HIV and Hepatitis C in Prisons

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

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2. High-risk behaviours in prisons
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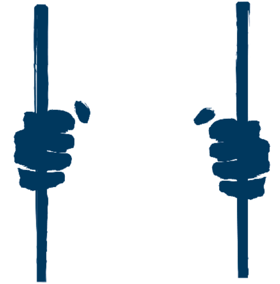

HIV and hepatitis C in prisons: the facts

This info sheet reviews some basic facts about HIV and hepatitis C virus (HCV) in prisons.

HIV and seroprevalence in prisons

Canadian federal prisons

In Canada's federal prison system (which houses people sentenced to prison terms of two years or more), the number of reported cases of HIV rose from 24 in 1989 to 170 in 1996 to 204 in 2005. This means that as of 2005, 1.66 percent of all federal prisoners were *known* to be HIV-positive. The actual number is likely to be higher: the reported cases, provided by the Correctional Service of Canada (CSC), include only cases of HIV infection *known* to CSC, but many prisoners may not have disclosed their HIV status to CSC, or may not know themselves that they are HIV-positive.

Canadian provincial and territorial prisons

Levels of HIV infection are also high in provincial prisons (which house people sentenced to prison terms of less than two years). Studies undertaken in prisons in British Columbia, Ontario and Quebec have reported HIV seroprevalence levels in prisons more than 10 times higher than in the general population, ranging from 1.0 to 8.8 percent of prisons participating in the studies. For example:

- A 1993 study carried out among over 12,000 people entering Ontario prisons found HIV seroprevalence rates of 1.0 percent among adult men and 1.2 percent among adult women.
- A 2003 study of 1,607 prisoners in 7 provincial institutions in Quebec found an HIV seroprevalence rate of 2.4 percent among men and 8.8 percent among women.
- In a 2003–2004 study of 1,877 people admitted to 13 remand facilities in Ontario (jails, detention centres and youth centres where inmates await the outcome of legal proceedings, serve short-term sentences of less than 60 days, or await transfer to provincial correctional centres or federal facilities), researchers found HIV seroprevalence rates of 2.1 percent among adult men and 1.8 percent among adult women.

As in federal prisons, the number of prisoners living with HIV in provincial prisons is on the rise. For example, in British Columbia, a study conducted in all adult provincial prisons in 1993 found an HIV seroprevalence of 1.1 percent. The study has not been repeated, but in 1996 a review of just known cases in B.C. provincial prisons revealed seroprevalence ranging from 2 to 20 percent in various prisons.

Worldwide

Worldwide, HIV infection in prison populations is much higher than in the general population. As in Canada, this is closely related to two factors: the proportion of prisoners who injected drugs prior to imprisonment, and the level of HIV infection among people in the community as a whole that inject drugs.

Many of those prisoners who are HIV-positive were already living with HIV on the outside. Indeed, the highest levels of HIV infection in prisons can be found in areas where HIV infection is high among people who inject drugs in the community. Many governments' policy of incarcerating people who use drugs has meant the incarceration of an increasing number of persons who are HIV-positive. As the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the Joint United Nations Programme

on HIV/AIDS (UNAIDS) recommended in 2006, "action to reduce prison populations and prison overcrowding should accompany — and be seen as an integral component of — a comprehensive strategy to prevent HIV transmission in prisons, to improve prison health care, and to improve prison conditions."

HIV infection levels are high in many prison systems. In Western Europe, particularly high seroprevalence has been reported in Portugal (11 percent), Spain (14 percent), Switzerland (4 to12 percent) and Italy (7.5 percent). In Eastern Europe, research indicates roughly 7 percent of Ukrainian prisoners and 15 percent of Lithuanian prisoners are HIV-positive. In South Africa, 41 percent of prisoners are reported to be HIV-positive. In Latin America, high HIV seroprevalence has been reported in Brazil (10.9 to 21.5 percent) and Honduras (7 percent).

In contrast, relatively low levels among prisoners have been reported from Australia. In the United States, the geographic distribution of cases of HIV infection is remarkably uneven. Many systems continue to report seroprevalence under 1 percent, while in a few prison systems the figure approaches 10 percent among men and 15 percent among women.

Hepatitis C seroprevalence in prisons

Canada

The prevalence of hepatitis C virus (HCV) in prisons is even higher than HIV prevalence. Studies undertaken in the early- and mid-1990s in Canadian prisons revealed HCV prevalence between 28 and 40 percent.

HCV prevalence continues to rise. In one federal prison, 33 percent of study participants tested positive in 1998, compared to 27.9 percent in 1995. In a study released in 2005 of a women's prison in British Columbia housing both provincial and federal prisoners, 52 percent of study participants reported HCV infection.

In 2002, 3,173 or 25.8 percent of federal prisoners were *known* to be HCV-positive: 25.5 percent of male and 38.6 percent of female prisoners. This figure increased again in 2005, with 29.1 percent of federal prisoners known to be HCV-positive: 28.6 percent of male and 39 percent of female prisoners.

Worldwide

A recent review of prevalence in prison populations worldwide found HCV prevalence levels ranging from 4.8 percent in an Indian jail to 92 percent in two prisons in Northern Spain.

Potential for further spread

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

Additional reading

Betteridge G. and G. Dias. *Hard Time: Promoting HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, Canadian HIV/AIDS Legal Network and PASAN, 2007. The introduction provides an overview of HIV and HCV prevalence in Canadian prisons. Available via www.aidslaw.ca/prisons.

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Correctional Service of Canada. *Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries 2000–01*, 2003. This is a report of the Correctional Service of Canada's Infectious Diseases Surveillance System. Available at www.csc-scc.gc.ca/text/pblct/infectiousdiseases/index-eng.shtml.

Elliott R, "Prisoners' Constitutional Right to Sterile Needles and Bleach," Appendix 2 of R. Jürgens, *HIV/AIDS in Prisons: Final Report*, Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996, at pp. 3–4. Provides a summary of early Canadian seroprevalence studies in prisons. Available via www.aidslaw.ca/prisons.

Elwood M. et al. "Drug use and risk of bloodborne infections: A survey of female prisoners in British Columbia," *Canadian Journal of Public Health*, 96(2) (2005): 97–101.

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for HIV/AIDS and Hepatitis Prevention in Prison; contains a review of literature on HIV risk behaviours in prisons and an overview of the situation in Germany, Scotland, France, Italy, the Netherlands and Sweden. See also 2nd *Annual Report,* European Network on HIV/AIDS and Hepatitis Prevention in Prisons, 1998. The second report by the European Network features detailed information on HIV/AIDS and hepatitis in prisons in 16 European countries and an updated European bibliography on HIV/AIDS in prison.

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Macalino G.E. et al. "Hepatitis C infection and incarcerated populations," *International Journal of Drug Policy* 15 (2004): 103–114. A review of HCV infection in prisons worldwide.

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Poulin C. et al. "Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons," Canadian Medical Association Journal 177(3) (2007): 252–256.

Shewan D. and J. Davies (eds). *Drug Use and Prisons: An International Perspective* (Amsterdam: Harwood Academic, 2000). Provides a comprehensive account of patterns of drug use and risk behaviours in prisons, and of the different responses to this feature of prison life. Contains articles from Europe, North and South America, Africa and Australia.

Stöver H. *Study on Assistance to Drug Users in Prisons*, European Monitoring Centre for Drugs and Drug Addiction, 2001. A comprehensive study on HIV/AIDS and drug use in prisons. Available via www.emcdda.org.

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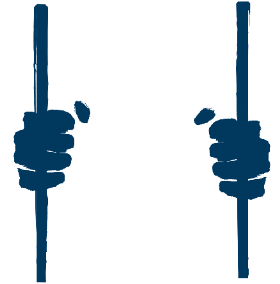

High-risk behaviours in prisons

This info sheet presents some of the evidence of the prevalence of activities in prisons that pose a risk of transmitting HIV and hepatitis C virus (HCV).

Drug use

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

Canada

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

The use of drugs by injection is also prevalent, and the scarcity of needles often leads to use of non-sterile injecting equipment. In 1994, members of the Expert Committee on AIDS and Prisons (ECAP), a body established to assist the federal government to promote and protect the health of prisoners and CSC staff, and to prevent the transmission of HIV and other infections in federal correctional institutions, were told by prisoners that injection drug use and needle sharing are frequent and that sometimes 15 to 20 people will use one needle. Many staff also acknowledge that "drugs are part of prison culture and reality" and that "there does not seem to be a way to ensure that there will be no use of drugs."

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

- In a 1995 CSC survey, 11 percent of 4,285 federal prisoners self-reported having injected since arriving in their current institution. Injection drug use was particularly high in the Pacific Region, with 23 percent reporting injection drug use.
- In a 1995 study among men and women in provincial prisons in Montréal, 73.3 percent of men and 15 percent of women reported drug use while incarcerated. Of these, 6.2 percent of men and 1.5 percent of women injected drugs.
- In a 1995 study in a provincial prison in Québec City, twelve of 499 prisoners admitted injecting drugs during imprisonment, of whom 11 shared needles and three were HIV-positive.
- In a 1998 study, 24.3 percent of prisoners at Joyceville Penitentiary in Kingston, Ontario reported using injection drugs in prison, compared to 12 percent in a similar study at the same prison in 1995.
- In a 2003 study of women in federal prisons, 19 percent reported injection drug use while in prison.
- In a study released in 2004, 76 percent of 1,475 injection drug users enrolled in the Vancouver Injection Drug Users Study (VIDUS) reported being in prison since they first began injecting drugs. Of these, 31 percent reported injecting in prison.
- In a study released in 2005, 36 percent of study participants in a British Columbia women's prison reported using illicit drugs in prison. Of these, 21 percent reported injecting drugs.

Worldwide

Many other countries report high rates of injection drug use in prison. Typically, injection drug use decreases somewhat in prisons among prisoners who were users on the outside. However, when they inject, prisoners are more likely to do

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

- In Russia, a 2000 study of 1,087 prisoners found that 43 percent had injected at some point in their lives and that 20 percent had injected while in prison. Of these, 64 percent used injection equipment that had already been used by somebody else, and 13.5 percent started injecting in prison.
- In Mexico, a 2000 study in two jails found injection drug use by 37 percent and 24 percent, respectively, of prisoners.
- A 2002 report prepared for the European Union found that between 0.3 and 34 percent of prisoners in the European Union and Norway injected while incarcerated, that between 0.4 and 21 percent of injection drug users started injecting in prison, and that a high proportion of injection drug users in prison shared injection equipment.
- In Thailand, a 2003 study among 689 prisoners found 25 percent had injected during imprisonment and that 77.8 percent of those had shared injection equipment.

Sexual activity

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

Sex, both consensual and non-consensual occurs inside prisons, despite laws or policies prohibiting it. The prevalence of sexual activity in prison is based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification and the extent to which conjugal visits are permitted.

Estimates of the proportion of prisoners who engage in consensual sexual activity with other prisoners vary widely. In a survey conducted among 1,100 male prisoners in Russia, only 10 to 15 percent of the prisoners reported having had no sexual contacts while serving their term. Non-consensual sexual activity was prevalent.

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

Tattooing

In prison, tattooing is a social activity and involves sharing needles, which creates the risk of transmitting blood-borne viruses such as HIV and HCV. In a 1995 CSC survey, 45 percent of federal prisoners reported having had a tattoo done in prison.

In September 2005, CSC started a pilot project for safer prison tattoo parlours, and tattoo shops were established in six federal prisons, including a women's prison. The shops were run by prisoners and supervised by staff. Prisoners working in the shops received training in infection prevention and control practices, and were taught to be peer health educators. Although the evaluations conducted by CSC indicated that the program may have reduced the risk of transmission of HIV and HCV and resulted in cost savings in the long run, the project was terminated by the government in late 2006, before a final evaluation of the program was completed.

Additional reading

Betteridge G. and G. Dias. *Hard Time: Promoting HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, Canadian HIV/AIDS Legal Network and PASAN, 2007. Provides recommendations and reviews best and promising programs for supporting safer sex in prisons, and for cleaning injecting and tattooing or piercing equipment in prisons. Available via www.aidslaw.ca/prisons.

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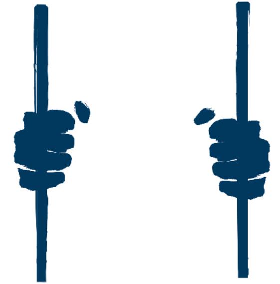

HIV and hepatitis C transmission in prison

This info sheet presents some of the evidence of the extent of HIV and hepatitis C virus (HCV) transmission behind bars. It shows that outbreaks of HIV and HCV have occurred and will continue to occur in prisons unless prevention is taken seriously.

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

However, most of the studies that have reported relatively low levels of HIV transmission in prison were conducted early in the HIV epidemic and sampled long-term prisoners who would have been at less risk of infection than short-term prisoners. The extent of HIV infection occurring in prisons may have been underestimated.

Conversely, it is well-recognized that HCV prevalence among persons in prisons, especially those who inject drugs, is high, and that most persons who inject drugs eventually become incarcerated. Based on its own research and surveillance, the Correctional Service of Canada (CSC) has noted that HCV prevalence is higher in the general prison population than among new entrants.

In recent years, a growing number of studies undertaken in Scotland, Australia, Lithuania and Russia have shown how quickly HIV can spread behind bars. Two of these studies are summarized in more detail here.

Outbreak of HIV infection in a Scottish prison

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

Outbreak in a Lithuanian prison

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

Canadian prisons

Springhill, Nova Scotia

In 1996, two HIV and HCV-positive prisoners at Springhill Institution, a federal institution in Nova Scotia, informed health care staff that they had shared needles and other injection equipment with a significant number of other prisoners. A disease outbreak containment intervention was initiated, and 17 contacts of the two men were tested, though the results of those tests were not made public. No attempt was

made to prove that, as a result of sharing needles and injection equipment with the known positive prisoners, the contacts had contracted HIV or HCV while in prison.

Joyceville, Ontario

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

The study showed that risk behaviours and rates of infection in the prison had increased substantially since a previous study that had been undertaken at the same prison in 1995. In addition, the researchers reported individuals with equivocal test results who were likely in the process of seroconverting. After the study was completed, they became aware of one person who had injected drugs and was negative for HIV in 1998, who subsequently tested HIV-positive, and one person who had also injected drugs, who contracted HCV.

Additional reading

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Dolan K. "Evidence about HIV transmission in prisons," *Canadian HIV/AIDS Policy & Law Newsletter* 3(4)/4(1) (1997/98): 32-35. An excellent summary of the evidence as of 1997. Available via www.aidslaw.ca/review.

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

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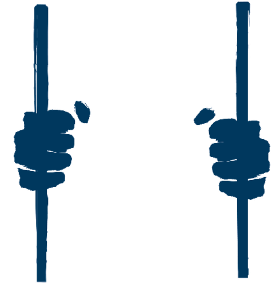

Prevention: condoms

This info sheet reviews what needs to be done to equip prisoners with safer sex materials.

Providing condoms

According to the World Health Organization, 23 of 52 prison systems surveyed allowed condom distribution as early as late 1991. Significantly, no system that has adopted a policy of making condoms available in prisons has reversed the policy, and the number of systems that make condoms available has continued to grow every year. By 2001, condoms were available in all but five prison systems in the then 23 countries of the European Union.

In 1995 in Australia, 50 prisoners launched a legal action against the state of New South Wales (NSW) for its failure to ensure access to condoms in prisons, arguing that "[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded." Since then, at least in part because of the legal action, the NSW government has decided to make condoms available. Other Australian systems have also made condoms available.

Today, prisons systems including in Australia, Brazil, Indonesia, Iran, South Africa and some countries from the former Soviet Union provide condoms to prisoners. In the United States, only a small minority of prison systems make condoms available.

Canadian federal prisons

In Canada's federal prisons, condoms were made available as of 1 January 1992. After some initial opposition, the decision to make them available has been well accepted and has not created any problems. However, in some prisons access to condoms remained limited. In particular, where access was restricted to distribution through health-care services, prisoners were reluctant to pick up condoms for fear of being identified as engaging in homosexual activity and of discrimination. In response, and as a result of a recommendation by the Expert Committee on AIDS and Prisons, the federal prison system announced in 1994 that condoms, dental dams and water-based lubricant would become more easily and discreetly available. In 2004, the Correctional Service of Canada (CSC) also issued a Commissioner's Directive mandating that "non-lubricated, non-spermicidal condoms, water-based lubricants, dental dams and bleach are [to be] discreetly available to inmates at a minimum of three locations, as well as in all private family visiting units."

Canadian provincial/territorial prisons

On 1 October 1989, the Northwest Territories became the first province or territory in Canada to adopt a policy allowing for the distribution of condoms to prisoners. Most other prison systems followed. However, even today, in some provincial and territorial prisons, condoms, dental dams and lubricant are not available, and in many prisons they are not easily and discreetly available:

- British Columbia is an exception. In its provincial prison system, condoms have been easily and discreetly accessible for years.
- In Quebec, a working group established by the Quebec ministry of public security released a report in 1997 recommending wider and more discreet access to condoms. At present, distribution methods vary between prisons.
- Some jurisdictions, such as Ontario, Alberta, Newfoundland and Nova Scotia, continue their policy of making condoms available only

- through prison health services. Others, such as Saskatchewan, use different methods of distribution in different prisons, some requiring a request to the health unit and some not.
- In three provincial or territorial prison systems (New Brunswick, Nunavut and Prince Edward Island), condoms and dental dams are still not made available.

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

Recommendation

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

Denial of HIV prevention measures such as condoms exposes prisoners and the general community to disease. The potential liability of correctional authorities to civil action was recently illustrated by an out-of-court financial settlement obtained by a South African former prisoner who claimed that he had contracted HIV through sex while in prison between 1993 and 1994, before condoms were introduced in South African prisons in 1996.

Additional reading

Betteridge G. and G. Dias. *Hard Time: Promoting HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, Canadian HIV/AIDS Legal Network and PASAN, 2007. Provides recommendations and reviews best and promising programs on condoms, dental dams and lubricant distribution in prisons. Available via www.aidslaw.ca/prisons.

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

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

Dolan K. et al. “Evaluation of the condom distribution program in New South Wales prisons, Australia,” *Journal of Law, Medicine & Ethics* 32 (2004): 124–128. One of only a few evaluations of prison condom distribution programs.

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

Jürgens R. *Interventions to Address HIV/AIDS in Prisons: Prevention of Sexual Transmission, Evidence for Action Technical Papers,* World Health Organization, United Nations Office on Drugs and Crimes and Joint United Nations Programme on HIV/AIDS, 2007. Examines studies on condom distribution in a range of prison settings worldwide and provides recommendations on how to increase the accessibility and effectiveness of condoms in reducing HIV transmission in prison.

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

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

Lines R. and H. Stöver. *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, United Nations Office on Drugs and Crime, World Health Organization and the Joint United Nations Programme on HIV/AIDS, 2006. Recommends the provision of condoms to prisoners to prevent HIV transmission through unsafe sex

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HIV and Hepatitis C in Prisons

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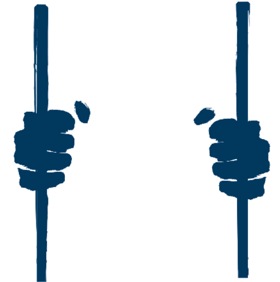

Prevention: bleach

This info sheet discusses one way of possibly reducing the spread of HIV, hepatitis C virus (HCV) and other infections in prisons through injection drug use: providing bleach or other disinfectants, together with instructions on correct use, to sterilize needles and syringes.

Experience has shown that drugs find their way into even the most secure of prisons and prisoners find ways to inject them, with needles and syringes that are also smuggled in or that are fashioned out of other materials. Therefore, while continuing and often stepping up drug interdiction efforts, prison systems around the world have taken steps to reduce the risk of the spread of HIV and other diseases through injection drug use. These include provision of bleach or other disinfectants to sterilize needles and syringes, making sterile needles available (see info sheet 6) and methadone maintenance treatment (info sheet 7). Cleaning syringes with bleach does not reduce the risk of HIV and HCV transmission sufficiently among people who share drug injection equipment to rely on this measure exclusively; it is not an adequate substitute for access to sterile equipment. However, numerous experts, guidelines and reports have recommended bleach as a means of reducing HIV transmission in the absence of access to sterile needles and syringes.

Providing bleach

According to the World Health Organization's network on HIV/AIDS in prison, 16 of 52 prison systems surveyed made bleach available to prisoners as early as 1991. As of 2007, bleach or other disinfectants were available in some prisons in Western Europe, including Germany, France, Denmark, the United Kingdom, Spain, Switzerland, Belgium, Luxembourg and the Netherlands; in some prisons in Eastern Europe and Central Asia, including Russia and Estonia; and in prisons in Australia, Indonesia, Iran, Mauritius, Tanzania and Costa Rica.

Significantly, no prison system that has adopted a policy of making bleach available in prisons has ever reversed the policy, and the number of prison systems that make bleach or other disinfectants available continues to grow.

Canadian federal prisons

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

Initially, the Correctional Service of Canada (CSC) rejected ECAP's recommendation, agreeing only to pilot a bleach-distribution program in one institution. However, in the spring of 1995, the Commissioner of CSC instructed CSC to start distributing bleach in all institutions. As a result, bleach became available in all federal institutions in the fall of 1996. In 2004, the CSC issued a Commissioner's Directive on bleach distribution, with the policy objective being to "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 means of distribution of the kits.

Provincial and territorial prisons

In a small number of provincial prison

systems, bleach has also become available or has continued to be informally available.

A model to follow

In 1992, the British Columbia provincial system issued a policy directing that bleach be made available to prisoners. Adoption of the policy did not lead to any "incidents of misuse ... or any evidence to indicate an increase in needle use." In August 2002, a revised policy was adopted, requiring that filtered household bleach be "available and accessible" to prisoners. The policy further specifies that the bleach must be full-strength 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 treated as evidence establishing drug use, which is against prison rules.

Few other provincial or territorial prison systems, with the exception of the Northwest Territories and Quebec, make bleach available to prisoners.

Recommendation

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

Limitations

Making bleach available is important, but not enough:

- Providing people who inject drugs with bleach to decontaminate injection equipment is a sub-optimal intervention for preventing the transmission of blood-borne diseases. In 2004, the World Health Organization concluded that the "evidence supporting the effectiveness of bleach in decontamination of injecting equipment and other forms of disinfection is weak." Sterile needles and syringes that have never been used are safer than previously used needles and syringes that have been cleaned with bleach. With regard to HCV infection, bleach is not fully effective in killing the hepatitis C virus.
- Research has shown that even outside of prison many people who inject drugs (as many as half or more in some studies) do not know, or do not consistently practise, the proper method of using bleach for disinfecting needles. The probability of effective decontamination is decreased further in prison. Drug use is prohibited in prisons. Because prisoners can be accosted at any moment by prison staff, injecting is a hurried affair, particularly if injecting equipment is being shared. Studies have shown that bleach disinfection takes more time than most prisoners can afford.
- Where bleach programmes exist in prisons, but sterile needles and syringes are not made available, needle and syringe programmes should be introduced as a primary strategy to prevent HIV and HCV infection.

Additional reading

Betteridge G. and G. Dias. *Hard Time: Promoting HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, Canadian HIV/AIDS Legal Network and PASAN, 2007 at p. 43. Sets out the enabling policies in Canada regarding the provision of bleach in federal and provincial/territorial prisons. Available via www.aidslaw.ca/prisons.

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

Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention. *HIV/AIDS Prevention Bulletin*, 19 April 1993. States that "bleach disinfection should be considered as a method to reduce the risk of HIV infection from re-using or sharing needles and syringes when no other safer options are available."

Dolan K. et al. *Bleach Availability and Risk Behaviours in New South Wales, Technical Report No 22*, NDARC, 1994; and K. Dolan et al., *Bleach Easier to Obtain But Inmates Still at Risk of Infection in New South Wales Prisons*, *Technical Report*, NDARC, 1996. The first studies to allow the independent monitoring of a prison bleach distribution program.

Ford P.M. et al. "HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison," *Canadian HIV/AIDS Policy & Law Newsletter* 4(2/3) (1999): 52–54. Commenting on the bleach solutions being made available in prisons at the time, the researchers conclude that we must "stop pretending that weak bleach solutions are the answer to anything. There is no good evidence to suggest that strong bleach works, let alone solutions that can be drunk with impunity." Available via www.aidslaw.ca/review.

Harding T. and G. Schaller. *HIV/AIDS and Prisons: Updating and Policy Review. A Survey Covering 55 Prison Systems in 31 Countries,* World Health Organization Global Programme on AIDS, 1992.

Jürgens R. *Interventions to Address HIV/AIDS in Prisons: Needles and Syringe Programmes and Decontamination Strategies, Evidence for Action Technical Papers,* World Health Organization, United Nations Office on Drugs and Crimes and Joint United Nations Programme on HIV/AIDS, 2007. Examines studies regarding bleach and decontamination strategies in prison settings and concludes that "because of their limited effectiveness, bleach programmes can only be regarded as a second-line strategy to NSPs [needle and syringe programmes]."

Kapadia F. et al. "Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users?" *Epidemiology* 13(6) (2002): 738–741. This study shows that bleach disinfection may provide some protection against HCV.

Taylor A. and D. Goldberg. "Outbreak of HIV infection in a Scottish prison: why did it happen?" *Canadian HIV/AIDS Policy & Law Newsletter* 2(3) (1996): 13–14. Explains why, even if bleach is available in prison, it may remain unused or ineffectively used. Available via www.aidslaw.ca/review.

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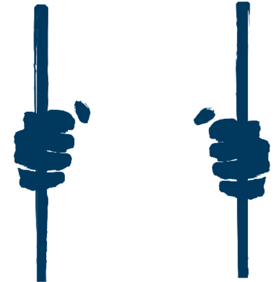

Prevention: needle and syringe programs

This info sheet provides important information about needle and syringe programs (NSPs) in prisons. It shows that needles and syringes can be made available in prisons safely with good results.

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

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

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

International developments

As of 2007, NSPs had been introduced in over 60 prisons of varying sizes and security levels in Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Armenia, Luxembourg and Iran. In Kyrgyzstan and Spain, needle and syringe programs have been rapidly scaled up and operate in a large number of prisons.

Switzerland

In Switzerland, distribution of sterile injection equipment has been a reality in some prisons since the early 1990s. Sterile injection equipment first became available to inmates in 1992, at Oberschöngrün prison for men. A part-time medical officer working at the prison was faced with the ethical issue that as many as 15 of 70 prisoners were regularly injecting drugs, with no adequate measures to prevent the spread of blood-borne diseases such as HIV through shared equipment. He began distributing sterile injection equipment without informing the warden. When the warden discovered this action, he listened to the medical officer's arguments and sought approval to sanction the distribution of needles and syringes. As of 2004, distribution is ongoing, has not resulted in any negative consequences and is supported by prisoners, staff and the prison administration. Initial skepticism by staff has been replaced by their full support:

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

In June 1994, another Swiss prison, Hindelbank institution for women, started a one-year pilot HIV-prevention program including needle distribution. Hindelbank's program was evaluated by external experts in 1995 with very positive results: the health status of prisoners had improved; no new cases of infection with HIV or hepatitis had occurred; a significant decrease in needle sharing had been observed; there had been no increase in drug consumption; needles had not been used as weapons; and only about 20 percent of staff disagreed with the project. Following the first evaluation, a decision was taken to continue the program. The prison has also experienced a drastic reduction in fatal overdoses since the program began. Other Swiss prisons have since initiated their own programs, and since 2004, distribution of sterile needles has been ongoing in seven prisons in

different parts of the country.

Germany

In Germany, approval for the development and implementation of the first two pilot NSPs was given in 1995, and the first pilot project started on 15 April 1996 in Lower Saxony. An evaluation undertaken after two years showed positive results, and recommendations were made to not only continue the two existing pilot projects but to expand them to all prisons in Lower Saxony. At the end of 2000, needle exchange schemes had been successfully introduced in seven prisons in Berlin, Hamburg and Lower Saxony, and others were looking at how to implement them. However, since then six of the programs were closed down, not based on any reported problems with the programs, but as a result of political decisions by newly-elected state governments. In each of these cases, the decision to cancel the programs was made without consultation with prison staff, and without an opportunity to prepare prisoners for the impending loss of access to the programs. It has been reported that since the programs closed, prisoners have returned to sharing needles and to hiding them, increasing the likelihood of transmission of HIV and hepatitis C (HCV), as well as the risk of staff accidentally getting stuck by concealed needles, which needles are also more likely to have been used by multiple people. Staff have been among the most vocal critics of the governments' decisions to close down the programs, and have lobbied the governments to reinstate the programs.

Spain

In Spain, the first pilot prison NSP started in August 1997. An evaluation undertaken after 22 months showed positive results and, therefore, in June 2001, the Directorate General for Prisons ordered that needle exchange programs be implemented in all prisons. As of 2006, exchanges were operating in more than 35 prisons, and a pilot program had also been established in a prison in the autonomous region of Catalonia.

Eastern Europe

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

Moldova started a pilot project in one prison in 1999. Based on its success, the program has been expanded to six other prisons.

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

Belarus started a pilot project in one prison in April 2003. In 2004, the Ministry of Internal Affairs stated that it was prepared to establish them in all prisons in the country.

Canadian situation

As of 2007, no Canadian prison system had established a NSP. A few systems, including the federal prison system, have studied the issue. A 1999 committee established by the Correctional Service of Canada (CSC) to examine the feasibility of establishing NSPs in Canadian federal institutions recommended that pilot programs be initiated across Canada.

Since then, a number of organizations, including the Canadian HIV/AIDS Legal Network, the Canadian Medical Association and the Ontario Medical Association have recommended that CSC develop, implement and evaluate pilot NSPs in prisons under its jurisdiction.

In 2006, the Public Health Agency of Canada (PHAC), at the request of CSC, studied the potential risks and benefits of prison NSPs and concluded that, in prisons where NSPs are in place, they do not lead to injection drug use, that needle-sharing practices and health-care interventions related to injection-site abscesses, overdoses and death decrease, and that referrals to drug-treatment programs increase. PHAC also concluded that NSPs do not compromise the safety and security of prison staff. In spite of PHAC's findings, the CSC has yet to develop pilot NSPs in federal prisons.

People opposed to NSPs in prisons have argued that distributing sterile needles in Canadian prisons would condone drug use. In reality, it is not an endorsement of illicit drug use by prisoners. Rather, it is a pragmatic public health measure that recognizes that drugs get into prisons, prisoners inject drugs, and that efforts to eliminate drugs from prisons do not succeed. *Not* undertaking NSPs, with the knowledge that HIV, HCV and other infections are being transmitted in prisons, condones the spread of infections among prisoners and ultimately to the general public.

What can we learn?

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

1. *Prison NSPs are safe*

   Needles can be made available in prisons in a manner that is non-threatening to staff and that increases staff safety. Since the first prison NSP started in 1992, there have been no reported cases of a needle being used as a weapon either against prison staff or other prisoners. In addition, prisoners are usually required to keep their kits in a pre-determined location in their cells. This assists staff when they enter the cell to conduct searches and has decreased accidental needle-stick injuries to staff.

2. *Prison NSPs do not lead to increased drug use*

   Evaluations of existing programs have consistently found that the availability of needles does not result in an increased number of drug injectors,

an increase in overall drug use or an increase in the amount of drugs in the institutions.

3. *Prison NSPs do not condone illegal drug use and do not undermine abstinence-based programs*

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

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

4. *Prison NSPs have been successfully introduced in various prison environments*

   While programs were first introduced in small Swiss prisons, they have since been successfully implemented in prisons for men and for women, in small, medium and large institutions, and in prisons of all security classifications. After having been introduced in well-resourced prison systems, programs have also been established in systems with very limited resources. There are several models of distribution of sterile injection equipment, including automatic dispensing machines, distribution by medical staff or counsellors and distribution by prisoners trained as peer outreach workers. What is appropriate in a particular institution depends on many factors, such as the size of the institution, the extent of injection drug use, the security level, whether it is a prison for men or for women, the commitment of health-care staff and the "stability" of the relations between staff and prisoners.

5. *Prison NSPs reduce risk behaviour, thereby helping to prevent disease transmission*

   Most importantly, evaluations of existing programs have shown that reports of needle sharing declined dramatically. In addition, other positive health outcomes have been documented in some prisons, such as a decrease in fatal and non-fatal overdoses and a decrease in abscesses and other injection-related infections.

6. *Prison NSPs function best when prison administration, staff and prisoners support them*

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

7. *Prison NSPs can be compromised if access to needles or syringes is limited*

   Limitation of access may result from physical barriers, such as dispensing machines not working, or inappropriate needles or syringes provided; from restrictive practices, such as limited program hours; and from prisoners fearing that, because of a lack of anonymity or confidentiality, using the program could result in negative consequences for them. In order to benefit from the protective effects of NSPs, prisons must ensure that prisoners have easy access to adequate numbers of needles and syringes.

Recommendation

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

Additional reading

Canadian Human Rights Commission. *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women,* December 2003. In its report, the Canadian Human Rights Commission recommended that the CSC implement a pilot needle exchange program in three or more correctional facilities, at least one of them a women's facility, by June 2004.

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

Dolan K. et al. "Prison-based syringe exchange programmes: a review of international research and development," *Addiction* 98 (2003): 153−158. A good summary of evaluations of prison needle exchange programs in Switzerland, Germany and Spain.

Jürgens R. *HIV/AIDS in Prisons: Final Report*, Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996, at pp. 52–66. Still relevant for an account of the early history of the introduction of prison needle exchange programs. Available via www.aidslaw.ca/prisons.

Jürgens R. *Interventions to Address HIV/AIDS in Prisons: Needles and Syringe Programmes and Decontamination Strategies, Evidence for Action Technical Papers,* World Health Organization, United Nations Office on Drugs and Crimes and Joint United Nations Programme on HIV/AIDS, 2007. Examines studies of needle and syringe programmes in prison settings and concludes that "there is evidence that NSPs [needle and syringe programmes] are feasible in a wide range of prison settings" and "appear to be effective in reducing needle sharing and resulting HIV infection."

Kerr T. et al. *Needle and Syringe Programs and Bleach in Prisons: Reviewing the Evidence*, Canadian HIV/AIDS Legal Network, 2008. A current review of the evidence. Available via www.aidslaw.ca/prisons.

Lines R. and H. Stöver. *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, United Nations Office on Drugs and Crime, World Health Organization and the Joint United Nations Programme on HIV/AIDS, 2006. Recommends that measures available outside of prisons to prevent HIV transmission, such as the provision of sterile needles and syringes, are also made available in prisons.

Lines R. et al. *Prison Needle Exchange: Lessons from A Comprehensive Review of International Evidence and Experience*, *Second edition,* Canadian HIV/AIDS Legal Network, 2006. The most comprehensive and detailed report available on the international experience of prison syringe exchanges. Available via www.aidslaw.ca/prisons.

Ministerio Del Interior/Ministerio De Sanidad y Consumo. *Needle Exchange in Prison Framework Program*, 2002. Detailed implementation plan for needle exchange programs in all Spanish prisons, and important reading for anyone wishing to see how a successful needle exchange program is established in a prison. Available in English and Spanish.

Nelles J. and A. Fuhrer. *Drug and HIV Prevention at the Hindelbank Penitentiary, Abridged Report of the Evaluation Results of the Pilot Project*, Swiss Federal Office of Public Health, 1995. The first-ever evaluation of a needle-distribution program.

Nelles J. and T. Harding. "Preventing HIV transmission in prison: a tale of medical disobedience and Swiss pragmatism," *The Lancet* 346 (1995): 1507–1508. Describes how Dr. Franz Probst, a part-time medical officer working at Oberschöngrün prison, began distributing sterile injection material without informing the prison director and thus began the world's first distribution of injection material inside prison.

Stöver H. *Study on Assistance to Drug Users in Prisons*, European Monitoring Centre for Drugs and Drug Addiction, 2001. A now outdated, but still relevant overview of needle exchange programs in prison. Available via www.emcdda.org.

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

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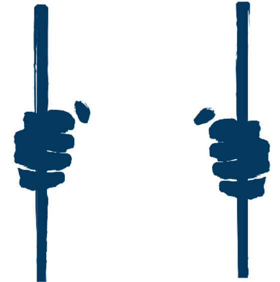

Prevention and treatment: methadone

This info sheet provides important information about methadone maintenance treatment (MMT) in prisons. It explains that providing MMT is an HIV and hepatitis C (HCV) prevention strategy that provides people dependent on opioids with an additional option for reducing or avoiding needle use and sharing.

Why methadone maintenance treatment?

Methadone is a long-acting synthetic narcotic which is taken orally to effectively block craving or withdrawal symptoms from opioids such as heroin. Introducing or expanding MMT in prisons is an HIV and HCV-prevention strategy that provides people dependent on drugs with an additional option for avoiding needle use and sharing. *The main aim of MMT is to help people get off injecting, not off drugs.* Methadone dose reduction, with the ultimate goal of helping the client to get off drugs, can be a longer-term objective where medically appropriate and when done in accordance with good clinical guidelines.

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

With the emergence of HIV, the arguments for offering MMT to those who were not following treatment outside are even more compelling. Prisoners who inject drugs are likely to continue injecting in prison and are more likely to share injection equipment, creating a high risk of HIV and HCV transmission (see info sheets 2 and 3). As in the community, MMT has the potential to reduce injecting and syringe sharing in prisons.

Where is it being offered?

Worldwide, an increasing number of prison systems are offering MMT to prisoners, including most Western European systems (with the exception of Greece, Sweden and some states in Germany). Programs also exist in Australia, the United States, Iran and Indonesia. Finally, an increasing number of prison systems in Eastern Europe and the former Soviet Union are starting MMT programs or planning to do so.

In Canada, MMT in prisons was initiated in part because of recommendations urging prison systems to provide MMT and partly because of legal action. One such case was in British Columbia. An HIV-positive woman who was receiving methadone by prescription before going to prison, undertook action against the provincial prison system for its refusal to allow her to continue MMT in prison. She argued that, under the circumstances, her detention was illegal. The prison system arranged for a doctor to examine the woman, and he prescribed methadone for her. After this, she withdrew her petition. In another case, a man with a longstanding heroin addiction was sentenced to two years less one day in prison, and thus to imprisonment in a provincial prison in Quebec, rather than a longer term in a federal prison, because that prison had agreed to provide him with methadone treatment. The defence had submitted that it was necessary to deal with the root causes of the man's crimes, namely his heroin addiction, and that treatment with methadone was essential to overcoming that addiction.

In September 1996, the B.C. Corrections Branch adopted a policy of continuing methadone for incarcerated adults who were already on MMT in the community, becoming the first correctional system in Canada to make MMT available in a uniform way. On 1 December 1997, the federal prison system followed suit. Today, in the federal and in most provincial and territorial systems, prisoners who were already on MMT outside can continue such treatment in prison.

Fewer systems allow prisoners to start MMT while incarcerated. As of 2007, only the federal system and the B.C. provincial system had formal methadone initiation programs. In Saskatchewan, Nova Scotia, Prince Edward Island, Alberta and the Yukon, prisoners who request MMT are referred to a physician or outside health clinic or treatment centre for consideration.

Are there other alternatives?

Some prison systems are still reluctant to let prisoners start MMT while in prison, and other prison systems are reluctant to make it available at all, even to those receiving this prescription medication before their imprisonment. Some consider methadone as just another mood-altering drug, and that providing it delays the necessary personal growth required to move beyond a drug-centred existence. Some also object to MMT on moral grounds, arguing that it merely replaces one drug of dependence with another. This would indeed be a meagre achievement, if there were reliably effective alternative methods of achieving lasting abstinence. However, as Dolan and Wodak have explained, there are no such alternatives for most:

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

In recent years, evaluations of prison MMT programs in Canada, Australia and the U.S. have provided clear evidence of their benefits. For example, formal evaluations of CSC's MMT program found that prisoners receiving MMT had lower readmission rates, were readmitted at a slower rate, and had a reduced rate of serious drug-related prison charges following their release from prison than persons who were assessed as having a substance abuse problem but were not receiving MMT.

Other treatment options

Buprenorphine is a relatively new treatment option for opioid dependence, and is available in a limited number of prisons in Australia and in several European countries. Opioid substitution treatment with buprenorphine has similar outcomes as opioid substitution treatment with methadone. The choice between the two medications should be based on a clinical assessment. Recently, the World Health Organization (WHO) concluded that pharmacotherapy with methadone or buprenorphine is the most effective form of treatment for opioid dependence, and in 2005, added both medications to the WHO's Model List of Essential Drugs.

Providing MMT *and* other treatment options is crucial, and respects the rights of prisoners to the kind of care and concern that is available outside prison, rather than simply denying that drug injecting takes place inside.

Recommendation

MMT is a medically indicated form of treatment that should be available, along with other drug treatment options, to opioid-dependent people regardless of whether they are outside or inside prison.

Additional reading

Betteridge G. and G. Dias. *Hard Time: Promoting HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, Canadian HIV/AIDS Legal Network and PASAN, 2007. Provides an overview of enabling policy and best and promising programs in opioid substitution therapy in Canadian prisons. Available via www.aidslaw.ca/prisons.

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HIV and Hepatitis C in Prisons

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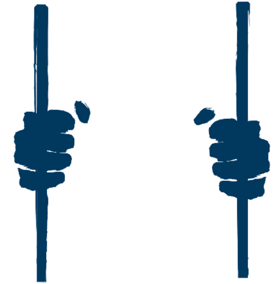

Care, treatment and support

This info sheet deals with providing prisoners with care, treatment and support for HIV and hepatitis C virus (HCV) infection that is equivalent to that available to other members of the community.

The principle of equivalence

The 1993 World Health Organization *Guidelines on HIV Infection and AIDS in Prisons* state, as a general principle, that prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination. The right of people in prison to be provided with "equal access" to the health-care services available in the community is also reflected in international declarations from the United Nations General Assembly, and policy recommendations from the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Moreover, the right to the highest attainable standard of health, as well as the right to equality in the enjoyment of other human rights, are explicitly retained by persons in detention and recognized by numerous international conventions, including *the International Covenant on Economic, Social and Cultural Rights*.

Most Canadian prison health-care services do their best to provide prisoners with HIV with good care, and often refer prisoners to outside specialists for HIV-related care. However, prisoners report that they sometimes receive care and treatment that is not up to the standard that they received in the community, or even in other prisons they have been in.

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

Antiretroviral therapies

Left untreated, most people infected with HIV will eventually develop HIV-related illnesses and die. The standard for treating HIV infection involves a combination of antiretroviral medications known as highly active antiretroviral therapy (HAART). Throughout Canada, prisoners with HIV are prescribed HAART. Many HAART regimens are complex. Some medications must be taken with food, others on an empty stomach; some must be taken once a day, others twice, many at specific, fixed times of day every day. Taking HAART medications as prescribed is crucial to good health. Several studies have shown that 90 to 95 percent of doses must be taken as prescribed in order to achieve optimal suppression of HIV in the body. Interruptions in HAART can have serious detrimental consequences for individual prisoners' health and for public health.

Anecdotal evidence, epidemiological studies and coroners' inquests have shown that interruptions in HAART occur in prisons, both federally and provincially. Prisoners report going without their HAART medications for days, not getting their dose at the prescribed time of day, and not getting the correct dose. Doses are missed because medications are not re-ordered, prisoners are too ill to get their medications from health services, lock-downs prevent them from getting to health services, and steps are not taken to ensure access to medications in segregation. A high degree of HIV-related stigma and discrimination in correctional institutions is another potential disincentive to HIV-positive individuals seeking HAART in custody. Prisoners also report missing doses of HAART when they are arrested and incarcerated, make court appearances or are transferred between provincial and federal systems or even between institutions in the same system. Prisoners

also report being released from custody without HAART or without sufficient medication to maintain the regime uninterrupted until they are able to get a supply in the community.

Adequate Medication for Pain

Some prisoners with HIV also report they do not receive adequate medication for pain. Many prisons are reluctant to provide narcotic pain relief as it conflicts with the prison system's ethos of "zero-tolerance" to drugs. This is compounded by attitudes toward people who use drugs, who typically require higher doses of pain medication than non-users because of their high tolerance for narcotics. Prisoners requesting higher doses of pain medication may be perceived as wanting to "get high" in prison. Without appropriate pain medication, prisoners may resort to the use of illicit drugs, including through unsafe injecting if they have no access to sterile needles, to manage their pain.

Recommendations

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

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

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

Additional reading

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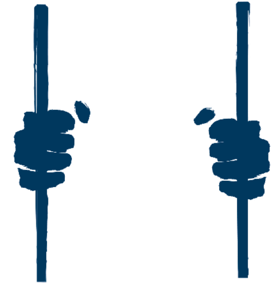

A comprehensive strategy

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

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

What has been recommended?

All organizations and committees have recommended that a *comprehensive strategy* be adopted to deal with HIV/AIDS in prisons. Probably the most inclusive list of recommendations was issued in 2006 by the UNODC, WHO and UNAIDS in "A Framework for an Effective National Response for HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings." To mount an effective national response to HIV/AIDS in prisons that meets international standards, prioritizes public health, is grounded in best practice and supports the management of custodial institutions, the Framework set out 11 principles and 100 actions for the treatment of prisoners and the management of prisons.

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

A long-term, strategic approach

Prison systems need to:

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

A health issue

Because prisoners come from the community and return to it, and because what is done, or is not done, in prisons with regard to HIV, hepatitis and drug use has an impact on the health of all, health ministries need to take an active role and work in close collaboration with correctional systems to ensure that the health of all, including prisoners, is protected and promoted. Another option, which has been widely recommended, is to transfer control over prison health to public health authorities. Since 2005, the Minister of Health in Nova Scotia has been responsible for the provision, administration and operation of health services for offenders in custody in

Nova Scotia. This legislative authority is unique in Canada. Other jurisdictions have also introduced such a change, including Norway, England and Wales in the UK and the state of New South Wales in Australia. In France, where prison health was transferred to the Ministry of Health in 1994, a positive impact is already evident. Each prison in France is twinned with a public hospital and, according to UNAIDS, "conditions have improved noticeably since the transfer of responsibility for health."

HIV testing

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

Educational programs for prisoners

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

Educational programs for staff

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

Protective measures for staff

Making sure that prison staff's workplace is safe is crucial. Staff are rightly concerned about overcrowding and understaffing in the institutions. These factors — rather than measures taken to prevent the spread of HIV and HCV in prisons — constitute the real threats to the safety of staff. Prison systems have to address staff members' concerns in these areas.

Drug policy

Legislation introduced by the federal government in 2007 to establish mandatory minimum sentences for drug offenders will inevitably compound the public health problems in prisons. Reducing the number of drug users who are incarcerated needs to become an immediate priority. Many of the problems created by drug use in prisons, including HIV and HCV transmission, could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available.

Additional reading

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PASAN. *HIV/AIDS in Prisons Systems: A Comprehensive Strategy*, 1992. Available via www.pasan.org. Provides recommendations to both provincial and federal governments on the contents of a comprehensive HIV/AIDS policy in prisons.

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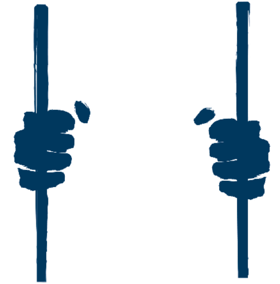

Aboriginal prisoners

All the measures described in info sheets 4–9 will help address the issues Aboriginal prisoners face in the context of HIV and hepatitis C virus (HCV), but the additional measures described in this sheet are also necessary.

The numbers

In a 1999 judgment, the Supreme Court of Canada said that prison has replaced residential schools as the likely modern-day fate of many Aboriginal people in Canada. Recent statistics highlight that:

- While approximately 3 percent of the population is Aboriginal, Aboriginal people represent 20 percent of all adult inmates in Canadian correctional facilities and up to 64 percent of the prison population in the Correctional Service of Canada (CSC)'s Prairie region.
- While the overall incarceration rate for non-Aboriginal people is 117 per 100,000 adults, the overall incarceration rate for Aboriginal people in Canada is estimated to be 1,024 per 100,000, or almost 9 times higher for Aboriginal persons than for non-Aboriginal people.
- While Aboriginal people make up only 15 percent of the general population in Manitoba and Saskatchewan, they comprised 64 percent of the provincial jail admissions in Manitoba and 76 percent in Saskatchewan in a 2000–2001 survey of provincial prisons.

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

What must be done?

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

In addition, however, there is a need for initiatives, by and for Aboriginal prisoners, which recognize their special needs and cultural values and promote opportunities for them to improve their health. As noted in a 2007 report surveying programs for Aboriginal persons in prison in Canada, procedures of the penal system (policing, courts and prisons) are often not in keeping with the traditional values or customs of Aboriginal people, and overall programming for Aboriginal people is inconsistent and under-funded. More Aboriginal programs need to be supported, funded and encouraged in prisons. In its 1994 report, the Expert Committee on AIDS and Prisons (ECAP) proposed the following initiatives:

- Development of information and prevention programs that will respond to the specific needs of Aboriginal prisoners.
- Inclusion of community and peer input into these programs.
- Increased efforts, for and by Aboriginal prisoners, their communities and elders, with the assistance of CSC and others, to improve the health status of Aboriginal inmates.
- Increased efforts to decrease the vulnerability of Aboriginal prisoners to exposure to infectious diseases, in particular HIV infection, to drug use

and its harms and to imprisonment.

The Committee made a series of recommendations:

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

In addition, the Canadian Aboriginal AIDS Network (CAAN) has recommended alternative justice mechanisms for Aboriginal offenders, such as circle sentencing and healing lodges, which emphasize victim and community healing, and an Aboriginal "continuum of care" to connect Aboriginal offenders to their culture, families and communities with the assistance of elders, Aboriginal liaison officers and Aboriginal correctional program officers. In recent years, the CSC has undertaken a variety of initiatives aimed at providing education specific to the needs of Aboriginal prisoners, and a strategy and action plan for Aboriginal people and HIV/AIDS in corrections has been developed. For example, "knowledge keepers" who serve as Aboriginal peer health educators and act as traditional storytellers have been trained to help prevent and reduce the spread of HIV among Aboriginal people in federal prisons. However, this has been a slow process and much more needs to be done.

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

Additional reading

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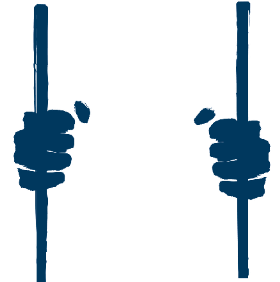

Women in prison

The measures described in info sheets 4-9 will help address the issues women prisoners face in the context of HIV and hepatitis C virus (HCV) infection, but the additional measures described in this sheet are also necessary.

The numbers

Seroprevalence studies undertaken in Canadian prisons, as well as a series of studies undertaken in prison systems in other countries, have shown that HIV and HCV infection is prevalent among women prisoners, in particular among those who have a history of injection drug use. Indeed, HIV and HCV prevalence among women prisoners generally exceeds that of male prisoners. For example, in a 2003 study in provincial prisons in Quebec, the HIV seroprevalence rate among women was 8.8 percent, compared to 2.4 percent among male prisoners. In the same study, HCV prevalence among women prisoners was 29.2 percent compared to 16.6 percent among male prisoners. Similarly, in 2005, 3.6 percent of prisoners in federal women's institutions, compared to 1.6 percent of male prisoners in the Canadian federal prison system, were known to be HIV-positive. At the same time, Canadian women — not just women prisoners — are increasingly becoming infected with HIV, especially those who use injection drugs and whose sexual partners are at increased risk for HIV:

- The proportion of AIDS cases among adult women has increased from 5.6 percent of all AIDS cases before 1990 to 8.3 percent in 1995 to 16 percent in 2001 and 24.2 percent in 2006.
- The proportion of AIDS cases among adult women attributed to injection drug use has increased dramatically from 7.3 percent before 1990 to 24.7 percent in 2006.
- It is estimated that by the end of 2005, 11,800 women in Canada were living with HIV, accounting for 20 percent of the national total. This represents an increase of 23 percent from the 9,600 estimated at the end of 2002.
- The proportion of positive HIV test reports in women attributed to heterosexual contact has increased over time, from 47.9 percent for the 1985–2000 period to 61.1 percent in 2006.

What must be done?

Women in prison need the same preventive measures (see info sheets 4–7), and the same level of care, treatment and support (see info sheet 8) as men in prison.

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

Underlying issues

Underlying many of the problems that women in prison encounter is the fact that, as the United Nations Office on Drugs and Crime (UNODC) has recognized, "[t]he majority of women in prisons are members of social groups marginalized not only on the basis of gender, but also on the basis of race, class, sexual orientation, disability, substance use, and/or occupation as sex workers." Women in prison often have more health problems than male prisoners. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition and poor preventive health care.

Many women infected with HIV or HCV do not receive the diagnostic and

treatment services that could benefit them as early as do men. Among the reasons for this is that women are often unaware of having been exposed to HIV or HCV by their sexual or drug-using partners and as a result do not seek counselling, HIV or HCV testing, and care and treatment. Second, the needs of women infected with HIV or HCV differ from those of men, and social and community support are often less frequently available and less accessible. As a consequence, women are often less educated than men about HIV and HCV infection and do not have the support structures they need. Third, disease manifestations attributable to HIV infection are often different in women, leading to under-recognition or delays in diagnosis. Thus, women who are infected have often been diagnosed as infected or having AIDS later than men, when disease may be further advanced.

While women constitute a small minority of prisoners in most countries, including Canada, they are sometimes housed in small units beside men's prisons where they are likely to find health services designed for men. Sometimes their small numbers make it difficult for prison authorities to justify special services for women. Because fewer institutions house women, women prisoners are more likely to be located far from their families, communities and support networks. Community-based organizations providing services for prisoners may thus be unable to reach women as easily as they can men. In addition to the risks associated with injecting drugs, often with non-sterile and shared equipment, women in prison may face HIV and HCV risk from tattooing or body-piercing with contaminated equipment. Self-mutilation, involving the cutting of skin, which is little studied in prison, also probably occurs more among women than men in prison. In Canada, one expert concluded that self-injury among women in prison is a coping strategy frequently linked to experiences of sexual abuse in childhood.

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

Recommendation

Prison systems need to take immediate action to develop and implement effective HIV and HCV education and prevention programs targeted specifically to women in prison.

Additional reading

Betteridge G. and G. Dias. *Hard Time: Promoting HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, Canadian HIV/AIDS Legal Network and PASAN, 2007. Observations, recommendations and best and promising programs related to women in prison are discussed from pages 82–88. Available via www.aidslaw.ca/prisons.

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Public Health Agency of Canada. *HIV/AIDS Epi Updates*, November 2007. Information on the status of HIV and AIDS among women in Canada. Available via www.phac-aspc.gc.ca/aids-sida/publication.

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13. A moral and legal obligation to act

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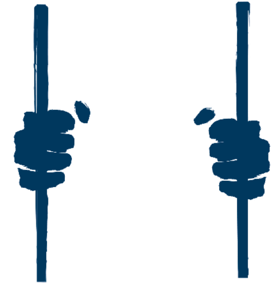

Other prison populations

Youth, transgender and transsexual prisoners, and prisoners from ethno-cultural minority communities need the same preventive measures and the same level of care, treatment and support (see info sheets 4–8) as other prisoners. However, there is a need for initiatives by and for these prison populations that recognize their special needs and cultural values and promote opportunities for them to improve their health.

The United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) framework for HIV/AIDS prevention, care, treatment and support in prisons 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 youth, transgender and transsexual prisoners, and prisoners from ethno-cultural minority communities. This requires the specific needs of vulnerable populations in prisons to be taken into account when designing policy and programs, and calls for collaboration and funding mechanisms to include services for vulnerable populations.

Imprisoned youth

There is a lack of published research about the prevalence of HIV and hepatitis C virus (HCV) or risk behaviours among youth in prison, not only in Canada but internationally. A study from Ontario published in 1994 reported no HIV-positive youth among 1,582 youth entering prison. However, approximately three percent of male youth and two percent of female youth had a history of injection drug use. In 2006, a B.C. study of 417 youth prisoners was carried out, and found that youth in custody admitted to a broad range of risk behaviours both prior to admission and in custody, including injecting drugs, unprotected sex, tattooing and piercing, which make them vulnerable to sexually transmitted infections (STIs) and blood-borne viruses.

No jurisdiction in Canada has comprehensive HIV and HCV prevention and harm reduction policies for imprisoned youth. Only a minority of jurisdictions have adequate policy in place with respect to education and information for youth (i.e. Saskatchewan and Northwest Territories), and with respect to the provision of condoms, dental dams and lubricant for youth (i.e. Northwest Territories). Numerous HIV and HCV prevention and harm reduction policies for youth are institution-specific rather than province-wide.

The 1993 *WHO Guidelines on HIV infection and AIDS in prisons* stipulate that health education programmes adapted to the needs of young prisoners should be organized to "foster attitudes and behaviour conducive to the avoidance of transmissible diseases including HIV/AIDS." In 1996, the Prisoners' HIV/AIDS Support Action Network (PASAN) published 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. The guiding principles applicable to harm reduction are:

- that 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 youth criminal justice legislation; and
- that youth in custody have a right to protect themselves against HIV and HCV infection, through education and access to proper protective materials (such as condoms, bleach and needles).

Accordingly, all youth in custody and all staff providing services for incarcerated youth, should be provided with comprehensive HIV/AIDS education. Other recommendations include access to condoms, dental dams, lubricant and other safer sex materials; implementation of a confidential needle exchange program; distribution of bleach kits; provision of tattoo and body piercing

equipment and supplies; and access to treatment programs for youth in custody with substance use concerns.

Transgender and transsexual prisoners

A 1999 study by PASAN found that discrimination and stigmatization of male-to-female transgender and transsexual prisoners housed in men's prisons rendered them vulnerable to HIV and HCV infection. Some transgender prisoners report consensual sex in prison; others may engage in sex in exchange for their safety or otherwise be sexually assaulted. Sharing equipment used for injecting illicit hormones is an additional, specific risk factor for HIV and HCV transmission among transgender prisoners. Overall, the findings of the report indicated that both federal and provincial policies and programs did not adequately meet the HIV, HCV and harm reduction needs of this population at that time.

There are still no programs specific to transgender and transsexual prisoners in Canadian prisons. To meet the needs of this prison population, PASAN's recommendations include:

- individual information sessions on HIV/AIDS education (in addition to group sessions) for transsexual and transgender prisons upon entering and exiting custody;
- protection of transsexual and transgender prisoners from other prisoners with a known history of sexual assault; and
- choice for transsexual and transgender prisoners in where they are housed within an institution.

Prisoners from ethno-cultural minority communities

According to data from the Correctional Service of Canada (CSC), after Aboriginal prisoners, Black prisoners represent the largest "ethnic" group in CSC prisons with 6.2 percent of the prison population, despite representing only about 2 percent of the Canadian population. As is the case with federal Aboriginal prisoners, the proportion of Black prisoners varies considerably among regions, and there is great diversity among the culture and traditions of Black prisoners. Statistics indicate that some members of ethno-cultural minorities are experiencing increasing prevalence of HIV, with an increase in the proportion of total reported HIV and AIDS cases in Canada attributable to people from countries with high HIV prevalence. Within this group, women represent over half of HIV cases. Most of the people from countries with high HIV prevalence identify themselves as Black.

Persons from countries with high HIV prevalence are disproportionately affected by many social, economic and behavioural factors that not only increase their vulnerability to HIV infection but also act as barriers to access to prevention, testing and treatment programs. Two community surveys conducted in African and Caribbean communities in Canada and among service providers found that such factors as racism, homelessness, transience, poverty, underemployment and settlement and status concerns presented barriers to program access. Other barriers identified by the surveys included fear and stigma; denial as a coping mechanism; social isolation; lack of social support; job loss; fear of deportation; discrimination; power relations; and cultural attitudes and sensitivities about HIV/AIDS transmission, homosexuality, the status of women and sex/sexuality. In addition to these barriers, the surveys also found that there is a lack of culturally competent and accessible services in Canada because of the location of services, language barriers and the fact that health care may not be free, depending on immigration status.

Many of these barriers are reinforced in the prison setting.

Nevertheless, aside from programs for Aboriginal prisoners, no HIV and HCV prevention and harm reduction programs for ethno-cultural minorities are available in Canadian prisons. Existing policies and programs may not be meeting the HIV and HCV prevention and harm reduction needs of prisoners from ethno-cultural minority communities, given the increasing diversity of the Canadian population, and by extension, prisoners, and given systemic racism and the recent history of over-incarceration of Black people.

At the federal level, CSC has developed policy to address the needs of prisoners from ethno-cultural minorities, including making every reasonable effort to meet the needs of those minorities for linguistic, cultural or spiritual programs, either within the institutions or in the community. In addition, where community services are available for social or cultural activities, operational units will facilitate and foster access to such services. The policy also established ethno-cultural advisory bodies. However, it does not appear that there are any programs for prisoners in relation to HIV/AIDS, HCV or in other health-related areas.

To meet the particular needs of prisoners from ethno-cultural minority communities:

- Funding should be made available to community-based organizations working with racial and ethno-cultural minority communities to provide prevention education for prisoners, and to provide care, treatment and support for those prisoners who are living with HIV/AIDS.
- Culturally competent harm reduction education, which meets prisoners' diverse values, beliefs and behaviours, and is delivered to meet their social, cultural and linguistic needs, should be developed and delivered in prisons.

- Brochures, handouts and other materials should be translated into the languages understood by prisoners for accessibility.
- 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 minority communities.

Additional reading

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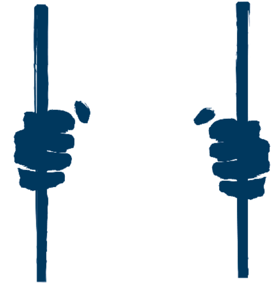

A moral and legal obligation to act

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

The state's duty with respect to health

By its very nature, imprisonment involves the loss of the right to liberty. However, prisoners retain their other rights and privileges except those necessarily removed or restricted by the fact of their incarceration. Canada's *Corrections and Conditional Release Act,* which governs federal prisons, explicitly recognizes this principle. In particular, prisoners, like every other person, have a right to the highest attainable standard of physical and mental health. The state's duty with respect to protect and promote health does not end at the prison gates.

Recommendations on HIV/AIDS, hepatitis C virus (HCV) and drug use in prisons have all stressed the importance of prevention in prisons, and have suggested that condoms, bleach, sterile needles and methadone maintenance treatment be available to prisoners, and have stressed the importance of providing inmates with care, treatment and support equivalent to those available outside. According to the 1993 World Health Organization (WHO) *Guidelines on HIV Infection and AIDS in Prisons*, "[a]ll prisoners have the right to receive health care, *including preventive measures*, equivalent to that available in the community without discrimination." WHO states that prison administrations have a responsibility to put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike. This is implied in the federal *Corrections and Conditional Release Act* which states that health care "shall conform to professionally accepted standards", and arguably entitles prisoners to equivalence of essential health services, including prevention programs.

Legal action by prisoners

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

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

In at least two cases, Australian prisoners initiated legal action to secure damages for having contracted HIV in prison. The first prisoner seroconverted while in a maximum-security institution in Queensland and launched an action for damages for negligence against the prison system. The action was eventually dropped because the case had become too costly to pursue. The second prisoner testified from his hospital bed that he had contracted HIV while under the control and custody of the New South Wales prison authorities, and instituted a negligence claim against the authorities for failing to provide him with access to condoms and sterile needles while he was incarcerated. Because he died shortly after the commencement of the pre-trial hearing and left no estate or dependants, the case ended with his passing.

In South Africa, a former inmate sued the South African Department of Correctional Services in 1997 after being infected with HIV in prison. The suit was ultimately settled out of

court and the terms of the agreement are confidential. It is known that the Department of Corrections "denied any liability" for the plaintiff's infection but admitted that prisoners were not allowed to have condoms until 1996.

In Canada, a prisoner in 2002 claimed that he had contracted HIV in prison because of the prison system's negligence, and that, once infected, he did not receive proper care. He sued the Correctional Service of Canada for damages, and the case was eventually settled out of court, with the terms of the settlement kept confidential.

These legal cases have been important, but prisoners should not have to keep turning to the courts in order to have their rights to protect themselves against disease recognized, or their rights to access care if needed. The issue of providing proper access to HIV and HCV prevention measures and to appropriate care, treatment and support would be more appropriately dealt with by swift action by correctional systems than by court action.

Why should we care?

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

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

Introduction of HIV and HCV prevention measures in prisons, and providing prisoners with health care equivalent to that available outside, is in the interest of all concerned. Any measure undertaken to prevent the spread of HIV, HCV and other infections will benefit prisoners, staff and the public. It will protect the health of prisoners, who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. It will protect staff: lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered. It will protect the public. Most prisoners are in prison only for short periods of time and are then released into their communities. In order to protect the general population, prevention measures need to be available in prisons, as they are outside.

Additional reading

Betteridge G. "Prisoners' health and human rights in the HIV/AIDS epidemic," *HIV/AIDS Policy and Law Review* 9(3) (2004): 96–99. Discusses the legal responsibilities of prison systems. Available via www.aidslaw.ca/review.

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