Harm Reduction and Women in the Canadian National Prison System: Policy or Practice?

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ABSTRACT. Applying the principles of harm reduction within the context of incarcerated populations raises a number of challenges. Although some access to harm reduction strategies has been promoted in general society, a divide between what is available and what is advocated continues to exist within the prison system. This paper explores the perceptions and lived experiences of a sample of nationally incarcerated women in Canada regarding their perceptions and experiences in accessing HIV and Hepatitis C prevention, care, treatment and support. In-depth interviews were conducted with 156 women in Canadian national prisons. Q.S.R.Nud*ist© was used to assist with data management. A constant comparison method was used to derive categories, patterns, and themes. Emergent themes highlighted a gap between access to harm reduction in policy and in practice. Despite the implementation of some

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harm reduction techniques, women in Canadian prisons reported variable access to both education and methods of reducing HIV/HCV transmission. Concerns were also raised about pre- and post-test counseling for HIV/HCV testing. Best practices are suggested for implementing harm reduction strategies within prisons for women in Canada.

KEYWORDS. Canadian women in prison, HIV, Hepatitis C, harm reduction

INTRODUCTION

Although harm reduction as a conceptual framework or as a policy approach has been widely discussed in the health promotion and illness prevention literature, how this unfolds in practice, particularly among incarcerated populations, is not well understood (Hilton, Thompson, Moore-Dempsey, & Janzen, 2001). Harm reduction assists in developing "people's control, individually and collectively, over their health . . . by increasing the participation of individuals and communities in identifying and modifying risk behaviours and in gaining control over their health and environment" (Hilton et al., 2001, p. 361). More broadly, harm reduction is often referred to as "any policy or program that aims to reduce drug-related harms" (Single, 2001, p. 3). As there is increasing evidence to suggest that HIV and Hepatitis C (HCV) infections occur in prison settings, in part, because of a lack of accessible harm reduction programming aimed at this population, exploring harm reduction for incarcerated populations is of particular importance (Canadian HIV/AIDS Legal Network, 2001a; MacDougall, 1998).

Research has found that the number of people living with HIV/AIDS and/or HCV in national prisons has increased over the last several years (Canadian HIV/AIDS Legal Network, 2001a; Jurgens, 1996). In fact, rates of HIV infection among inmate populations are higher than the general population (Canadian HIV/AIDS Legal Network, 2001a). In a review of several studies, MacDougall (1998) found that the rate of HIV/AIDS in the U.S. prison system was actually four times that of the general population. An even higher rate has been cited among women, with projections of 23 times those in the general population (Jurgens, 2000).

Higher prevalence rates among women have also been documented in Canada, in a study of provincial prisons in British Columbia. Rothon, Mathias, and Schechter (1994) found prevalence rates among women were 3.3% and only 1.0% for males. In the overall Canadian prison system, the prevalence of HIV/AIDS has been identified as approximately 2% of the inmate population with higher rates for injection drug users (IDUs, 9%) and those who share needles (14%) (MacDougall, 1998). Higher prevalence rates for IDUs were also found in the provincial study conducted by Rothon et al. (1994). These higher prevalence rates in the prison system may be a result of people accessing the health care system, including HIV/HCV testing, for the first time while incarcerated (Rich et al., 2001).

High-risk behaviours, such as injection drug use, unsafe sex, and tattooing, are prevalent due, in part, to a lack of knowledge or access to prevention techniques. Although the availability of condoms and bleach are now part of the harm reduction programming instituted by Correctional Services of Canada (CSC), variations in access have been reported (Canadian HIV/AIDS Legal Network, 2002). Access to condoms, lubricant, and dental dams are required at a minimum of three locations within the prison without having to make a request from a staff member (CSC, 1996b). To date, a sterile needle exchange or distribution program is not available in Canadian prisons. As a result of this variability in access, there have been studies noting increasing rates of transmission of HIV and/or HCV following high-risk behaviours within the Canadian prison system (Canadian HIV/AIDS Legal Network, 2001b).

Part of the variability in access to and utilization of healthcare within the prison system may be a result of a loss of control among prisoners within an organizational culture that is created to depersonalize interactions and to promote a perception of the incarcerated as "a permanent criminal" among prison staff (Stoller, 2003, p. 2264). As Stoller (2003) explains, the prison system tends to be set up as an "anti-place" in which the "regulatory construction of prison naturalizes the prisoner as a depersonalized unit, teaching both the staff and the prisoner that this hyper-management and loss of agency is normal within the walls of this total institution" (p. 2264). As a result, the staff becomes legitimized in providing healthcare that is not at a similar standard to that provided in the broader community. Through this process, the incarcerated woman "becomes more of an object to manipulate and less of a person in a relationship" (Stoller, 2003, p. 2274). Clearly, the provision of harm reduction programs within a largely depersonalized prison healthcare system may be insufficient to meet the needs of women in prison, particularly

where such perceived and actual barriers to accessing such programs remain unchallenged.

Harm reduction approaches advocated for Canadian prisoners by organizations such as the Canadian HIV/AIDS Legal Network, the Canadian Association of Elizabeth Fry Societies, and the Canadian Human Rights Commission include methadone maintenance treatment, needle exchange or distribution, anonymous HIV/HCV testing, bleach distribution, condom, dental dam and water-based lubricant availability and accessibility. According to the Canadian HIV/AIDS Legal Network (2002), the province of British Columbia on Canada's west coast has been a leader in addressing issues of HIV/AIDS and HCV among prisons using a comprehensive, harm reduction approach. For example, methadone maintenance treatment has been available in British Columbia prisons since 1996 and anonymous HIV testing is available in the majority of these provincial institutions. It is noteworthy, that the provision of such programs is often subject to programming cuts due to budgetary constraints faced by the provincial government. At the overall national level, which is the focus of this paper, methadone maintenance treatment was implemented in all national prisons in May 2002 under a new Correctional Service of Canada policy (Canadian HIV/AIDS Legal Network, 2002). However, access to needle exchange programs is still not available despite a 1999 recommendation from a Correctional Service of Canada's working group to allow access to sterile injection equipment in all regions of the country (Canadian Association of Elizabeth Fry Societies, 2004).

A significant challenge to implementing harm reduction strategies such as needle exchange, bleach, and condom access as a component of health care and health promotion in the Canadian prison system is overcoming the perception of "encourag[ing] drug use and sex" (Hilton et al., 2001, p. 363). Even as some harm reduction techniques are being implemented within the Canadian prison system, they are often limited in scope. Further, there are often no systematic mechanisms in place to monitor and evaluate the dissemination and uptake of such harm reduction mechanisms. As well, other aspects generally included within the realm of harm reduction (e.g., drug and alcohol use) outside of the prison system are not permitted within prisons. Correctional Service of Canada (1996a, p.1) "will not tolerate drug or alcohol use or the trafficking of drugs in federal institutions." CSC also has strong objections to tattooing and individuals can be charged for this practice. Charges for either drug/alcohol use or tattooing could include one or more of the following, "a warning or reprimand; a loss of privileges; an order to make

restitution; a fine; performance of extra duties; and in the case of a serious disciplinary offence, segregation from other inmates for a maximum of thirty (30) days" (CSC, 2004, p. 14-15). Therefore, the humanistic principles of harm reduction such as do no harm, respect for dignity of persons who use drugs, maximizing intervention options, and starting from where the drug user is at (MacPherson, 2001) are only partially adhered to within the Canadian prison system.

Within the following paper, the challenges between promoting the principles of harm reduction and the actual practice of these principles will be explored from the context of an incarcerated population of women in Canada. This study describes the HIV and HCV risk behaviours of these women as well as their perceived or actual access to and utilization of harm reduction programs to prevent HIV and HCV within the Canadian prison system. This study will contribute to the literature by providing contextual information to help situate the HIV/HCV related experiences of women in Canadian prisons relative to harm reduction and to assist in informing future directions in meeting the harm reduction programming needs of this population.

METHODOLOGY

Given the dearth of qualitative data available on the HIV/HCV related experiences of women in the national prison system in Canada, a qualitative methodology was selected to explore the lived experiences and perceptions of a sample of nationally incarcerated women about their knowledge and/or utilization of HIV and HCV programming (DiCenso, Dias, & Gahagan, 2003). Qualitative techniques are regarded as most appropriate when the issue under study is complex and not well understood (Berg, 1998). In keeping with this, in-depth interviews with a sample of 156 female inmates were audio-taped where possible and notes were also taken at the time of the interviews as a means of exploring the contextual issues experienced by this population regarding harm reduction. A brief demographic survey was also completed by each participant following the in-depth interview. Both the interview guide and demographic survey were developed from the review of the literature by the research team and in consultation with the National Steering Committee. Both instruments were pilot tested prior to data collection.

All personal identifiers, including institutional references were removed from the transcripts to help protect the confidentiality of the participants. The data from the interviews were analyzed for recurring

themes and were used to develop a series of best practices recommendations. Prior to undertaking interviews, ethics approval was obtained from a Canadian university research ethics board as well as Correctional Services of Canada. The interviews were conducted during 2001 and 2002 in nine of the eleven Canadian national prisons for women, including the Nova Institution for Women (Truro, Nova Scotia), Springhill Institution (Springhill, Nova Scotia), Establissement Joliette (Joliette, Quebec), Regional Reception Centre (Ste-Anne-des Plaines, Quebec), Grand Valley Institution for Women (Kitchener, Ontario), Okimaw Ohci Healing Lodge (Maple Creek, Saskatchewan), Saskatchewan Penitentiary (Prince Albert, Saskatchewan), Edmonton Institution for Women (Edmonton, Alberta), and the Burnaby Centre for Women (Burnaby, British Columbia). Interviews could not be set up in the other two institutions due to scheduling problems and delays.

Women were recruited into the study through posters placed within each prison facility. Those interested in the study were asked to call the toll free number on the poster and were then asked if they wished to participate in an in-depth interview on a particular date and time within their respective institution. In an effort to help ensure the confidentiality of the participants, a unique identification number was assigned to each participant and this information was only accessible to the research team. A team of three female interviewers with experience working with prison populations conducted interviews. Two of the interviewers were able to communicate in both official languages (French and English) so the interview could be completed in either language. Each interview lasted approximately one hour and all interviews were transcribed into English text for data analysis purposes.

Upon transcription of the interviews, data were input into a qualitative data management program (Q.S.R.Nud*ist©). Constant comparison as described by Patton (2002) was used as a data analysis technique to search for emergent categories, patterns, and themes in the data. To help ensure that these emergent categories were established within the data before determining the patterns or themes, a method of cross case and within case analysis was used to examine each woman's experience alone and against those of the other participants. This process was achieved by maintaining a focus on observing both instances of similarities as well as differences in themes throughout the analysis of the data (Berg, 1998).

RESULTS

The Participants

The women interviewed were from diverse demographic backgrounds. In terms of ethnicity, 47% identified themselves as white or Caucasian, 38% as Aboriginal, and 15% as other (e.g., African, Caribbean, German) (see Table 1). English was the language of preference for most of the participants (85.8%), with French as the next most frequently cited (9.7%). Nearly half of the women had less than grade 12 (48%), with an additional 33% having achieved grade 12 or Grade 12 Equivalency (GED), and 13% with post-secondary education. A large number of the women were single (n = 51), however, more than half had children. Forty-three women were married or living common-law (n = 34 with children) with an opposite sex partner. Six women were living common-law with a same sex partner and four of these women had children.

TABLE 1. Demographic Background of Participants

Race/Ethnicity	White/Caucasian	47%
	Aboriginal	38%
	Other	15%
Language	English	85.8%
	French	9.7%
Education	< Grade 12	48%
	Grade 12 or GED	33%
	Post-secondary	13%
Marital/Family status	Single	32.7%
	Married or common-law with opposite sex partner	27.6%
	Common-law same sex partner	3.8%
	Divorced, separated, engaged, widowed	10.3%
Age	18 to 25	21.2%
	26 to 35	22.4%
	36 to 45	25%
	46 to 59	4.5%

An additional 16 women (14 of which had children) were divorced, separated, engaged, or widowed. No marital or family status data were available for 41 women. The majority of the women (60%) were between the ages of 18 to 35 years.

In terms of the length of their prison sentence, the majority of the women (71%) were serving short-term sentences of 2 to 5 years. An additional 11% were serving 6 to 10 year sentences, 5% were serving 10 or more years, and 13% were serving life sentences. For many of the women, they had not spent much time previously within an institution as 40% had spent 5 years or less, with the next most frequently cited range of 6 to 10 years (10%). Although not asked of these women, national statistics indicate that 75% of women serving time in Canada were doing so for minor offences such as shoplifting and fraud, and drug related offences accounted for approximately 33% of women serving time in a national prison (CAEFS, 2004).

Despite a large number of emergent themes, this paper will focus on issues identified by the women in relation to their perceptions of high-risk HIV/HCV behaviours, prevention education, harm reduction measures, and HIV/HCV testing. This focus will allow for an exploration of any gaps between harm reduction policies and practices within the national prison system.

Prevalence of High Risk Behaviours

High-risk behaviours in relation to both sexual and intravenous transmission of HIV and HCV were common among this sample of female prisoners. In fact, 27% of women were found to be engaging in tattooing, 24% reported having unprotected sex (with 81% of these women reporting being sexually active within the institution either through conjugal visits or same sex partners), 19% reported engaging in injection drug use, 16% were body piercing, and 9% were slashing or using some other form of self-injury. Self-injury, which includes slashing with razors and knives, is considerably higher among women in prisons than the overall Canadian population (CAEFS, 2004). As these data suggest, many women were engaging in a variety of high-risk behaviours while in the national prison system.

Access to Prevention Education–The Need for More Information

Although women reported a number of sources of prevention education, such as Correctional Services of Canada (CSC), community, and

educational materials, many concerns were raised regarding the type, quantity, and quality of the information they were receiving. Prevention education programs offered by CSC were the most prevalent source of information for women in the prison system with 42% of women having attended a workshop. However, a distinct gap was noted in the current programming, as more information was required during these workshops that was specific to HIV/HCV prevention. The workshops tended to be generic in content, addressing several health issues at one time and therefore providing insufficient depth of content on HIV/HCV.

Types of programs. The two primary programs that women identified attending within the prison system were those where they had received some information related to HIV/HCV and included Choosing Health in Prisons (CHIPS) and Reception Awareness Program (RAPS). CHIPS is the primary health education program offered by CSC and includes sections on HIV and HCV, while RAPS was less frequently cited but also noted for some information on these topics. Concerns were identified with both of these programs for lacking depth of information on HIV/HCV, as the following participant explained:

> Well, there's RAPS and there's CHIPS. I know that a lot of the stuff that's told in CHIPS and RAPS . . . There's information, but there's not that much. There's also not much of anything for the effects. Like, you know, how it is [for] somebody getting tested for HIV or Hep C and it come[es] back negative . . . There's nothing on counseling, what you went through during the time you're waiting for it.

Therefore, large gaps were noted in the current prevention education women received from CSC related to HIV/HCV.

Community-based AIDS service organizations were also identified as a source for prevention education by 37% of women. Greater depth in content on HIV/HCV was provided by community groups; however, concerns were raised regarding the frequency with which the organizations were able to offer programming. More sessions were desired, although women recognized that due to location of some prisons, this was not always possible.

Access to educational materials. Women also expressed interest in having additional educational materials available to them. The format and content of current materials was considered problematic. That is, women wanted more videos or visual materials as they reported being able to learn more effectively from such sources. As well, written mate-

rials that were provided needed to be written in plain, non-medical language and to not draw too much attention to the fact that they were on HIV/HCV, as the following woman explained:

> [N]ot all these tiny, tiny pamphlets. [They] get bulky. But a piece of paper with all the information. This [Prisoner's AIDS/HIV Support Action Network] pamphlet is a good sign. And you don't have to write it big for what it is . . . So you can read it on the bus and when someone comes over [and] says, 'Hey,' you know, you can turn and say you're reading the crossword.

Women did not want others to immediately recognize that they were reading pamphlets on HIV/HCV, so if it could be "disguised" then they felt more comfortable reading them.

The location of educational materials was another issue raised. In particular, most information was available at the health care unit; however, women felt it should be widely disseminated. Otherwise, they needed a rationale for visiting the health care unit to access it. Obtaining such access could be problematic, especially if they did not have any other reasons or "excuses" for visiting health care.

In summary, a number of concerns were raised with regards to accessing prevention education information related to HIV/HCV in the prison system. Women felt the current programs were not frequent enough and did not provide sufficient details. As well, information materials were not always accessible in form, content, or availability.

Access to Harm Reduction Measures–Universal Access?

Harm reduction measures provided by Correctional Service of Canada were not consistently available or accessible to this sample of nationally incarcerated women, particularly those who were engaging in high-risk behaviour. Inconsistencies were identified in the provision of safer sex measures, access to bleach, and information on tattooing and slashing.

Access to safer sex. Safer sex measures such as access to condoms, dental dams, and water-based lubricants were not universally available, despite CSC policies. Some access to safer sex measures was reported by 78% of participants. However, 69% of the women who reported being sexually active, either through conjugal visits with partners from outside the institution or with same sex partners within the institution, identified dissatisfaction with current provision of safer sex measures.

Condoms were more accessible than either dental dams or lubricant. Yet, even access to condoms was not universal. For some women (22%), a "kit" was given upon admission that included both condoms and lubricant. After admission, access was primarily through a box placed in one of the following locations: the health care units, bathrooms, laundry rooms, in the Private Family Visiting Unit (PFV), or they were stored in first aid kits, or condom dispensers in the hallways, gyms, nurseries, or bathrooms. Problems were noted with whether the boxes or dispensers were routinely refilled and about the anonymity in obtaining them. As well, access to dental dams was much more inconsistent with 17% of women never having received any. When dental dams were provided, concerns were raised about the quality and/or unsanitary nature of them. According to the participants, they were not individually packaged and they were regarded as too thick.

Access to bleach. The provision of bleach for reducing the risk of HIV transmission through injection drug use was another area where much variability was noted in availability and accessibility. Several women (34%) commented on the provision of bleach at their facility. Many were interested in using it for personal hygiene purposes (e.g., cleaning and laundry) in addition to cleaning syringes, although exact numbers using bleach for either purpose was not recorded in this study. However, the participants did note that the large demand for bleach that could not always be met. Others raised concerns about not being able to receive bleach due to the high demand and that stockpiling often resulted when it was available. Of particular concern was that 70% of women who self-identified as injection drug users noted concerns regarding access to bleach. The quality of the bleach at one institution was also questioned as several women felt it had been diluted and was therefore, not as effective.

Another issue related to the bleach programs was the method of distribution whereby women were commonly expected to request bleach from either healthcare staff or correctional officers. Concerns regarding a lack of confidentiality were raised as a result of this technique, particularly due to the types of questions women were asked in the process of requesting bleach. The following dialogue between a participant and interviewer demonstrates this tension:

> Participant: It's very monitored. They ask if you're using it for needles or . . . or if you're using it to clean. It's very difficult to get.
> Interviewer: How do you actually access the bleach?
> Participant: You more or less lie.

Interviewer: So you have to ask staff for it, and then lie about what you're using it for?
Participant: Yeah.

Bleach was not widely accessible or available to the participants in this study, despite the desire for it. Supply was not sufficient to meet demand and a lack of confidentiality was perceived in the distribution process as requests had to be made to staff.

Access to sterile syringes. Potentially due to the problems with the bleach distribution program, many women wanted access to sterile syringes. In fact, although there was no specific question regarding this issue included within the interviews, it was raised consistently by 16% of the women as desirable. Interestingly, this number is even larger than those who self-identified as injection drug users.

Access to safer tattooing, body piercing, and slashing/cutting information. The final harm reduction measures which women noted as not having access to but desiring, were programs on safer tattooing, body piercing, and slashing/cutting. The most common high-risk behaviour in which the women participated was tattooing; however, as it is currently prohibited in the institutions it is driven underground and occurs in secret. The women raised concerns about reusing and sharing needles and ink, but had little information on the HIV/HCV risks of this activity. Similar concerns were raised about body piercing. The lack of information about slashing/cutting was also noted as a gap despite the fact that slashing represents a risk of HIV/HCV transmission through sharing of "sharps" or implements to cut the skin.

In summary, many gaps currently exist in the access to harm reduction measures within the national prison system in Canada. Condoms and bleach were irregularly available and concerns were identified with methods of distribution for each, while dental dams, syringes, and information on methods of reducing HIV/HCV transmission from high-risk behaviours were identified as desirable but lacking.

HIV/HCV Testing–Availability and Confidentiality

Most of the women interviewed for this study had been tested for HIV (89%) and HCV (78%) while in the prison system. In fact, the percentage of women tested in prison was higher than those who had been tested in the community (i.e., 64% tested for HIV and 62% tested for HCV in the community). Although this high uptake of testing services is a positive step in ensuring early access to appropriate care and treat-

ment for those infected with HIV and/or HCV, concerns regarding testing procedures and follow up were identified.

Accurate information and pre- and post-test counseling regarding HIV/HCV testing was not uniformly provided to the women. In fact, some women (10%) believed testing was mandatory. Many (34% who received testing) had not received any counseling and others reported not receiving their negative test results, and/or only minimal pre-and post-test counseling. The variability in information provided during pre- and post-test counseling is reflected in the following two women's voices:

> When it's blood work day, you go down and you get the blood work done. If it's negative you don't get a phone call. You never see the information unless you ask. You never see it. You just take their word. There are some women in here that nobody has phoned.

> They basically took my blood. They asked, 'Why do you feel you need it?' and I think they asked one or two questions.

A small number of women were satisfied with the pre- and post-test counseling they had received as they had positive experiences. Having questions answered and having the opportunity to discuss concerns were what had created positive experiences for these women. The opportunity to discuss questions with an external public health nurse was also noted as beneficial due to the perception of greater confidentiality and faster access to test results. However, this option was only available at one institution and, therefore, this was not an option for most women in the national prison system.

Despite the large number of women receiving HIV/HCV testing within the national prison system, problems with pre- and post-test counseling, the option to refuse testing, and concerns related to confidentiality were noted.

DISCUSSION

Although this study provides a much-needed exploration of the context of harm reduction for women in Canadian prisons, several limitations of the study must be noted. Since the recruitment of participants was based on those who were willing to come forward to participate, a

self-selection bias may have influenced the findings. We do not know how women unwilling to come forward differ in their experiences from those who did come forward to participate. As well, since we were unable to access two of the national women's prisons due to scheduling difficulties, we do not know how these institutions differ in terms of harm reduction programming from those that were included. Future research in this area should consider these issues since both may have an impact on the results.

The women in this study identified a number of challenges in protecting themselves from the transmission of HIV/HCV within the national prison system in Canada. Many women reported engaging in a variety of high-risk behaviours including tattooing, injection drug use, and slashing. According to the Canadian Association of Elizabeth Fry Societies (2004), slashing is a means of relief from distress and many women who self-injure have a history of childhood sexual and physical abuse. It is crucial that these underlying causes of self-injurious behaviours among this population be situated in terms of the broader harm reduction efforts, including ongoing access to appropriate counselling programs and services.

Although a high rate of testing for HIV/HCV was evident, many problems were noted with accessing pre- and post-test counseling, prevention education and information materials, and harm reduction measures. To improve access to harm reduction for incarcerated women, a number of issues require address. First, pre- and post-test counseling, which is required in the broader community, should be similarly offered in the prison system. Women had questions they were not able to address and several were not certain as to their HIV/HCV status as they did not receive confirmation of negative results. Although all national prisons fall under the same HIV/HCV policy direction as set out by Correction Service of Canada, the variability of the provision of pre- and post-test counseling from one region to the next must be addressed. Community-based AIDS Service Organizations exist in most regions and these groups should be engaged in augmenting HIV/HCV information and counseling services within the prison system (Canadian HIV/AIDS Legal Network, 2002).

Next, prisons should provide universal and equitable access to condoms, dental dams, bleach, and syringes. Clearly, each of these items is required to promote HIV/HCV risk reduction behaviours. Methods for distribution will need to be determined in a manner that promotes confidentiality and anonymity of participants. That is, consideration will have to be given as to whether they are available in easily accessible locations (e.g., bathrooms, laundry rooms) or if distributed by staff then

women are not questioned as to the end usage. It is noteworthy that no needle distribution or exchange programs exist in any of the national prisons despite clear indication that injection drug use and sharing of needles and related equipment is occurring and that these behaviours are contributing to HIV/HCV rates within prison settings. Findings from a recent international study on prison needle exchange programs found that the feared negative consequences did not occur. For example, of the six countries with prison-based needle exchanges, needles have not been used as weapons, and there was no reporting of increase in injection drug use. In fact, the study found that there was a reduction in needle sharing and there were no new cases of HIV/HCV reported (Jurgens et al., 2004). In addition to drug use issues, it is essential that sufficient recognition be given to the fact that sexual activity within the prison system occurs and that failing to ensure adequate access to condoms–both male and female condoms–is further exacerbating the infection rates (Canadian HIV/AIDS Legal Network, 2002).

Finally, additional prevention education programs and information materials need to be provided to increase the knowledge level of women regarding HIV/HCV transmission. A strong desire was identified for greater depth of information as well as coverage of a broader number of topics (e.g., living with HIV/HCV, methods of reducing risk from slashing/cutting, tattooing, and body piercing). Based on the experiences of the women in this study, current information provided on HIV/HCV is often inadequate and too superficial to address their information needs. The need for more educational programs for inmates has also been identified by the Canadian HIV/AIDS Legal Network (2001c) as important in promoting and protecting the health of inmates. Providing harm reduction tools such as bleach, condoms, or dental dams without adequate educational programs on how to use them to effectively prevent HIV/HCV is clearly inadequate and may in fact contribute to the spread of infection among incarcerated populations (Canadian HIV/AIDS Legal Network, 2002; Health Canada, 2001).

Each of these best practices needs to be implemented to reduce the risk of transmission of HIV/HCV within the prison system. Women should not be placed at any greater risk for HIV or HCV within a prison institution than they are in the wider community due to a lack of access to harm reduction measures and knowledge of self-protection techniques (American College of Physicians, 1992; Arnott, 2001). Further research is clearly needed to ensure the changes required to correct the system allow for the bridging, both ideologically as well as practically, between harm reduction principles and the lives of incarcerated women in the national prison system in Canada.

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