information and knowledge that needs to be shared over and over to teach Aboriginal prisoners (and other prisoners) how to make choices to stay healthy and to become healthier. The manual acknowledges that not all Knowledge Keepers will be teaching groups of prisoners. Knowledge Keepers may invite guest speakers, or their principal role may be to make sure condoms, lubricant and bleach kits are generally available. Other duties might include arranging activities for World AIDS Day, setting up support groups or providing resources to prisoners.

The Knowledge Keeper (Morris Bowen) at La Macaza (Quebec) said that in this role he answers many questions unrelated to HIV/AIDS and hepatitis C. Often other

prisoners will come to talk about other health and life issues, including inter-personal relationships, healthy eating, and diabetes.

He talked about trying to break the cycle of HIV and drug use with his interventions. He tries to respect the native culture and rituals. About five activities a year for Aboriginal prisoners are run under his supervision.

Lessons learned

Aboriginal prisoners should be supported in selecting an appropriate peer representative as a Knowledge Keeper. Bowen has strong connections with other Aboriginal prisoners within the prison and he is committed to help stop the spread of HIV/AIDS and HCV both in prison and on reserves (where many Aboriginal prisoners return after their release). He is well respected among the other Aboriginal prisoners and actively seeks elders, healers and Aboriginal organizations to come into the prison to help educate prisoners.

Limitations

Appropriate training in communication skills is important to the Circle of Knowledge Keepers program. In this case, Bowen felt that the training program was good but that there were more areas that needed to be covered, including barriers to communication, good communication techniques and access to hands-on information.

A lack of access to community organizations creates barriers for prisoners. One of the greatest limitations that Bowen mentioned was the difficulty getting in contact with people on the outside. The Knowledge Keepers are dependent on the health care staff to make phone calls; if they are busy, this is not an easy process. Also, many community organizations do not accept collect calls so he cannot call them on his own.

Funding

Correctional Service of Canada

Supporting documents

K. Barlow, J. Serkiz and A. Fulton, *Circle of Knowledge Keepers: Training for Inuit, Metis and First Nations Offenders and Peer Educators and Counsellors*, Correctional Service of Canada, March 2001. Materials include eight chapters and a nine-part “tool kit.”

Evaluation

N/A

Aboriginal AIDS service organization engaged to train Knowledge Keepers

Contact:

Leona Quewezance
All Nations Hope AIDS Network
2815–5th Street
Regina, SK S4T 0L4
Telephone: +1 877 210-7622
Fax: +1 306 525-3698
lquewezance@sasktel.net
www.allnationshope.ca

Overview

All Nations Hope AIDS Network (All Nations Hope) is a network of Aboriginal people, organizations and agencies that provides support and services to First Nations, Métis and Inuit families and communities affected by HIV/AIDS and hepatitis C. Beginning in January of 2000, All Nations Hope was contracted by CSC to train Aboriginal prisoners as Knowledge Keepers (i.e., peer educators) using the Circle of Knowledge Keepers educational program manual developed for CSC by Aboriginal consultants. According to the manual, the Knowledge Keepers' objective is to help prevent and reduce the spread of HIV/AIDS among Aboriginal prisoners in federal prisons. Knowledge Keepers seek to create a climate whereby Aboriginal prisoners living with HIV/AIDS receive the best care, treatment and support, and to encourage and to empower Aboriginal prisoners to sustain behavioural and lifestyle changes in the community.

All Nations Hope trained 28 Aboriginal prisoners at three prisons or healing lodges (Saskatchewan Penitentiary, Okimaw Ohci Healing Lodge and Willow Cree Healing Lodge) to be Knowledge Keepers. At each prison or healing lodge, the training lasted 10 days.

The facilitator (Leona Quewezance) and her co-facilitator (Ron Horsefall) consciously adopted an open, honest and realistic approach with the prisoners they were training. Recognizing that the participants were already in prison and did not need more rigidity, they worked to empower prisoners and give them choices, and created a climate where their experiences were valued and they were valued as experts. Participants were encouraged to be creative and to personally engage with the training materials through poetry, collages and stories. Their understanding and appreciation of the content of the manual was verified through “homework” assignments.

In 2006, the program was discontinued for lack of funding.

Lessons learned

Aboriginal people have a unique history, which calls for cultural sensitivity in prison programs and an understanding of the common challenges faced by Aboriginal people. The facilitators from All Nations Hope had experience with issues faced by many imprisoned Aboriginal people — e.g., the effects of colonization, HIV and hepatitis C, addiction and recovery. As a result of the experience shared between facilitators and prisoners, participants were able to relate to one another in a climate of respect and understanding, and were able to discuss and address their relationship with the material

they were called upon to learn. This type of learning process and environment is essential for preparing Knowledge Keepers to provide peer education to other Aboriginal prisoners.

Aboriginal programs should be flexible enough to address the needs of Aboriginal prisoners with different backgrounds. In Saskatchewan Penitentiary, there were people with different languages and ceremonies. Knowledge Keepers reached out to Cree, Dena and Saulteaux people.

Limitations

The separation of responsibility for on-going support of Knowledge Keepers from training fails to take advantage of the knowledge shared and connections developed during the training sessions. Resources for sustained and ongoing support of the Knowledge Keepers program were not funded by CSC. CSC infectious disease nurses and the Regional Aboriginal Health Service Coordinator are responsible for providing ongoing support to the Knowledge Keeper groups. Quewezance said, however, that the infectious disease nurse was so busy that she was unable to attend the training. It is unclear how much time the ID nurse would be able to dedicate to this program.

Lack of program resources affected participant satisfaction. Each prison with a Circle of Knowledge Keepers program is provided with one manual. However, participants, while satisfied with the program, expressed the desire to have one manual per Knowledge Keeper in order to be able to review materials when time permitted.

The process for selection of potential Knowledge Keepers was not as open and inclusive as it could have been. From All Nations Hope's perspective, prisoners, Aboriginal community members and the trainers should also be included in the selection of potential Knowledge Keepers. All Nations Hope reported that a number of the prisoners came to get the certificate but did not want to be peer trainers. All Nations Hope was also of the opinion that the program should target prisoners serving a life sentence since this might help ensure continuity and sustainability of the Circle of Knowledge Keepers programs within each prison.

All Nations Hope staff reported that they experienced ongoing difficulties entering the prisons. Over the ten-day period, they were asked daily by security staff who they were, what they were doing there, where were they going, was there a memo, did someone at the institution know that they were coming, etc. Though this may be standard security procedure, it created tension each time they went into a prison.

For some participants, the training brought up personal issues that needed to be addressed during the training sessions.⁸⁵ All Nations Hope reported that participants raised experiences of physical and sexual abuse, systemic racism, the colonization of Aboriginal people, residential schools, victims' needs, and addiction. According to All Nations Hope, some of these issues were not adequately addressed in the manual. While such issues are not the focus of the Knowledge Keepers training as

⁸⁵ When she reviewed this account in this report, Leona Quewezance felt the information was accurate but also noted that the structure of this account of the program did not lend itself to capturing adequately the richness of the experience of the training sessions with the Knowledge Keepers. In the training, prisoners talked about their victims and how they would respond if they had the opportunity to meet their victims or victims' families. Many of the prisoners stated that they would never be back in prison if they had to meet with their victims. Those interested in more information are invited to contact Ms. Quewezance for further details.

currently structured, potential Knowledge Keepers may need to be able to address such issues before they are comfortable and prepared to become peer trainers, given that such issues may underlie many Aboriginal prisoners' vulnerability to HIV and HCV infection. All Nations Hope reported that this was the first time that some of the prisoners revealed and wanted to address historic abuse and the resulting challenges in their lives.⁸⁶

Funding

Correctional Service of Canada

Supporting Documents

K. Barlow, J. Serkiz and A. Fulton, *Circle of Knowledge Keepers: Training for Inuit, Métis and First Nations Offenders and Peer Educators and Counsellors*, Correctional Service of Canada, March 2001. See a description of the content of the manual in "Circle of Knowledge Keepers: Peer HIV/AIDS programming for federal Aboriginal prisoners," above.

Evaluation

Evaluations forms were distributed to participants at the end of each 10-day training session. Overall, the workshops met the expectations of participants with most participants stating the training was excellent. All participants felt encouraged to participate in the learning process and increased their knowledge on HIV and HCV. The information was beneficial and the handouts met their needs. The facilitators of the training were rated as "excellent." Comments on the program included: "I thought it was really good the way it was presented. Thank you very much you did awesome work"; "It was good and the facilitators gave each and every one of us strength, hope and courage"; "Learned more about life than just diseases"; "This workshop was straight forward and therefore easy to understand. It involved heart and true experiences, which made it great." Participants indicated that rather than one manual per prison, each participant should have a copy for him or herself.

⁸⁶ In its review of the draft report, CSC responded to this limitation, as follows: "All Nations Hope was not contracted to help the participants deal with issues of physical and sexual abuse and CSC did not sanction the delivery of the aforementioned material. The CKK [Circle of Knowledge Keepers] manual was to be utilized for the training, and if All Nations Hope delved into these other areas, it was without the knowledge and the approval of CSC. The purpose of the Knowledge Keepers training is to provide specialized training to a select group of inmates who can later act as peer educators who provide information about HIV/AIDS, Hep C and STIs to their peers. Psychological services and Elder supports are available in all of the institutions to provide counselling for offenders who have had issues with physical and sexual abuse."

Aboriginal AIDS service organization educates prisoners about HIV/AIDS prevention and health promotion

Contact:

LaVerne Monette
Executive Director
Ontario Aboriginal HIV/AIDS Strategy
2nd Floor, 43 Elm Street
Toronto, ON M5G 1H1
Telephone: +1 800 743-8851
Fax: +1 416 944-0541
strategy@2spirits.com

Overview

The Ontario Aboriginal HIV/AIDS Strategy (OAHAS) promotes awareness about HIV/AIDS, and supports Aboriginal individuals, families and communities living with or affected by HIV/AIDS. OAHAS was funded by the Ministry of Health to provide time-limited programming in prisons. The goal of the project was to reach out to Aboriginal prisoners to deliver culturally specific HIV/AIDS programs and services in south and central Ontario prisons, both federal and provincial. This was viewed as particularly important in CSC prisons where no Native Liaison Officers or Native Brotherhoods/Sisterhoods existed. At least five monthly information sessions and an additional five monthly discussion circles took place over the course of the project.

Aboriginal prisoners were provided with up-to-date information on HIV/AIDS prevention and health promotion techniques. In addition, it was hoped that Aboriginal prisoners would develop better personal support systems in the prisons and jails and gain better access to access to Aboriginal elders, traditional healers and teachers.

The profile of OAHAS (its work and its capacity) has been raised among Aboriginal prisoners and some corrections staff. More than five monthly visits and five monthly discussion groups were successfully completed in the prisons in spite of all the barriers encountered.

Lessons learned

Providing specific Aboriginal programming in prisons has led to an increased awareness of teachings and practices for Aboriginal prisoners. This has also led to increasing requests for information on the prevention of HIV/AIDS from among the Aboriginal prison population. There is some reason to believe that once out of prison, Aboriginal people exposed to the program will practice less risky behaviours related to substance use and sexual activities.

While some progress was made to provide information and support related to HIV/AIDS to the Aboriginal population in Ontario prisons, this effort cannot be sustained through time-limited projects that are not supported by prison administrations or public health authorities.

Limitations

Those involved with the project thought it should be sustained beyond the funding period, but resources – both financial and human – were unavailable. Aboriginal

prisoners continue to request the services of OAHAS and the workers try to respond as much as possible, but there is a need for continuing support for this activity.

According to OAHAS, working with prison security staff was one of the greatest challenges. For example:

- Aboriginal workers are viewed as “volunteers” and are therefore not treated as professionals by security staff.
- The spiritual practices of Aboriginal people are not respected because they are viewed as outside of “organized religion.”
- Smudging and the use of ceremonial tobacco were often not allowed because of the “non-smoking” policy in the prison system. In one case where the smudging was permitted, prison guards staged a work stoppage because they said the smudge was a health hazard.
- Some people experienced homophobia among some prison guards and prison chaplains.
- The Prison Outreach Worker was often required to attend 2- and 3-day orientation sessions before entering the prisons, and this took up valuable time.

A great deal of time and effort was spent educating the system and battling bureaucratic obstacles before any real work could be done with the Aboriginal population.

Community partnership is difficult to develop. It was originally planned to partner with PASAN for this project but due to the workload of both PASAN and OAHAS, there was little activity of a partnership nature undertaken other than sharing a ride to the prison from time to time. This is not viewed as an obstacle as much as a reality in the field.

Project funding is time-limited and cannot satisfy an ongoing need. As a result of the experience with this project, OAHAS decided to apply only for long-term funding for any future prison work.

Funding

Ministry of Health, AIDS Bureau

Supporting Documents

N/A

Evaluation

Over 1200 Aboriginal prisoners were reached by the Prison Outreach Project, including men, women and transgendered people. Without exception, on the evaluations completed, all workshop participants said the information provided was valuable and relevant. They noted that they would not only use the information themselves but share it with others. In many cases, the Prison Outreach worker was invited to return on an ongoing basis.

During the project period, the prisoners had better personal support systems in place, especially those who had attended the workshops and discussion circles. In fact, many non-Aboriginal prisoners expressed envy over what they perceived as a special spiritual bond formed among Aboriginal prisoners. Since the conclusion of the Prison Outreach Project, it is difficult to measure the degree to which these personal supports have been sustained.

Community methadone clinic and Aboriginal AIDS service organization partner to provide education for federal Aboriginal prisoners

Contact:

Cindy MacIsaac
Direction 180 and Mi'kmaq Native Friendship Centre
2158 Gottingen Street
Halifax, NS B3K 3B4
Telephone: +1 902 420-0566
Fax: +1 902 423-6130
cynthmacisaac@aol.com

Overview

The project entitled Traditional Education for Aboriginal Communities on HIV/AIDS (TEACH) responds to recommendations for educational initiatives made by the Aboriginal Issues and Health Services Branches of the CSC. In April 1998, that office organized a National Aboriginal and HIV/AIDS Strategy Roundtable. Representatives from various national Aboriginal AIDS service organizations, Health Canada, and CSC attended this forum and produced a draft document entitled: "Strategy and Actions for Aboriginal People and HIV/AIDS in Corrections" (1998–2003). A second roundtable held in 2000 identified steps to ensure sustained momentum for the initiative.

The main activities undertaken in the TEACH program were education workshops facilitated in five federal prisons. The first objective was to provide education related to HIV/AIDS and blood-borne pathogens through culturally sensitive health promotion. This was accomplished through activities appropriate to the culture and traditions of Aboriginal and Inuit populations, including self care, talking and healing circles, smudging, and creating traditional Aboriginal and Inuit crafts. The second objective of the project was to improve awareness among nursing staff of culturally appropriate approaches to providing care, treatment and support to Aboriginal and Inuit populations living with and affected by HIV/AIDS and other blood-borne pathogens.

One staff member from the Mic Mac Native Friendship Centre (an organization dedicated to improving the life of Aboriginal people in an urban environment) and a staff member from Direction 180 (a methadone program provider) facilitated two-day workshops at the Nova Institution for Women and Springhill, Westmorland, Dorchester and Atlantic prisons. A one-day cross-cultural training workshop was also facilitated for 15 nurses, three from each of five prisons in New Brunswick.

Lessons learned

More time was required to complete the project, especially to explore the feelings that arise with respect to the presence of HIV/AIDS among Aboriginal people.

Maintaining contact with community organizations is essential in supporting prisoners from Aboriginal communities.

The workshops were successful because the information presented was clear and concise, and Aboriginal traditions were taught and respected. Assumptions were not

made regarding the cultural knowledge of workshop participants. The workshops fostered an atmosphere wherein participants were able to appreciate the significance associated with Aboriginal traditions.

The workshop was co-facilitated by an Aboriginal elder and a non-Aboriginal woman from a community-based methadone program. The two facilitators were equally well received by the prisoners, resulting in a positive learning experience. The co-facilitation employed in this project created a unique learning environment — by presenting traditional beliefs alongside a community-based perspective, the full continuum of ways to reduce harm was promoted. Participants engaged in healthy debate regarding the benefits of and need for services to engage prisoners who hold different perspectives and views.

Limitations

The belief systems of chiefs and elders as they relate to harm reduction and two-spirited individuals were strongly rooted, making it difficult to promote information and activities among Aboriginal people.

In maximum-security units where the health risks appear greater, access to prisoners can be more limited. Prisoner counts and the need for escorted movement within the prison often disrupt the timing, the flow and, ultimately, the effectiveness of the education.

Lack of funding does not allow for continued programming. Project staff noted that participants often feel abandoned when there are no resources to provide continued support. As well, ongoing programming and support would help offenders establish ties to the community to assist them in a successful transition into their communities.

Population-specific needs: imprisoned youth

Guidance, recommendations and international perspectives

The UNODC Framework states that programs and services must be responsive to the unique needs of vulnerable or minority populations within the prison system, including incarcerated children and young people, whose needs should therefore be given particular priority and focus when developing HIV/AIDS services.⁸⁷ The Framework mentions youth several times, all in the context of taking into account the specific needs of vulnerable populations in prison when designing policy and programs, and calls for collaboration and funding mechanisms to include youth services.⁸⁸ UNODC recommends that prisoners be housed so as to take into account their age (youth versus adult) [Action 8; p. 17]. It calls on prison authorities to “[i]ntegrate and resource actions to promote prison health within national and international strategies that address HIV/AIDS, drug use and access to health services, with a particular emphasis on vulnerable populations, including young people and women” [Action 43; p. 22].

Comprehensive guidelines and recommendations regarding youth in prison in Ontario and HIV/AIDS, including the HIV and HCV prevention and harm reduction needs of youth, were published in 1996 by PASAN.⁸⁹ The guiding principles applicable to harm reduction are as follows: Youth in custody living with HIV/AIDS have a basic right to maintain their health, especially given that the principle of rehabilitation is paramount in the structure of young criminal justice legislation.⁹⁰ Also, youth in custody have a right to protect themselves against HIV infection, through education and access to proper protective materials (such as condoms, bleach and needles).⁹¹ The guidelines include 14 recommendations for prevention:

1. HIV/AIDS education should be compulsory for all youth in custody (male and female) and all staff providing services for incarcerated youth (all workers at the Ministry of Community and Social Services, of Correctional Services, Clinical Support Staff, members of the staff union, open custody facilities staff and their union members, etc.)
2. Education must be comprehensive for both youth in custody and staff.
3. All educational presentations and materials must recognize and respond to the needs of youth in custody with disabilities, from different ethnic and linguistic backgrounds, with varying language skills and schooling, and of different races, sexes, and sexual orientation.
4. In addition to group HIV/AIDS educational sessions, information should be made available to youth in custody individually upon entering and exiting the custody facility.
5. External, community-based AIDS and health organizations should lead educational sessions. Peer education should also be promoted.
6. Condoms, dental dams, latex gloves, appropriate lubricants, and other safer sex materials must be made available to all youth in custody.
7. Consensual sex between youth in custody should not be an institutional offence.
8. A public relations campaign should be initiated to combat anticipated resistance by parents, staff or the public to condom distribution, safer sex education and sexual activity.

⁸⁷ UNODC Framework, p. 13.

⁸⁸ UNODC Framework, pp. 13, 35, 36.

⁸⁹ L. Batelaan, *HIV/AIDS in Youth Custody Settings: A Comprehensive Strategy*, PASAN, June 18, 1996. Available via www.pasan.org.

⁹⁰ *Ibid.*, p. 10.

⁹¹ *Ibid.*, p. 10.

9. A confidential needle exchange program should be implemented.
10. Bleach kits should be distributed in a non-identifying manner.
11. A public relations campaign should be initiated to combat anticipated resistance by parents, staff, or the public to a needle exchange program.
12. Community-based workers, in conjunction with custody staff, should educate youth in custody about substance use as a health issue.
13. Treatment programs for youth in custody with substance use concerns should be accessible and programs for youth under the age of 16 should be established.
14. Tattoo and body piercing equipment and supplies should be covered under ‘hobby/ craft’; extra safety precautions should be established.⁹²

Additional recommendations suggested by PASAN youth outreach worker Rai Reece include:

1. Program evaluation for education sessions should be developed so that youth in custody can provide feedback as to HIV/HCV program delivery.
2. Youth in custody should also receive education that addresses violence against women, sexual assault, incest, and self-empowerment.
3. Specific programming for young women is needed and should be delivered in group or one-on-one settings.

ECAP’s *HIV/AIDS in Prisons: Final Report* recommends that PASAN’s strategy be implemented [recommendation 13, p. 116].

Observations

No jurisdiction has comprehensive HIV and HCV prevention and harm reduction policies for imprisoned youth. The majority of provinces and territories appear not to have *any* policies specific to this population. A minority of jurisdictions have adequate policy coverage with respect to education and information for youth (four of 13 jurisdictions have policy); and with respect to the provision of condoms, dental dams, and lubricant for youth (three of 13 jurisdictions have policy). As with policies applicable to adult corrections, there is a great variation in the terms and scope of the policies that do exist. However, unlike the case of adult prisons, numerous HIV and HCV prevention and harm reduction policies for youth are institution-specific (i.e., standing orders applicable in a given institution) rather than province-wide. Several examples of enabling policy are set out in Table 1 (p. 24). (See Appendix C for references.)

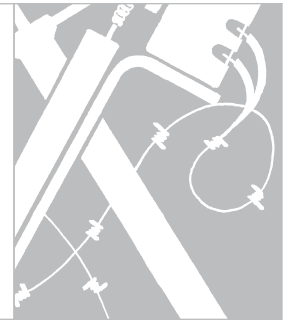
We were unable to document best and promising programs for youth to the same extent as we did for adult prisoners. The resources for the project did not permit visits to youth facilities, or interviews with youth, or with prison staff or community-based organizations providing programs to youth. Our “paper review” based on access to information requests revealed that a small number of jurisdictions that did not have policy in place nevertheless had programs in place. As with youth-specific policy, the majority of these programs related to education and information, or the provision of condoms, dental dams, and lubricant. Several examples of such programs are set out in Table 2 (p. 25). (See Appendix D for references.)

Underlying these significant policy and program gaps is a lack of published studies about the prevalence of HIV, HCV and risk behaviours among youth in prison, not only in Canada but internationally. Two studies

⁹² Ibid. at pp. 6, 7.

have been undertaken in Ontario. A study published in 1994 reported on HIV prevalence among 1582 youth entering prison.⁹³ No youth tested positive for HIV. Approximately three percent of male youth and two percent of female youth had a history of injection drug use. A study published in 2006 reported on HIV and HCV prevalence and risk factors among 299 youth.⁹⁴ None of the youth tested HIV-positive; one tested positive for HCV. Approximately five percent of youth reported a history of injection drug use; of these, approximately 30 percent had shared a needle for injecting. Approximately 78 percent reported ever having had unprotected sex. Forty-three percent of the 114 youth who had been tattooed, reported getting a tattoo while in prison.

The majority of provinces and territories appear not to have *any* policies specific to [youth in custody].



In 2006 the B.C. Ministry of Children and Family Development and the B.C. Center for Disease Control carried out a youth prisoner study, following up on a similar study conducted in 1994. The study sought to determine the prevalence of, and associated risk factors for, HIV and HCV infection in a population of youth entering or resident in provincial youth custody services facilities in British Columbia, in order to develop and target appropriate education, prevention and harm reduction strategies.⁹⁵ Four hundred and seventeen youth were enrolled in the study, 22 percent of whom were female, 48 percent of whom were Aboriginal, and 72 percent of whom had been previously incarcerated. HIV and HCV status were determined by anonymous saliva testing, and risk behaviours were studied using a cross-sectional, structured survey. The study found that youth in custody admitted to a broad range of risk behaviours prior to admission and, to a lesser extent, risk behaviour in custody, rendering them vulnerable to the acquisition of STIs and blood-borne viruses.⁹⁶ For example:

- 7.7 percent reported injecting drugs.
- 68.8 percent reported having sex without using condoms.
- 32 percent reported getting a tattoo in the community from a non-professional.
- 40.5 percent reported getting a piercing in the community from a non-professional.
- 13 percent reported getting a tattoo in prison.

Two youth tested HIV-positive (0.5 percent); five tested HCV positive (1.2 percent).

⁹³ L. Calzavara et al., *The Study of HIV Prevalence in Ontario Jails, Detention & Youth Centres: Final Report*, University of Toronto, 1994.

⁹⁴ L. Calzavara et al., *Prevalence and Risk Factors for HIV and Hepatitis C in Ontario's Jails and Detention Centres (2003-2004)*, University of Toronto, 2006.

⁹⁵ D. Rothern et al, "HIV/Hepatitis C Prevalence and Associated Risk Factors in At Risk Youth at Three BC Correctional Facilities," project proposal, October 2005; and D. Rothern, "HIV/HCV Prevalence and Risk Factor Study of Youth in Custody," presentation slides, prepared 5 April 2007. See, also, D. Rothern et al, "BC's Youth in Custody: A Profile of Demographics and Risk Behaviours: An Opportunity for Harm Reduction Interventions." See also J. Buxton et al, "Identifying prevalence of and risk factors for HIV/hepatitis C in B.C. Youth Custody," Abstract Mo 094P, presented at International Conference on the Reduction of Harm, May 1, 2006, concluding that nearly half of street youth have spent time in custody. Unpublished documents on file with the authors.

⁹⁶ D. Rothern, "HIV/HCV Prevalence and Risk Factor Study of Youth in Custody," presentation slides, prepared 5 April 2007.

The prevalence of HIV, HCV and risk behaviours among youth in prison and the HIV and HCV prevention and harm reduction needs of these youth should be further studied. Such study should inform existing and new programming for imprisoned youth.

Enabling policy

The following policies support HIV and HCV prevention and harm reduction in prison:

- **Condoms:** Northwest Territories, Corrections Service – Operations Manual, Young Offender Secure Custody, *12.07 AIDS* (January 16, 2001). Section 4.20, states that youth in secure custody will be provided with access to condoms through health care units and will be advised upon admission about their availability and proper use. See, similarly, with respect to youth in open custody, Northwest Territories, Corrections Service — Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) ss. 4.13, 5.2; Northwest Territories, Corrections Service — Standing Order, North Slave Young Offenders Facility Open Custody, *1004.00, Acquired Immune Deficiency Disease* (April 30, 2002), ss. 4.12, 5.2. Regarding female youth, see Northwest Territories, The Arctic Fern Facility — Standing Orders, *1207.01 AIDS* (January 2, 2006), s 4.21.
- **Education:** Saskatchewan Corrections and Public Safety, Young Offender Programs, Custody, Policy Statement, *Prevention of Pregnancy and Sexually Transmitted Diseases* (2005). The policy provides that “[y]outh in open or secure custody facilities will receive approved, guided instruction concerning the risk and prevention of pregnancy and sexually transmitted diseases.” The policy specifically includes HIV/AIDS, and highlights the importance of confidentiality and culturally sensitive and appropriate information. Wherever possible, the facility nursing staff will be responsible for providing the education; where this is not possible, facility staff are instructed to team with community health nurses.
- **Education:** Northwest Territories, Corrections Service — Operations Manual, Young Offender Secure Custody, *12.07 AIDS* (January 16, 2001) s. 4.19. The policy clearly establishes the responsible person and standards expected: “The Manager shall ensure that an AIDS/HIV education program delivered at the facility follows the guidelines in the Department of Health and Social Services Manual” (section 4.5). Youth should be given pamphlets upon admission, and the education sessions should include material on HIV and AIDS, how HIV is and is not transmitted, how to protect oneself, and how to behave towards someone living with HIV. See, similarly, Northwest Territories, Corrections Service — Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) s. 4.11; Northwest Territories, Corrections Service — Standing Order, North Slave Young Offenders Facility Open Custody, *1004.00, Acquired Immune Deficiency Disease* (April 30, 2002), s. 4.11. Regarding female youth, see Northwest Territories, The Arctic Fern Facility — Standing Orders, *1207.01 AIDS* (January 2, 2006) s.4.19.

Other prison populations and emerging needs

Prisoners from ethno-cultural minority communities

The UNODC Framework states that it is essential that programs and services be responsive to the unique needs of vulnerable or minority populations within the prison system, including racial and ethnic minorities, whose needs should therefore be given particular priority and focus when developing HIV/AIDS services.⁹⁷

Federal prisoners are overwhelmingly Caucasian (72.6 percent) yet extremely diverse.⁹⁸ According to CSC data, after Aboriginal prisoners (17.2 percent), Black prisoners (6.2 percent) represent the largest “ethnic” group in CSC prisons, followed by 10 groups, each comprising less than one percent of prisoners. As is the case with federal Aboriginal prisoners, the proportion of prisoners of African heritage varies considerably among regions, and there is great diversity among the culture and traditions of prisoners of African heritage.⁹⁹ Statistics indicate that some members of ethno-cultural minorities are experiencing increasing prevalence of HIV. According to the latest national epidemiological statistics, over time there has been an increase in the proportion of total reported HIV and AIDS cases in Canada attributable to people from countries where HIV is endemic, a group which appears to be over-represented in the Canadian HIV epidemic compared with representation in the Canadian population.¹⁰⁰ Within this group, women represent over half of HIV cases. Most of the people from countries where HIV is endemic identify themselves as being of African heritage.

Aside from programs for Aboriginal prisoners, no HIV and HCV prevention and harm reduction programs for ethno-cultural minorities were identified through this project. Nor did we find any literature on program models for the delivery of specific HIV and HCV prevention and harm reduction programs for prisoners from ethno-cultural minority communities. Consequently, it is our observation that existing policies and programs may not be meeting the HIV and HCV prevention and harm reduction needs of prisoners from ethno-cultural minority communities. This is an area that merits further consideration, given the increasing diversity of the Canadian population and, by extension, prisoners, given systemic racism and the recent history of over-incarceration among people of African heritage.

Culturally competent programming involves accounting for people’s diverse values, beliefs and behaviours, and tailoring program delivery to meet their social, cultural and linguistic needs. Having an understanding of the community being served, and the cultural influences on individual health beliefs and behaviours is an important determinant of effectiveness of services. Developing strategies to identify and address cultural barriers to accessing services is also important.¹⁰¹ HIV and HCV prevention and harm reduction programming for prisoners from ethno-cultural minorities should move beyond a Eurocentric understanding of the determinants of health, or else they run the risk of not adequately addressing all of the factors that may make a prisoner vulnerable to HIV and HCV infection. The onus of establishing awareness and taking into account cultural diversity and holistic programming should not be placed upon the person from the minority or racialized community.

⁹⁷ UNODC Framework, p. 13.

⁹⁸ “A health care needs assessment of federal inmates in Canada,” *Canadian Journal of Public Health* 95(S1) (2004): S1–S63, at Appendix 1, p. s56.

⁹⁹ “African heritage” refers to African Canadian, African, and African Caribbean people, and people of African heritage from Central or South America living in Canada.

¹⁰⁰ Public Health Agency of Canada. *HIV/AIDS Epi Updates, August 2006*, Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, 2006, Chapter 12, pages 95–108. Countries where HIV is endemic are countries in which over one percent of the adult population is living with HIV — for example, many countries of sub-Saharan Africa and the Caribbean.

¹⁰¹ For further information, see Nova Scotia Department of Health, *A Cultural Competence Guide for Primary Healthcare Professionals in Nova Scotia*, 2005. Available via www.canadian-health-network.ca.

At the federal level, CSC has created policy to address the needs of prisoners from ethno-cultural minorities.¹⁰² According to CSC policy, prisons housing ethno-cultural minority prisoners who have a demonstrated need for linguistic, cultural or spiritual programs will make every reasonable effort to meet those needs by offering specialized programs and services, either within the institutions or in the community.¹⁰³ In addition, where community services are available for social or cultural activities, operational units will facilitate and foster access to such services.¹⁰⁴ The policy also established ethno-cultural advisory bodies.¹⁰⁵ Our understanding from speaking with prisoners from ethno-cultural minority groups, from their point of view, their needs are not being met.

Many community-based AIDS organizations in Canada serve ethno-cultural minority communities and have developed HIV and HCV prevention and harm reduction programming to meet the particular needs of these populations. These community-based efforts provide an important focal point for collaboration between prisons and community to meet the needs of prisoners from diverse ethno-cultural minority communities within federal and provincial/territorial prisons. However, based on our interviews with community-based organizations, it is evident that they do not have the resources to provide services to prisoners to any great extent.

The following recommendations have been adapted from guidelines that are in use in Canada.¹⁰⁶

- Funding must be made available to community-based organizations working with racial and ethno-cultural minority communities to provide prevention education for prisoners. Funding should also be available to provide care, treatment and support for ethno-cultural minority prisoners living with HIV/AIDS.
- There needs to be recognition and education/training on racial and ethno-cultural minorities, beliefs and values for people facilitating harm reduction education in prisons.
- There needs to be increased representation of persons of racial and ethno-cultural minorities in correctional health-care units.
- Culturally competent programming means developing programs to meet people's diverse values, beliefs and behaviours, and tailoring delivery to meet their social, cultural and linguistic needs. Having an understanding of the community being served and the cultural influences on individual health beliefs and behaviours is an important component of service delivery.
- It must be recognized that racism has a negative effect on determinants of health (self-esteem, education, employment, income, housing and living standards).
- Brochures, handouts and other materials should be translated into the languages understood by prisoners for accessibility.

¹⁰² The CSC does have a number of ethno-cultural initiatives underway, as reported on their website at: http://www.csc-scc.gc.ca/ethnoculture/index_e.shtml. However, it does not appear that there are any programs for prisoners in relation to HIV/AIDS, hepatitis C, or in other health-related areas.

¹⁰³ CSC, Commissioner's Directive 767, Ethnocultural Offender Programs (March 19, 2001), s. 8.

¹⁰⁴ *Ibid.*, s. 9.

¹⁰⁵ *Ibid.*, ss. 16 – 18.

¹⁰⁶ See Health Promotion and Population Outreach in the Black and Caribbean Canadian Community, April 2000, available at http://www.calgaryhealthregion.ca/hecomm/diversity/health_black_communities.htm; and A Cultural Competence Guide for Primary Healthcare Professionals in Nova Scotia and How being Black and female affects your health, available at <http://www.canadian-health-network.ca/servlet/ContentServer?cid=1168525557692&pagename=CHN-RCS/CHNResource/CHNResourcePageTemplate&c=CHNResource>

- Harm reduction programming for prisoners should be grounded in an anti-racist framework that addresses issues of race, class, gender, sexism and homophobia.
- Agencies should develop strategies to identify and address cultural barriers to accessing services.
- Research is urgently needed on best practices for HIV and HCV prevention among prisoners from racial and ethno-cultural minorities.

There needs to be recognition and education/training on racial and ethno-cultural minorities, beliefs and values for people facilitating harm reduction education in prisons.



Transgender and transsexual prisoners

The UNODC Framework states that it is essential that programs and services be responsive to the unique needs of vulnerable or minority populations within the prison system, including transsexual and transgender prisoners. The Framework contains a number of recommendations directed to prison authorities related to transgender and transsexual prisoners' vulnerability to HIV/AIDS and hepatitis C. Foremost among them, prison authorities should “[a]cknowledge that high risk behaviours for the transmission of HIV occur within prisons (especially injecting drug use, sexual activity, and sexual abuse/violence), and “[r]ecognize that consensual sexual activity occurs in prisons, and ensure that consensual sexual activity is not penalised as this will discourage prisoners accessing condoms” [Actions 1, and 22; pp. 15, 19]. Such acknowledgment is seen as a prerequisite to implementing policies (1) to “[e]nsure that prisoners and prison staff are guaranteed protection against discrimination on grounds including gender, age, race, ethnicity, culture, religion, language, sexual orientation, gender identity, and HIV status” (2) to ensure that non-consensual sex, coerced sex, bullying and rape are prohibited and reduced; (3) to outline structures and processes to punish or segregate sexual predators; and (4) to provide comprehensive and compassionate care and counselling for survivors of sexual violence [Actions 9, 23, 29; pp. 17, 19, 20]. Finally, the UNODC Framework calls on prison authorities to ensure that the content and messages of educational materials are specific and relevant to the realities of — and resources available in — the prison environment; and that materials respect and are relevant to differences in gender, sexual orientation and gender identity [Action 55; p. 24].

In 1999, PASAN published *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy*.¹⁰⁷ Fifteen male-to-female prisoners and ex-prisoners in Ontario living with HIV/AIDS were interviewed and consulted for the report. The research found discrimination and stigmatization of male-to-female transgender/transsexual prisoners housed in men's prisons, which makes them vulnerable to HIV and HCV transmission. Irrational fear and hatred of transgender and transsexual prisoners can place such prisoners at greater risk of sexual violence. While some transgender prisoners will have consensual sexual relationships, others may engage in sex in exchange for their safety. Sharing equipment used for injecting illicit female hormones is an additional, specific risk factor for HIV and HCV transmission among transgender prisoners. Overall, the findings of the report indicate that both federal and

¹⁰⁷ A.V. Scott and R. Lines, *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy*, PASAN, May 1999. Available via www.pasan.org.

provincial policies and programs did not adequately meet the HIV and harm reduction needs of this population at that time (i.e., in 1999).

Among other topics, the report made recommendations regarding HIV prevention education, injection drug use and HIV, and HIV antibody testing. Many of the recommendations are general in nature and similar to recommendations in other reports by PASAN, ECAP and the Legal Network. Some of the recommendations in *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population* are specific to that population:

- In addition to group HIV/AIDS educational sessions, information should be made available to transsexual and transgender prisoners individually upon entering and exiting the custody facility.
- All educational presentations and materials must recognize and respond to the needs of transsexual and transgender prisoners with disabilities, from different ethnic and linguistic backgrounds, with varying language skills and literacy levels, and of different races, gender, and sexual orientations.
- Transsexual and transgender prisoners should be protected from other prisoners with a known sexual assault history.
- Transsexual and transgender prisoners should have a choice in where they are housed within the institution.
- They must not be placed against their will in protective custody solely because they are transsexual or transgender.
- Treatment programs for TS/TG prisoners who use drugs should be developed and accessible.

Additionally, PASAN believes that transgender and transsexual prisoners should be able to choose if they are housed in a men's or women's prison.

There were no programs specific to transgender and transsexual prisoners identified through our research. The HIV and HCV prevention and harm reduction needs of these populations merit urgent consideration.

Drug-free living units and therapeutic communities

In its recommendations regarding drug treatment options for prisoners, the UNODC Framework calls on prison authorities to ensure that prisoners have access to the same drug treatment and counselling programs available to the population outside prisons, including drug-free options and drug-free living areas [Action 77; p. 26]. In *HIV/AIDS in Prisons: Final Report*, the Legal Network recommended in relation to drug treatment that federal and provincial prison systems should “offer a greater variety of treatment options to inmates, including drug-free prisons or wings” [recommendation 6; p. 110].

We requested from Canadian prison authorities information on drug-free living units. In addition, prison authorities had an opportunity to provide feedback about such policies and programs when reviewing a draft of this report. We identified two jurisdictions with policy or programs. In February 2000, CSC set out to implement five pilot Intensive Support Units (ISUs), one in each of its administrative regions. National guidelines were published in October 2002.¹⁰⁸ According to these guidelines, ISUs are “intended to provide a positive living environment for offenders who wish to remain free of alcohol and drugs and to support and reinforce offender efforts to change substance abuse behaviour.” ISUs are voluntary, and open to prisoners with substance use problems and those without “who wish to live in an institutional environment that is free

¹⁰⁸ CSC, *National Guidelines: Intensive Support Units*, October 2002.

of drugs and the interpersonal problems associated with inmate drug use.” The ISUs do not deliver specific programs; according to CSC’s national guidelines, informal and formal peer support and interaction with staff are integral to the supportive environment. According to prisoners with whom we spoke, compared with other living units within the same prison, the ISU has increased security controls, focused on drug interdiction and no support such as that specified in the guidelines.

In 2003, Guthrie House, a 40-bed “clean and sober” unit, was opened at the B.C. provincial Nanaimo Correctional Centre. In 2006, Guthrie House was given authority to expand to become a therapeutic community pilot project within the prison, a residential program for up to 170 male prisoners.¹⁰⁹ The therapeutic community model views recovery from drug addiction as a process that utilizes positive peer pressure within a highly structured social environment where all community members (staff and prisoners) are seen as equally respected and responsible for positive change.¹¹⁰ The program focuses on long term substance abuse recovery and aims to address the physical, psychological, social and spiritual needs of each individual. The therapeutic community program involves inmates in intensive programming with a focus on abstinence from illicit drugs and alcohol and participation in programs for successful community re-entry. The Vancouver Island Health Authority (VIHA) and the B.C. Corrections Branch were involved in the initial planning of Guthrie House.

The therapeutic community has five goals: (1) to facilitate a drug-free environment; (2) to facilitate prisoners taking responsibility for their daily living; (3) to provide treatment in a safe and supportive environment; (4) to reduce criminal thinking and anti-social behaviours among prisoners; and (5) to prepare prisoners for life in the outside community. Prisoners move through four phases: orientation (lasting three weeks to one month); primary treatment (two to three months); re-entry/transition (one to two months); and aftercare (six months or greater). Prisoners are involved in intensive, comprehensive programs, including work, training programs, core programs designed to change prisoner behaviour and reduce recidivism, and other seminars, workshops and counselling. Core programming includes topics such as violence prevention, substances abuse management, maintaining respectful relationships, and literacy. Intake to the program is provided on a continuous basis as beds become available. Prisoners seeking admission to the program may at times be placed on a waiting list. An evaluation framework has been developed.

A significant percentage of prisoners in Canada reports illicit drug use prior to and during their imprisonment.¹¹¹ The results of drug use often include imprisonment, disciplinary offences often resulting in longer sentences while imprisoned and, potentially, HIV and HCV infection. Drug-free living units and therapeutic communities present additional harm reduction options for prisoners suffering from significant and long-standing drug addiction.

¹⁰⁹ Nanaimo Regional John Howard Society, *The Guthrie House Therapeutic Community Pilot Project at the Nanaimo Correctional Centre*, November 8, 2006 and related documents on file with the authors and available from Dr. Diane A. Rothern, Medical Director, British Columbia Corrections.

¹¹⁰ Personal correspondence with Dr. Diane A. Rothern, Medical Director, British Columbia Corrections.

¹¹¹ See for example, CSC, 1995 *National Inmate Survey: Final Report*, 1996, No. SR-02, p. 145, where it is reported that 38 percent of prisoners reported illicit drug use. See also, “A health care needs assessment of federal inmates in Canada,” *Canadian Journal of Public Health* 95(S1) (2004): S1–S63, pp. S31, S36–S48.

Concluding observations and strategic directions for action

Concluding observations

Based on the observations documented in this report, we offer a number of observations in relation to the prison HIV and HCV and harm reduction programs we visited.

Need for comprehensive policy and programs

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 (and other equipment) for injecting and tattooing. 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, in every province and in two out of three territories, people who inject drugs can obtain clean needles through government-financed programs to reduce the risk of HIV, HCV and other infections.¹¹² Furthermore, pharmacy sale of syringes is legal, and professional regulatory bodies have encouraged pharmacists to sell syringes openly.¹¹³ As for tattooing, people in the community have access to tattoo parlours that follow universal precautions to prevent the transmission of infections.

In some important respects, the HIV and HCV prevention and harm reduction programs provided in Canadian prison systems mirror such programs in communities across Canada. Community programs differ from province to province to territory, and from community to community within a province or territory. Similarly, prison programs differ in federal and provincial prison systems, and among prisons within the same jurisdiction. The resource constraints that lead to restrictions in programming in the community similarly affect HIV and HCV and harm reduction programming in prison — e.g., there are often waiting lists for community MMT and for programs in prisons that offer MMT.

In providing HIV and HCV prevention and harm reduction programs for prisoners, prison authorities should endeavour to:

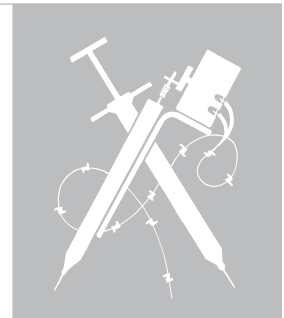
- operate on the basis of public health and human rights principles and their inter-relationship, recognizing that prisoners have the same human right to the highest attainable standard of health as people outside prisons, and that the promotion and protection of health requires explicit and concrete efforts to protect and promote human rights and dignity of prisoners;
- recognize that public health authorities, prisoners, and non-governmental and community-based organizations (e.g., hospitals, universities, prisoner and AIDS service organizations) have a vital role to play in providing services to prisoners; and
- form partnerships with public health authorities, prisoners, and non-governmental and community-based organizations in developing policy and in developing, delivering and evaluating programs.

¹¹² See A. Klein, *Barriers to Access to Needle and Syringe Programs in Canada*, Canadian HIV/AIDS Legal Network, forthcoming 2007: “As of February 2006, Prince Edward Island became the last province in Canada to provide material support for NSP when it agreed to supply syringes and swabs to AIDS PEI. The community-based AIDS service organization had previously been running the province’s only NSP through private donations.” Personal communication with A. MacKinnon, Program Coordinator, AIDS PEI, 23 June 2006. Nunavut does not provide needle exchange, ostensibly because there is no injection drug use in the territory. Personal communication with G. Osborne, Associate Chief Medical Officer of Health for Nunavut, 24 April 2006.

¹¹³ T. Myers et al., “Community pharmacist perspectives on HIV/AIDS and interventions for injection drug users in Canada,” *AIDS Care* 10(6) (1998): 689–700, p. 691 (“[A]t the time of this study, three of ten provincial pharmacy regulatory bodies encouraged the open display of needles and syringes to allow for customer self-selection.” Cited in A. Klein, *Barriers to Access to Needle and Syringe Programs in Canada*, Canadian HIV/AIDS Legal Network, forthcoming 2007.

Where community programs are lacking, prisons should not be excused from meeting their legal obligations to provide prisoners with the means to protect their health. Prison authorities and authorities responsible for health care and public health in the community should work together to find solutions to common problems or to meet unmet needs. There are many examples of effective cooperation in the report. The prime example where prison authorities and those responsible for health in the community need to do more is methadone maintenance therapy (MMT) — both community and prison MMT provision are hampered by a lack of physicians licensed to prescribe methadone, especially outside of cities. Among provincial and territorial prison systems, some do not offer MMT at all, some offer MMT continuation but not initiation, and there are problems finding physicians in the community to provide care to prisoners upon release. Prison authorities, provincial and territorial Ministries of Health and provincial colleges of physicians, (which are the bodies responsible for licensing physicians to prescribe methadone), must work together to find ways to increase the number of physicians licensed to prescribe this treatment.

[P]risoners have the same human right to the highest attainable standard of health as people outside prisons, . . . the promotion and protection of health requires explicit and concrete efforts to protect and promote human rights and dignity of prisoners . . .



Challenges to providing programs in prison

Prisons are a challenging environment in which to provide HIV and HCV prevention and harm reduction programs. In many instances a lack of resources or of decisions on how to prioritize resources, both financial and human, have had a detrimental impact upon the how much programming prison staff, public health staff and staff from community-based organizations can provide to prisoners. Some community-based organizations with expertise in providing prison programs are able to provide programs to only a limited number of prisoners and prisons because of a lack of resources. We also observed that there are 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 (full- or half-time), it is extremely challenging for prison health care staff to find time to play a role in HIV and HCV prevention and harm reduction programs, either as the primary provider of such programs or as a support to peer groups or NGOs.

We observed that programs worked best where there is “buy-in” from prison staff and that successful programs take this into account in the design and delivery of the programs. There also needs to be an opportunity for outside service providers and prison staff to have dialogue about their respective roles and concerns. Outside organizations, including public health and community-based organizations, need to understand the prison environment well, including security concerns, in order to effectively undertake programming inside prisons. And prison staff — health care, program and security staff — need to have an understanding of the need for HIV and HCV prevention and harm reduction and of the role played by outside organizations in delivering such programs. It is crucial that prison staff, especially staff responsible for security, be provided with an opportunity to receive information and ask questions about HIV and HCV prevention and harm reduction and how these types of programs support the prison’s interdependent mandates of protecting public safety, preparing prisoners to reintegrate into the community, and promoting the health of prisoners.

The prison environment also presents significant challenges for building and sustaining peer programs. 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, new peers must come forward to be trained.

We also observed that starting up a successful peer program involves finding an appropriate peer from a prisoner's perspective and offering adequate office space, computer, printer, harm reduction materials and pamphlets, as well as other resources.

The physical facilities of prisons can also present a challenge when delivering programs. Peers and staff from some of the peer and public health programs that we visited observed that they could operate more effectively if they had more office space or space that is dedicated (i.e., not shared with prison services or other prisoner groups). In many cases, this was not possible given the space constraints of the building itself, or lack of resources to make changes to the building. Unfortunately, these space constraints at times may limit the extent to which services can be provided in private, which may act as a barrier to prisoners' access to some programs.

Focus on security and drug interdiction can overwhelm health concerns

Institutional prison "culture" is heavily focused on security and drug interdiction. In some prison systems, principally through the efforts of committed prison health care authorities and staff and community advocates and prisoners, this focus has been tempered somewhat by an appreciation of the government authorities' 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 such materials, despite the fact that no such legal impediment exists in the community. It is hard to imagine that prevention of HIV transmission in prisons in Canada will ever succeed without serious and systematic attention to universal condom access.

Another example of the influence of security and drug interdiction concerns is the lack of access to MMT in provincial and territorial prisons. MMT has proven effective, safe and cost-effective for the management of opioid dependence. In Canada, it is the standard of care for treating opioid dependence. Yet there is resistance in some quarters to ensuring that prisoners with such dependence have access to this substitute that can be legally prescribed. The fact that many prisoners do not have access to it for reasons totally unrelated to individual need and clinical criteria is indicative of the extent to which prison health care in numerous jurisdictions falls far short of equivalence with community standards.

We have also observed in our visits to prison programs that security concerns along with sometimes negative attitudes toward harm reduction on the part of prison staff, combined with a lack of resources, can compromise the confidentiality to which prisoners are entitled in services provided to them.

Learning from reviews and evaluation

Our policy scan, coupled with visits to prisons and interviews with prisoners, prison staff and staff at community-based organizations, also revealed frequent gaps between policy and practice. There were many instances where, within a prison, the applicable policy was not being 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. We did not examine in detail the issue of performance standards for, or evaluation of, programs. CSC advised us that in its prisons, accountability mechanisms and performance standards are applied to HIV and HCV prevention and harm reduction programs. However, from the perspective of prisoners we interviewed, it is unclear if these mechanisms and performance standards are effective.

We referenced and summarized in this report a number of formal reviews and evaluations of programs. Most of these have been undertaken by CSC. Others (in Quebec) have been undertaken by public health researchers evaluating community-provided provincial prison programs, and a few have been less formal evaluations based principally on questionnaires completed by program participants. While thorough evaluation of programs (including soliciting input from prisoners and prison staff) is time-consuming and involves financial costs,

evaluation results are crucial for determining the extent to which a program is meeting prisoners' needs and for providing directions for improvement.

Needs of specific prison populations require attention

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.

In the research for this report we did not find a single HIV and HCV prevention program specifically designed to address the needs of ethno-cultural minority prisoners (other than Aboriginal prisoners) or transsexual and transgender prisoners. Given the ethnocultural diversity of the Canadian prison population, these prisoners' HIV and HCV prevention require attention.

Collaboration improves policy and programming

We found that HIV and HCV prevention and harm reduction policies and programming are strengthened by collaboration between public health authorities and prisons. In some jurisdictions, this collaboration is governed by written, formal agreements (CSC, Saskatchewan, and New Brunswick), while in other jurisdictions it has not been formalized (Quebec, Ontario,¹¹⁴ Manitoba, and British Columbia). For example, CSC has entered into a number of memoranda of understanding with the Public Health Agency of Canada related to infectious disease surveillance and HIV and HCV prevention and harm reduction.¹¹⁵ At the individual prison level, there are numerous examples of public health nurses from local health units providing services to prisoners (e.g., HIV testing and counselling, health education) and prison staff (e.g., infection control training, expert consultation). These work very effectively when the public health nurses work and make decisions autonomously within the prison setting.

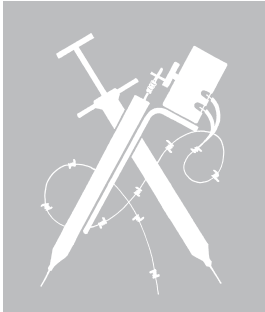
Based on our review, we believe that greater collaboration of this kind at both the policy and programmatic levels would help ensure more comprehensive programming for prisoners in Canada. One challenge to scaling up this collaboration is the organizational structure of public health authorities in Canada: In many provinces, decisions about public health resource allocation and programming are made at the level of local public health units, which do not have an administrative counterpart in corrections structures. The challenge will be for prison systems and public health officials to engage at the provincial level (or the federal-provincial level in the case of CSC) to craft policy and agreement so that programs can be implemented consistently in prisons throughout a province or territory. One example where some provincial-level collaboration is taking place is

¹¹⁴ In Ontario, local public health units are fairly independent. Consequently, the Ministry of Community Safety and Correctional Services (MCSCS) has worked with the priorities established by the health units. In addition, all Ontario public health units contribute health teaching and contact tracing to all MCSCS sites for communicable diseases, and each prison has an infection prevention and control committee with representation from local public health authorities, the local occupational health and safety committee, front line and managerial staff. In the recent *Ontario Public Health Standards, Consultation Draft*, the partnership between public health and corrections is acknowledged in the area of infectious diseases. Correspondence from Joanne Shaw, Manager, Corporate Health Care Services, Professional and Shared Services, Strategic and Operational Branch, Ministry of Community Safety and Correctional Services (March 8, 2007; March 15, 2007).

¹¹⁵ CSC. *Infectious Disease Surveillance in Canadian Federal Penitentiaries*. Fact Sheet. August 2006; CSC, *Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries 2000-01, 2003*. Both documents refer to the infectious disease surveillance infrastructure developed in partnership between CSC and Health Canada. See, e.g., with respect to partnership around harm reduction measures, CSC, Memorandum of Understanding – Needle Exchange Program (NEP) in Canadian Federal Penitentiaries, 2005, and the earlier work of the Study Group for Risk Management of Infectious Diseases.

British Columbia, where nurse-educators from the Division of STI/HIV Control of the B.C. Centre for Disease Control travel to provincial prisons throughout the province.¹¹⁶ Many of the best and most promising programs described in this report are the result of collaboration among two or more of prisons, public health, community-based organizations and prisoners themselves.

Greater collaboration is also needed between prison services in different jurisdictions, and at times prison staff and corrections administration within the same jurisdiction. Policies in a given program area vary widely by jurisdiction; also, some jurisdictions have policy and some do not. From the outside, it almost appears as if each jurisdiction has “reinvented the wheel” each time an HIV and HCV prevention or harm reduction policy is put in place.



Without monitoring and evaluation, it is difficult to determine whether HIV and HCV prevention and harm reduction policies 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.

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.

¹¹⁶ Personal correspondence with Dr Diane A. Rethon, Medical Director, British Columbia Corrections (March 7, 2007).

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 policies 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 policies 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.

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Appendix A — Advisory Committee Members

Cavalieri, Walter, Canadian Harm Reduction Network (Toronto, ON)

Charboneau, Randy, workshop facilitator, artist of Sacred Path, and ex-prisoner (Toronto, ON)

Clarke, Chris, Prisoner, Maplehurst Correctional Centre

Collins, Peter, Prisoner, Bath Institution federal prison

Grandy, Linda, Advocacy Support Worker, Stepping Stone Association (Halifax, NS)

Jardine-Douglas, Aisha, Support worker, Black CAP (Toronto, ON)

McEwen-Gaulton, Tricia, Regional Outreach and Support Services – South Eastern Ontario, Ontario Aboriginal HIV/AIDS Strategy (Kingston, ON)

Myers, Kathleen, Consultant, prisoner support (Montreal, Québec)

O’Briain, Warren, Executive Director, Communicable Disease and Addiction Prevention, Ministry of Health Services (Vancouver, BC)

Ongoiba, Fanta, Executive Director, Africans In Partnership Against HIV/AIDS (Toronto, ON)

Pate, Kim, Executive Director, Canadian Association of Elizabeth Fry Societies

Quewezance, Leona, Technical Support Co-ordinator, All Nations Hope AID Network

Rattner, Maxxine, Program Consultant, HIV/AIDS Policy, Coordination and Programs Division, Public Health Agency of Canada (Ottawa, ON) (ex-officio)

Smith, Stephen, Manager, Blood Borne Pathogens, Communicable Disease and Addictions Prevention, B.C. Ministry of Health (Vancouver, BC)

Thomas, Gerald, Senior Policy Analyst, Canadian Centre on Substance Abuse (Ottawa, ON)

Veresh, Tim, Executive Director, John Howard Society of British Columbia (Vancouver, BC)

Appendix B — Prisons and programs visited, and people interviewed or consulted

Federal community-based organizations and individuals

Kevin Barlow, Executive Director, Canadian Aboriginal AIDS Network

Correctional Service of Canada (National Headquarters)

Mary Beth Pongrac, Project Officer- HIV/AIDS, Correctional Service of Canada

Joanne Barton, Senior Project Manager, Health Services, Correctional Service of Canada

Samar Sarkesh, Project Officer, Infectious Diseases, Correctional Service of Canada

British Columbia

Prisons visited:

Alouette Correctional Center for Women

Fraser Valley Institution

Pacific Institution (Regional Treatment Centre)

Fraser Regional Correctional Center

North Fraser Pre-trial Correctional Center

People interviewed and consulted:

Terry Howard, Prison Outreach Worker, BC PWA POP

May McQueen, Volunteer, Prison Outreach Program, BCPWA

Dr. Diane A. Rothon, M.D., Medical Director, British Columbia Corrections

Joye Morris, President, Joye Morris Health Services Inc.

Jane Merndier, Deputy Warden, Alouette Correctional Center for Women

Alyson Granger Brown, Volunteer Coordinator, Alouette Correctional Center for Women

Amy Slater, Health Care Manager, Alouette Correctional Center for Women

Gillian Edworthy, Researcher, University of British Columbia

Renee, Betty, and a group of women serving time at Alouette Correctional Center

Ruth Elwood Martin, MD, FCFP, Clinical Professor, UBC Department of Family Practice

Tim Veresh, Executive Director, John Howard Society of Lower Mainland of BC

Ken Clement, Executive Director, Healing Our Spirit, BC Aboriginal HIV/AIDS Society

Cole Rheaume, Community Development, Healing Our Spirit, BC Aboriginal HIV/AIDS Society

Nicole Giesbrecht, Social Worker, Regional Treatment Center (PAC)

Alberta

Prison visited:

Edmonton Institution for Women

People interviewed and consulted:

Siofean Coddere, Prisoner, Edmonton Institution for Women

Deborah Jakubec, Executive Director, HIV Edmonton

Lynn Sutankayo, Community Development, HIV Edmonton

Mike Clark, Solicitor Generals Office of Alberta

Sandra Johnson, Outreach Worker, Streetworks

Saskatchewan

Prisons visited:

Prince Albert Correctional Center

Saskatchewan Penitentiary

People interviewed and consulted:

Leona Quewezance, Support Worker, All Nations Hope

Tony de Padua, Public Health Nurse, Prince Albert, Sexual Health Clinic

Angela Weber, Chief of Health Services, Saskatchewan Penitentiary

Lori Herzog, Prince Albert Correctional Center

Heather Sriver, Director, Pine Grove Correctional Centre

Manitoba

Prisons visited:

Headingly Correctional Center

Stony Mountain Institution

People interviewed and consulted:

Marilyn Sloane, Director, Health Services, Manitoba Corrections

Jean Orton, RN, PHN, Central Region Health Authority

Darlene McDonald, RN, PHN, Brandon Regional Health Authority

Jodene Dudgeon, RN, PHN, North East Health Authority

Andrea Rees Bergan, Nurse Educator, Stony Mountain Institution
Sarah Bettess, Health Promotion Social Worker, Stony Mountain Institution
Richard Fortin, Prisoner, Health Awareness Group, Stony Mountain Institution
Lars Desoray, Prisoner, Peer Health Educator, Stony Mountain Institution
Doug Brown, Prisoner, Health Awareness Group, Stony Mountain Institution
Hessler Peltier, Prisoner, Health Awareness Group, Stony Mountain Institution

Ontario

Prisons visited:

Warkworth Institution
Maplehurst Correctional Complex

People interviewed and consulted:

Mooky Cherian, Provincial Program Coordinator, PASAN
Eveline Allen, Regional Outreach and Education Coordinator, PASAN
LaVerne Monette, Executive Director, Ontario Aboriginal HIV/AIDS Strategy
John Bellosillo, Chairman, Peer Health Counselling, Warkworth federal prison
Peter Collins, Prisoner, Peer Education Counsellor, Bath federal prison
Felix Parum, Prisoner, Peer Education Counsellor, Fenbrook Institution
Chris Clarke, Prisoner, Maplehurst Correctional Complex
Joanne Shaw, Manager, Corporate Health Care, Ministry of Community Safety and Correctional Services
Cathy Ball, Infectious Disease Nurse, Fenbrook Institution

Quebec

Prisons visited :

La Macaza
Joliette Institution
Federal Training Center
Cowansville Institution
Leclerc Institution
Centre de Detention de Montréal (also known as Bordeaux Correctional Centre)

People interviewed and consulted:

Helene Racicot, Administration régionale, Correctional Service of Canada
Chantal Perron, Agent d'information senior, Sante et traitements, Comite des personnes atteintes du VIH du Québec
Thierry Pinet, CLSC Sherbrooke
Sebastien Houle, CLSC Sherbrooke
Vivian Bain, Psychologist
Sylvain Turgeon, Le Centre Option-Prévention TVDS
Alexandre, Intern, Le Centre Option-Prévention TVDS
Claire Thiboutot, Executive Director, Stella
Diane Deslauriers, Counsellor, Stella
Jacues Giguere, Peer Education Counsellor, Leclerc Institution
Francine Prevost, Sexologist, CLSC Bordeaux-Cartierville
Jean Guy Tremblay, Prisoner, Peer Education Counsellor, Federal Training Center
Réjean Bérard, Chief of Health Services, Federal Training Center
Bruno Gingras, Infectious Disease Nurse, Leclerc Institution
Daniel Benson, Intervenant, Option-vie
Gail Levesque, Chief of Health Services, Joliette Institution
Diane Perreault, Infectious Disease Nurse, Joliette Institution
Isabel, Prisoner, Joliette Institution
Julie, Prisoner, Joliette Institution
Michel Cloutier, Social Programs Officer, Cowansville Institution
Louis Mirandette, Prisoner, tattooist, Cowansville Institution
Andree Menard, Chief of Health Services, Cowansville Institution
Lyne Giroux, Infectious Disease Nurse, Cowansville
Alex Calvin Chartier, Prisoner, Peer Education Counselor, La Macaza
Morris Bowen, Prisoner, Circle of Knowledge Keeper, La Macaza
Solange Cyr, Chief of Health Services, La Macaza

New Brunswick

Prison visited:

Westmorland Institution

People interviewed and consulted:

David Lewis, Regional Infectious Disease Coordinator Atlantic, Correctional Service of Canada
Jeff Chetwynd, Prisoner, Peer Education Counsellor, Westmorland Institution
Annette Depuis, Infectious Disease Nurse, Westmorland Institution

Nova Scotia

Prison visited:

Nova Institution for Women

People interviewed and consulted:

Michele Steele, Program Manager, East Coast Forensic Hospital, Offender Health Services

Cindy Macisaac, Direction 180

Monique Fong, Executive Director, Healing Our Nations

Debbie Fury, Infectious Disease Nurse, Nova Institution for Women

Tanya Morrison, Prisoner, Nova Institution for Women

Diane Bailey, Executive Director, Mainline

Kathy Boudreau Jonson, Outreach worker, Mainline

Linda Grandy, Advocacy Support Worker, Stepping Stone

Jeff Liberatore, Program Coordinator, Stepping Stone

Appendix C — References for policy table

^a Note in relation to British Columbia that youth corrections used to be the responsibility of B.C. Corrections. While this is no longer the case, youth corrections continue to follow B.C. Corrections policy pending the completion of the youth corrections policy manual. Personal correspondence with Dr Diane A. Rothon, Medical Director, British Columbia Corrections (March 7, 2007).

^b The policy situation in Nova Scotia is not straightforward. The table does not include the policies of the Department of Justice. According to section 25 of the *Correctional Services Act*, S.N.S., 2005, c 37, the Minister of Health is responsible for the provision, administration and operation of health services for offenders in custody. Section 26 provides that the Minister may, in the case of adults in custody, delegate the delivery of health services to a district health authority or, in the case of youth in custody, delegate to the IWK Health Centre (IWK). Accordingly, medical care for prisoners in Nova Scotia is provided by the Capital District Health Authority (CDHA) and IWK for adult and youth, respectively. See letter from Francine Comeau, Assistant FOIPOP Coordinator (February 16, 2006): “The CDHA and the IWK are responsible for the policies and practices with respect to health issues. The Correctional Services Division of the Department of Justice does have a Policy and Procedures Manual which includes a section on health issues. Although these policies have not been repealed, they are not usually enforced because CDHA and the IWK have assumed responsibility for the medical care of offenders and young persons held at the youth prison. As agreed, I am therefore, not considering these Policies and Procedures for the purpose of processing your application at this time. I have, however, included a few policies as staff still refer to them for general guidance pending the creation of policies by CDHA and the IWK.” Since the Solicitor General is no longer legally responsible for the provision of health services, the Solicitor General arguably lacks legislative authority to publish and enforce policy in relation to health care. This legislative authority appears to now rest with the Minister of Health. Therefore, we have not included the Department of Justice policies in this table. However, we have reviewed these policies from the perspective of programs and included the relevant information in the program table.

^c In response to the “access to information” request for policies, guidelines and training materials, the Acting Deputy Attorney General wrote, in part: “In situations where there are no copies of directives, policies, training materials, etc., attached, it is because the practice is simply an accepted operating procedure and has not been formalized in written format, or because the material (brochures, pamphlets, etc.) are under the control of another Public Body, such as Health.” Letter from Edison Shea, Acting Deputy Attorney General (February 9, 2006).

^d CSC, Commissioner’s Directive, *821 Management of Infectious Disease* (November 4, 2004) ss. 19a, 23–26 provides for pre- and post-test counselling offered to prisoners at admission and throughout their incarceration. See, also, CSC, Commissioner’s Directive, *800 Health Services* (September 30, 2004) ss. 18e, which provides that within 14 days of admission, a prisoner shall be offered counselling regarding HIV and testing. Under a Memorandum of Agreement between Health Authority #9 Sexual Health Program of the Province of Saskatchewan and the Department of the Solicitor General of Canada as represented by CSC (October 31, 2002), a project nurse from the Health Authority provides anonymous HIV testing and counselling to prisoners and carries out contact tracing (see ss. 2.1, 2.2), the costs of which are paid by CSC.

^e Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Health Services, *Infectious / Communicable Disease – AIDS and HIV 20.15.03* (January 26, 2004) Procedure 3 provides for referral for voluntary testing at admission for prisoners “who claim or are known to be HIV positive or who are experiencing symptoms suggestive of HIV infections.” Pre- and post-test counselling are mandated.

^f B.C. Corrections Branch – Adult Custody Division, Health Care Service Manual, *Chapter 12 Testing – Communicable Diseases* (August 2002) and B.C. Corrections Branch – Adult Custody Policy, *Chapter 9 Inmate Health Care Services* (April 2005) s. 9.18 provide that prisoners are offered voluntary testing

for communicable diseases upon admission, and upon request thereafter. Pre- and post-test counselling accompanies HIV and HCV testing.

[§] Manitoba, Justice, Corrections Division, Custodial Policy, *Communicable Disease Control* (May 10, 2004) Purpose (s. 2) provides for voluntary HIV antibody testing, accompanied by pre- and post-test counselling. See, also, Headingly Correctional Centre, Standing Orders, *Communicable Disease Control 50-10* (August 25, 2003) s. 2.

^h New Brunswick, Public Safety Corrections, Adult Institutional Policy, *G-42 Universal Precautions – Blood-Borne Pathogens* (March 2001) provides for voluntary HIV antibody testing with pre- and post-test counselling, upon request and for those at risk. As part of a memorandum of understanding (MOU) (June 30, 2003) between the Minister of Health and Wellness (Public Health Management Service) and the Minister of Public Safety, anonymous, non-nominal or nominal HIV antibody testing is provided to prisoners. The MOU covers a range of public health services provided by public health nurses for a five-year term in relation to HIV, hepatitis B and C, and sexually transmitted infections.

ⁱ Newfoundland and Labrador, Department of Justice, Corrections and Community Services, Health Care Services, Policy Directive, *Special Health Care Services – 16.40.06 HIV/AIDS* (April 1, 2004), ss. 2–4, 12 provides for voluntary testing with pre- and post-test counselling.

^j Northwest Territories, North Slave Correctional Facility – Standing Orders, *12.08, Infectious and Communicable Diseases* (November 6, 2001) ss. 3.2, 3.3, 3.6, together provide for voluntary HIV testing and pre- and post-test counselling. See, similarly, Northwest Territories, South Mackenzie Correctional Centre – Standing Orders, *1209, AIDS* (September 5, 1998) s. 4; Northwest Territories, Territorial Women’s Correctional Centre – Standing Orders, *12.08 AIDS* (February 8, 2006), s. 3; Northwest Territories, Corrections Service – Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) s. 4.9.

^k Nunavut, Corrections and Community Justice Division, Operations Manual – Adult, *12.06 Infectious and Communicable Disease* (September 7, 2001) ss. 4.3, 5.1; Baffin Correctional Centre – Standing Orders *1207 Infectious and Communicable Diseases* (May 31, 1996) s. 3.2; Baffin Correctional Centre – Standing Orders, *1209 AIDS* (June 3, 1996) s. 3.5 — according to which voluntary HIV testing is offered to prisoners during intake and subsequent assessments.

^l Saskatchewan Justice, Corrections Division Policy, *Management of Inmates with Communicable Diseases* (January 1, 1996) s. 3.0.

^m When possible, provided by Communicable Disease Nurse at walk-in clinic. No record on inmate’s file. Yukon Department of Justice, Community and Correctional Services Branch, Policies and Procedures, Whitehorse Correctional Centre, No. 11-1 (23 July 1997) ss. 46–48; Whitehorse Correctional Centre, *Inmate Handbook* (2004) section K1; Yukon Health and Social Services, *Pre- and post-test information about testing for HIV infection* (August 2005).

ⁿ Northwest Territories, Corrections Service – Operations Manual, Young Offender Secure Custody, *Chapter 12, Services* (January 16, 2001) s. 5.1 provides: “Testing for communicable diseases such as hepatitis, AIDS, tuberculosis and sexually transmitted diseases will be available at any time subject to Doctors examination and order.” See, similarly, Northwest Territories, Corrections Service – Operations Manual, Young Offender Secure Custody, *12.07 AIDS* (January 16, 2001), ss. 3.0, 4.10–4.12; Northwest Territories, Corrections Service – Standing Order, North Slave Young Offenders Facility Open Custody, *1006.01, Infectious Disease* (April 30, 2002) s. 5.1; Northwest Territories, Corrections Service – Standing Order, North Slave Young Offenders Facility Open Custody, *1004.00, Acquired Immune Deficiency Disease* (April 30, 2002), s. 4.9. Regarding female youth, see Northwest Territories, The Arctic Fern Facility – Standing Orders, *1206.01 Infectious & Communicable Diseases* (January 2, 2006) ss. 4.3, 5.1; Northwest Territories, The Arctic Fern Facility – Standing Orders, *1207.01 AIDS* (January 2, 2006) ss. 4.10, 4.11.

^o Urine testing is voluntary as per Corrections and Public Safety, Young Offender Programs, Custody, Policy Statement, *The Use of Urinalysis Testing in Custody Facilities* (2005). The policy applicable to the Yarrow Youth Farms (*Drug Testing of Youth*; November 1, 1987, revised June 22, 2001) states that staff can request a urine sample, but youth can refuse. According to a response provided by Kilburn Hall Youth Centre, while urinalysis is not mandatory, “if a YO Worker requests same it will be accommodated” (undated).

^p CSC, Commissioner’s Directive, *821 Management of Infectious Disease* (November 4, 2004) s. 21 provides, in part, that “non-lubricated, non-spermicidal condoms, water-based lubricants, dental dams ... are discreetly available to inmates at a minimum of three locations, as well as in all private family visiting units.”

^q Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Health Services, *Issuing of Condoms / Dental Dams / Lubricant to Offenders 20.15.07* (January 26, 2004) at Standard 2 provides: “An offender may forward a request form asking for a confidential appointment with the centre physician, who may subsequently issue contraceptives at the end of the scheduled meeting.”

^r B.C. Corrections Branch – Adult Custody Division, Health Care Service Manual, *Chapter 14 Blood and Body Fluid Borne Pathogens* (August 2002) s. 14.4 and B.C. Corrections Branch – Adult Custody Policy, *Chapter 9 Inmate Health Care Services* (April 2005) s. 9.19. provide that condoms, one-time use packages of lubricant, and printed material regarding the use of condoms are to be made freely available and readily accessible to prisoners.

^s Manitoba, Justice, Corrections Division, Custodial Policy, *Communicable Disease Control* (May 10, 2004) s. 9.2 and Appendix “B” provides for lubricated condoms, lubricant for release packages containing at least 6 condoms. See also, Headingly Correctional Centre, Standing Orders, *Communicable Disease Control 50-10* (August 25, 2003) s. 12.2b. Winnipeg Remand Centre, Standing Orders, *Distribution of Condoms 15.8* (August, 1993) provides that condoms will be available through the medical services and counsellors.

^t Newfoundland and Labrador, Department of Justice, Corrections and Community Services, Health Care Services, Policy Directive, *Special Health Care Services – 16.40.06 HIV/AIDS* (April 1, 2004), s. 8.

^u Northwest Territories, North Slave Correctional Facility – Standing Orders, *12.08, Infectious and Communicable Diseases* (November 6, 2001) s. 3.2.

^v Ontario Ministry of Correctional Services, Health Care Services Policy and Procedures, *Sexually Transmitted Diseases HCS 01 27 01* (October 1999) provides that one condom and one package of lubricant will be made available to male prisoners upon request to health services, and one dental dam will be made available to a female prisoner upon request to health services. Provision of these measures must be accompanied by an “HIV/AIDS Information Sheet.” Prisoners may accumulate two of each item (i.e., condom, lubricant, dental dam). Prisoners are advised of condom, lubricant and dental dam availability via notices posted in several areas of the institution.

^w Agassiz Youth Centre, Institutional Standing Order, *Control of Communicable Diseases #906* (October 22, 2002) s. 2g, Appendix B provides that condoms are available through health services, offender units and in release packages.

^x Northwest Territories, Corrections Service – Operations Manual, Young Offender Secure Custody, *12.07 AIDS* (January 16, 2001) s. 4.20, according to which section youth in secure custody “shall” be provided with access to condoms through health care and advised upon admission about their availability and proper use. See, similarly, with respect to youth in open custody, Northwest Territories, Corrections Service – Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) ss. 4.13, 5.2; Northwest Territories, Corrections Service – Standing Order, North Slave Young Offenders Facility Open Custody, *1004.00, Acquired Immune Deficiency Disease* (April 30, 2002), ss. 4.12. 5.2. Regarding female youth, see Northwest Territories, The Arctic Fern Facility – Standing Orders, *1207.01 AIDS* (January 2, 2006), s. 4.21.

^y Saskatchewan Corrections and Public Safety, Young Offender Programs, Custody, Policy Statement, *Prevention of Pregnancy and Sexually Transmitted Diseases* (2005) s. 4.6 provides that youth in secure custody will have access to condoms on request, and youth in open or referred custody will have condoms available in a discreet area of the facility. In addition, the policy states that “[d]istribution of condoms must be administered respecting confidentiality, sensitivity, embarrassment, etc.” See, also, Saskatchewan Social Services, Residential, Therapeutic & Custodial, Family and Youth Services, Procedure, *Prevention of Sexually Transmitted Diseases by Young Offender*, Chapter 5, s. 5, p. 5 (May 29, 1996). Under the latter policy, youth leaving the facility either temporarily (i.e., not for work, education or training) or upon discharge are eligible for access to condoms. In Kilburn Hall Youth Centre and Drumming Hill Youth Centre, youth do not have access to condoms while in custody, as per the response to an access to information request (Kilburn, undated; Drumming Hill, as per e-mail from Joan Hayes, January 24, 2006).

^z CSC, Commissioner’s Directive, *821-2 Bleach Distribution* (November 4, 2004); CSC, Commissioner’s Directive, *821 Management of Infectious Disease* (November 4, 2004) ss. 21, 22.

^{aa} B.C. Corrections Branch – Adult Custody Division, Health Care Service Manual, *Chapter 14 Blood and Body Fluid Borne Pathogens* (August 2002) s. 14.5; B.C. Corrections Branch – Adult Custody Policy, *Chapter 9 Inmate Health Care Services* (April 2005) s. 9.20.

^{ab} CSC, Commissioner’s Directive, *800 Health Services* (September 30, 2004) s. 41; CSC, Commissioner’s Directive, *800-1 Methadone Treatment Guidelines* (May 2, 2002); CSC, *Correctional Service of Canada: Specific Guidelines for Methadone Maintenance Treatment* (November 2003).

^{ac} Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Health Services, *Methadone Maintenance 20.00.12* (April 30, 2004).

^{ad} B.C. Corrections Branch – Adult Custody Division, Health Care Service Manual, *Chapter 10 Methadone* (August 2002; revised March 2007) s. 10.1(1).

^{ae} Manitoba, Justice, Corrections Division, Custodial Policy, *Communicable Disease Control* (May 10, 2004) Appendix “B”; Manitoba Justice, Corrections Division, (Adult Only) Custodial Policy, *Methadone Maintenance Program* (July 5, 2005).

^{af} New Brunswick, Public Safety Corrections, Adult Institutional Policy, *G-43, Methadone Control* (July 2001).

^{ag} Ontario Ministry of Correctional Services, Health Care Services Policy and Procedures, *Methadone HCS 01 21 01* (October 1999).

^{ah} Québec, Ministère de la Sécurité publique, Direction générale des services correctionnels, *Soins de santé aux personnes incarcérées 4 D 3* (18 janvier 2000), ss. 3.4, 5.8.

^{ai} Saskatchewan Corrections and Public Safety, Corrections Division Policy, *Methadone Maintenance Treatment for Offenders* (October 5, 1998; revised June 2003).

^{aj} CSC, Commissioner’s Directive, *800 Health Services* (September 30, 2004) s. 41; CSC, Commissioner’s Directive, *800-1 Methadone Treatment Guidelines* (May 2, 2002); CSC, *Correctional Service of Canada: Specific Guidelines for Methadone Maintenance Treatment* (November 2003).

^{ak} B.C. Corrections Branch – Adult Custody Division, Health Care Service Manual, *Chapter 10 Methadone* (August 2002; revised March 2007) ss. 10.1(4), 10.4.

^{al} Ontario Ministry of Correctional Services, Health Care Services Policy and Procedures, *Methadone HCS 01 21 01* (October 1999) provides for the possibility of MMT initiation for pregnant prisoners: “Based on a clinical decision, an opiate dependent pregnant inmate not already on a methadone maintenance programme may be considered for initiation for methadone.”

^{am} Saskatchewan Corrections and Public Safety, Corrections Division Policy, *Methadone Maintenance Treatment for Offenders* (October 5, 1998; revised June 2003).

^{an} There was no province-wide policy provided. However, according to a standing order, one youth facility provides MMT continuation: Saskatchewan Corrections and Public Safety, Standing Order, Kilburn Hall Youth Centre, *Methadone Administration* (undated).

^{ao} CSC, Commissioner's Directive, *566-10 Urinalysis Testing in Institutions* (April 28, 2005) provides for random urine testing, and testing for program purposes.

^{ap} Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Security Procedures, Drug Control, *Urinalysis 10.35.06* (January 26, 2004) provides for urinalysis where there are "reasonable and probable grounds" to believe a prisoner has used illicit drugs, where a prisoner is in possession of illicit drugs and it is not possible to obtain a sample of same, as part of a Random Selection Urinalysis Program, and as a requirement for participation in certain programs or activities. See, also, Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Security Procedures, Drug Control, *Alert Breath Test Program 10.35.07* (January 26, 2004), which provides for breath analysis upon "reasonable and probable grounds" to believe a prisoner has consumed alcohol and as a requirement for participation in certain programs or activities.

^{aq} B.C. Corrections Branch – Adult Custody Policy, *Chapter 1 Security and Control* (April 2005) ss. 1.18 and 1.16.8 provide for urinalysis "on reasonable grounds when it is an adjunct to security and programming services."

^{ar} Headingly Correctional Centre, Standing Orders, *Offender Urine Testing 35-13* (June 24, 2003) provide for urine testing where reasonable grounds exist to believe a prisoner used or is using an intoxicant.

^{as} New Brunswick, Public Safety Corrections, Adult Institutional Policy, *G-1, Health Assessment* (March 2001). Urinalysis is part of health assessment upon admission.

^{at} Northwest Territories, Corrections Service – Directives – Adult, Chapter 6, *Security Management* (August 24, 2005); Northwest Territories, North Slave Correctional Facility – Standing Orders, *6.12 Drug Testing* (March 14, 2005) provides for urinalysis testing where there are reasonable grounds to suspect illicit drug use ("for cause"); random testing is not permitted. See, similarly, Northwest Territories, South Mackenzie Correctional Centre – Standing Orders, *612 Drug Testing* (June 1, 2001); see, similarly, with respect to women, Northwest Territories, Territorial Women's Correctional Centre – Standing Orders, *6.12 Drug Testing* (February 8, 2006).

^{au} Agassiz Youth Centre, Institutional Standing Order, *Drug Screening #790* (September 14, 2005) provides for urine testing on reasonable grounds and as part of reintegration leaves, and for ion drug testing of possessions.

^{av} New Brunswick, Public Safety Corrections, Adult Institutional Policy, *G-1, Health Assessment* (March 2001). Urinalysis is part of health assessment upon admission.

^{aw} Northwest Territories, Corrections Service, River Ridge Young Offenders Facility – Standing Order, *612.01, Urinalysis* (May 9, 1995) provides for urine testing where there are reasonable grounds to suspect illicit drug use; random testing is not permitted. See similarly, Northwest Territories, Corrections Service – Standing Order, North Slave Young Offenders Facility Open Custody, *614.01 Urinalysis* (November 30, 2001).

^{ax} CSC, Commissioner's Directive, *821 Management of Infectious Disease* (November 4, 2004) ss. 15, 18 provide, in part, that the Peer Education and Counselling (PEC) Program must be in place in all penitentiaries, and that "wherever possible and appropriate, opportunities for community service agencies and peer involvement in the delivery of education and counselling to inmates in infectious diseases shall be pursued." Section 20 refers to the Reception Awareness Program. See also CSC, Commissioner's Directive, *800 Health Services* (September 30, 2004) ss. 18e and f, which provide, respectively, that within 14 days of admission,

a prisoner shall be offered counselling regarding HIV and testing, and concerning health promotion and education programs.

^{ay} Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Health Services, *Infectious / Communicable Disease – AIDS and HIV 20.15.03* (January 26, 2004) Standard 6.

^{az} B.C. Corrections Branch – Adult Custody Division, Health Care Service Manual, *Chapter 13 Infection Control and Prevention* (August 2002) s. 13.1.

^{ba} Manitoba, Justice, Corrections Division, Custodial Policy, *Communicable Disease Control* (May 10, 2004) Purpose (s. 4), s.9, Appendix “B,” Appendix “E” (Health Issues Booklet). See, also, Headingly Correctional Centre, Standing Orders, *Communicable Disease Control 50-10* (August 25, 2003) s. 4; Headingly Correctional Centre, Standing Orders, *Communicable Disease Control 50-10* (August 25, 2003) s. 12.2a; Winnipeg Remand Centre, Standing Orders, *Infectious Disease Control 50-2* (Revised November, 1993) s. IIIh.

^{bb} New Brunswick, Public Safety Corrections, Adult Institutional Policy, *G-42 Universal Precautions – Blood-Borne Pathogens* (March 2001).

^{bc} Newfoundland and Labrador, Department of Justice, Corrections and Community Services, Health Care Services, Policy Directive, *Special Health Care Services – 16.40.06 HIV/AIDS* (April 1, 2004), ss. 13, 14, 15; Newfoundland and Labrador, Department of Justice, Corrections and Community Services, Health Care Services, Policy Directive, *Special Health Care Services – 16.40.11 Health Promotion* (April 1, 2004), ss. 13, 14, 15.

^{bd} Northwest Territories, North Slave Correctional Facility – Standing Orders, *12.08, Infectious and Communicable Diseases* (November 6, 2001) s. 3.2; Northwest Territories, South Mackenzie Correctional Centre – Standing Orders, *1207.01, Infectious Diseases* (September 5, 1998) s. 3; Northwest Territories, South Mackenzie Correctional Centre – Standing Orders, *1209, AIDS* (September 5, 1998) .

^{be} Baffin Correctional Centre – Standing Orders, *1209 AIDS* (June 3, 1996) s. 3.4.

^{bf} Saskatchewan Corrections and Public Safety, Adult Corrections Branch Policy, *Healthcare Standards in Provincial Correctional Centres* (January 1996, revised November 2004). The Purpose section of the policy states that basic health services shall include, amongst other things: (1) health services encompassing preventive, promotional, curative, supportive, rehabilitative and palliative services with culturally sensitive components; and (2) health services designed and delivered by a range of providers, in keeping with the multi-disciplinary approach. Section 1.3 provides: “In support of providing basic health services, emphasis will be placed on health promotion/illness prevention.”

^{bg} Alberta, Solicitor General, Correctional Services, Young Offender Centre Policy Manual, Health Services, *Infectious / Communicable Diseases – AIDS and HIV 4.10.03* (undated) s. 3.

^{bh} Agassiz Youth Centre, Institutional Standing Order, *Control of Communicable Diseases #906* (October 22, 2002) Appendix B provides for “written [d]rug education materials with a harm reduction focus aimed at high-risk population [to be] available in Health Services.”

^{bi} Northwest Territories, Corrections Service – Operations Manual, Young Offender Secure Custody, *12.07 AIDS* (January 16, 2001) s. 4.19; Northwest Territories, Corrections Service – Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) s. 4.11; Northwest Territories, Corrections Service – Standing Order, North Slave Young Offenders Facility Open Custody, *1004.00, Acquired Immune Deficiency Disease* (April 30, 2002), s. 4.11. Regarding female youth, see Northwest Territories, The Arctic Fern Facility – Standing Orders, *1207.01 AIDS* (January 2, 2006) s.4.19.

^{bj} Ontario Ministry of Community and Social Services, Youth Justice Services Manual, *Communicable Diseases* 0403-04 (September, 2003) provides that policies and procedures for health care must describe an education plan for young persons, the prevention of sexually transmitted diseases, testing for communicable diseases, and HIV/AIDS-specific considerations. Further, the “educational plan for the prevention and control of communicable diseases can be delivered either be medical staff, external professional resource personnel or adequately trained facility/teaching staff.”

^{bk} Saskatchewan Corrections and Public Safety, Young Offender Programs, Custody, Policy Statement, *Prevention of Pregnancy and Sexually Transmitted Diseases* (2005), s. 4.0; Saskatchewan Social Services, Residential, Therapeutic & Custodial, Family and Youth Services, Policy Statement, *Prevention of Sexually Transmitted Diseases by Young Offender*, Chapter Y-1, s. 3,37 (May 31, 1996). See, also, North Battleford Youth Centre, Local Procedure Manual, *Prevention of Sexually Transmitted Diseases in NBYC* (March 14, 2001; revised February 26, 2003; reviewed March 11, 2005).

^{bl} CSC, Commissioner’s Directive, *821 Management of Infectious Disease* (November 4, 2004) s. 18.

^{bm} Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Health Services, *Infectious / Communicable Disease – AIDS and HIV 20.15.03* (January 26, 2004) Standard 3, Procedures 11 – 12, 13a, 14a, c and d, 15a. Regarding training for youth staff, see Alberta, Solicitor General, Correctional Services, Young Offender Centre Policy Manual, Health Services, *Infectious / Communicable Diseases – AIDS and HIV 4.10.03* (undated) ss. 3, 10b.

^{bn} B.C. Corrections Branch – Adult Custody Division, Health Care Service Manual, *Chapter 13 Infection Control and Prevention* (August 2002) s. 13.1.

^{bo} Manitoba, Justice, Corrections Division, Custodial Policy, *Communicable Disease Control* (May 10, 2004) Purpose (s. 3), s. 8, Appendix “B.” See also Headingly Correctional Centre, Standing Orders, *Communicable Disease Control 50-10* (August 25, 2003) s. 3; Headingly Correctional Centre, Standing Orders, *Communicable Disease Control 50-10* (August 25, 2003) s. 12.1a; Winnipeg Remand Centre, Standing Orders, *Infectious Disease Control 50-2* (Revised November, 1993) s. IIIg. See, also, Agassiz Youth Centre, Institutional Standing Order, *Control of Communicable Diseases #906* (October 22, 2002) s. 2f.

^{bp} New Brunswick, Standards and Application of Health and Safety, *AD-2705 HIV/AIDS in the Workplace* (August 1998).

^{bq} Newfoundland and Labrador, Department of Justice, Corrections and Community Services, Health Care Services, Policy Directive, *Special Health Care Services – 16.40.06 HIV/AIDS* (April 1, 2004), ss. 13, 14, 15.

^{br} Northwest Territories, North Slave Correctional Facility – Standing Orders, *Infectious and Communicable Diseases 12.06.01* (May 25, 2005) s. 3.2. provides: “Nursing staff shall provide staff orientation and training in the use of standard precautions.” See, similarly, Northwest Territories, South Mackenzie Correctional Centre – Standing Orders, *1207.01, Infectious Diseases* (September 5, 1998) s. 6.1; Northwest Territories, Territorial Women’s Correctional Centre – Standing Orders, *12.06.01 Infectious Disease* (February 8, 2006); with respect to young offenders’ secure custody, see Northwest Territories, Corrections Service – Operations Manual, Young Offender Secure Custody, *Chapter 12, Services* (January 16, 2001) ss. 4.8, 4.10; with respect to young offenders’ open custody, see Northwest Territories, Corrections Service – Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) s. 4.1, which mandates education and information regarding AIDS, with annual “or sooner” updates; Northwest Territories, Corrections Service – Standing Order, North Slave Young Offenders Facility Open Custody, *1006.01, Infectious Disease* (April 30, 2002) s. 4.9. Regarding female youth, see Northwest Territories, The Arctic Fern Facility – Standing Orders, *1206.01 Infectious & Communicable Diseases* (January 2, 2006) s. 4.8; Northwest Territories, The Arctic Fern Facility – Standing Orders, *1207.01 AIDS* (January 2, 2006) s. 4.2.

^{bs} Baffin Correctional Centre – Standing Orders, *1209 AIDS* (June 3, 1996) s. 3.1.

^{bt} Ontario Ministry of Community and Social Services, Youth Justice Services Manual, *Communicable Diseases* 0403-04 (September, 2003) provides that policies and procedures for health care must describe staff training.

^{bu} Saskatchewan Justice, Corrections Division Policy, *Management of Inmates with Communicable Diseases* (January 1, 1996) s. 10.0, 12.0; Saskatchewan Corrections and Public Safety, Young Offender Programs, Custody, Policy Statement, *Prevention of Pregnancy and Sexually Transmitted Diseases* (2005) s. 4.7; Saskatchewan Social Services, Residential, Therapeutic & Custodial, Family and Youth Services, Procedure, *Prevention of Sexually Transmitted Diseases by Young Offender*, Chapter 5, s. 5, p. 5 (May 29, 1996). As per an access to information response from Drumming Hill Youth Centre, full-time staff are trained by Battleford's Sexual Health Clinic.

^{bv} Alberta, Solicitor General, Correctional Services, Adult Centre Operations Branch Policy Manual, Health Services, *Infectious / Communicable Diseases – AIDS and HIV 20.15.03* (January 26, 2004) Procedure 9a.

^{bw} NWT Clinical Practice Guidelines for Primary Community Care Nursing, Chapter 11, *Communicable Disease* (September 2004). Regarding education for medical professionals responsible for young persons' medical services, see Northwest Territories, Corrections Service – Operations Manual, Young Offender Open Custody Resources, *10.04, Acquired Immunodeficiency Syndrome (AIDS)* (September 1, 2003) s. 4.13; Northwest Territories, Corrections Service – Standing Order, North Slave Young Offenders Facility Open Custody, *1004.00, Acquired Immune Deficiency Disease* (April 30, 2002), s. 4.13. Regarding female youth, see Northwest Territories, The Arctic Fern Facility – Standing Orders, *1207.01 AIDS* (January 2, 2006) s. 4.2.

^{bx} Baffin Correctional Centre – Standing Orders, *1209 AIDS* (June 3, 1996) ss. 3.1, 3.11.

^{by} Correctional Service of Canada, Commissioner's Directive 821, section 10: "The gender and cultural requirements of individuals and groups shall be respected and reflected in all activities aimed at addressing infectious diseases in the inmate population."

^{bz} CSC, Commissioner's Directive, *702 Aboriginal Programming* (September 6, 1995) s. 5 provides as one of five policy objectives: "To ensure that the needs of all Aboriginal offenders are identified and that programs and services are developed and maintained to meet those needs."

Appendix D — References for programs table

^a See, generally, letter from Edison Shea, Acting Deputy Attorney General (February 9, 2006).

^b Nominal and non-nominal HIV testing offered upon request, with pre- and post-test counselling. Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Infection Control – Blood-Borne Pathogens* 12.56.00 CL (September 1, 1998); Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Blood Collection for Blood-Borne Pathogens HBV, HCV, HIV* 12.57.00 CL (September 1, 1998); Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Infection Control – Blood-Borne Pathogens Pretest Counselling – Hepatitis B & C, HIV* 12.58.00 CL (September 1, 1998); Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Post-test Counselling for Blood-Borne Pathogens Serologic Testing* 12.59.00 CL (September 1, 1998); and Nova Scotia Department of Justice, Correctional Services, Policy & Procedure, *Distribution of Condoms and Dental Dams* 12.73.00 (September 1, 1998). See, also, Nova Scotia Department of Justice, Correctional Services, Policy & Procedure, *Infection Control – Blood-Borne Pathogens* 12.74.00 (September 1, 1998).

^c Ontario, Ministry of Community Safety and Correctional Services, *Health Care Record – Part A (Health Assessment)*. According to an e-mail received from Joanne Shaw, Manager, Corporate Health Care Services, Professional and Shared Services, Strategic and Operational Branch, Ministry of Community Safety and Correctional Services: “HIV/HCV/HBV testing. This has always been offered on admission by both the nurse and MD. I am attaching the current and most recent revision of the Nursing History & Assessment tool (Part A) we use. In the document titled Health Care Record, the inmate is asked re HIV, Hepatitis and Chlamydia status and offered these tests. If the inmate wishes these tests the MD will order. It is one of the diagnostic tests that can be ordered by the MD and is referred to as that in the manual: As soon as possible after the inmate’s admission, the physician shall: review the nursing history and assessment; order diagnostic investigations where clinically indicated” (March 15, 2007).

^d E-mail from Charisse Giarraputo, Youth Justice Consultant – Youth Custody Services (March 20, 2006): “Upon admission all youth are offered tests, and the youth determines the mode of testing (often anonymous). Health care professionals offer pre- and post-test counselling.”

^e Letter from Michelle Skanes-Culleton, RN, Newfoundland and Labrador Youth Centre to Rick Langer, Manager of Resident Programs, Newfoundland and Labrador Youth Centre (April 17, 2006).

^f HIV testing generally available upon request; offered to persons with clinical or laboratory indications, pregnant women, persons with high risk behaviours or whose mother had such history, received unscreened blood products, persons who were sexually abused where type of contact indicates risk of transmission, and clients potentially exposed while in custody. Test requisition coded. Pre-test counselling offered. A similar policy is in effect at IWK forensic institution. IWK Health Centre, Mental Health Program and Clinical Policy Manual, *IWK Clinical and Forensic Services, Blood Borne Viral Testing*, Draft #3 (April 20, 2005). See, also, Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Infection Control – Blood-Borne Pathogens* 12.56.00 CL (September 1, 1998); Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Blood Collection for Blood-Borne Pathogens HBV, HCV, HIV* 12.57.00 CL (September 1, 1998); Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Infection Control – Blood-Borne Pathogens Pretest Counselling – Hepatitis B & C, HIV* 12.58.00 CL (September 1, 1998); Nova Scotia Department of Justice, Correctional Services Policy & Procedures, *Post-test Counselling for Blood-Borne Pathogens Serologic Testing* 12.59.00 CL (September 1, 1998); and Nova Scotia Department of Justice, Correctional Services, Policy & Procedure, *Distribution of Condoms and Dental Dams* 12.73.00 (September 1, 1998). See also, Nova Scotia Department of Justice, Correctional Services, Policy & Procedure, *Infection Control – Blood-Borne Pathogens* 12.74.00 (September 1, 1998).

^g Condoms and dental dams provided upon request made to health care staff, as per Nova Scotia Department of Justice, Correctional Services, Policy & Procedures, *Distribution of Condoms and Dental Dams* 12.73.00

(September 1, 1998). Prisoners are permitted to possess four condoms (male) or two dental dams (female) at any one time.

^h Direction de la détention, Services à la clientèle, Politique Relative aux Maladies Infectieuses en Milieu Carcéral (Avril 1992).

ⁱ E-mail from Charisse Giarraputo, Youth Justice Consultant – Youth Custody Services (March 20, 2006). “[A]ll youth custody centres shall ensure that condoms are made available to youth.... One-time packages of water-soluble lubricants ... are supplied with condoms at the point of distribution to ensure maximum protection for users.”

^j Letter from Michelle Skanes-Culleton, RN, Newfoundland and Labrador Youth Centre to Rick Langer, Manager of Resident Programs, Newfoundland and Labrador Youth Centre (April 17, 2006), stating that condoms are provided to male youth upon release when requested.

^k Nova Scotia Department of Justice, Correctional Services, Policy & Procedure, *Distribution of Condoms and Dental Dams 12.73.00* (September 1, 1998).

^l E-mail from Penny Winter to Marvin McNutt, Director of Corrections and Community Services (March 15, 2006).

^m E-mail from Penny Winter to Marvin McNutt, Director of Corrections and Community Services (March 15, 2006).

ⁿ E-mail from Charisse Giarraputo, Youth Justice Consultant – Youth Custody Services (March 20, 2006).

^o Correspondence from Joanne Shaw, Manager, Corporate Health Care Services, Professional and Shared Services, Strategic and Operational Branch, Ministry of Community Safety and Correctional Services (March 8, 2007): “The Centre for Addiction and Mental Health in Ontario does not recommend Methadone Maintenance treatment in youth under 18. Consequently, we have no formal program; however, if a youth was already participating in a Methadone program, we would continue the program.”

^p Kilburn Hall Youth Centre apparently permits MMT initiation, as per response to an access to information request (undated).

^q E-mail from Penny Winter to Marvin McNutt, Director of Corrections and Community Services (March 15, 2006). Urinalysis on reasonable and probable grounds; no random testing.

^r IWK Health Centre, Mental Health Program and Clinical Policy Manual, *Mental Health Program – Forensic – Intoxicant Use* (December 1, 2005). Patients in forensic units suspected of intoxicant use can be tested involuntarily.

^s Upon admission to custody, urine screen.

^t Since 2002-2003, CSC, National Infectious Disease has operated the Special Initiatives Program “HIV Prevention Strategies By Inmates for Inmates,” under which prisoners and prison groups can apply for funding to undertake HIV/AIDS and HCV awareness activities. See AIDS 2006 – XVI International AIDS Conference, 2006, Abstract no. WEPE0458. In response to the access to information request, several HIV/AIDS and HCV information and education pamphlets were provided.

^u Through a partnership between Alberta Correctional Services, the Non Prescription Needle Use Initiative Corrections Task Group and HIV Edmonton, training materials were developed, and HIV Edmonton has conducted a number of trainings for Alberta correctional staff. The training encompasses HIV basics, hepatitis C basics, risk and harm reduction and accessing services. Additional resource materials from government and non-governmental organizations are also distributed. Correspondence from J. Mah, Access and Privacy

Advisor, Alberta Solicitor General and Public Security (February 8, 2006) and various correspondence with L. Sutankyo and D. Jakubec of HIV Edmonton.

^v According to British Columbia Ministry of Health, *Priorities for Action in Managing the Epidemics: HIV/AIDS in B.C. (2003-2007) 2004 Annual Progress Report*, page 24, “most BC Correctional centres are also linked with community agencies that provide additional information for inmate education.” In addition, B.C. Corrections provided the authors with numerous examples of pamphlets they make available to prisoners.

^w It appears that education is provided on an individual basis to prisoners as part of a memorandum of understanding (June 30, 2003) between the Minister of Health and Wellness (Public Health Management Service) to the Minister of Public Safety, provided by public health nurses for a five-year term. The response to the access to information request included numerous pamphlets from governmental and non-governmental organizations on communicable and infectious diseases.

^x In response to the access to information request, Northwest Territories justice provided copies of 21 fact sheets and pamphlets covering subjects such as infectious diseases and drug use, some of which are specifically intended for First Nations and female audiences.

^y “Educational pamphlets which outline basic information on HIV/AIDS, information leaflets on sexually transmitted diseases – genital Herpes, Gonorrhea, Syphilis, Chlamydia, Trichomoniasis, Hepatitis B – and instruction as the use and disposal of condoms shall be available.” Nova Scotia Department of Justice, Correctional Services, Policy & Procedure, *Distribution of Condoms and Dental Dams 12.73.00* (September 1, 1998). See also, Nova Scotia Department of Justice, Correctional Services, Policy & Procedure, *Infection Control – Blood-Borne Pathogens 12.74.00* (September 1, 1998).

^z *Programme de formation, Stratégies de réduction des méfaits liés à l’usage des drogues : enjeux et défis en milieu correctionnel* (20 février 2003); Direction de la détention, Services à la clientèle, Politique Relative aux Maladies Infectieuses en Milieu Carcéral (Avril 1992). See also the *Use Your Trumps* card game and harm reduction educational program developed by the Association des interventants en toxicomanie du Québec Inc. (AITQ).

^{aa} Saskatchewan Corrections and Public Safety, Adult Corrections, *Health Issues Booklet*. This booklet is intended to be given to all offenders upon admission.

^{ab} According to the response to an access to information request: “Guest speakers include Yukon AIDS Alliance, Blood Ties Four Directions and Alcohol and Drug Services. Counselling with physician on contract to Young Offenders Facility as required.”

^{ac} E-mail from Charisse Giarraputo, Youth Justice Consultant – Youth Custody Services (March 20, 2006). “Information is regularly provided to the youth by our Doctors, Lifeskills and Alcohol and Drug Counsellors.”

^{ad} Letter from Michelle Skanes-Culleton, RN, Newfoundland and Labrador Youth Centre to Rick Langer, Manager of Resident Programs, Newfoundland and Labrador Youth Centre (April 17, 2006). Education is provided on an individual basis by a nurse or physician.

^{ae} Weekly sessions on healthy sexuality include information on HIV/AIDS and other blood-borne or sexually transmitted infections, drug use, injection drug use and harm reduction. The registered nurse is responsible for delivering this information. Letter from Ruth Carter, Director of Forensic Services, IWK Child and Adolescent Mental Health Program (January 24, 2006).

^{af} CSC, *Infectious Disease Module 1: Session 18* (July 17, 1998); CSC, *Substance Abuse: Self Directed Learning Manual* (September 1999). CSC developed a brief 10 section training manual when bleach kits were introduced as a harm reduction measure: CSC, National Working Group, National Bleach Kit Distribution Program *Education Package: National Bleach Kit Distribution Program*, April 1996. CSC developed extensive training materials and conducted training sessions across Canada to support the implementation of

the methadone maintenance policy (Commissioner's Directive, *800-1 Methadone Treatment Guidelines* (May 2, 2002)), including VHS / DVD (*National Methadone Training*, June 27, 2002); CSC, *National Methadone Training* (2005); CSC, *National Methadone Maintenance Treatment Program, Riverbend Institution, Saskatchewan Penitentiary Staff Awareness Presentation* (undated); R. Hajela, *Addiction 101: Awareness of Self and Others in Health and Disease* (undated); *Welcome to the Many Hats of CSC* (undated); L. Wall, B. Rath, *Methadone Maintenance Treatment Program (MMTP) "Phase II" 2002 Induction while incarcerated*; Drug Policy Alliance, *About Methadone*, 2nd ed.,(2003).

^{ag} In response to the access to information request, we were advised that "[i]n terms of staff training the division is presently laying out the framework for a three year, professional development framework. Included in this framework will be training to all divisional staff on HIV, Hepatitis B and C and sexually transmitted diseases. As well institutional nurses (ands at time Public Health Nurses), are involved with the local staff orientation. Included in this orientation are discussions about HIV, Universal Precautions, AIDS videos, related Community and Correctional Services Policies and Procedures" (no author provided; undated).

^{ah} Northwest Territories, Justice, *Module 1: Session 17, Infectious Diseases* (June 4, 2002); Northwest Territories, Justice, *Self Directed Learning Manual, Substance Abuse* (December 2005).

^{ai} I. Clarke, Ontario Ministry of Correctional Services, *Communicable Diseases: C.O. Start Program* (undated).

^{aj} Direction de la détention, Services à la clientèle, *Politique Relative aux Maladies Infectieuses en Milieu Carcéral* (Avril 1992).

^{ak} CSC developed a brief 10-section training manual when bleach kits were introduced as a harm reduction measure: CSC, National Working Group, *National Bleach Kit Distribution Program Education Package: National Bleach Kit Distribution Program*, April 1996. CSC developed extensive training materials and conducted training sessions across Canada to support the implementation of the methadone maintenance policy (Commissioner's Directive, *800-1 Methadone Treatment Guidelines* (May 2, 2002)), including VHS / DVD (*National Methadone Training*, June 27, 2002); CSC, *National Methadone Training* (2005); CSC, *National Methadone Maintenance Treatment Program, Riverbend Institution, Saskatchewan Penitentiary Staff Awareness Presentation* (undated); R. Hajela, *Addiction 101: Awareness of Self and Others in Health and Disease* (undated); *Welcome to the Many Hats of CSC* (undated); L. Wall, B. Rath, *Methadone Maintenance Treatment Program (MMTP) "Phase II" 2002 Induction while incarcerated*; Drug Policy Alliance, *About Methadone*, 2nd ed. (2003).

^{al} Several resources, presumably used by health care staff for their own education and information purposes, were provided in response to the access to information request.

^{am} Northwest Territories, Health and Social Services, *NWT HIV Infection and AIDS: Information for Health Professionals Manual* (August 1999); *Communicable Disease Manual, Hepatitis* (February, 2000); *Communicable Disease Manual, AIDS* (February, 2000); Canadian Nurses Association, *Hepatitis C: A Nursing Guide* (September 2002).

^{an} According to the response to our access to information request, community nurses take direction from, participate in training with, and are involved in policy creation with Yukon Communicable Disease Control. Yukon Communicable Disease Control uses and distributes materials to increase understanding and knowledge of HIV, hepatitis C and other blood-borne infectious diseases.

^{ao} CSC's National HIV/AIDS Peer Educational and Counselling Program has a women's component which is intended to addresses women-specific needs.

^{ap} Some education materials available to prisoners are specifically intended for a female audience.

^{aq} K. Barlow, J. Serkiz and A. Fulton, *Circle of Knowledge Keepers: Training for Inuit, Metis and First Nations Offenders and Peer Educators and Counsellors* (CSC, March 2001). Materials include eight chapters and a nine-part tool kit.

^{ar} Some education materials available to prisoners are specifically intended for a First Nations audience.

^{as} As per e-mail from Joan Hayes, January 24, 2006, Drumming Hill Youth Centre is working in partnership with Battleford's Sexual Health Centre to develop harm reduction strategies for First Nations and Metis youth.

^{at} According to Yukon Substance Abuse Action Plan, Existing Substance Abuse Programs and Services (October 2005), "The Department of Justice is working on a program that will provide an opportunity for First Nations inmates to reconnect with their culture to address their mental, physical, spiritual and emotional needs."



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