

*Final Report*

HIV/AIDS IN THE MALE-TO-FEMALE  
TRANSSEXUAL AND TRANSGENDERED  
PRISON POPULATION:  
A COMPREHENSIVE STRATEGY

A Brief from the

**PRISONERS' HIV/AIDS SUPPORT ACTION NETWORK (PASAN)**

to

the Solicitor General of Canada,  
the Minister of Health of Canada,  
the Ontario Minister of Solicitor General and Correctional Services,  
the Ontario Minister of Community and Social Services,  
and the Ontario Minister of Health.

May 1999

Authors: Ann V Scott, MSW and Rick Lines, MA

# TABLE OF CONTENTS

Acknowledgements.....	3
About the Authors	
Introduction.....	4
Guiding Principles	
Summary of Recommendations.....	5

## BACKGROUND

Who is the Transsexual and Transgendered Community?.....	9
Terminology	
Pronoun Usage	
Transgendered Human Rights Protections.....	11
TS/TG Youth, Prostitution, & HIV/AIDS.....	14
Why Prostitution?	
Other Risks of HIV Infection	
Unemployment and TS/TG Adults	
Transphobia & Violence	
Prisoners and Risk for HIV Infection.....	17
Transsexual and Transgendered Prisoners' Risk for HIV/AIDS	
Correctional Services Response to the Health Care Needs of TS/TG Prisoners	

## RECOMMENDATIONS

Background to Recommendations.....	20
Preventing HIV/AIDS among Transsexual and Transgendered Prisoners.....	21
Injection Drug use and HIV.....	26
Medical and Support Services for TS/TG Prisoners Living with HIV/AIDS.....	30
Human Rights, Compassionate Release, and Confidentiality.....	37
Anonymous HIV Antibody Testing.....	42
Aftercare.....	43

## ACKNOWLEDGEMENTS

The authors would like to thank the following individuals who generously shared their time and expertise in the preparation of this report.

[Organizational affiliations are for identification purposes only.]

Evelyn Allen (Streetlink)  
Lydia Batelaan (PASAN)  
Ruth Carey (HIV & AIDS Legal Clinic Ontario)  
Christine Decelles (PASAN)  
Anne Marie DiCenso (PASAN)  
Victoria Glencross (consultant)  
Ralf Jürgens (Canadian HIV/AIDS Legal Network)  
Ann McLaughlin-Rich (Community AIDS Treatment Information Exchange)  
Dierdre McLean (Community AIDS Treatment Information Exchange)  
Dr. Viviane K. Namaste (researcher)  
Mira Soleil Ross (519 Church Street Community Centre)  
Transsexual/Transgender Action Committee  
Wayne Travers (Street Outreach Services)  
Diana Walker (Youthlink-Inner City)  
Jason Zigelstein (Fife House)

We would like to extend our special thanks to the fifteen transsexual and transgendered prisoners and ex-prisoners living with HIV/AIDS who worked as consultants on this project. Without their dedication and honesty, this report would not have been possible.

ABOUT THE AUTHORS

Ann Scott received her MSW from the University of Toronto in 1998. She has been working with the transgendered community since 1989, and has been involved with PASAN since 1997. Her past work has included assisting the Catholic Children's Aid Society to develop and implement their service policies for transsexual and transgendered youth.

Rick Lines received his MA in Sociology from York University, Toronto in 1992, and since 1993 has been employed as the National Programs Coordinator for PASAN. He has spoken on HIV/AIDS and prison issues before the *Parliamentary Subcommittee on AIDS* (Ottawa, 1996) and the *Presidential Advisory Council on HIV/AIDS* (Washington, DC, 1998).

## INTRODUCTION

The Prisoners' HIV/AIDS Support Action Network (PASAN) is a community-based network of prisoners, ex-prisoners, organizations, activists and individuals working together to provide advocacy, education and support to prisoners on HIV/AIDS and related issues. PASAN formed in 1991 as a grassroots response to the AIDS crisis in the Canadian prison system. Today, we are the only organization in Canada exclusively providing HIV/AIDS education and support services to prisoners, ex-prisoners, young offenders, and their families.

Since 1993, PASAN has worked with over 200 HIV positive prisoners from across Canada. Approximately 10% of PASAN's HIV positive clients identify as transsexual or transgendered (TS/TG). This experience has led us to document many specific barriers faced by TS/TG prisoners living with HIV/AIDS in accessing proper HIV/AIDS care and other support services. This brief has been produced in an attempt to identify these specific and significant issues, and recommend solutions.

The research used to compose this brief is based exclusively on the needs of male-to-female transsexual and transgendered prisoners with HIV/AIDS housed in male prisons, due to the fact that this population group was found to be more accessible. Fifteen male-to-female TS/TG prisoners and ex-prisoners living with HIV/AIDS were interviewed and used as consultants in preparation of this brief. Their experiences were expressed both through anonymous written questionnaires and through personal interviews. PASAN agreed to maintain their anonymity in order to encourage their participation and openness in this project, and excerpts of their testimony have been used with their permission. PASAN has excised all references to specific provincial and federal institutions and staff occurring in their testimonials. PASAN also made an effort to seek out individual correctional medical staff in order to document their experiences in serving the TS/TG prisoner community. Unfortunately, the health workers contacted did not feel able to participate.

This document is based primarily upon the experiences of male-to-female transsexual and transgendered people in Ontario region federal and provincial prisons and jails. While PASAN

believes our recommendations are significant for the Canadian prison system as a whole (particularly in the case of federal institutions), we are also aware that differing correctional, health care, and human rights legislation from province to province will impact specific policy recommendations and changes. While these differences may influence the need for and/or implementation of policies from province to province, PASAN believes that the findings of this report are illustrative of the HIV/AIDS service needs of male-to-female transsexual and transgendered prisoners on a national basis.

Rather than an end point, PASAN hopes that this document will help stimulate further discussions about the specific HIV/AIDS needs of transsexual and transgendered prisoners in both correctional services and the community, and lead to changes in prison policy. We welcome further contributions to this important effort both from other provinces, and from the perspective of female-to-male transsexual and transgendered people.

## PASAN'S GUIDING PRINCIPLES

PASAN maintains five guiding principles which inform our approach to questions concerning HIV/AIDS in the prison system.

- 1) Prisoners with HIV/AIDS have a basic right to maintain their health.
- 2) Prisoners have a right to protect themselves against HIV infection.
- 3) Prisoners have a right to keep their health status private. This means (i) HIV-antibody testing should only be done anonymously, and (ii) prisoners with HIV/AIDS should be able to keep their status confidential.
- 4) Prisoners have a right to informed consent with respect to HIV-antibody testing and HIV/AIDS treatment.
- 5) Prisoners have the right to access support, education and treatment programs of their choice. Therefore, HIV/AIDS support, education and treatment programs should be available from community-based organizations brought into the institutions, rather than by correctional staff alone.

## SUMMARY OF THE RECOMMENDATIONS

## **HIV PREVENTION**

1. HIV/AIDS education should be compulsory for all TS/TG prisoners, and all staff providing services to incarcerated transsexual and transgendered persons. Staff education should emphasize not only the specific medical and social needs of the TS/TG prison population, but also anti-transphobia (an aversion to those individuals who live outside normative sex-gender roles.)
2. HIV/AIDS education must be comprehensive for both transsexual and transgendered prisoners, and staff.
3. All educational presentations and materials must recognize and respond to the needs of transsexual and transgendered prisoners with disabilities, from different ethnic and linguistic backgrounds, with varying language skills and literacy levels, and of different races, gender, and sexual orientations.
4. In addition to group HIV/AIDS educational sessions, information should be made available to transsexual and transgendered prisoners individually upon entering and exiting the custody facility.
5. External, community-based AIDS and health organizations should lead educational sessions. Peer education should also be promoted.
6. Condoms, dental dams, latex gloves, appropriate lubricants, and other safer sex materials must be made available to TS/TG prisoners in a discreet, non-identifying manner.
7. Consensual sex between prisoners should not be an institutional offense.
8. Known sexual offenders and sexual predators must not be segregated in the same protective custody units where transsexual and transgendered prisoners are housed.

## **INJECTION DRUG USE AND HIV**

9. A confidential needle exchange program should be implemented.
10. Bleach kits should be distributed in a non-identifying manner.
11. A public relations campaign should be initiated to combat anticipated resistance by staff or the public to a needle exchange program.

12. Methadone maintenance should be made available to all TS/TG prisoners who could benefit from such programs. Methadone should be an option for all prisoners regardless of HIV status or previous participation in a methadone maintenance program.
13. Sterile tattooing equipment and supplies should be authorized for use in prisons.
14. Clean equipment and supplies should be authorized for body piercing.
15. Community-based workers, in conjunction with custody staff, should educate transsexual and transgendered prisoners about drug use as a health issue.
16. Treatment programs for TS/TG prisoners with drug use issues should be developed and accessible.

## **MEDICAL AND SUPPORT SERVICES**

17. HIV/AIDS medications should be administered at the appropriate times, and in conjunction with the appropriate diets, in order to ensure the maximum benefit from the medications.
18. Hormones should be given to all transsexual and transgendered prisoners who have used them in the community, regardless of HIV status. Hormone access should not be contingent solely upon the approval of Gender Identity Clinics or specific doctors approved by these clinics. Hormone usage should be monitored closely by health professionals who understand the effects of hormones on the endocrinological system.
19. Transsexual and transgendered prisoners living with HIV/AIDS must be guaranteed access to medical and dental workers of their choice. In particular, they must have access to experienced and expert HIV primary care physicians and endocrinologists, who are gender positive and aware of the health care needs of transgender people.
20. The services of community-based workers serving the transsexual and transgendered community and/or persons living with HIV/AIDS must be made available to all TS/TG prisoners who desire them. Within federal penitentiaries, CSC staff must facilitate the placing of community-based organizations on the general access phone lists available for all prisoners to call.
21. All transsexual and transgendered prisoners living with HIV/AIDS should have access to alternative therapies and non-approved treatments.
22. The special dietary needs of TS/TG prisoners living with HIV/AIDS must be met. Prison systems must ensure that - in those instances where diet and mealtime are integral

components of a therapy's effectiveness - that the proper provision of dietary services is addressed as a medical concern rather than a kitchen issue.

23. The comfort needs of transsexual and transgendered prisoners living with HIV/AIDS (e.g. extra clothing or blankets, bras) must be met.
24. A pain management program should be put in place to assist with the control of the pain which often accompanies HIV/AIDS related illnesses and hormone replacement therapy.
25. Careful attention must be given to evaluating the degree to which the clinical drugs (for HIV/AIDS), and biochemical drugs (for hormone replacement therapy) interact and affect the progression of HIV/AIDS.
26. Special programs must be established for transsexual and transgendered prisoners living with HIV/AIDS who are suffering from AIDS-related illnesses and who are ineligible for medical parole/probation. Standards for palliative care must be consistent with the community standards set out by the Canadian Palliative Care Association.

## **HUMAN RIGHTS, COMPASSIONATE RELEASE, CONFIDENTIALITY**

27. No male staff has the right to search female transsexual and transgendered prisoners. Only female staff should be allowed to do searches.
28. Sentencing guidelines for judges and prosecutors regarding transsexual and transgendered prisoners living with HIV/AIDS need to be developed.
29. A compassionate release and/or medical parole/probation program should be implemented for transsexual and transgendered prisoners with HIV/AIDS in a timely fashion.
30. HIV-related information in the possession of medical providers should be released to custody authorities only under extraordinary circumstances and only with the consent of the TS/TG prisoner.
31. The confidentiality of transsexual and transgendered prisoners' HIV status must be respected. Staff members who break the confidentiality of TS/TG prisoners should be disciplined and/or terminated.
32. The distribution of medications, special diets, and nutrient drinks should not require a breach of confidentiality of transsexual and transgendered prisoners living with HIV/AIDS.
33. Transsexual and transgendered prisoners who want access to supportive counselling, medical treatment, etc. must be guaranteed that their confidentiality will be respected.



34. All transsexual and transgendered prisoners should have the right to privacy due to their status as females in male prisons.
35. Transsexual and transgendered prisoners have the right to live in an environment in which they feel safe and are not harassed because of their gender.
36. Transsexual and transgendered prisoners living with HIV/AIDS should not be involuntarily isolated or segregated.

### **ANONYMOUS HIV ANTIBODY TESTING**

37. HIV - antibody testing of TS/TG prisoners must be done voluntarily and anonymously.
38. Testing should be carried out by “outside” community-based agencies.
39. HIV-antibody testing must be accompanied by access to medical monitoring and treatment (when necessary).

### **AFTERCARE**

40. Parole officers, probation officers, discharge planners, workers in group homes and halfway houses, and other aftercare workers must be educated about HIV/AIDS and TS/TG issues.
41. Exit kits with HIV/AIDS information, contacts with gender positive community-based organizations, condoms, bleach kits, etc. must be made available to TS/TG prisoners when they are released from custody facilities.
42. Programs providing continuity of care after release must be established for the transsexual and transgendered prison population.
43. Community-based groups must be involved with the development and implementation of aftercare strategies.
44. The federal and provincial correctional services should work with community-based gender positive HIV/AIDS housing programs and service organizations to ensure that they meet the needs of transsexual and transgendered ex-prisoners.

## **WHO IS THE TRANSSEXUAL AND TRANSGENDERED COMMUNITY?**

“Transgender” is an umbrella term used to describe those who live outside of normative sex/gender relations (Ki Namaste, *Access Denied*, 1995). These are people who identify with a core gender identity which society believes is not congruent with their external genitalia. Transsexual (TS), Transgender (TG), Intersexed people, Cross-dressers, Drag Kings and Queens, and Transvestites are six of the most prominent groups within the transgendered community. According to the International Foundation for Gender Education (IFGE), 12% of the population of Canada and the United States identify under one of the above groups (cited in Travers, *Transgendered Youth Workshop*, 1996).

## ρ TERMINOLOGY

In 1996, the American Education Gender Information Services produced a document entitled *Watch Your Language*, intended to provide a guide to transsexual and transgendered terminology. Because the document was created by transsexual and transgendered persons themselves, it provides an important and useful listing of terms and definitions created by and for the transgendered community.

*Watch Your Language* identifies the following terms and definitions.

***Transsexuals*** (TS) are extremely unhappy in the gender to which they are assigned at birth and change their gender roles and bodies in order to live as members of the “other” sex. Modern medical technology (synthesized sex hormones, electrolysis, plastic surgery) makes this much easier than it was in the past. About 50% of transsexuals are male-to-female (M to F) and 50% are female to male (F to M). Many have sex reassignment surgery, in which their genitals are modified. Transsexuals identify completely as members of their new gender.

***Transgenderists*** (TG) live as members of the other sex, but without the extreme need or desire to modify their bodies shown by transsexuals. Some live as members of the other sex, while others stake out “third gender” status. Transgenderists may take hormones, but do not have genital surgery.

***Cross-dressers*** wear the clothing of the other sex on occasion but do not desire to change their sex. They dress for personal reasons, which can range from a need to express their feminine or masculine side, in a way which pleases themselves erotically.

***Drag Kings and Drag Queens*** present larger than life images of men and women, exaggerating sexual stereotypes for entertainment or self-gratification.

***Transvestites*** wear clothing of the other sex for sexual gratification. They do not desire to change their gender and are often heterosexual men.

***Androgynous, Gender Benders and Gender Blenders*** merge the characteristics of both sexes in ways subtle or shocking.

***Intersexed (hermaphroditic) persons*** are born with genitals which show characteristics of both sexes. Many have surgery in infancy, and grow up feeling they have been robbed of an essential part of themselves.

***Transsexual/Transgendered People*** are group nouns used to describe transgendered and transsexual people.

***The Transgender Community*** is the term for the organized community of transpeople.

Transsexuals, transvestites and transgenderists may be homosexual, lesbian, bisexual or heterosexual. In other words, gender identity (the general term for the way one relates to one's gender role) is not the same as sexual orientation.

## ρ PRONOUN USAGE

Appropriate usage of names and pronouns is important to transsexual and transgendered people. This can sometimes become a power struggle, with pronouns linked to the gender of birth used in disregard to the appearance and life situation of the individual. The appropriate pronoun is the one which best describes the way the individual is living his or her life. A cross-living male-to-female transsexual or transgenderist should be referred to with feminine pronouns (she, her, hers, etc.) regardless of surgical status. Masculine pronouns should be used for female-to-male transsexuals (American Educational Gender Information Service, Inc., 1995).

## TRANSGENDERED HUMAN RIGHTS PROTECTIONS

PASAN believes that transsexual and transgendered people must be provided specific human rights protections. In order to ensure that those rights are exercised, all Canadians must be provided access to effective, timely avenues of redress of human rights complaints. In order to accomplish this goal, those complaint bodies must receive adequate funding to enable them to investigate and act on all complaints in a comprehensive manner.

According to *Finding Our Place*, a report prepared by the Transgendered Law Reform Project of the Law Foundation of British Columbia, "there is currently no Canadian jurisdiction which explicitly protects transgendered people in its human rights legislation." *Finding Our Place* identifies "only one reported Canadian human rights case dealing with transgendered

human rights", although this complaint was not considered under grounds of gender identity. (Findlay, *Finding Our Place*, p. 17)

*Finding Our Place* credits Laura Denise Masters with identifying two specific ways that discrimination against TS/TG people often occurs, "discreditation" and "constructive refusal".

*Discreditation* is defined as "the assumption that transgendered people are either incompetent or prone to lie." (Findlay, p.19) For example,

The prison system discriminates against transgendered prisoners on the basis of "discreditation" because they believe that transgendered people carry drugs into the prison system and are lying about it, as well as blaming them for being responsible for spreading the HIV/AIDS virus to the prison population. (Findlay, 1996 p. 19)

*Constructive refusal* is described as "making promises with no intention of keeping them - putting a person off," a discriminatory practice described as often being "very subtle". (Findlay, p.19)

One of the best constructive refusals within the prison system is when a doctor refuses to give transgendered prisoners their hormones. [The prison doctor] may say that he needs to procure permission from a renowned doctor in the community, or the Gender Identity Clinic at the Clarke Institute of Psychiatry, before giving out the hormones. The transgendered prisoner may go back to the doctor on several occasions and still not be given her hormones (Scott, A Needs Assessment of the Transgendered Community, 1997, p.16).

Given that there is no explicit human rights protection for TS/TG people, what have individuals done when they have faced discrimination? According to *Finding Our Place*, "For the most part, transgendered people have done nothing." (Findlay, p.20) As part of their study, the Transgendered Law Reform Project researched the use of Canadian federal and provincial human rights statutes to address discrimination against TS/TG persons.

A BC survey of Canadian human rights jurisdictions indicates that there have been very few human rights complaints from transgendered people who have suffered discrimination. In the few cases where transgendered people have filed human rights complaints, they have been processed on the grounds of sex/gender, disability, or sexual orientation. (Findlay, p.20)

*Finding Our Place* also documents the specific human rights protections afforded transsexual and transgendered people on a province by province basis. The study concluded

**Quebec** is the only province in which a complaint by a transgendered person has made it all the way through a human rights process and resulted in a decision... The Quebec case is called *La Commission des Droits de la Person du Quebec v. Anita Anglsberger*. In that case, the Quebec Provincial Court held that transsexuals were protected under the

category of “civil status”. This is a ground which is unique to Quebec and which refers to a person's status in society.

In response to BC’s Human Rights Council telephone survey, the **Alberta** Commission said that it had never had a complaint. If it did, it would process it under the category of “physical disability”.

The **Saskatchewan** Human Rights Commission has also never received a complaint [from a transgendered person], but because their legislation defines “sex” and restricts the gambit of physical disability, and did not include “sexual orientation”, the commission doubted that it could accept a complaint on any ground from a transgendered person.

In **Manitoba**, there had been complaints from transgendered people, these were accepted under “sex” and “physical disability”. None of those cases resulted in a reported decision. The Manitoba commission indicated that it chose physical disability because the individuals involved were going through physical changes.

The **Ontario** Human Rights Commission reported it received one complaint which was taken under [grounds of] sexual orientation. The commission had received a legal memo that stated that “handicap” rather than “sex” would be the proper basis on which to proceed. However, the commission did not seem to be sure of the accuracy of that opinion.

**Newfoundland** and **P.E.I.** have never received a complaint from a transgendered person. **New Brunswick** reported one case, which it processed under sex.

The **Canadian Human Rights Commission** reported that it had had one complaint, which, according to an official memo, was processed under “sex” and “physical disability”, and dismissed because “sex” did not include transsexuality and under “physical disability” the respondent had tried to accommodate the complainant.

Although the British Columbia memo reports this case in the federal human rights system there is no reported decision about it. (Findlay, pp. 20-21)

Given their findings, *Finding Our Place* concludes by asking

Without any specific protection for [the category of] gender identity under human rights legislation, is it possible for transgendered people to file under current human rights grounds? Of course, transgendered people should file human rights complaints under all available grounds until there is a specific remedy for gender identity; but what are the chances of succeeding in a complaint on [the grounds] of sex, disability, or sexual orientation? (Findlay, p.22)

PASAN believes that the small number of complaints found by the Transgendered Law Reform Project is not evidence of a lack of discrimination against transsexual and transgendered

people. Rather, it is indicative of the systemic barriers inhibiting TS/TG people from laying human rights complaints. Given that specific human rights protections do not exist for transsexual and transgendered people, there is no basis for human rights tribunals to accept human rights complaints from TS/TG persons when the discrimination has occurred, *because* they are transsexual or transgendered. Therefore, unless the complaint can be investigated under an alternative, protected category - as in the Québec case cited above [p. 12] - human rights investigators have no basis on which to even receive complaints of discrimination from transsexual and transgendered Canadians.

PASAN believes this situation has contributed to an overall lack of confidence felt by the TS/TG community in the system of Canadian human rights protection, which is also reflected by the small number of complaints.

Chronic underfunding of the human rights complaint processes in many provinces has resulted in the inability to investigate a vast majority of complaints laid, long backlogs in hearing cases that are investigated, and a lack of ability of human rights tribunals to enforce judgements. This scenario has contributed to a crisis of confidence in the human rights complaints process among many communities who routinely suffer discrimination. In this sense, the TS/TG community is not unique in their apparent skepticism of human rights tribunals as a remedy.

To help alleviate this situation, the Transgendered Law Reform Project made a series of recommendations towards guaranteeing human rights protections for TS/TG people. They include:

- ® That the Human Rights Commission hold hearings into the situation of transgendered people in order that they may understand fully the dimensions of discrimination.
- ® That the Human Rights Commission create a campaign of public education on the issue of discrimination against transgendered people.
- ® That the Legislature amend the Human Rights Act to prohibit discrimination on the basis of gender identity, including transsexualism, transgenderism, transvestitism, and cross-dressing. (Findlay, p.28)

PASAN would further recommend that all human rights bodies be provided sufficient funding to enable them to investigate complaints and enforce judgements in a timely and effective manner.

Since the publication of *Finding Our Place*, two important developments have occurred on the provincial level in the area of human rights protections for transsexual and transgendered persons. In British Columbia, on January 19, 1998 the BC Human Rights Commission recommended that transsexual and transgendered people receive full protections under that province's human rights code. [Fisher, et al. *Gay and Lesbian Issues and HIV/AIDS: Final Report*. 1998, p. 54] More recently in July 1998, the Human Rights Commission in Quebec ruled that TS/TG people are protected from discrimination under the category of sex.

## TS/TG YOUTH, PROSTITUTION, & HIV/AIDS

The act of transitioning - the process of changing from one state to another - often occurs among youth, who begin the process by experiencing cross-dress living (Travers, 1996). Many transsexual and transgendered youth live in isolation because messages from family, school and society inform them that they are not living up to the gender roles set out for them in a bi-gendered society. This social isolation all too often escalates to verbal and physical abuse, or emotional neglect, in the family and at school. As a result, many TS/TG youth run to the streets. A 1996 survey by Street Outreach Services, a Toronto-based agency serving TS/TG youth working in the sex trade, found that 97% of street youth surveyed came from abusive or dysfunctional homes. Therefore, for these youth, the act of running away becomes an act of survival.

While living on the streets, prostitution is an occupation which attracts these TS/TG youth because they are often denied safety and support within the educational system or at child protection agencies. Many of these youth continue to work in the sex-trade well into their adulthood, because stigmatization and discrimination in the "traditional" workplace make it difficult for them to secure other employment opportunities. (Namaste, *Access Denied*, 1995) Others continue to work in the sex trade as their profession of choice.

Although very few TS/TG youth indicate that they plan to undergo sex-reassignment surgery, they are still in desperate need of funds both to pay for hormones and other surgical procedures [i.e. electrolysis, breast implants, etc.], to maintain their lifestyles, and to meet their survival needs. [*note: the percentage of those wishing to undergo sex-reassignment surgery increases as these youth enter their 20s and 30s*] While street prostitutes, who are often TS/TG youth, make a little less than those who provide escort services out of their homes, the trade still provides them with financial incentives to continue with sex-trade work (Travers, 1996). Most sex-trade workers are under the age of thirty, and in many cases started in the business in their early teens (Travers, 1996). Research shows that transsexual and transgendered sex-trade workers in Canada are often young, poor, and people of color (Namaste, *Access Denied*, 1995).

### o WHY PROSTITUTION?

The transsexual and transgendered street youth community is a closely-knit circle, where young prostitutes are often supported in the sex-trade by older, more experienced prostitutes, who refer to the youth as their "daughters". These older sex trade workers not only provide support and protection to these youth, but also help them learn their way around the often dangerous profession. Many of the TS/TG youth working on the streets are youth of color, who have faced further disenfranchisement and societal barriers resulting from institutionalized racism. (Namaste, *Access Denied*, 1995).

The youth working the streets are often at great risk of violence, and live in a street subculture marked by drug use (both injection and non-injection) and unsafe sex. For these

youth, this living environment often places them at increased risk of HIV infection. Sex-trade workers have revealed that unsafe sex practices occur frequently, particularly among individuals working the streets. The use of alcohol and/or drugs, as well as financial incentives (more money for unsafe sex), leads to a high risk of HIV/AIDS infection in the TS/TG sex-trade community. (Namaste, *Access Denied*, 1995)

Of forty-three TS/TG youth surveyed by Street Outreach Services, thirty-five were living with HIV/AIDS, nineteen of them believing they were infected by a husband (consistent partner in their life, their protector) or boyfriend. (Travers, 1996) While this rate of seroprevalence should in no way be extrapolated to apply to TS/TG sex trade workers as a whole, it is indicative of the conditions of vulnerability in which many young transsexual and transgendered prostitutes live and work.

The discrimination and violence experienced by transsexual and transgendered sex-trade workers are related to the denigration of prostitutes in Canadian society. Because of criminal prohibitions against soliciting, many sex-trade workers (male, female, and TS/TG) are forced to take their business practices underground. They work in dark parking lots, stairwells, and other remote areas away from the eyes of police. Unfortunately, these types of environments also make prostitutes physically vulnerable, placing put them at increased risk of violence and death. Discriminatory attitudes and legislation against sex trade work are at the root of this situation, and contribute not only to unsafe working conditions for TS/TG prostitutes, but also to creating social conditions where the risks of HIV infection are increased.

Because both drug use and communicating for the purposes of prostitution are penalized under the criminal code, many of these transsexual and transgendered youth and adults will come into conflict with the law, and may end up spending time in prison. Inequitable treatment of TS/TG sex trade workers before the courts may also be an issue which increases their likelihood of incarceration. Anecdotal testimony received in preparation of this report from both transsexual and transgendered sex trade workers and agencies serving the TS/TG community suggest a pattern of differential, more punitive, responses to TS/TG individuals at trial. A 1998 study in Quebec further revealed that 50% of the transsexual and transgendered sex trade workers interviewed had done time in jail. [Namaste, *Evaluation des besoins: Les travesti(e)s et transsexuel(le)s a l'egard due VIH/Sida*, 1998].

## o OTHER RISKS FOR HIV INFECTION

Postoperative transsexuals with vaginas created by a colon resection are also at high risk of contracting HIV because reconstructed vaginas cannot lubricate. Therefore, intercourse can often cause minor abrasions or tearing. If these individuals have unprotected sex without proper lubrication, there is an increased risk of tissue damage causing bleeding. If their male partner is HIV infected, this creates a high risk situation for the transmission of HIV. (High Risk Project Society, Transgendered HIV/AIDS, 1996) Many postoperative transsexuals also falsely believe they are at no risk for HIV infection because there is no body channel for the virus to penetrate. This misinformation often results in unsafe sexual practices. (Namaste, *HIV/AIDS and*



*Transgender Communities in Canada*, 1995) [note: post-operative male-to-female transsexuals would not be housed in male prisons]

Male-to-female transsexuals may also still have a prostate gland, which secretes pre-ejaculatory fluid. In a person living with HIV/AIDS, this pre-ejaculatory fluid can contain the virus, which increases the risk of infection during oral sex. (High Risk Project Society, 1996)

Society has taught transsexual and transgendered people to be ashamed of their genitals, because their genitals do not conform to their presentation of themselves. Therefore, TS/TG people will hide their genitals from their partners in order to "pass" in their desired gender, and to be accepted as such without becoming victims of violence. This impacts power balances in their relationships and the ability of TS/TG people to negotiate safer sex with their partners. For example, fear of violence may make it difficult for a TS/TG person to insist that her male partner wear a condom during intercourse, thereby placing her at increased risk for HIV infection.

## o UNEMPLOYMENT AND TS/TG ADULTS

Society is still struggling with gender roles in the workplace, and having an employee transition from one gender to another challenges workplace norms. For this reason, transsexual and transgendered people often lose their jobs when they begin the transitioning process. Once the transition phase has been completed, it is still difficult for a transsexual or transgendered person to find employment unless they can totally "pass" as a non-TS/TG person. Many male-to-female TS/TG women have employment histories in male-dominated fields, and therefore have difficulty finding jobs following their transition because of sexism and assumptions about female workplace roles. (Namaste, *Access Denied*, 1995).

These employment barriers can be factors contributing to the decision of some TS/TG adults to work in the sex trade both during and after their transition stage. (Namaste, *Access Denied*, 1995) In order to "pass" in society, many TS/TG adults must continue to pay for electrolysis, save for breast augmentation and later perhaps sex-reassignment surgery. In Ontario, for example, individuals hoping to qualify for gender confirmation surgery under OHIP at the Clarke Institute of Psychiatry's Gender Reassignment Clinic must meet the criteria of the "real life test", which includes holding steady employment for two years. Without employment opportunities, transsexual and transgendered people must find other ways to provide funds to pay for the surgery themselves. For many, prostitution is the most viable employment choice to accomplish this goal. [note: At the time of writing, the Ontario government had decided to exclude sex-reassignment from OHIP coverage, whether the surgery has been sanctioned by the Ontario Gender Identity Clinic or not. This creates a situation where all transsexual and transgendered people seeking sex-reassignment surgery will be forced to fund it themselves.]

## TRANSPHOBIA & VIOLENCE

Transsexual and transgendered people often face humiliation in both society and their families because of their gender orientation. *Transphobia*, an aversion to those individuals who

live outside normative sex-gender roles, creates an unsafe environment in which TS/TG people struggle against not only barriers to employment, social and medical services, but often violence. To escape this reality, large numbers of transsexual and transgendered people move to urban centres where they can find a place to feel safe, where they can meet other TS/TG people and access a community of moral support. (Namaste, *Access Denied*, 1995)

Transsexual and transgendered people suffer from severe discrimination and unequal treatment in society (Findlay, 1996). They are faced with multiple risks to their health, well being, and safety, particularly if they are using street hormones or working in the sex-trade industry. Transsexual and transgendered sex-trade workers face increased vulnerability to violence from clients and partners, police harassment, drug and alcohol problems, and imprisonment. (Namaste, 1995) Those TS/TG people living in this high stress environment often move towards clinical depression and sometimes suicide (AEGIS, 1996). Many transsexual and transgendered people stay involved in the sex-trade profession because they find acceptance and appreciation for their bodies, and feel affirmation when a client is willing to pay money to appreciate their body.

Transsexual and transgendered people often experience violence in the sex-trade industry, which is unfortunately considered part of their general working conditions. Of 34 respondents surveyed by researcher Dr. Ki Namaste in 1995, twelve had been sexually assaulted (35%), and in eight of the assaults condoms were not used.

## PRISONERS AND RISK FOR HIV INFECTION

Since 1992, various studies have documented the increased risk of HIV infection among incarcerated populations. These reports by PASAN (1992), the Expert Committee on AIDS and Prisons (1994), and the Canadian HIV/AIDS Legal Network and Canadian AIDS Society (1996) have all highlighted the urgency of this public health crisis, and have called on the government to act to ensure the health of prisoners.

Since 1993, studies in both provincial and federal institutions have continued to demonstrate HIV infection rates among prisoners between 1% to 7.2%. These rates of HIV/AIDS among prisoners are many times higher than among the general public. Between April 1994 and March 1996, Correctional Service Canada reported a forty-six percent increase in known HIV/AIDS cases within federal custody facilities (Jürgens, *HIV/AIDS in Prisons: Final Report*, 1996). A 1998 HIV seroprevalence study among prisoners at Joyceville Institution (Ontario), revealed an HIV rate of 1.7%, seventeen times higher than on the "outside" [Dr. Peter Ford, 1998].

We know that HIV infection is primarily transmitted through unprotected sexual intercourse and sharing needles for injection drug use and tattooing. We also know that despite correctional prohibitions on these activities, sex, drug use, and tattooing are common in Canadian prisons and jails.

HIV infection in prison populations has been closely related to the proportion of prisoners who inject drugs prior to their imprisonment, and to the rate of HIV among injection drug users in the community. (Gilmore, N. et al. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*, 1994, p.6) Canada's prohibitionist, criminalization approach to drugs has resulted in the incarceration of large numbers of drug users. A 1989/90 survey by Correctional Service Canada [CSC], for example, revealed that 64% of prisoners had used drugs or alcohol on the day their crime was committed. (Riley, *Drug Use in Prison*, 1992) We know that these people continue to use drugs, including injection drugs, while incarcerated.

CSC's *National Inmate Survey* in 1995 revealed that 11% of respondents admitted to injecting drugs while incarcerated (with 23% of respondents in the Pacific region reporting IV drug use). This same survey indicated that 6% of respondents reported having sex while in prison (only one-third of whom reported using a condom), and 45% indicated that they had been tattooed in prison. (cited in Jürgens, *HIV/AIDS in Prisons: Final Report*, 1996) A 1998 study conducted at Joyceville (federal) Institution near Kingston, Ontario reported that 24.3% of participating prisoners had injected drugs while incarcerated. This figure is more than double the number reporting IV drug use at the same institution in a similar study conducted in 1995 [Ford, 1998]. PASAN's experience demonstrates that many prisoners are reluctant to provide personal information on drug use and sexual activity, and we therefore believe that the results from these studies must be considered low estimates.

Given the high rates of HIV infection in prisons, continuing high risk behaviours among prisoners, and the fact that these populations are denied access to comprehensive safer sex and/or harm reduction measures, the risk of ever increasing numbers of new HIV infections in Canadian prisons remains high. This reality calls for government action.

## o TRANSSEXUAL AND TRANSGENDERED PRISONERS' RISK FOR HIV/AIDS

The discrimination, inequality, health, and safety issues faced by transsexual and transgendered prisoners are proportionate to the issues faced by TS/TG people in the community. Canadian prisons incarcerate both gay men and men who identify as "straight" but who engage in same sex activities while inside. Male-to-female transsexual and transgendered prisoners (who have not undergone sex reassignment surgery and had their gender change legally registered) are housed in male prisons, and are among the most marginalized and disadvantaged in the prison community. They are often used as sex objects and as a result are at increased risk of violence within the institution. Many TS/TG prisoners find it necessary to trade sex for protection. Therefore, their very survival hinges on their willingness to provide sex for their partners, who are often very abusive to them.

The fact that many transsexual and transgendered prisoners are forced to trade sex for survival indicates that the Canadian prison system does a poor job of ensuring their safety. As one TS/TG prisoner interviewed by PASAN recalled,

Although the guards make fun of the fact that I am transgendered and call me "chick with a dick", the male inmates consider me to be a woman, and believe that they are having

heterosexual sex with me. I usually stay with my old man, my “husband”, in prison for protection against violence and rapes, and many of us girls go in and out of the prison system so we can spend time with our husbands.

The TS/TG prisoner population, both adults and youth, are placed at increased risk for HIV infection due to the conditions of their imprisonment. Despite this fact, very little has been written about the needs of transsexual and transgendered prisoners with HIV/AIDS. We hope this brief will begin to change that fact, and help to highlight the important needs of this community.

## o CORRECTIONAL SERVICES' RESPONSE TO THE HEALTH CARE NEEDS OF TS/TG PRISONERS

Correctional Service Canada’s [CSC’s] *Commissioner’s Directive 800* on Health Services specifically refers to male-to-female transsexual and transgendered prisoners under the heading of “Gender Dysphoria”. Gender Dysphoria is a psychiatric term describing a TS/TG person who is struggling with issues of gender identity ranging from mild to acute. In the acute stage, transsexual and transgendered people have difficulty accomplishing their normal routines of daily living. In attempting to address the needs of those transsexual and transgendered prisoners who suffer with Gender Dysphoria, *CD 800* states that

27. The diagnosis of transsexualism shall be made by a recognized psychiatrist-expert in the area of gender identity. A referral to such an expert may only be initiated by the institutional psychiatrist following regional approval.

28. Assessment results shall be sent to the Corporate Advisor, and the Health Services Sector for approval to commence or continue treatment and to ensure that proper standards of care are followed while treating the transgendered prisoner.

29. If an inmate has been on hormones prescribed through a recognized gender program clinic prior to incarceration, they may be continued under the following conditions:

- a. that the inmate be referred to and reassessed by a recognized gender assessment clinic; and
- b. that continuation of hormone therapy is recommended by the gender assessment clinic.

30. Unless sexual reassignment surgery has been completed, male inmates shall be held in male institutions.

31. Sexual reassignment surgery may be considered during the inmate’s sentence but must receive prior Regional Deputy Commissioner and Commissioner approval.

32. Subject to operational considerations, the institutional head may permit cross-gender dress.

(Correctional Service Canada *CD 800*, pp. 7-8, 1995-05-01)

Inquiries made to the Ontario Ministry of Correctional Services found no provincial guidelines or directives referring specifically to transsexual and transgendered prisoners.

Although the federal prison system does have a health policy in place to address issues of Gender Dysphoria, PASAN believes that it does not meet the needs of most transsexual and transgendered prisoners.

*CD 800* takes its recommendations from the Gender Identity Clinics, which determine whether a prisoner suffers with the psychiatric condition, "Gender Dysphoria". Only when a TS/TG prisoner has been given this label can s/he access hormones. However, Gender Identity Clinics are not inclusive in nature, and sex-trade workers [because prostitution is not considered "legitimate employment" by G.I.C.s] and drug users often face barriers in trying to access their services. As a result of this policy and its tight criteria, many transsexual and transgendered prisoners are denied access to the services of the Gender Identity Clinics by virtue of their incarceration. This calls into question whether the *CD 800* is meeting the needs of the majority of the transsexual and transgendered prison population, most of whom are incarcerated (at one time or another) on prostitution or drug charges. [note: This is also true because *CD 800* only applies to male-to-female TS/TG prisoners.] Even those TS/TG prisoners who are accepted by a gender reassignment clinic, and are therefore able to access prescription hormones while incarcerated, will have their therapy overseen by prison medical staff who often are not afforded specialized training in hormone replacement therapy.

Despite the above barriers to TS/TG sex-trade workers and drug users accessing prescription hormone replacement therapy, many still use hormones which they either access from friends who share their prescriptions, or which are purchased illegally on the street. When these transsexual and transgendered people are later denied access to prescription hormone treatment when incarcerated, they are left with little option but to access illegal hormones smuggled into the prison. In such cases, there is no opportunity for TS/TG prisoners to receive proper follow up and medical monitoring of their hormone usage. TS/TG prisoners fear reprisal if found to be using illegal hormones, yet they are driven to hormone usage for their very survival and personal identification.

## BACKGROUND TO RECOMMENDATIONS

An HIV/AIDS policy which addresses the needs of the transsexual and transgendered prison population must encompass two issues: the prevention of new HIV infections, and the care and support for those who are already infected with HIV or have AIDS. Although both federal and Ontario correctional services are mandated to provide prisoners with standards of care comparable to those available in the community, the reality is that this is not the case with HIV/AIDS care, or the access to, or administering and monitoring of, hormones for transsexual and transgendered prisoners.

In June 1992, PASAN released the document *HIV/AIDS in Prison Systems: A Comprehensive Strategy*. This document, the first ever comprehensive report in Canada specifically addressing the issue of HIV/AIDS and prisoners, detailed 40 recommendations

toward meeting the HIV/AIDS needs of Canadian prisoners. Since the release of that document, PASAN's recommendations have been further supported in reports by CSC's own *Expert Committee on AIDS and Prison* (1994) and *HIV/AIDS in Prisons: Final Report* (1996) by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society.

Despite the continuing calls from the community-based AIDS movement in Canada, corrections both federally and provincially have responded slowly - if at all - to many of the key recommendations made in these reports. Therefore, a majority of the recommendations outlined in this document once again restate those which have been made by PASAN and others over the past six years. This fact alone demonstrates the failure of correctional services across the board to respond in a timely and comprehensive manner to HIV/AIDS issues.

The unfortunate reality is that the continuing reluctance of correctional services on the federal and provincial levels to respond to the AIDS crisis continues to affect the lives of all prisoners, placing many at risk of HIV infection, or illness or death due to HIV-related causes. While transsexual and transgendered prisoners have specific needs in HIV/AIDS services, in many cases these needs are inseparable from those of the prison population as a whole. Therefore, while many of the key recommendations herein remain essentially unchanged since PASAN's 1992 brief, many have been modified to specifically address the needs of the TS/TG prison population, and/or address changes in correctional policy and the advent of new HIV/AIDS therapies.

PASAN interviewed fifteen HIV positive male-to-female transsexual and transgendered prisoners and ex-prisoners as part of our research and consultation process in preparing this document. We agreed to maintain the confidentiality of those participating in our research in order to encourage their participation and openness. Various statements recorded during this consultation have been reproduced throughout the body of the recommendations with their permission. PASAN also made an effort to seek out individual correctional medical staff in order to document their experiences in serving the TS/TG prisoner community. Unfortunately, the health workers contacted did not feel able to participate.

The recommendations are based primarily upon the experiences of male-to-female transsexual and transgendered people in federal and provincial prisons and jails in Ontario. While PASAN believes our recommendations are significant for the Canadian prison system as a whole (particularly in the case of federal institutions), we are also aware that differing correctional, health care, and human rights legislation from province to province will impact specific policy recommendations and changes. While these differences may influence the need for/implementation of policy from province to province, PASAN believes that the findings of this report are illustrative of the HIV/AIDS service needs of male-to-female transsexual and transgendered prisoners on a national basis.

## **PREVENTING HIV/AIDS AMONG MALE-TO-FEMALE TRANSSEXUAL AND TRANSGENDERED PRISONERS**

HIV is transmitted through unsafe needle use (sharing needles through injection drug use, tattooing, body piecing) and unsafe sex. Transsexual and transgendered prisoners engage in these activities and put themselves at risk for HIV infection because they either do not know that these activities are unsafe, do not know how to engage in them safely, or are denied access to the materials necessary to engage in them safely.

PASAN believes that comprehensive education and responsive, gender positive programs are the first steps in preventing HIV infection in the transsexual and transgendered prison population.

## **Recommendations**

- 1. HIV/AIDS education should be compulsory for all TS/TG prisoners, and all staff providing services to incarcerated transsexual and transgendered persons. Staff education should emphasize not only the specific medical and social needs of the TS/TG prison population, but also anti-transphobia.**

Education for TS/TG prisoners should begin at the time of admission, at the medical unit or as part of the general orientation process. This education must be part of the intake process of all correctional facilities; provincial and federal; adult and young offender; detention centres, correctional centres, penitentiaries, youth open and closed custody facilities. During the course of their incarceration, prisoners must have access to staff trained to answer questions, provide additional information, and respond to personal HIV/AIDS issues in a competent and confidential manner.

Education for all prison staff on transsexual and transgendered issues must be seen as an integral part of raising the level and accessibility of HIV/AIDS services for TS/TG prisoners. One TS/TG prisoner interviewed for this brief noted,

Medical staff and guards are not taught anything about transgender issues. They have their own biases out of ignorance. Prison personnel are not interested or motivated in learning about us.

Comprehensive educational sessions for medical staff should be implemented which address the unique medical issues of transsexual and transgendered prisoners. These should address issues such as

- hormones and their effect on an individual's overall health
- the regular monitoring of hormones
- drug interactions between hormones, street drugs, and HIV/AIDS medications

Educational services must also be provided to prison social workers and/or case management officers to assist them in developing the professional skills to serve the unique needs of TS/TG prisoners while incarcerated, (i.e. ensuring that all requirements and documentation necessary for sex re-assignment surgery are being met in the prison system), as well as to help them access appropriate community supports upon release.

Educational services must also be implemented for all correctional officers.

**All staff education must address issues of prejudice, homophobia, and transphobia.**

Many transgendered prisoners reported their perception of a standard of care in prisons which separated prisoners into the “deserving” and the “un-deserving” of proper and compassionate care. Transgendered sex-trade workers in particular felt themselves placed into the latter category because of the presumption that they have brought their HIV infection on themselves by their choice of work.

**2. HIV/AIDS education must be comprehensive for both transsexual and transgendered prisoners, and staff.**

HIV/AIDS educational programming for TS/TG prisoners (and for staff) must address

1. Definitions of HIV and AIDS and how they differ; issues involved with living with HIV and AIDS.
2. A review of how HIV is transmitted, focusing on unprotected sexual intercourse and needle sharing for injection drugs, tattooing, and piercing.
3. How HIV is not transmitted.
4. The means of protection against HIV infection, identifying safer sex options and advocating for TS/TG prisoners access to condoms, clean needles, bleach.
5. Availability of HIV prevention tools (i.e. condoms, bleach, peer health educators) in the institution and how they can be accessed.
6. Harm reduction and safer drug use education. Availability of methadone and other drug treatment options for those wishing to access them.
7. Clarification that it is the behaviors in which a person participates, rather than the profession in which a person works (being in the sex-trade), that places someone at risk of HIV infection (risk behavior vs. risk group model).
8. Sexual assault and the risks of HIV transmission, advocating against discrimination and marginalization of TS/TG sex- trade workers in order to reduce their risk of sexual assault
9. Homophobia, heterosexism, gender phobia and oppression.
10. Testing options for those with HIV/AIDS, issues of pre- and post-test counselling, confidentiality, and informed consent.
11. Treatment options for people living with HIV/AIDS.
12. Available community resources (such as community-based AIDS service organizations and local health clinics which are gender positive).
13. TS/TG prisoners' rights and existing services while incarcerated.
14. Universal precautions, reinforcing for staff and TS/TG prisoners that if these precautions are followed by everyone, there is no need to know a person's HIV status.
15. Available educational resources such as audio tapes and pictorial materials (comics and cartoons).

In addition to group HIV/AIDS educational sessions, individual counselling should be available to prisoners and staff upon request.

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

The goal of all health education programs must be to promote and protect the health of TS/TG prisoners, and to prevent the transmission of HIV and other infectious diseases. But



transsexual and transgendered prisoners are not a homogeneous group, and the differences among TS/TG prisoners must be acknowledged in the creation of health education programs.

**4. In addition to group HIV/AIDS educational sessions, information should be made available to transsexual and transgendered prisoners individually upon entering and exiting the custody facility.**

At the beginning of incarceration, each TS/TG prisoner should be given kits at the point of entry which would include condoms, bleach kits, information about the educational topics mentioned (Recommendation 2), as well as information regarding the HIV/AIDS services which are available to them in the custody facility.

Exit kits (containing condoms, bleach, written information about HIV/AIDS, needle exchange sites and anonymous test sites and gender positive social service agencies) are recommended for distribution at the time of release. It is essential that a great deal of effort and sensitivity be put into the creation of these exit kits, and that they be geared to the specific needs of transsexual and transgendered prisoners infected or affected by HIV/AIDS.

Written material should cover the topics listed above, with added emphasis on gender friendly community resources. The kits should also include information about obtaining identification in female name, welfare, SIN and health card; options for safe and affordable housing; information about accessing HIV-knowledgeable counselling, drug use counselling and support groups. Community resource lists must be well researched to ensure that the agencies identified are accessible to, and supportive of, transsexual and transgendered individuals, and knowledgeable about TS/TG issues. Local correctional institutions should collaborate with community agencies, who will be able to provide a more complete guide to support services available to the transsexual and transgendered community.

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

HIV prevention education must be a crucial component of any comprehensive HIV/AIDS strategy for the prison system. PASAN's experience has been that such education is better received by prisoners when provided by community-based health and HIV/AIDS education workers from agencies outside of corrections, rather than by correctional staff alone. Given the frank discussions about sexuality, sexual practices, and drug use which are essential parts of HIV prevention education, it is not surprising that prisoners are often reluctant to engage openly in such exchanges with correctional staff.

HIV prevention education must be adapted to reflect the specific needs and issues of the TS/TG prisoner community. In this process, transsexual and transgendered prisoners should be considered the experts in TS/TG issues, and their input should be considered invaluable in developing HIV/AIDS educational programs. Peer education can and must be an integral part of this process, and interested transsexual and transgendered prisoners should be provided support and training to assist them in educating their peer group inside the institution.

Community-based HIV/AIDS agencies should also be invited to participate in the training of staff. Community involvement in staff training, and in particular the involvement of people living with HIV/AIDS, is essential to ensure that the programming and information remains not only current and accurate, but also directly challenges AIDS-phobia and transphobia. Similarly, federal and provincial correctional services should recognize and utilize the expertise of community-based gender positive agencies when planning any transsexual and transgendered HIV/AIDS programs.

PASAN recognizes that not all communities will have adequate community-based resources to facilitate HIV/AIDS education, particularly around TS/TG community issues. To address this reality, we recommend that provincial and federal correctional services allocate funding to subsidize the costs of community-based HIV/AIDS workers to travel to facilities in under-served areas. Such a mobile HIV/AIDS educational unit could assist in delivering consistent HIV/AIDS education to prisoners and staff in isolated areas, and could play a particularly significant role in providing education on transsexual and transgendered people and HIV/AIDS.

## **6. Condoms, dental dams, latex gloves, appropriate lubricants, and other safer sex materials must be made available to transgendered prisoners in a discreet, non-identifying manner.**

We have to ask for condoms, but most people don't. It's not safe to do so. –  
*transgendered prisoner*

Condoms prevent the sexual transmission of HIV/AIDS. Lubrication is essential for transsexual and transgendered prisoners due to their risk of tissue damage during intercourse, which may cause bleeding and place transgendered individuals at increased risk for HIV/AIDS transmission. Condoms and other safer sex materials must be distributed in such a way as not to stigmatize those individuals seeking access to them.

Although condoms have been available in the federal prison system since 1992, and the Ontario system since 1993, many prisoners still experience barriers in accessing condoms in a discreet or anonymous fashion. As a result, accessing safer sex materials often makes these prisoners the targets of hostility or ridicule, or places them under increased surveillance from staff. One transgendered prisoner noted how

You are stripped of all human dignity. If you ask for condoms, then they ask you what you are going to do with them. The guards are alerted and they bug you.

CSC's commissioner's directives are intended to apply uniformly to all federal institutions. The Ontario Ministry of Corrections' guidelines are intended to apply uniformly to all provincial institutions. However, in reality these directives and guidelines are often implemented inconsistently from institution to institution. In PASAN's experience, these inconsistencies sometimes verge on the ludicrous. *For example, one transgendered prisoner recalled how "In some institutions we are asked to return the used condom to the medical unit after use."*

The inconsistent application of correctional HIV/AIDS policies too often results in increased barriers and stigmatization for those prisoners wishing to access condoms, a patchwork availability of safer sex materials overall, and a de facto undermining of correctional policy directives at a local level. Corrections must act to ensure that their own guidelines around condoms are implemented in a uniform manner across the board.

Research by Dr. Viviane K. Namaste has also indicated that TS/TG prisoners experience delays in accessing condoms in the Quebec prison system. (Namaste, "Evaluation des besoins: Les travesti(e)s et transsexuel(le)s à l'égard de VIH/Sida". May, 1998.)

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

Sexual activity in prison is a fact of life, a fact which, through their condom distribution policies, both CSC and the Ontario Ministry of Corrections acknowledge. Still, consensual sex between prisoners remains prohibited. This means that when prisoners are having sex, they will be less likely to have safer sex because (1) the increased time necessary to practice safer sex increases the possibility of detection, and (2) as outlined in Recommendation 6, the very act of accessing condoms often draws additional, unwanted surveillance from correctional staff. In order to fight the transmission of HIV most effectively, there must be no penalties for consensual sex between prisoners.

PASAN recommends that consensual sex be allowed not only because this change will increase the effectiveness of HIV prevention, but also because we see sexuality as an integral and positive part of human nature. Transsexual and transgendered prisoners do participate in sexual activity. Prohibiting consensual sexual relations between people in prison is a violation of human rights.

The position put forward by correctional services is that sex must be prohibited in order to maintain institutional security. This argument is unsound. Sexual activity continues in prisons despite the existing prohibitions and penalties, and does not constitute a loss of order and control. In fact, the need to be furtive while engaging in sexual activity is more a source of disorder than the sex itself.

Consensual sex should be allowed for all prisoners, regardless of HIV status, and safer sex practices should be encouraged for all sexually active prisoners. **However, prisoners known to be HIV positive must not have their confidentiality breached in a misguided attempt to "protect" his/her sexual partner(s).** Rather, all prisoners must be educated on the risks associated with various sexual activities, and be provided easy and discreet access to prevention materials. Only in this way will prisoners be able to make informed choices, and be able to act to protect themselves and each other from HIV transmission.

## **8. Known sexual offenders and sexual predators must not be segregated in the same protective custody units where transsexual and transgendered prisoners are housed.**

Rapes occur at night, no condoms used. Sometimes I can prevent rape by telling the person that I have HIV and that it could be passed on to them. - *transsexual prisoner*

Transsexual and transgendered prisoners are vulnerable to sexual assault. Sexual predators should be identified and segregated from the general population. However, it is crucial that sexual predators not be segregated in the same protective custody units where TS/TG prisoners are housed.

Many transsexual and transgendered prisoners are routinely held in protective custody. Individuals charged with or convicted of sexual offenses (who are not physically safe in the general prison population) are often held in these same units. This is particularly common in jails and detention centres. This creates a situation where transsexual and transgendered prisoners, who are especially vulnerable to sexual assault, are often living on the same ranges as men with histories of sexual violence. This is clearly an unacceptable situation which must be addressed by correctional services.

In order to reduce their risk of rape in this situation, transsexual and transgendered prisoners must often find another prisoner to act as their "protector". This guarantee of "safety" is often based upon the provision of sexual services by the TS/TG prisoner to her "protector".

The HIV & AIDS Legal Clinic of Ontario (HALCO) noted that in their experience, when transsexual or transgendered prisoners find themselves in vulnerable situations with sex offenders, it is usually the TS/TG prisoner who is placed in administrative segregation instead of the perpetrator. The institutional rationale for placement in isolation is said to be for the protection of the TS/TG prisoner – a valid reason for segregation under correctional policy. However, placing the transsexual/transgendered prisoner in segregation under these circumstances does not protect TS/TG prisoners from rapists, but instead punishes TS/TG persons who fear for their safety, or who report sexual assault to prison authorities.

If sexual assault does occur the perpetrator should be prosecuted to the fullest extent of the law.

## **INJECTION DRUG USE AND HIV**

The link between drug use and transmission of HIV can be direct (through injecting with contaminated needles) or indirect (when impaired judgment leads to unplanned or unprotected sexual intercourse). PASAN therefore has advocated a multifaceted approach to dealing with drug use and the risk of HIV infection since 1992. This approach should include a needle exchange program, bleach kit distribution, education on injection drug use and hormone injection as health issues, and drug treatment options - including methadone maintenance - for prisoners wishing to access them.

A 1991 study of injection drug users by Peggy Millson of the University of Toronto found that "Over 80% had been in jail overnight or longer since beginning to inject drugs, with 25% sharing injecting equipment while in custody." (Millson, "Evaluation of a Programme to Prevent

HIV Infection in Injection Drug Users in Toronto”, 1991) Furthermore, of those who reported sharing while incarcerated, 65% admitted that this was the only situation where they had shared injection equipment. (Malkin, "The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody", 1995) Research such as this influenced PASAN's initial calls in 1992 for the implementation of comprehensive harm reduction measures in prisons. More recently, a 1998 survey of 355 prisoners at Joyceville Penitentiary conducted by Dr. Peter Ford revealed that 11.4% of the men reported sharing injection equipment while incarcerated (Ford, 1998).

In recent years, the risk of HIV infection via injection drug use has been highlighted by the epidemic rates of HIV among IDU populations in Vancouver and Montreal. This unfortunate reality increases the urgency for corrections to act in implementing comprehensive harm reduction programs, such as needle exchange and methadone maintenance. Given Canada's prohibitionist, criminalization approach to drug policy, drug users are threatened with arrest and incarceration on a daily basis. For this reason, the rising rates of HIV infection among injection drug users in the community will inevitably have an impact on the prison system as these people come into conflict with the law. This fact will increase the need for responsive HIV/AIDS treatment services to meet their needs within corrections, as well as highlighting the continuing risk of HIV transmission among incarcerated injection drug using communities.

Since the release of the first PASAN brief in 1992, the risk of HIV transmission through injection drug use has been further reinforced by the continuing rise in Hepatitis C rates among prisoners. The Ford study at Joyceville Penitentiary demonstrated Hepatitis C infection rates of 33%. These results are comparable to those found by Dr. Ford in similar studies at Joyceville and the Kingston Prison for Women in 1994. Given that Hep C is primarily transmitted via sharing needles (for injection drugs or tattooing, for example) many public health and medical professionals see Hep C infection rates as reliable indicators of high risk behaviours for HIV transmission. These figures further demand that corrections respond to this crisis by immediately implementing those harm reduction measures proven successful in the community.

## **Recommendations**

### **9. A confidential needle exchange program should be implemented.**

Drug use is a fact of life in prisons. Despite strict prohibitions and penalties for drug use, and interventions ranging from random urinalysis of prisoners to electron micro-scanning of visitors, drugs continue to be not only available, but indeed plentiful, behind prison walls. Strict prohibitions against drug use in prison have failed to reduce the use and availability of drugs, in much the same way as these policies have failed to reduce drug use in the community. They will continue to fail. Ignoring this reality creates serious public health issues for prisoners, many of whom inject drugs while incarcerated yet are denied access to harm reduction tools which would enable them to protect themselves from HIV infection.

Needle exchange programs have been essential components of successful HIV prevention programs in Canada and around the world. Yet despite the evidence gathered in communities

across Canada supporting the value of needle exchange in reducing the spread of HIV and Hepatitis C infection among IV drug users, the federal and provincial governments have continued to refuse to make these crucial programs available for prisoners.

Among transgendered prisoners, needles are also shared for injecting hormones, placing them at additional risk of HIV infection (Burrows, 1995; Jacob, 1996). The syringes needed for the proper injection of hormones are intramuscular. Therefore, corrections must also ensure access to intramuscular syringes.

Since PASAN first called for the implementation of prison needle exchange programs in 1992, our position has been widely supported by HIV/AIDS organizations, community health workers, and medical professionals across Canada. In particular, the implementation of prison needle exchange programs have been supported by

® the *Final Report of the Expert Committee on AIDS and Prison* (1994)

® the *HIV/AIDS and Prisons: Final Report* by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society (1996)

® The October 2, 1997 *Verdict of Coroner's Jury* investigating the AIDS-related death of William Bell while in federal custody in Kingston, Ontario

® Allan Kerpan, MP, Critic of the Solicitor General for the Reform Party of Canada (interview with CBC Radio, May 1998)

Since the release of PASAN's 1992 brief, successful prison needle exchange projects have been implemented in several European prisons. These experiences clearly demonstrate that such program are not only possible within prisons, but are indeed effective in reducing the sharing of needles among injection drug using prisoners while at the same time not increasing injection drug use (Jürgens, *HIV/AIDS and Prisons: Final Report*, p.54). Because prisoners at these institutions do not need to hide their syringes - as is the case now in Canada - staff at these prisons have also reported a reduction in needle stick injuries, and therefore an increase in workplace safety (Jürgens, *HIV/AIDS and Prisons: Final Report*, p.59).

#### **10. Bleach kits should be distributed in a non-identifying manner.**

Sterile injecting equipment prevents HIV transmission among drug injectors. Cleaning injecting equipment with full strength bleach has been shown to be an important harm reduction option for IDUs who cannot access sterile syringes. Therefore, full strength bleach should be made discreetly accessible to prisoners as a tool for reducing the transmission of HIV.

In September 1996, Correctional Service Canada announced the implementation of a bleach distribution project in all federal penitentiaries as a harm reduction measure. While this

was an important decision by CSC, the program has been implemented inconsistently, causing problems similar to those presented by the uneven distribution of condoms (see Recommendation 6). PASAN has received numerous reports from prisoners detailing problems ranging from chronically broken or empty bleach dispensing machines, to the distribution of diluted bleach. As with the condom distribution policies, it is imperative that CSC act to ensure consistent and full access to bleach if this program is to have its intended impact.

Despite the implementation problems, PASAN supports CSC's bleach program and urges the Ontario Ministry of Corrections (and all provincial ministries of corrections) to follow their lead. Unfortunately, the province of Ontario has historically demonstrated a firm refusal to consider any bleach distribution programs (whether inside prisons, or even to ex-prisoners leaving institutions). This refusal stems from a September 10, 1993 agreement between the Ministry and the Ontario Public Service Employees Union (OPSEU), which represents prison staff. This agreement, entitled *General Approach to Issuance of Condoms in Ontario Correctional Institutions as Agreed Between O.P.S.E.U. and the Correctional Services Division*, was obtained by PASAN through the Access to Information Act. The last of the agreement's seven points states that "The ministry does not intend to introduce bleach or needle and/or syringe exchanges within its institutions."

Why this statement against bleach and needle exchange programs is part of an agreement governing *condom distribution* in Ontario provincial prisons is unclear. Why five years later it is still being used to block the implementation in Ontario provincial prisons of harm reduction programs operating in Ontario-region federal institutions is a question which the government of Ontario must be called upon to answer. PASAN believes that both the Ministry and OPSEU have a public responsibility to move beyond this ill-considered agreement, and work in partnership with community agencies and prisoners to implement these critical public health programs.

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

Canada's prohibitionist approach to drug use (the "war on drugs") has entrenched a public prejudice against drug users. This prejudice, when combined with existing stigmatization of prisoners, creates an often difficult political environment in which to introduce controversial prison reforms such as needle exchange. These societal prejudices have also allowed some politicians and correctional staff to disguise their opposition to harm reduction and HIV prevention programs as opposition to programs which they charge "promote drug use". PASAN believes that Canadians have a commitment to the principles of universal access to health care and public health programs, and that reactionary arguments against prison harm reduction programs can and must be overcome through a process of public education highlighting the value of the programs as public health initiatives.

**12. Methadone maintenance should be made available to all TS/TG prisoners who could benefit from such programs. Methadone should be an option for all prisoners regardless of HIV status or previous participation in a methadone maintenance program.**

**Correctional services must ensure the provision of necessary staff support and training to facilitate the implementation of such a methadone program.**

Methadone maintenance programs have been proven successful as replacement treatments for opiate use, and are recognized by the College of Physicians and Surgeons of Ontario [College of Physicians and Surgeons of Ontario, et al. *Methadone Maintenance Guidelines*. August 1996]. For those who inject opiates, methadone maintenance also provides a non-injectable option for reducing the need to share injecting equipment among heroin users. For both these reasons, methadone maintenance program must be made available for all prisoners who would benefit from such programs.

At present, both CSC and the Ontario Ministry of Corrections have policies in place allowing those already on methadone programs when they enter the system to continue on the treatment. In the Ontario system, this policy is inconsistently enforced, creating situations where some institutions are permitted to cut off methadone patients from treatment when they enter the institution. This practice must be stopped, and the Ministry of Corrections must enforce their policies equally, and ensure consistent access across the province.

Given that certain prisoners are already accessing this treatment in the provincial and federal systems without incident, there is no reason that methadone access should not be expanded to include all prisoners. Because methadone programs will increase in amount and complexity of the work of correctional health staff, correctional services must ensure that staff training and support are integral components program implementation.

**13. Sterile tattooing equipment and supplies should be authorized for use in prisons.**

Tattooing is an art form in which many prisoners engage. It is also an activity which can place both the artist and the customer at risk for HIV or Hepatitis C infection.

Tattooing is an activity which can be practiced safely in prison if tattoo artists are given access to the information and materials to tattoo safely. Therefore, tattooing should be removed as a prohibitive activity in prison, and should be reclassified as a hobby craft. Prisoners should be allowed access to sterilized tattooing equipment and education on the use of such equipment.

**14. Clean equipment and supplies should be authorized for body piercing.**

Sharing needles for body piercing also creates a risk of HIV and Hepatitis C transmission. Using non-sterilized needles also increases the risks of other infections as a result of the piercing. Therefore, educational materials and clean equipment and supplies should be available to decrease the risk of HIV and Hep C infection.

**15. Community-based workers, in conjunction with custody staff, should educate transsexual and transgendered prisoners about drug use as a health issue.**



An educational component about drug use from a harm reduction perspective is an essential part of the health care model we are proposing. Such a program should be developed by an appropriate pool of community resources in conjunction with custody staff.

**16. Treatment programs for TS/TG prisoners with drug use issues should be developed and accessible.**

Outside resources and services should be available for those prisoners wishing to access drug treatment. However, care must be taken to ensure that treatment facilities free of gender phobia are available for transsexual and transgendered prisoners wishing to access such programs.

## **MEDICAL AND SUPPORT SERVICES FOR TRANSSEXUAL AND TRANSGENDERED PRISONERS LIVING WITH HIV/AIDS**

There are HIV specialists who must be aware of the disease, but they display no sensitivity. They don't give a damn about us. - *transgendered ex-prisoner*

Depression and suicidal thoughts end us up in seclusion. Why would we ask for help when it is not accessible to us? - *transgendered ex-prisoner*

Our health care needs are not getting met. If I insist I will get thrown into the hole. We must know how to play the game to get our health care needs met. We need to know how to manipulate the system. - *transgendered prisoner*

Transsexual and transgendered prisoners are a marginalized group within the prison system - marginalized by the prison population, and by prison staff. For male-to-female TS/TG prisoners living with HIV/AIDS, this marginalization creates additional barriers to accessing health care services.

While incarcerated, transsexual and transgendered prisoners must access a health care system which many described as indifferent, or sometimes even hostile, to their unique needs. In providing TS/TG prisoners with appropriate health care, it is therefore necessary to consider and address the specific barriers they face when trying to access optimal health care. Correctional health care providers must be given the resources and training to enable them to support the unique medical, hormonal, and psycho-social needs of transsexual and transgendered prisoners.

### **Recommendations**

**17. HIV/AIDS medications must be administered at the appropriate times, and in conjunction with the appropriate diets, to ensure the maximum benefit from the therapies.**

New and emerging drug therapies such as protease inhibitor combinations (“drug cocktails”) are offering new hope to many people living with HIV/AIDS. At the same time, these new therapies are creating new challenges to the ability of the provincial and federal prison systems to provide a proper standard of care to people living with HIV/AIDS.

The new drug cocktails - combinations of three or more medications (i.e., AZT, 3TC, and protease inhibitors) must be administered in a very rigorous and consistent manner in order for them to be effective. Proper administering of drug cocktails require precise timing of dosages in combination with specific dietary requirements to facilitate the body’s absorption of the medications. If these requirements are not met, the effectiveness of the drug therapies are significantly reduced. More importantly, improper administering of the cocktails, or missed dosages, can in fact lead to the development of drug resistance in people living with HIV/AIDS, thereby eliminating the effectiveness of that drug therapy completely. For this reason, correctional health services must be vigorous in ensuring the proper administering of all new HIV therapies. If not, their standard of care falls dangerous below community standards, which will ultimately have a severe impact on the health and life expectancy of prisoners living with HIV/AIDS.

To help ensure that the proper drug protocols are followed, correctional services must work to

® eliminate delays (sometimes amounting to days) in accessing medications when a prisoner is first arrested and incarcerated in a detention centre.

If a person is arrested on a weekend, and tells the health unit that s/he is on a specific combination therapy, that therapy must be continued despite the inevitable delay in verifying the prescription with the person’s outside physician. While correctional systems often accuse prisoners of “lying” about medications in order to access them, the dangers of interrupting a person’s HIV therapy for two or three days is far more dangerous than mistakenly starting a person on them for that same period of time. Given the serious consequences of missing doses of the drug cocktails, common sense must be incorporated into correctional policies and procedures regarding these new HIV therapies.

® eliminate missed dosages when prisoners are taken to court, which must include consideration of allowing prisoners living with HIV/AIDS to take their medications to court with them.

® ensure that prisoners living with HIV/AIDS receive diets and mealtimes which meet the instructions for their medications (see Recommendation 22)

® revise nurses’ drug dispensing schedules which conflict with the proper prescribed timing of dosages. The reality of new HIV therapies demands that prison health units change old routines and schedules where those routines impede proper administering of medical care.

® ensure that when prisoners living with HIV/AIDS are transferred from one institution to another, that their medications are transferred with them.

® coordinate continuation of therapies for prisoners living with HIV/AIDS upon release.

This must mean scheduling an appointment with an outside doctor to coincide with their release date, and providing the individual with sufficient medications to bridge the gap (often amounting to many days) between their release date and their doctor's appointment.

® ensure that all medications are distributed to prisoners in a discreet, non-identifying manner.

Many transsexual and transgendered prisoners indicated that their confidentiality is often breached when their HIV medication or supplement drinks are given to them in front of their peers who are not HIV positive.

® ensure that correctional health care staff are provided proper, ongoing training on new and emerging HIV therapies and their monitoring, as well as sufficient resources and staff to properly meet their responsibilities as medical professionals.

**18. Hormones should be given to all transsexual and transgendered prisoners who have used them in the community, regardless of HIV status. Hormone access should not be contingent solely upon the approval of Gender Identity Clinics or specific doctors approved by these clinics. Hormone usage should be monitored closely by health professionals who understand the effects of hormones on the endocrinological system.**

Why be concerned about my health if I can't get my hormones. Identity is fundamental. The transgendered prison population's needs are not being considered by medical staff. They assume that our life-style is a choice, but it isn't. - *transgendered ex-prisoner*

The medical staff know nothing about medication and hormones. Hormones are who I am and HIV [medications] keep me alive - both are just as important. - *transsexual ex-prisoner*

Hormones should be made available to all transsexual and transgendered prisoners who have used hormones in the community before their incarceration. Regular screening procedures and blood work should be done every three months by medical staff trained to monitor the effects of the hormones and prevent serious side effects.

In order to prevent serious health concerns, it is necessary that correctional medical staff be trained to recognize and meet the complex medical needs of TS/TG prisoners using hormone replacement therapy. For example, in the short term (6 months), transsexual and transgendered prisoners may experience vomiting, nausea, headaches, and depressive mood changes (Asscheman, Mortality and Morbidity in Transsexual Patients with Cross-Gender Hormone Treatment, 1997). Following the initial 6 month period, it is imperative that the TS/TG prisoner's

health status be monitored to prevent breast cancer, stroke, blood clotting, coronary heart disease, increased cholesterol, intense bruising and liver disease (Asscheman, 1997).

Transsexual and transgendered prisoners have reported to PASAN that some prison facilities have denied them access to hormones unless the prisoner is connected with Gender Identity Clinics such as that at the Clarke Institute of Psychiatry (in Ontario). At other prison facilities, transsexual and transgendered prisoners have reported having their hormone dosage decreased from three times a day to once a day. Others have complained about a lack of follow-up regarding their requests to have their hormones increased, even after the medical staff have received their blood results.

**19. Transsexual and transgendered prisoners living with HIV/AIDS must be guaranteed access to medical and dental workers of their choice. In particular, they must have access to experienced and expert HIV primary care physicians and endocrinologists, who are gender positive and aware of the health care needs of transsexual and transgendered people.**

Universal access to health care is a fundamental right of all Canadians. Correctional services on both the federal and provincial levels are mandated to provide a quality of care comparable to that available in the community. Given the unique health needs of transsexual and transgendered prisoners living with HIV/AIDS, medical staff must be available who are knowledgeable in both the areas of HIV treatment and hormone therapy. Transsexual and transgendered prisoners should have the opportunity to access the psychiatric or psychological services of a clinician who is an expert in dealing with the transgendered experience.

**20. The services of community-based workers serving the transsexual and transgendered community and/or persons living with HIV/AIDS must be made available to all TS/TG prisoners who desire them. Within federal penitentiaries, CSC staff must facilitate the placing of community-based organizations on the general access phone lists available for all prisoners to call.**

Medical and psycho-social support services should be available to all HIV-positive TS/TG prisoners. These services need to be coordinated and integrated with community-based services on the “outside” so that follow-up can be continued after release.

PASAN's experience is that many community-based HIV/AIDS workers take an active and constructive role in meeting the needs of transsexual and transgendered prisoners by considering their HIV status to be a top priority. Given the availability of such community supports, the proper monitoring of HIV medications and/or hormone therapy, the provision of up-to-date health information, and the accessibility tools to promote their health, TS/TG prisoners living with HIV/AIDS are able to identify and take care of their own needs.

**21. All transsexual and transgendered prisoners living with HIV/AIDS should have access to alternative therapies and non-approved treatments.**

It has become standard practice that the care for people living with HIV/AIDS on the “outside” includes access to alternative therapies and non-approved treatments. These options must also be available to the transsexual and transgendered prison population. This means that they must have access to information about such therapies and medications. Contacts with community-based groups such as the Community AIDS Treatment Information Exchange (CATIE) must be facilitated. Within federal penitentiaries, CSC staff must facilitate the placing of community-based organizations such as CATIE on the general access phone lists available for all prisoners to call.

**22. The special dietary needs of TS/TG prisoners living with HIV/AIDS must be met. Prison systems must ensure that - in those instances where diet and mealtime are integral components of a therapy’s effectiveness - that the proper provision of dietary services is addressed as a medical concern rather than a kitchen issue.**

Nutrition is fundamental to the health and well-being of a person living with HIV/AIDS. Prison food is often high in calories and fat. Transsexual and transgendered prisoners living with HIV/AIDS who wish to eat more healthy and nutritious diets should be assisted in doing so. Vitamins and diet supplements (i.e., Ensure or Boost drinks) should be made available on a regular and continuing basis. CSC must end its policy of making prisoners living with HIV/AIDS purchase vitamins through canteen, and instead make them available through the health unit.

Prison meals are usually served at designated times only. Thus, if a transsexual or transgendered prisoner does not have an appetite, or if they are away from the prison at meal time, they should not be made to wait until the next meal time in order to eat. In some institutions keeping food in one's cell is an offense, and many prisons make no provisions for alternative eating times. As people living with HIV/AIDS often have suppressed or erratic appetites, prisoners living with HIV/AIDS must have food available to them when they are hungry.

As outlined in Recommendation 18, diet and mealtimes are often integral components to the effectiveness of new HIV drug therapies. Because current prison schedules often do not meet these requirements, the health of prisoners living with HIV/AIDS is compromised. The reality of new HIV therapies demands that prisons adapt old routines and schedules where those routines impede proper administering of medical care.

Correctional services both provincially and federally must address this issue as a key priority in providing proper HIV/AIDS care to prisoners.

**23. The comfort needs of transsexual and transgendered prisoners living with HIV/AIDS (e.g. extra clothing or blankets, single cells, bras) must be met.**

Transsexual and transgendered prisoners living with HIV/AIDS must be provided with warm cells, sufficient clothing, and adequate bedding. One transgendered prisoner interviewed reported waiting two weeks for extra clothing, and living without socks for that period of time. This type of situation is clearly unacceptable, and can and should be easily remedied by correctional services.

The privacy of TS/TG prisoners must be respected. Given the vulnerability of immune-compromised persons to illnesses others would easily fight off, prisoners living with HIV/AIDS must be prioritized for single occupancy cells.

Transsexual and transgendered prisoners who have undergone hormone therapy and/or breast augmentation surgery must be provided easy access to bras.

**24. A pain management program should be put in place to assist with the control of the pain which often accompanies HIV/AIDS related illnesses and hormone replacement therapy.**

Pain management is another issue which challenges the conventional thinking of correctional services. Pain management medications are, by definition, narcotics. The fact that many prisoners living with HIV/AIDS have histories of drug use, combined with the prison system's zero tolerance approach towards drugs, create a situation where prison health care staff are often reluctant, or forbidden, to provide adequate levels of pain management medication. This is a serious issue for all prisoners living with HIV/AIDS.

People living with HIV/AIDS often live with chronic pain as a daily part of life. Often this pain is neurological, meaning there are few if any outward symptoms or physical manifestations to "prove" that the pain exists. Because of this, prison physicians who are unfamiliar with HIV/AIDS and/or possess negative stereotypes about drug users and are often reluctant to implement a sufficient pain management program, or are reluctant to provide it in the dosages necessary. This situation can be further complicated by the fact that drug users often have developed high levels of resistance or tolerance to the effects of narcotics, which means that a "standard" dose of a pain killer for a non-drug user can easily have no effect on a drug user. This also contributes to some physicians' unwillingness to prescribe sufficient pain management.

People living with HIV/AIDS who are accessing pain medication in the community often find their medication cut off or severely reduced upon incarceration. For those prisoners, this creates an often unbearable situation of both increased pain from HIV disease, and pain from withdrawal from their medication. Transsexual and transgendered prisoners living with HIV/AIDS, who may also be balancing the effects of hormones on the body, can suffer further discomfort which could be relieved by a well administered pain management program.

Prison administrators and staff often justify their practices by asserting that prisoners accessing narcotic medications are prone to trade or sell them to other prisoners, or that weaker prisoners (TS/TG are often assumed to be in this category) are vulnerable to having their medications stolen ("muscle") by stronger prisoners. PASAN believes that these concerns can

be alleviated through creative approaches to administering pain management (i.e. liquid forms rather than pills, crushing and diluting pills, etc.). In any case, the concerns about illegitimate use of the medications does not warrant their denial to people living with HIV/AIDS who need them.

Provincial and federal prison systems must re-think their current policies and practices regarding the provision of pain management medication. PASAN recommends

® that all prisoners living with HIV/AIDS entering prison on pain management have their normal dosage continued, and any change in dosage only be made in consultation with the prescribing (“outside”) physician.

® that prison physicians and nurses receive education on the management of HIV/AIDS related chronic pain.

® that prison physicians and nurses receive education on pain management for drug users.

® that no prisoner living with HIV/AIDS have his/her pain management denied them on the mere “suspicion” of trading them or giving them away.

If prison staff believe this to be happening, it is their responsibility to follow basic principles of due process and provide evidence substantiating their allegations before imposing sanctions. Unless the prison is able to prove their allegation, they have no right to deny prisoners living with HIV/AIDS access to legitimate prescription medications.

**25. Careful attention must be given to evaluating the degree to which the clinical drugs (for HIV/AIDS), and biochemical drugs (for hormone replacement therapy) interact and affect the progression of HIV/AIDS.**

As outlined above, transsexual and transgendered prisoners living with HIV/AIDS can often be using a variety of HIV therapies, pain management medication, hormones, and perhaps street drugs, all at the same time. This combination of drug use, hormone therapy, and HIV/AIDS related therapeutic interventions can have an impact on the TS/TG prisoner’s well-being. In order to provide the TS/TG prisoner with proper standards of care, it is necessary that the medical staff consider the effects of the interactions that drugs, hormones and HIV/AIDS medication have on their transsexual and transgendered patients. Risks and side effects must be clearly articulated to the transsexual and transgendered prisoners, who can then make informed decisions as to how they want to be treated for their health care issues.

In order to provide optimum care for these prisoners, it is important to understand the subtle interactions of these medications, and the effects of these interactions on individual prisoners. Therefore, TS/TG prisoners living with HIV/AIDS need to have access to a variety of specialized medical professionals including immunologists, endocrinologists, gynecologists, and neurologists. Correctional services should dialogue with these professionals to investigate and

monitor the effects of drug interactions on individual transsexual and transgendered prisoners living with HIV/AIDS.

**26. Special programs must be established for transsexual and transgendered prisoners living with HIV/AIDS who are suffering from AIDS-related illnesses and who are ineligible for medical parole/probation. Standards for palliative care must be consistent with the community standards set out by the Canadian Palliative Care Association.**

People living with HIV/AIDS are often in need of practical assistance, but are not sick enough to require hospitalization. PASAN recommends that most transsexual and transgendered prisoners with HIV/AIDS be considered for medical parole/probation so that they can have access to the various levels of support available in the community. The needs of TS/TG prisoners who are awaiting medical parole/probation must be met both medically and emotionally. A special area should be available where transsexual and transgendered prisoners with medical needs can access the support they require (such as help with bathing and meals etc.). Participation in such a program must be voluntary.

We recognize that when the medical needs of transsexual and transgendered prisoners with HIV/AIDS become more demanding, it can be difficult to provide necessary services without compromising the TS/TG prisoner's confidentiality. However, we believe this difficulty can be reduced or avoided if support services are provided in consultation with each individual TS/TG prisoner, and on the basis of the patient's individual medical needs. If workers need to know medical information, it should be released only with the consent of the prisoner. Workers should then be required to keep any such information confidential.

PASAN does not believe any prisoner should die from HIV/AIDS while incarcerated. We believe that compassionate release must always be seen as the first and best option for all prisoners living with HIV/AIDS, especially those whose health is in serious decline (see Recommendation 29). Still, in those cases where compassionate release is delayed or denied, both CSC and the Ontario Ministry of Corrections have a responsibility to ensure that their standards of palliative care meet that of the community. The current community standard is outlined by the Canadian Palliative Care Association (CPCA) in their document, Towards Standardized Principles of Practice.

In October 1997, CSC was instructed to raise their palliative care practices to meet those of the CPCA by the jury of the Coroner's Inquest investigating the AIDS-related death of William Bell while in federal custody in Kingston, Ontario (*Verdict of Coroner's Jury*, Frontenac County, October 2, 1997).

## **HUMAN RIGHTS, COMPASSIONATE RELEASE, AND CONFIDENTIALITY**

In my experience, I was put in the hole for disrespecting the guards, who belittled me by saying that I didn't pass [looking like the opposite gender] anyway, and then they told me that I had to be co-operative or they would get rid



of me....They believe that we are HIV carriers, we get labeled as having HIV and we are put in the hole. - *transsexual ex-prisoner*

When I entered the prison I was mocked for being transgendered. I was called a chick with a dick and was then thrown into the hole until my breasts, which were enlarged through hormone usage, went down. - *transgendered ex-prisoner*

Unfortunately, discrimination against people living with HIV/AIDS is a fact of life in Canada. This is true in our society, and it is true in the prison system. In Canadian prisons, societal AIDS-phobia is often exacerbated by anti-prisoner and anti-drug user prejudices, as well as racism, sexism, transphobia, and homophobia. For the transsexual or transgendered prisoner living with HIV/AIDS, they often find themselves even further marginalized by virtue of their gender (see Transphobia, p.12). In this atmosphere, anti-discrimination laws and human rights protections become even more crucial.

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

Discrimination against prisoners living with HIV/AIDS takes several forms. Crown attorneys have been known to increase the severity of charges in assault cases where the accused is known to be living with HIV/AIDS, whether or not the incident posed any risk of HIV transmission. Judges sometimes view a person's HIV-positive status as a reason to incarcerate them, or to lengthen their prison terms. Parole boards often view an incarcerated person's HIV positive status as a potential "risk" to the community-at-large, which can lead to denials of parole applications based upon discriminatory assumptions. Given that a sentence for someone with a life-threatening illness is qualitatively harsher than the same sentence given to a healthy person, PASAN continues to advocate for the development of an effective and accessible compassionate release program for HIV-positive prisoners.

While incarcerated, many people living with HIV/AIDS have their health status circulated among both staff and prisoners. An HIV-positive status is sometimes viewed as sufficient reason for the involuntary isolation of a prisoner. By being denied the right to keep their health status private, a prisoner living with HIV/AIDS is often also denied the supportive environment (insofar as this is possible inside prisons) she or he requires to maintain her or his health.

## **Recommendations**

**27. No male staff has the right to search female transsexual or transgendered prisoners. Only female staff should be allowed to do searches.**

Many transsexual and transgendered prisoners feel degraded and vulnerable while being searched by men. Some prisoners recounted incidents of ridicule and discrimination as a result

of being pat-searched by male guards. Therefore, searches of TS/TG prisoners should only be conducted by female correctional officers.

**28. Sentencing guidelines for judges and prosecutors regarding transsexual and transgendered prisoners living with HIV/AIDS need to be developed.**

Prostitution is not illegal in Canada. The government needs to review its policies on prostitution and allow communicating for the purpose of prostitution to be decriminalized so that transsexual and transgendered prostitutes would no longer be sentenced to prison for the services that they provide. Because of these laws, many prostitutes go in and out of jail for short stays, and as a result suffer disruptions in their medical care and medication schedule.

**29. A compassionate release and/or medical parole/probation program should be implemented for transsexual and transgendered prisoners living with HIV/AIDS in a timely fashion.**

The failure of correctional services on the federal and provincial levels to institute an effective, accessible, and accountable compassionate release process continues to lead to the deaths in custody of people living with HIV/AIDS. This must be addressed and changed.

At the 1997 Coroner's Inquest into the AIDS-related death of William Bell in federal custody, PASAN and the HIV & AIDS Legal Clinic of Ontario (HALCO) submitted recommendations towards implementing a system of compassionate release which would meet the needs of the community, the correctional system, and prisoners living with HIV/AIDS.

PASAN and HALCO recommended

® the development of clear eligibility criteria detailing who is and is not eligible for applying for compassionate release.

® the development of clear application and appeals processes.

® the education of prison medical, social work, and administrative staff on this new process so that they may better facilitate compassionate release applications.

® that decision-making on compassionate release applications be taken out of the hands of the National Parole Board (NPB), whose mandate is to consider issues of security alone rather than weigh the often multiple, complex issues surrounding compassionate release. Instead, a tribunal consisting of representation from NPB, medical specialists, and the community should be struck specifically to consider all compassionate release applications (not only those dealing with HIV/AIDS).

**30. HIV-related information in the possession of medical providers should be released to custody authorities only under extraordinary circumstances and only with the consent of the TS/TG prisoner.**

Staff must be trained to protect the privacy of prisoners' medical information. This is particularly important for transsexual and transgendered prisoners, who already stand out from the rest of the male prison population. Rules prohibiting the release of HIV-related information must be strictly enforced. A TS/TG prisoner living with HIV/AIDS should be consulted and his or her consent must be obtained before medical information is given to custody authorities, support workers, or prison guards.

**31. The confidentiality of transsexual and transgendered prisoners' HIV status must be respected. Staff members who break the confidentiality of TS/TG prisoners should be disciplined and/or terminated.**

Prison administrators and staff should not have access to the HIV-antibody status of transsexual and transgendered prisoners unless absolutely necessary, and with consent of the individual prisoner. When this information is shared outside of the medical unit, it must be held in strictest confidence by the staff. Professional codes of conduct regarding the protection of medical information must be expected of all prison employees, not simply the medical staff. All prison staff - whether guards, administrators, or other workers - have the responsibility to conduct themselves in a professional manner in this regard. This policy, and the penalties for breaking it, must be made widely known amongst all prisoners and staff. Breaches of confidentiality, even between correctional staff, must be met with disciplinary measures.

**32. The distribution of medications, special diets, and nutrient drinks should not require a breach of confidentiality of transsexual and transgendered prisoners living with HIV/AIDS.**

Non-medical prison staff should not have any knowledge of the medications or nutritional supplements given to transgendered prisoners. This means that non-medical prison staff should not be distributing medication. If medical staff alone are unable to distribute medications and nutritional supplements, we recommend that prisoners be allowed to keep such supplies in their own private lockers. This would help ensure the TS/TG prisoner's confidentiality and privacy.

**33. Transsexual and transgendered prisoners who want access to supportive counselling, medical treatment, etc. must be guaranteed that their confidentiality will be respected.**

The medical staff dealt with all of my examinations while wearing a rubber glove, which centered me out, as he did not do the same with everyone. I was degraded and they saw me as a sick, dying hookers with AIDS. This treatment effected my self-esteem and it drove me to the edge. I almost had a breakdown.  
- *transgendered ex-prisoner*

Requests for access to counselling, medical treatment and other services should be made through medical or social work staff, or through outside resources. Other staff do not need to know the reason for a prisoner's appointment with a worker from an outside agency, nor should they be present at or observe the meeting.

If a TS/TG prisoner is escorted outside the institution to access specialized HIV/AIDS treatment at a hospital or clinic, advance arrangements should be made so that the examination can happen in a secure room (i.e. one entrance, no windows). Guards should not be allowed inside the examination room during any examination or consultation. This is an intrusion on the doctor/patient relationship, creating an unnecessary breach of confidentiality. Correctional services must end the degrading and humiliating practice of keeping prisoners handcuffed and shackled during medical examinations.

**34. All transsexual and transgendered prisoners should have the right to privacy due to their status as females in male prisons.**

Because I've been around [done a lot of prison time], no one jumps into the shower with me. Other girls are given no choice but to shower with all the men. If a girl protests she is thrown in the hole. They ask us what our problem is because we have a dick, too. - *transsexual ex-prisoner*

Genital status is the overwhelming factor in determining placement of male-to-female TS/TG persons in male prisons, even though they identify as females (Peterson, "Transsexuals within the Prison System", 1996). In order to preserve the dignity of those individuals who identify as females, and who may have undergone hormone therapy and/or breast augmentation surgery, these prisoners should be afforded privacy while showering. Café/"dutch" doors (which are open at the top and bottom) should be installed on all shower openings to permit the act of showering to be a more humane and discreet experience for transsexual and transgendered prisoners (also cited in Namaste, *Evaluation des besoins: Les travesti(e)s et transsexuel(le)s a l'égard due VIH/Sida*, 1998.)

**35. Transsexual and transgendered prisoners have the right to live in an environment in which they feel safe and are not harassed because of their gender.**

Anti-harassment and anti-discrimination policies should be in place to protect the rights of transsexual and transgendered prisoners. In-depth anti-harassment and anti-discrimination training must form part of all staff education, and prisoner orientation. Prisoners must be made aware of all such policies, and how they can file complaints if they are subject to harassment or discrimination.

**36. Transsexual and transgendered prisoners living with HIV/AIDS should not be involuntarily isolated or segregated.**

In some cases testing is only done in order to protect the staff and guards from the disease that one of the transgendered prisoners is carrying. They often use segregation as a means of protection for themselves. - *transgendered ex-prisoner*

Involuntary isolation or segregation of transgendered prisoners (regardless of HIV status) is not justifiable nor in the best interest of that person or the general population. However, segregation of transsexual and transgendered prisoners is an all-too-frequent reality.

Clear policies should be implemented to eliminate unwarranted isolation or segregation of TS/TG prisoners. The reasons given for the punishment of isolation vary, but they share common themes. The prisoner somehow jeopardizes the “good order of the institution”, either because of HIV infection, or because assumptions about the TS/TG prisoner’s behavior (when coupled with the knowledge that s/he is HIV positive) is deemed to be a threat to either staff or other prisoners.

Sometimes it is thought by institutional authorities that segregation, if not isolation, is in the best interest of the transsexual or transgendered person living with HIV/AIDS, who may otherwise be subjected to threats of violence by staff or other prisoners (see Recommendation 8). Because prison authorities often assume TS/TG prisoners are smuggling drugs into the institution (“hooping”), they are often segregated for long periods of time in the hope that the drugs will surface. PASAN's experience reveals that some TS/TG prisoners are immediately placed in segregation for up to a month upon entering the prison system. This segregation often occurs immediately after arrest, and not because of any institutional charges or infractions on the part of the prisoner.

Isolation can cause depression and anxiety within the segregated prisoner, leading to the type of stress which suppresses the immune system. This can hasten the onset of illness for the transsexual or transgendered person living with HIV/AIDS. The involuntary isolation of transsexual and transgendered prisoners can further create a false sense of security among other prisoners and staff (i.e. now that infectious people are removed from their environment, they need not practice safe sex, nor take safer needle precautions). This can jeopardize the success of HIV prevention education among the prisoners and staff.

## **Anonymous HIV Antibody Testing**

Since PASAN first recommended the provision of anonymous HIV antibody testing to prisoners in 1992, our position has been supported in reports by the Expert Committee on AIDS and Prison (1994) and the Canadian HIV/AIDS Legal Network/Canadian AIDS Society (1996). Correctional Service Canada itself made unfulfilled promises in March 1994 and December 1997 to pilot test anonymous testing projects. Despite the findings of various reports, and CSC’s own public commitments, prisoners in both the federal and Ontario systems have no access to anonymous HIV testing.

## **Recommendations**

### **37. HIV - antibody testing of transsexual and transgendered prisoners must be done voluntarily and anonymously.**

Sometimes girls ask for [testing], they [medical staff] say no because they do not want to waste the taxpayer's money. In some cases testing is only done in order to protect the staff and guards from the disease that one of the transgendered prisoners is carrying. - *transsexual ex-prisoner*

Upon entering the prison, all prisoners should be made aware that HIV anti-body testing is available at their request. Prisoners should be educated about high risk behaviours, symptoms of HIV infection, and available treatment options so that they may make informed decisions about whether or not to get tested. All testing should be voluntary with expressed consent from the prisoner. Proper post-test counselling is absolutely necessary for all who test. Post-test counselling should discuss the meaning of the test result (whether positive or negative), possible sources of error, and ways to make behaviour changes concerning health (i.e. safer sexual practices, safer drug use). Proper counselling regarding precautions (e.g. the use of condoms, bleach to clean injection equipment) and the availability of necessary preventative materials will have an impact on transmissions both within the custody facility and “outside” when the transsexual and transgendered prisoners are released.

### **38. Testing should be carried out by “outside” community-based agencies.**

Transsexual and transgendered prisoners often have little faith in the ability of correctional services to protect the confidentiality of their medical information. This lack of confidence has a chilling effect on prisoners' willingness to access HIV testing through prison health units. For this reason, PASAN recommends that all prisoners have access to HIV testing conducted by “outside” health care agencies. We believe that the availability of such an option would encourage prisoners to seek HIV testing, thereby increasing the overall number of prisoners being tested and allowing for earlier access to specialized health care for those testing HIV positive. The numbers of prisoners (70% or more) at both Kingston Prison for Women (1994), and Joyceville Penitentiary (1994, 1998) who accessed anonymous testing as part of seroprevalence studies by Dr. Peter Ford of Kingston General Hospital would appear to confirm PASAN's conclusion that prisoners will choose to be tested for HIV infection if afforded an anonymous, non-correctional option.

In the city of Prince Albert, Saskatchewan, the local community STD Clinic has been offering anonymous testing services to prisoners at Price Albert and Pine Grove Correctional Centres since 1994. This service is provided on a weekly basis at each institution, and includes both pre and post test counselling for those prisoners requesting to be tested anonymously. This experience clearly demonstrates that such a partnership between correctional health units and community anonymous testing sites is both viable and effective. PASAN has often encountered anonymous testing agencies or public health units who are willing to provide anonymous testing to prisoners incarcerated in their regions. PASAN would recommend that correctional services

seek out such community health agencies on a region by region basis and facilitate their provision of anonymous testing services in local institutions.

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

When transsexual and transgendered prisoners know their HIV status, they are better able to make decisions regarding possible medical interventions to prevent and/or delay the onset of serious illness. Prisoners are more likely to choose to be tested if they know they have treatment options should they test HIV positive.

## **AFTERCARE**

This brief has recommended that numerous gender positive services, supports, and treatments be available in custody settings for the transsexual and transgendered prison population. Currently, many of these services are only offered outside of custody. In order to ensure the success of government efforts to provide such services and care, mechanisms must be implemented to ensure that these programs continue upon the release of TS/TG prisoners. It is essential that correctional services both federally and provincially provide the links necessary to facilitate a continuation of care and support for the transsexual and transgendered prison population who are released into the community. These links must not be limited solely to Gender Identity Clinics, or professionals approved by G.I.C.s, but also include community-based agencies who have credibility and experience working with street involved transsexual and transgendered people, with sex trade workers, and with ex-prisoners.

### **Recommendations**

**40. Parole officers, probation officers, discharge planners, workers in group homes and halfway houses, and other aftercare workers must be educated about HIV/AIDS and TS/TG issues.**

Aftercare workers should be provided with mandatory and comprehensive education on HIV/AIDS and transsexual and transgendered issues. Community resources should be accessible for TS/TG ex-prisoners, and these resources should meet the special needs of transsexual and transgendered people living with HIV/AIDS.

**41. Exit kits with HIV/AIDS information, contacts with gender positive community-based organizations, condoms, bleach kits, etc. must be made available to TS/TG prisoners when they are released from custody facilities.**

See Recommendation 4 for details

**42. Programs providing continuity of care after release must be established for the transsexual and transgendered prison population.**

It is PASAN's experience that many prisoners living with HIV/AIDS first seek medical and community supports for their illness during incarceration. Therefore, transsexual and transgendered prisoners living with HIV/AIDS who receive health care during their incarceration should be supported in continuing to access care after release. To maintain continuity of care during the transition from prison to community, every TS/TG person living with HIV/AIDS should be assisted in finding medical care and support services in the community. This should include arranging a doctor's appointment upon the person's release, providing sufficient HIV medication to bridge the period between release and the doctor's appointment (see Recommendation 17), and assisting the TS/TG prisoner in registering with gender positive services.

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

In order to facilitate the continuity of HIV/AIDS programs in the transition from incarceration to community, federal and provincial correctional services should consult with gender positive community groups and agencies which provide service and education to transsexual and transgendered people living with HIV/AIDS. These agencies and groups must be allowed to access correctional institutions to provide services so that a relationship can be established between the TS/TG prisoners and community resources prior to release.

**44. The federal and provincial correctional services should work with community-based gender positive HIV/AIDS housing programs and service organizations to ensure that they meet the needs of transsexual and transgendered ex-prisoners.**

Community-based housing programs (i.e. McEwan House, Fife House, and Casey House in Toronto) and service organizations should be supported in adapting their services to the needs of recently released transsexual and transgendered ex-prisoners living with HIV/AIDS. Discharge planners, correctional social workers, and case management officers must be educated on the availability of, and programs offered by, HIV/AIDS supportive housing in their regions. The National Parole Board must be similarly educated on the benefits offered by community-based HIV/AIDS supportive housing so that they can fairly and accurately assess the parole plans of transsexual and transgendered prisoners living with HIV/AIDS.



## BIBLIOGRAPHY

- AIDS Committee of London. Safety in Body Art - Tattooing, Body Piercing and HIV/AIDS. Counterpoint Needle Exchange, 1996.
- AIDS Education Global Information System (AEGIS). "Stella H: Addressing Sex Workers' Risk for HIV/AIDS in Context" presented at the *XI International Conference AIDS* [11(2):352, abstract no. Th.C. 4640, July 1996]
- American Educational Gender Information Service, Inc. (IFGE). Watch Your Language. Decatur, Georgia, 1995.
- Archibald, C. "HIV/AIDS In Prisons: Recommendations For Prevention and Surveillance Research" in Canadian AIDS News. (Vol. IX, no. 4. 1996)
- Asscheman, H. Mortality and Morbidity in Transsexual Patients with Cross-Gender Hormone Treatment. [[Http://www.sissify.com/realgirl/mortality.html](http://www.sissify.com/realgirl/mortality.html)], 1997.
- Bennett, M." An Ethnographic Study of HIV-Infected Male-to-Female Transgendered Clients" presented at *XI International Conference on AIDS*, Vancouver. 11(1): 421 (abstract no.Tu.D.2954). July 7-12, 1996
- Brady D. "Discrimination: Transgendered People, Discrimination and HIV/AIDS" in Canadian HIV/AIDS Policy and Law Newsletter. (Vol. 2, No. 3, 1996).
- Brown, "Endocrine Complications of AIDS and Drug Addiction" in Endocrinology and Metabolism Clinics of North America. (Vol. 20, No. 3, 1991).
- Burrows, D. "Update on Needle and Syringe Exchange in Swiss Prisons" in Canadian HIV/AIDS Policy & Law Newsletter. (Vol. 1, No. 4, 1995).
- College of Physicians and Surgeons of Ontario, et al. Methadone Maintenance Guidelines. August 1996.
- Correctional Service Canada. The Commissioners Directive on Health Services. 1997.
- Cox, S "Party At Your Own Risk - Will Mixing Recreational Drugs and your HIV Medication Kill You?" in Positively Aware, Victorian AIDS Council/Gay Men's Health Centre, Australia. (May/June 1997).
- Denenberg, R. "Women, Immunity, & Sex Hormones - AIDS Education Global Information System" in The Gay Men's Health Crisis Newsletter of Experimental AIDS Therapies. (Vol.6, No. 7, summer/fall 1992)
- Findlay, B. Finding Our Place: "Transgendered Law Reform Project". The Law Foundation

- of British Columbia. 1996.
- Fisher, J, et al. Gay and Lesbian Issues and HIV/AIDS: Final Report. Canadian HIV/AIDS Legal Network and the Canadian AIDS Society. 1998
- Ford, Dr. Peter. Report of Joyceville/Pittsburgh Study of HIV and Hepatitis C Seroprevalence. Queen's University Study Group. 1998.  
*General Approach to Issuance of Condoms in Ontario Correctional Institutions as Agreed Between O.P.S.E.U. and the Correctional Services Division* (September 10, 1993). Document on file at PASAN.
- Gilmore, N. et al. HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons. Correctional Service Canada. 1994.
- High Risk Project Society. Transgendered HIV/AIDS. High Risk Project Society, Vancouver, British Columbia. 1996.
- Jacob, J . "Germany - Needle Exchange in Prisons in Lower Saxony : Preliminary Review" in Canadian HIV/AIDS Policy and Newsletter (Vol. 3, Nos. 2-3, 1997).
- Jürgens, R. "Canadian HIV/AIDS Legal Network: Focus on HIV/AIDS in Prisons" in Canadian HIV/AIDS Policy and Law Newsletter. (Vol. 2, No.1, 1995).
- Jürgens, R. HIV/AIDS in Prisons: Final Report. Canadian HIV/AIDS Legal Network and Canadian AIDS Society. 1996.
- Jürgens, R. HIV/AIDS In Prisons: Priority Needs For Preventative Measures. [[Http://www.odyssee.net/~jujube/elements/PRELPRIS.html](http://www.odyssee.net/~jujube/elements/PRELPRIS.html)]. 1997.
- Jürgens, R. "Bleach and Anonymous HIV Testing in Federal Prisons" in Canadian HIV/AIDS Policy & Law Newsletter (vol. 1, no. 4, 1995).
- Jürgens, R. "HIV/AIDS and Drug Use In Prisons: Will Prisons Fail the Test?" Canadian HIV/AIDS Legal Network and Canadian AIDS Society. <http://www.acsp.uic.edu/IACO>]. 1997.
- Jürgens, R. "HIV/AIDS In Prisons: Final Report. Governments Could Be Held Morally and Legally Responsible for HIV and Hepatitis Epidemic in Canadian Prisons". Canadian HIV/AIDS Legal Network and Canadian Aids Society. 1996.
- King, E. "Recreational Dangers - Understanding Possible Interactions between Prescribed and Illegal Drugs" in AIDS Treatment Update: National AIDS Manual. (March 1997)
- Laframboise, S. "Discrimination - Transgendered People, Discrimination, and HIV/AIDS" in Canadian HIV/AIDS Policy and Law Newsletter. (Vol. 2, No. 3, 1996).
- Laframboise, S.. "Transgender Issues and HIV Prevention", Report on the *XI International*

*Conference on AIDS* (July 1996).

- Lai, A. "Spread of HIV in Prisons". [[Http://www.brown.edu/courses/Bio](http://www.brown.edu/courses/Bio) Community Health]. 1997.
- Lukits, A. "Coroner's inquest focus on care of inmates with AIDS, HIV" in the Kingston Whig Standard (Sept. 18, 1996).
- Malkin, I. "The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody" in Canadian HIV/AIDS Policy and Law Newsletter (Vol. 2, no. 1, 1995).
- Namaste, K. "Evaluation des besoins: Les travesti(e)s et transsexuel(le)s a l'egard due VIH/Sida". May, 1998.
- Namaste, K. "Genderbashing: Sexuality, Gender, and the Regulation of Public Space" in Environment and Planning D: Society and Space, (Vol 14, p.221-240, 1995).
- Namaste, K. Access Denied: A Report On The Experiences Of Transsexuals and Transgenderists with Health Care and Social Services in Ontario. Project Affirmation. (Toronto, Ontario). 1995.
- Namaste, K. "HIV/AIDS and Transgender Communities in Canada". 1995.
- Prisoners with HIV/AIDS Support Action Network (PASAN). HIV/AIDS in Prisons: A Comprehensive Strategy. June 1992.
- Prisoners with HIV/AIDS Support Action Network (PASAN). "Results From the First National HIV/AIDS and Prisons Workshop" in Canadian HIV/AIDS Policy and Law Newsletter. (Vol. 2, No. 1, 1995).
- Perkins, R. "Breaking Boundaries: Transgender Lifestyles and AIDS Risk" in National Centre in IV Epidemiology and Clinical Research. Australian HIV Surveillance Report. 1993.
- Peterson, M. "Transsexuals within the Prison System: An International Survey of Correctional Services Policies" in Behavioral Sciences and the Law. (Vol. 14, pp.219-229, 1996).
- Riley, D. "Drug Use in Prison: A Harm Reduction Approach". Canadian Centre on Substance Abuse. 1992.
- Scott, A. Demographic Study of Transgendered Community. Bachelor of Social Work Degree. Ryerson Polytechnical University. 1996.
- Scott, A. A Needs Assessment of the Transgendered Community. Master of Social Work Degree. University of Toronto. 1997.
- Tee, J. Health Issues of the HIV+ M-F Transgendered Prison Population. University of

Toronto. 1997.

Travers, W. "Transgendered Youth Workshop" (Toronto, Ontario). 1996.

*Verdict of Coroner's Jury/Verdict du jury du coroner*, Inquest into the death of William Bell, Frontenac County Court House, Kingston, Ontario, October 2, 1997.

Warren, B. "AIDS Prevention for Transgender and Transsexual Persons: A Collaborative Community-Based Program" presented at *the XI International Conference on AIDS* [abstract Mo.D:601, July 1996].