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HIV/AIDS
in
Prisons

2001/2002

HIV/AIDS and Hepatitis C in Prisons: The Facts

This info sheet reviews what is known about HIV/AIDS and hepatitis C in prisons.

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

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2. High-Risk Behaviours behind Bars
3. HIV Transmission in Prison
4. Prevention: Condoms
5. Prevention: Bleach
6. Prevention: Sterile Needles
7. Prevention and Treatment: Methadone
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HIV Seroprevalence in Prisons

Canadian federal prisons

In Canada's federal prison system (where offenders sentenced to prison terms of two years or more serve their terms), the number of reported cases of HIV/AIDS rose from 14 in January 1989 to 159 in March 1996 and 217 in December 2000. This means that 1.66 percent of all federal prison inmates are *known* to be HIV-positive. The actual numbers may be even higher: the reported cases, provided by the Correctional Service of Canada (CSC), include only cases of HIV infection and AIDS *known* to CSC, but many inmates may not have disclosed their HIV status to CSC, or may not know themselves that they are HIV-positive.

Canadian provincial prisons

In provincial prisons (where offenders sentenced to prison terms of less than two years serve their terms), rates of HIV infection are also high. Studies undertaken in prisons in British Columbia, Ontario, and Québec have all shown that HIV seroprevalence rates in prisons are over 10 times higher than in the general population, ranging from 1.0 to 7.7 percent. For example:

- A 1989 study of 248 women in a medium-security provincial prison in Québec found an HIV seroprevalence rate of 7.7 percent.
- A 1993 study carried out among over 12,000 people entering Ontario prisons found HIV seroprevalence rates of 1.0 percent among adult men and 1.2 percent among adult women.

As in federal prisons, the number of prisoners with HIV or AIDS in provincial prisons is on the rise. For example:

- In British Columbia, a study conducted in all adult BC provincial prisons in 1993 found an HIV seroprevalence rate of 1.1 percent. The study has not been repeated, but in 1996 a review of known cases alone revealed rates ranging from 2 to 20 percent in various prisons.

Worldwide

As in Canada, rates of HIV-infection in inmate populations worldwide are much higher than in the general population. They are, in general, closely related to two factors: the proportion of prisoners who injected drugs prior to imprisonment, and the rate of HIV infection among injection drug users in the community.

Many of those who are HIV-positive in prison were already living with the virus on the outside.

HIV/AIDS AND HEPATITIS C IN PRISONS: THE FACTS

Indeed, the highest rates of HIV infection in prisons can be found in areas where rates of HIV infection are high among injection drug users in the community. Commenting on the situation in the United States, the US National Commission on AIDS stated that “by choosing mass imprisonment as the ... governments’ response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection.”

HIV infection rates are high in many European prisons. One study carried out in 25 European prisons reported particularly high rates in Portuguese (20 percent) and Spanish prisons (13 percent); rates are also high in other countries, including Switzerland (4 to 12 percent) and Italy (7 percent). In Eastern Europe, 6 percent of prisoners in the Ukraine are HIV-positive.

In contrast, relatively low rates of HIV prevalence have been reported from Australia. In the United States, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. Many systems continue to have rates under one percent, while in a few rates approach or exceed 20 percent.

Hepatitis C Seroprevalence

Canada

Hepatitis C (HCV) prevalence rates in prisons are even higher than HIV prevalence rates: studies undertaken in the early and mid 1990s in Canadian prisons revealed rates of between 28 and 40 percent.

Rates continue to rise. In one federal prison, 33 percent of study participants tested positive in 1998, compared to 27.9 percent in 1995; and at the Burnaby Correctional Centre for Women in British Columbia, over 78 percent of 69 inmates tested for HCV between 1 January 1996 and 8 August 1996 were seropositive.

Worldwide

Similar figures are reported from other countries: 39 percent in prisons in Victoria, Australia, and 50

percent in New South Wales, Australia; 30 to 41 percent among US prisoners in California, Connecticut, Rhode Island, Maryland, Virginia and Washington; and 74.8 percent among injection drug users in a prison for women in Vechta, Lower Saxony, Germany.

Potential for further spread

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

Additional Reading

R Elliott. Prisoners’ Constitutional Right to Sterile Needles and Bleach. Appendix 2 of R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1996, at 3-4. Provides a summary of Canadian seroprevalence studies in prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP2.html.

C Hankins et al. HIV-1 infection in a medium security prison for women—Quebec. *Canada Diseases Weekly Report* 1989; 15(33): 168-170. The first HIV seroprevalence study in a Canadian prison.

PM Ford et al. HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 52-54. The most recent study in a Canadian prison. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/prisons.htm.

S Gore, G Bird. HIV, Hepatitis and Drugs Epidemiology in Prisons. In: D Shewan, JB Davies (eds). *Drug Use and Prisons: An International Perspective*. Amsterdam: Harwood Academic, 1999. A useful review.

Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d’information est également disponible en français.**

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High-Risk Behaviours behind Bars

This info sheet presents some of the evidence of the prevalence of high-risk behaviours – in particular, injection drug use – behind bars.

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Drug Use

Despite the sustained efforts of prison systems to prevent drug use by prisoners — by doing what they can to prevent the entry of drugs into prisons — the reality is that drugs can and do enter. A number of studies have provided evidence of the extent of injection and other drug use in prisons. “Many prisoners crave some form of drugs. Many of them are in prison in the first place because of offences related to drugs.”

Canada

In an inmate survey carried out by the Correctional Service of Canada (CSC) in 1995, 40 percent of 4285 federal inmates self-reported having used drugs since arriving at their current institution.

Injection drug use is also prevalent, and the scarcity of needles often leads to needle sharing. Members of the Expert Committee on AIDS and Prisons were told by inmates that injection drug use and needle sharing are frequent and that sometimes 15 to 20 people will use one needle. Many staff also acknowledge that drug use is a reality, admitting that “drugs are part of prison culture and reality” and that “there does not seem to be a way to ensure that there will be no use of drugs.”

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

- A study on HIV transmission among injection drug users in Toronto found that over 80 percent had been in prison since beginning to inject drugs, with 25 percent sharing injecting equipment while in custody.
- In a study among incarcerated men and women in provincial prisons in Montréal, 73.3 percent of men and 15 percent of women reported drug use while incarcerated; of these, 6.2 percent of men and 1.5 percent of women injected drugs.
- In a study among inmates of a provincial prison in Québec City, twelve of 499 inmates admitted injecting drugs during imprisonment, of whom 11 shared needles and three were HIV- positive.
- In a federal prison in British Columbia, 67 percent of inmates responding to one survey reported injection drug use either in prison or outside, with 17 percent reporting drug use *only in prison*.
- In CSC’s 1995 inmate survey, 11 percent of 4285 federal inmates self-reported having injected since arriving in their current institution. Injection drug use was particularly high in the Pacific Region, with 23 percent of inmates reporting injection drug use.

HIGH-RISK BEHAVIOURS BEHIND BARS

Worldwide

Many other countries report high rates of drug use behind bars:

- In Australia, in a survey of HIV risk-taking behaviour of male drug injectors while in prison, 75 percent of respondents reported having injected drugs at least once while in prison.
- In the United Kingdom, surveys found that the use and availability of injectable drugs greatly exceeds official estimates and that needles and syringes are commonly shared out of necessity. One study found that injection drug use decreased in prisons among inmates who had been users on the outside. However, inmates were more likely to inject in an unsafe manner when they did inject. The study concluded that imprisonment increases the risk of contracting HIV infection.
- A European Union study showed that injecting is highly prevalent in prisons in the countries that participated in the study (Belgium, Germany, Spain, Italy, France, Portugal and Sweden). 32 percent of over 3200 participants reported they had ever injected drugs. Of these, seven percent reported they had started to inject in prison and 45 percent that they had injected in prison.

Sexual Activity

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

Homosexual activity occurs inside prisons, as it does outside, as a consequence of sexual orientation. In addition, prison life produces conditions that encourage homosexual activity and the establishment of homosexual relationships between prisoners who do not identify themselves as homosexuals. The prevalence of sexual activity in prison is based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification, and the

extent to which conjugal visits are permitted. Studies of sexual contact in prison have shown “inmate involvement to vary greatly.” In a study in state prisons and city jails in New York, prisoners reported frequent instances of unprotected sex behind bars. One woman summarized the prevalence and range of sexual activity:

Male CO’s [correctional officers] are having sex with females. Female CO’s are having sex with female inmates, and the male inmates are having sex with male inmates. Male inmates are having sex with female inmates. There’s all kinds, it’s a smorgasbord up there.

In a survey conducted among 1100 male prisoners in Russia, only 10 to 15 percent of the prisoners reported having had no sexual contacts while serving their term. Non-consensual sexual activity was prevalent.

In Canada, according to CSC’s 1995 inmate survey, six percent of federal inmates self-reported having had sex with another inmate. This is consistent with the results of studies undertaken in provincial prisons.

Tattooing

In prison, tattooing is a social activity and involves sharing needles, which makes it risky. In Canada, 45 percent of federal inmates reported having had a tattoo done in prison.

Additional Reading

Correctional Service Canada. *1995 National Inmate Survey: Final Report*. Ottawa: The Service (Correctional Research and Development), 1996, No SR-02. The results of CSC’s 1995 inmate survey.

R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996, at 34-39. A summary of studies undertaken by 1996. Available at www.aidslaw.ca/Maincontent/issues/prisons/download1.html.

Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d’information est également disponible en français.**

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HIV Transmission in Prison

This info sheet presents some of the evidence of the extent of HIV transmission behind bars. It shows that outbreaks of HIV infection have and will continue to occur in prisons unless HIV prevention is taken seriously. This raises important questions about the moral and legal obligations of prison systems to prevent the further spread of HIV in prisons (see info sheet 12).

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

However, most of the studies that have reported relatively low levels of HIV transmission in prison were conducted early in the HIV epidemic and sampled long-term prisoners who would have been at less risk of infection than short-term prisoners. The extent of HIV infection occurring in prisons may have been underestimated. In recent years, a number of studies have shown how frighteningly quickly HIV can spread behind bars.

Outbreak of HIV Infection in a Scottish Prison

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

Outbreak of HIV Infection in an Australian Prison

Epidemiological and genetic evidence was used to confirm an outbreak of HIV in an Australian prison. Criteria for establishing that HIV infection had indeed occurred in prison included: HIV-antibody test results, documented primary HIV infection assessed by a panel of HIV experts, time and location in prison, risk behaviour in prison, and genetic relatedness of HIV sequences obtained from respondents. Attempts to trace 31 injection drug users resulted in 25 being located. Of these, two were HIV-negative, seven were deceased, two declined to participate, and 14 were enrolled in the study. It could be proven that eight of the 14 were infected with HIV while in prison.

HIV TRANSMISSION IN PRISON

Transmission of Drug-Resistant HIV in a Texan Prison

In 2000, scientists conducting a study on drug-resistant HIV among prisoners in Texas identified a prisoner who had become infected with drug-resistant HIV while behind bars.

Canadian Prisons

Springhill, Nova Scotia

In 1996 two HIV- and HCV-positive inmates at Springhill Institution, a federal prison in Nova Scotia, informed health-care staff that they had shared needles and injection equipment with a significant number of other inmates. A disease outbreak containment intervention was initiated, and 17 contacts of the two inmates were tested. However, no attempt was made to prove that, as a result of sharing needles and injection equipment with the known positive inmates, the contacts had contracted HIV or HCV while in prison.

Joyceville, Ontario

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

The study showed that risk behaviours and rates of infection in the prison had increased substantially since a previous study that had been undertaken at the same prison in 1995. In addition, the

researchers who undertook the study "saw individuals with equivocal test results who were likely in the process of seroconverting." Since the study was completed, they became aware of one individual, negative for HIV in March 1998, who is now positive, and one individual who has contracted HCV.

Additional Reading

Correctional Service Canada. *Springhill Project Report*. Ottawa: CSC, May 1999. A report on the outbreak intervention at Springhill Institution.

K Dolan. Evidence about HIV transmission in prisons. *Canadian HIV/AIDS Policy & Law Newsletter* 1997/98; 3(4)/4(1): 32-35. An excellent summary of the available evidence, at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/winter9798/26DOLANE.html.

PM Ford et al. HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 52-54. A summary of the study at Joyceville Institution. Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/prisons.htm#1.

A Taylor et al. Outbreak of HIV infection in a Scottish prison. *British Medical Journal* 1995; 310: 289-292. The first documented outbreak of HIV infection in prison. See also A Taylor, D Goldberg. Outbreak of HIV infection in a Scottish prison: why did it happen? *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(3): 13-14. The account of why the outbreak of HIV infection occurred. Available at www.aidslaw.ca/maincontent/otherdocs/Newsletter/April1996/14avriIE.html.

Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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HIV/AIDS in Prisons

2001/2002

Prevention: Condoms

Info sheets 1-3 in this series showed how prevalent HIV infection and hepatitis C are in prisons; that the behaviours through which these infections can be transmitted are also prevalent; and that outbreaks of infection have and will continue to occur unless efforts to prevent the spread of infections are stepped up. Info sheets 4-7 discuss what can be done to reduce the spread of HIV and other infections in prison.

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Providing Condoms

According to the World Health Organization, 23 of 52 prison systems surveyed allowed condom distribution as early as late 1991. Significantly, no system that has adopted a policy of making condoms available in prisons has reversed the policy, and the number of systems that make condoms available has continued to grow every year. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made condoms available rose from 53 percent in 1989 to 75 percent in 1992 and 81 percent in 1997. In the most recent survey, condoms were available in all but four systems.

In 1995 in Australia, 50 prisoners launched a legal action against the state of New South Wales (NSW) for non-provision of condoms, arguing that “[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded.” Since then, at least in part because of the legal action, the NSW government has decided to make condoms available. Other Australian systems have also made condoms available. Only in the United States does only a small minority of prison systems make condoms available.

Canadian Federal Prisons

In Canada’s federal prisons, condoms were made available on 1 January 1992. After some initial opposition, the decision to make them available has been well accepted and has not created any problems. However, in some prisons access to condoms remained limited. In particular, where access was restricted to distribution in health-care services, inmates said they were afraid to pick up condoms for fear of being identified as engaging in homosexual activity and of being discriminated against. In response, and as a result of a recommendation by the Expert Committee on AIDS and Prisons, the federal prison system announced in 1994 that condoms, dental dams, and water-based lubricant would become more easily and discreetly available.

Canadian Provincial Prisons

On 1 October 1989 the Northwest Territories adopted the first prison policy in Canada to allow for the distribution of condoms to inmates. Most other prison systems followed. However, even today, in some provincial prisons condoms and lubricant are not available, and in many provincial prisons they are not easily and discreetly available:

- British Columbia is an exception. In its provincial prison system, condoms have been easily and discreetly accessible for years.

PREVENTION: CONDOMS

- In Québec, a working group established by the Québec ministry of public security released a report in 1997 recommending wider and more discreet access to condoms.
- Ontario, Alberta, Saskatchewan, Manitoba, and Nova Scotia, among others, continue their policy of making condoms available only through prison health services.
- In three prison systems (New Brunswick, Newfoundland, and Prince Edward Island), condoms are still not made available.

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

Recommendation

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

Additional Reading

LM Calzavara et al. *Understanding HIV-Related Risk Behaviour in Prisons: The Inmates' Perspective*. Toronto: HIV Social, Behavioural and Epidemiological Studies Unit, Faculty of Medicine, University of Toronto, 1997. A study showing that “inmates engage in high-risk behaviour and that many do not use the harm reduction tools available to them. The structure of prison life and prison culture are barriers to their use.”

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

Federal/Provincial/Territorial Heads of Corrections Working Group on HIV/AIDS. Summary of Proceedings, May 2-4, 2000, Moncton, New Brunswick. Ottawa: CSC, 2000. Includes a good summary of the current harm-reduction strategies in Canadian provincial and federal prisons.

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

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

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Prevention: Bleach

This info sheet discusses one way of reducing the spread of HIV and other infections in prisons through injection drug use: providing bleach, together with instructions on correct use, to sterilize needles and syringes. Info sheets 6 and 7 will discuss two other ways: making needles available, and methadone maintenance treatment.

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Experience has shown that drugs, needles, and syringes will find their way through the thickest and most secure of prison walls. While continuing and often stepping up drug interdiction efforts, prison systems around the world have therefore taken steps to reduce the risk of the spread of HIV and other diseases through injection drug use. These include provision of bleach to sterilize needles and syringes, making sterile needles available (info sheet 6), and methadone maintenance treatment (info sheet 7).

Providing Bleach

According to the World Health Organization's network on HIV/AIDS in prison, 16 of 52 prison systems surveyed made bleach available to prisoners as early as 1991. Bleach was available in some prison systems in Germany, France, and Australia, in prisons in Spain, Switzerland, Belgium, Luxembourg, and the Netherlands, and in some African and at least one Central American prison system.

Significantly, no system that has adopted a policy of making bleach available in prisons has ever reversed the policy, and the number of systems that make bleach available continues to grow every year. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made bleach available rose from 28 percent in 1992 to 50 percent in 1997. In the most recent survey, bleach was available in 11 of 22 systems. Of the 11 respondents who did not make it available, three said that it should be made available and five said that both needles and bleach should be made available.

Canadian Federal Prisons

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

Initially, the Correctional Service of Canada (CSC) rejected ECAP's recommendation, agreeing only to pilot-test a bleach-distribution program in one institution. However, in the spring of 1995 the Commissioner of CSC instructed CSC to initiate the implementation of bleach distribution in all institutions. As a result, bleach became available in all institutions in the fall of 1996.

Provincial Prisons

In a small number of provincial prison systems bleach has also become available or has continued to be informally available.

PREVENTION: BLEACH

A model to follow

In 1992, the British Columbia provincial system issued a policy directing that bleach be made available to inmates. Adoption of the policy did not lead to any “incidents of misuse ... or any evidence to indicate an increase in needle use.” In April 1995 a revised policy was approved, requiring that bleach be freely available, readily accessible, and distributed in a way that ensures anonymity and minimizes risk of injury.

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

Recommendation

Full-strength liquid bleach, together with instructions on how to sterilize needles and syringes, needs to be made easily and discreetly accessible to inmates in all prisons.

Limitations

Making bleach available is important, but not enough:

- Based on research, bleach disinfection should be considered as a method to reduce the risk of *HIV infection* from the re-use or sharing of needles and syringes only when *no other safer options are available*. Sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and syringes.
- The probability of effective decontamination is decreased further in prison. Injecting is an illicit activity. Because prisoners can be accosted at any moment by prison staff, injecting and cleaning is a hurried affair. Studies have shown that bleach disinfection takes more time than most prisoners can take.
- Even when bleach is provided, prisoners may find it difficult to access.
- There is no conclusive evidence that bleach is effective in preventing HCV transmission.

Additional Reading

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PM Ford et al. HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 52-54. Concludes that we must “stop pretending that weak bleach solutions are the answer to anything. There is no good evidence to suggest that strong bleach works, let alone solutions that can be drunk with impunity.” Available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/prisons.htm#1.

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Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). Ce feuillet d'information est également disponible en français.

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in
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Prevention: Sterile Needles

This info sheet provides important information about needle-distribution programs in prisons. It shows that needles can be made available in prisons safely with good results.

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

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

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

International Developments

Recently, an increasing number of prisons have established needle exchange or distribution programs.

In Switzerland, distribution of sterile injection equipment has been a reality in some prisons since the early 1990s. Sterile injection equipment first became available to inmates in 1992, at Oberschöngrün prison for men. Dr Probst, a part-time medical officer working at Oberschöngrün, was faced with the ethical dilemma of as many as 15 of 70 inmates regularly injecting drugs, with no adequate preventive measures. Probst began distributing sterile injection material without informing the warden. When the warden discovered this, instead of firing Probst he listened to Probst’s arguments and sought approval to sanction the distribution of needles and syringes. Many years later, distribution is ongoing, has never resulted in any negative consequences, and is supported by prisoners, staff, and the prison administration. Initial scepticism by staff has been replaced by their full support:

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

In June 1994 another Swiss prison – Hindelbank institution for women – started a one-year pilot AIDS prevention program including needle distribution. Hindelbank’s program has been evaluated by external experts, with very positive results: the health status of prisoners improved; no new cases

PREVENTION: STERILE NEEDLES

of infection with HIV or hepatitis occurred; a significant decrease in needle sharing was observed; there was no increase in drug consumption; needles were not used as weapons; and only about 20 percent of staff did not agree with the installation of the needle-distribution machines. Following the first evaluation, a decision was taken to continue the program.

Other prisons have since started their own programs, and at the end of 2000, distribution of sterile needles was being undertaken in seven prisons in different parts of the country.

In Germany, a green light to the development and implementation of the first two pilot schemes was given in 1995, and the first pilot project started on 15 April 1996. At the end of 2000, needle exchange schemes had been successfully introduced in seven prisons, and more were discussing to implement them. In Spain, the first pilot project started in August 1997. Four more prisons have since started distribution schemes and it has been recommended to implement such schemes in all prisons. Finally, in Australia a study concluded that needle and syringe exchange is feasible.

Canadian Developments

No Canadian prison systems have yet started pilot needle-distribution projects. However, a few systems, including the federal prison system, are studying the issue. Those opposed to making needles available have said that this would be seen as condoning drug use. In reality, however, it is not an endorsement of illicit drug use by inmates. Rather, it is a pragmatic public health measure that recognizes that injection drug use in prisons is a reality, all efforts to eliminate it notwithstanding. *Not* undertaking pilot needle-distribution studies, in the knowledge that HIV and other infections are being transmitted in prisons, could be seen as condoning the spread of infections among prisoners and to the general public.

What Can We Learn?

1. The experience of prisons in which needles have been made available shows that they can be made available in a manner that is non-threatening to staff and indeed seems to increase staff's safety.

2. There are several models of distribution of sterile injection equipment. Thus far, every institution has chosen its own model. What can and should be done in a particular institution depends on many factors: the size of the institution, the extent of injection drug use, the security level, whether it is a prison for men or for women, the commitment of health-care staff, and the "stability" of the relations between staff and inmates.

3. A good way for a prison system to start a needle-distribution program and to overcome objections is to treat it first as an experiment and to evaluate it after the first year of operation.

Recommendation

Sterile injection equipment needs to be made available in prisons. In prison systems where distribution has not yet started, selection of prisons in which pilot projects can be undertaken should begin immediately.

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Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). Ce feuillet d'information est également disponible en français.

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HIV/AIDS
in
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2001/2002

Prevention and Treatment: Methadone

This info sheet provides important information about methadone maintenance treatment (MMT) in prisons. It explains that providing MMT is an AIDS-prevention strategy that provides people dependent on drugs with an additional option for getting away from needle use and sharing; and points out that, since it is a medically indicated form of treatment, it should be available to opiate-dependent people regardless of whether they are outside or inside prison.

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Why Methadone Maintenance Treatment?

Many have recommended the introduction or expansion of MMT in prisons as an AIDS-prevention strategy that provides people dependent on drugs with an additional option for getting away from needle use and sharing. *The main aim of MMT is to help people get off injecting, not off drugs.* Methadone dose reduction – with the ultimate goal of helping the client to get off drugs – is a longer-term objective.

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

Further, with the advent of HIV/AIDS, the arguments for offering MMT to those who were not following such a treatment outside are compelling: prisoners who are injection drug users are likely to continue injecting in prison and are more likely to share injection equipment, creating a high risk of HIV transmission (see info sheets 2 and 3). As in the community, MMT, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons.

Where Is It Being Offered?

Worldwide, an increasing number of prison systems are offering MMT to inmates. For example: in a 1997 survey undertaken in Europe, 9 of the 22 systems that participated offered MMT to opiate-dependent prisoners; in approximately half the prisons in New South Wales in Australia, MMT is provided to prisoners; in the United States, Rikers Island, New York City, has an MMT program.

In Canada, methadone was rarely prescribed to anyone in prison until quite recently. However, this is changing, partly because of the recommendations urging prisons systems to provide MMT, partly because of legal action. One such case was in British Columbia: an HIV-positive woman undertook action against the provincial prison system for failing to provide her with methadone. The woman had been refused continuation of MMT in prison. She argued that, under the circumstances she found herself in, her detention was illegal. In response, the

PREVENTION AND TREATMENT: METHADONE

prison system arranged for a doctor to examine the woman, and he prescribed methadone for her. After this, she withdrew her petition. In another case, a man with a longstanding, “serious heroin problem” was sentenced to two years less one day in prison – and thus to imprisonment in a provincial prison in Québec – because that prison had agreed to provide him with methadone treatment. The defence had submitted that it was necessary to deal with the root causes of the man’s crimes, namely his heroin addiction, and that treatment with methadone was essential to overcoming that addiction.

In September 1996 the British Columbia Corrections Branch adopted a policy of continuing methadone for incarcerated adults who were already on MMT in the community, becoming the first correctional system in Canada to make MMT available in a uniform way. On 1 December 1997 the federal prison system followed suit. Today, in the federal and in many – but not all – provincial systems, inmates who were already on MMT outside can continue such treatment in prison. However, only in the British Columbia provincial system and under “exceptional circumstances” in the federal system can inmates access MMT even if they were not on such treatment on the outside. In early 2001, however, preparations were underway to further increase access to MMT initiation in the federal system.

Are There Other Alternatives?

Some prison systems are still reluctant to make MMT available, or to extend availability to those prisoners who were not receiving it prior to incarceration. Some consider methadone as just another mood-altering drug, the provision of which delays the necessary personal growth required to move beyond a drug-centred existence. Some also object to MMT on moral grounds, arguing that it merely replaces one drug of dependence with another. If there were reliably effective alternative methods of achieving enduring abstinence, this would be a meagre achievement. However, as Dolan and Wodak have explained, there are no such alternatives:

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

Other Treatment Options

Offering other treatment options to help break dependence on drugs is also important. Providing MMT and other treatment options is crucial, and respects the rights of prisoners to the kind of care and concern that is available on the outside, rather than simply denying that drug injecting takes place inside.

Recommendation

- MMT is a medically indicated form of treatment that should be available to opiate-dependent people regardless of whether they are outside or inside prison.
- In addition, opiate-dependent prisoners should have other treatment options, including methadone detoxification programs with reduction-based prescribing, which should be routinely offered to all opiate-dependent prisoners on admission.

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Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). Ce feuillet d’information est également disponible en français.

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HIV/AIDS in Prisons

2001/2002

Care, Treatment, and Support

Info sheets 4-7 in this series emphasize the importance of preventing the further spread of HIV and other infections in prisons. This info sheet deals with an equally important issue: providing prisoners with HIV/AIDS with care, treatment, and support equivalent to that available to other members of the community.

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Concerns

Most Canadian prison health-care services do their best to provide inmates with HIV or AIDS with good care, and inmates are often referred to outside specialists for HIV-specific diagnosis and treatments. However, on some occasions inmates report that they are receiving care and treatment of lower quality than that received before entering prison, or before being referred to the particular institution at which they are currently staying.

Further, a variety of other concerns exist, such as the increase in the number of sick inmates; prisons not being equipped to deal with inmates who require long-term, ongoing care and treatment (including palliative care); and the difficulty of accessing investigational drugs or nonconventional therapies.

The Emergence of Antiretroviral Therapies

The emergence of antiretroviral combination therapies as the standard of care has exacerbated the difference in treatment available to inmates as compared with treatment available in the community. The regime stipulated for a particular combination of drugs – ingestion at specific intervals, with or without food – is often not followed in prison because it does not fit in with the prison routine. Prisoners may miss medications when they go to court, when they are transferred, or when they are released; contingency plans that are customary for ensuring that inmates with TB or diabetes receive their medication are not always made for prisoners with HIV/AIDS. Given the need to adhere closely to drug regimens in order to avoid the development of drug resistance, these failures are cause for serious concern.

Adequate Medication for Pain

There are continuing reports that prisoners with HIV/AIDS do not receive adequate medication for pain. They have been summarily cut off from pain medication, without due process, on the grounds that they were “hoarding drugs.” The problems are compounded by attitudes toward drug users, who typically require higher doses of pain relievers than non-users because of the tolerance they develop to narcotics. Inmates requesting higher doses of pain medication may be perceived as wanting to “get high” in prison. In the absence of pain medication, inmates may resort to illicit drugs to manage their pain.

Coroners Inquests

Many of the failings of prison systems were brought to light in a 1997 inquest into the care of Billy Bell, an inmate who died of AIDS-related causes at the Regional Hospital Unit of Kingston Penitentiary. At the inquest into Billy Bell’s death,

CARE, TREATMENT, AND SUPPORT

a specialist from the HIV clinic at the Kingston General Hospital, Dr Sally Ford, testified about how the prison failed to provide Billy the quality care that her patients outside the prison receive. The prison pharmacy would run out of doses of AZT and Billy would miss his dose days at a time. Billy experienced difficulty accessing proper pain management medication, lack of compassion from staff, and dangerous delays in the diagnosis of AIDS-related illnesses. It was a chaplain, not the prison health staff, who suggested that his chronic migraine headaches might be caused by the deadly meningitis.

In addition, when Billy Bell was released to a halfway house in Toronto, six months before his death, no arrangements were made for his medical care. After hearing the evidence at the inquest, the coroner's jury recommended, among other things, that the Correctional Service of Canada review and upgrade their palliative care approach; that pain management be available to prisoners; and that proper pre-release planning be done.

Nevertheless, many of the issues raised at the 1997 inquest were raised again at another inquest under the *Coroners Act* held in Kingston in early 2001. Michael Joseph LeBlanc probably became infected with HIV and Hepatitis C while incarcerated in a Federal Penitentiary. In November 1999, he died inhumanely at the Regional Hospital in Kingston Penitentiary, in extreme physical, psychological and emotional distress.

Recommendations

Increased efforts need to be undertaken in prisons to ensure that prisoners receive care, support, and treatment equivalent to that available outside. This includes, but is not limited to:

- making sure that inmates in pain have equal access to narcotics routinely given for pain relief to patients on the outside;
- allowing inmates equal access to investigational drugs and complementary therapies;

- ensuring that inmates have access to information on treatment options and the same right to refuse treatment as exists in the community;
- emphasizing health promotion strategies for all prisoners, prisoners with HIV or AIDS in particular, in order to slow the progression of their disease;
- making sure that complaints from inmates about lack of care, support, and treatment be dealt with appropriately; and
- assessing health-care services in each prison in consultation with outside experts, to ensure that the expertise necessary for the care, support, and treatment of inmates with HIV/ AIDS is available, accessible, and efficient.

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

Additional Reading

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HIV/AIDS in Prisons

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A Comprehensive Strategy

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

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A Rare Case of Consensus

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

What Has Been Recommended?

All organizations and committees have recommended that a *comprehensive strategy* be adopted to deal with HIV/AIDS in prisons. Probably the most inclusive list of recommendations (88) was issued in 1994 by ECAP – a list that was updated in the 1996 report on HIV/AIDS in prisons of the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society.

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

A long-term, strategic approach

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

A health issue

Because prisoners come from the community and return to it, and because what is done – or is not done – in prisons with regard to HIV/AIDS, hepatitis, and drug use has an impact on the health of all, health ministries need to take an active role and work in close collaboration with correctional systems to ensure that the health of all, including prisoners, is protected and promoted. Another option, which has been widely recommended, is to transfer control over prison health to public health authorities. Some countries have already introduced such a change. Norway was one of the first. And in France, where prison health was transferred to the Ministry of Health in 1994, a positive impact is already

A COMPREHENSIVE STRATEGY

evident. Each prison in France is twinned with a public hospital and, according to UNAIDS, “conditions have improved noticeably since the transfer of responsibility for health.”

HIV testing

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

Educational programs for inmates

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

Educational programs for staff

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

Protective measures for staff

Making sure that staff’s workplace is safe is crucial. In this context, staff are rightly concerned about overcrowding in the institutions, and understaffing,

which – rather than measures taken to prevent the spread of HIV in prisons – constitute the real threats to their safety. Prison systems have to address staff’s concerns in these areas.

Drug policy

Reducing the number of drug users who are incarcerated needs to become an immediate priority. Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available.

Additional Reading

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Aboriginal Prisoners and HIV/AIDS

Aboriginal people are vastly overrepresented among prisoners in both federal and provincial prisons in Canada. At the same time, the HIV epidemic among Aboriginal people shows no sign of abating. All the measures described in info sheets 4-9 will help address the issues Aboriginal prisoners face in the context of HIV/AIDS, but the additional measures described in this sheet are also necessary.

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The Numbers

In a judgment rendered on 23 April 1999, the Supreme Court of Canada said that prison has replaced residential schools as the likely fate of all too many modern-day Aboriginal Canadians. The Court pointed out that:

- While less than three percent of the national population is Aboriginal, Aboriginal people represent 15 percent of the federal inmate population.
- In the Prairie Region of the Correctional Service of Canada (CSC), Aboriginal people account for 64 percent of the inmate population.
- A male treaty Indian is 25 times more likely to be incarcerated in provincial jail than a non-Native.
- A female treaty Indian is 131 times more likely to be incarcerated in provincial jail than a non-Native.
- While Aboriginal people make up only six to seven percent of the general population in Manitoba and Saskatchewan, they comprise 72 percent of the provincial jail admissions in Manitoba and 55 percent in Saskatchewan.

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

What Must Be Done?

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

In addition, however, there is a need for initiatives, by and for Aboriginal inmates, that recognize their special needs and cultural values and promote opportunities for them to improve their health. In its 1994 report, the Expert Committee on AIDS and Prisons (ECAP) proposed the following initiatives:

- Development of information and prevention programs that will respond to the specific needs of Aboriginal inmates.
- Inclusion of community and peer input into these programs.
- Increased efforts, for and by Aboriginal inmates, their communities, and elders, with the assis-

ABORIGINAL PRISONERS AND HIV/AIDS

tance of CSC and others, to improve the health status of Aboriginal inmates.

- Increased efforts to decrease the vulnerability of Aboriginal inmates to exposure to infectious diseases, in particular HIV infection, to drug use and its harms, and to imprisonment.

The Committee made a series of recommendations:

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

In recent years, an Aboriginal People and HIV/AIDS in Corrections Action Committee has developed an HIV/AIDS Strategy specific to Aboriginal people in the federal prison system. In 2000, the Committee agreed on an action plan that includes, among other things, the development and implementation of an Aboriginal Peer Education and Counseling Model; awareness and education sessions on HIV/AIDS for Elders; and an Aboriginal-specific training package for staff.

Finally, implementing that action plan and the recommendations of the Expert Committee on AIDS and Prisons and adopting strategies and actions for Aboriginal people and HIV/AIDS in prison, while essential, will not be enough. Various government inquiries have concluded that the

justice system is failing Aboriginal people on a crushing scale. As the Supreme Court of Canada said, “[t]hese findings cry out for recognition of the magnitude and gravity of the problem, and for responses to alleviate it.” Every attempt should be made to divert Aboriginal people away from prison and toward alternatives.

Additional Reading

R v Gladue, SCC, 23 April 1999, File no 26300. A must-read. Available at www.droit.umontreal.ca/doc/csc-scc/en/index.html.

Aboriginal People and HIV/AIDS: Legal Issues. Montréal: Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 1999. A series of info sheets on issues of discrimination, jurisdiction and funding, and testing and confidentiality. Available at www.aidslaw.ca/Maincontent/issues/aboriginalcomm.htm.

Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994. See pages 114-118 for a discussion of issues of relevance to Aboriginal offenders.

Health Canada. *HIV/AIDS Epi Update: HIV and AIDS Among Aboriginal People in Canada*. Ottawa, April 2000. Available at www.hc-sc.gc.ca/hpb/lcdc/bah.

D McCaskill, M Thrasher. *Final Report on AIDS and Aboriginal Prison Populations for the Joint Committee on Aboriginal AIDS Education and Prevention*. March 1993. An early report on Aboriginal people and HIV/AIDS in prisons.

B Warhaft. *Aboriginal People and HIV in Prison – The Report*. Vancouver: Public Policy Program, Simon Fraser University, 1998. The report of a conference held in October 1997.

Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). Ce feuillet d'information est également disponible en français.

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HIV/AIDS
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Women Inmates and HIV/AIDS

Studies have shown that the prevalence of HIV among women inmates is even higher than among male inmates. At the same time, the proportion of women among new HIV infections in Canada is increasing steadily. The measures described in info sheets 4-9 will help address the issues women inmates face in the context of HIV/AIDS, but the additional measures described in this sheet are also necessary.

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

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The Numbers

Seroprevalence studies undertaken in Canadian prisons, as well as a series of studies undertaken in prison systems in other countries, have shown that HIV infection is prevalent among women prisoners, in particular among those who have a history of injection drug use. Indeed, HIV seroprevalence among women prisoners generally exceeds that of male prisoners. For example, in studies in provincial prisons in Québec, the HIV seroprevalence rate among female inmates in one prison was 7.7 percent, while it was 4.7 and 2.0 percent among male prisoners in two prisons. Similarly, in December 2000, 4.7 percent of inmates in federal women's institutions, compared to 1.66 percent of all inmates in the Canadian federal prison system, were known to be HIV-positive.

At the same time, Canadian women – not just women prisoners – are increasingly becoming infected with HIV, especially those who use injection drugs and whose sexual partners are at increased risk for HIV:

- The proportion of AIDS cases among adult women has increased from 5.6 percent of all AIDS cases before 1990 to 7.7 percent in 1994 and 16.3 percent in 1999.
- The proportion of AIDS cases among adult women attributed to injection drug use has increased dramatically from 7.3 percent before 1990 to 26.6 percent in 1994 and 43.8 percent in 1998.
- It is estimated that by the end of 1999, 6,800 women in Canada were living with HIV, out of an estimated total of 49,800 people with HIV.
- Women accounted for 23.9 percent of all HIV-positive test reports in 1999 that included information on gender. Injection drug use was a risk factor for 46 percent of these HIV-positive women.

What Must Be Done?

Women inmates need the same preventive measures (see info sheets 4-7), and the same level of care, treatment, and support (see info sheet 8) as male prisoners.

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

WOMEN INMATES AND HIV/AIDS

Underlying issues

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

Many HIV-positive women do not receive the diagnostic and treatment services that could benefit them as early as do HIV-positive men. Among the reasons for this is that women are often unaware of having been exposed to HIV by their sexual or drug-using partners and as a result do not seek counseling, HIV testing, and care and treatment. Second, the needs of HIV-positive women differ from those of men, and social and community support are often less frequently available and less accessible. As a consequence, women are often less educated than men about HIV infection and AIDS and do not have the support structures they need. Third, disease manifestations attributable to HIV infection or AIDS are often different in women, which has led to underrecognition or delays in diagnosis. Thus, women who are infected have often been diagnosed as infected or having AIDS later than men.

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

A model to follow

Many prison systems still have not implemented education and prevention programs targeted specifically to female inmates. Some, including the Canadian federal prison system, are now developing such programs. In some systems,

however, programs have been in place for many years. For example, at a provincial medium-security prison for women in Montréal, community input into information and prevention efforts started as early as 1987, after the first case of an HIV-infected woman in that prison became known. These efforts have included education about HIV/AIDS for both staff and prisoners, access to anonymous HIV testing carried out by outside community-health clinics, and cooperation with external resources for medical and psychosocial support. Research on HIV seroprevalence and on risk factors among prisoners started in January of 1988. As a result of these efforts, a climate of tolerance replaced the initial reactions of fear and discrimination against HIV-infected prisoners.

Recommendation

Prison systems need to take immediate action to develop and implement effective education and prevention programs targeted specifically to female inmates.

Additional Reading

Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994. Pages 109-113 discuss issues of particular relevance to women inmates.

Health Canada. *HIV/AIDS Epi Update: HIV and AIDS among Women in Canada*. Ottawa, April 2000. Information on the status of HIV and AIDS among women in Canada. Available at www.hc-sc.gc.ca/hpb/lcdc/bah.

World Health Organization. *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva: WHO, 1993 (WHO/GPA/DIR/93.3). Recommendations 44-46 concern women inmates. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP5.html.

Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). Ce feuillet d'information est également disponible en français.

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A Moral and Legal Obligation to Act

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

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

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The State's Duty with Respect to Health

By its very nature, imprisonment involves the loss of the right to liberty. However, prisoners retain their other rights and privileges "except those necessarily removed or restricted by the fact of their incarceration." In particular, prisoners, as every other person, have "a right to the highest attainable level of physical and mental health": the state's duty with respect to health does not end at the gates of prisons.

Recommendations on HIV/AIDS and drug use in prisons have all stressed the importance of prevention in prisons, and have suggested that condoms, bleach, sterile needles, and methadone maintenance treatment be available to prisoners; and have stressed the importance of providing inmates with care, treatment, and support equivalent to those available outside. According to the 1993 World Health Organization (WHO) Guidelines on HIV/AIDS in Prisons, "[a]ll prisoners have the right to receive health care, *including preventive measures*, equivalent to that available in the community without discrimination." WHO states that prison administrations have a responsibility to put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike. This is consistent with the *Mission of the Correctional Service of Canada*, according to which the provision of a "safe, secure and clean environment that promotes health and well-being" is a "strategic objective."

Legal Action by Prisoners

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

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

Further, in at least two cases, Australian prisoners initiated legal action to secure damages for having contracted HIV in prison. The first prisoner seroconverted while in a maximum-security institution in Queensland and launched an action for damages for negligence against the prison system. The second prisoner testified from his hospital bed that he had contracted HIV while under the control and custody of the New South Wales prison authorities, and instituted a negligence claim against the authorities for failing to provide him with access to

A MORAL AND LEGAL OBLIGATION TO ACT

condoms and sterile needles while he was incarcerated. Because he died shortly after the commencement of the pre-trial hearing and left no estate or dependants, the case ended with his passing.

These legal cases have been important, but it would be a shame if prisoners were obliged to have recourse to the courts in order to claim and have recognized their rights to access preventive means. There can be no question that the issue of providing protective means to prisoners would be more appropriately dealt with by swift action by correctional systems than by court action.

Why Should We Care?

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

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

Introduction of preventive measures in prisons, and providing inmates with medical care equivalent to that available outside, is in the interest of all concerned. Any measure undertaken to prevent the spread of HIV and other infections will benefit prisoners, staff, and the public. It will protect the health of prisoners, who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. It will protect staff: lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered. It

will protect the public. Most inmates are in prison only for short periods of time and are then released into their communities. In order to protect the general population, prevention measures need to be available in prisons, as they are outside.

Additional Reading

Correctional Service Canada. *Mission of the Correctional Service of Canada*. Ottawa: Ministry of Supply and Services Canada, 1997.

One of CSC's "fundamental goals and directions" is the provision of a safe environment and the promotion of health. For copies, contact the Communications Branch, Correctional Service Canada, 340 Laurier Avenue West, Ottawa, K1A 0P9 (www.csc-scc.gc.ca).

Joint United Nations Programme on HIV/AIDS. United Nations Commission on Human Rights (Fifty-second Session, item 8 of the agenda). *HIV/AIDS in Prisons – Statement by UNAIDS*. Geneva, April 1996. Argues that the treatment of prisoners in many countries constitutes a violation of the prisoners' human rights. Available at www.unaids.org.

R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & CAS, 1996. Pages 81-94 and appendices 1 and 2 discuss the legal responsibility of prison systems. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm.

H Krever, The Honourable Mr Justice. *Commission of Inquiry on the Blood System in Canada: Final Report*. Volumes 1-3. Ottawa: Minister of Public Works and Government Services Canada, 1997. After this report, governments should know better than to continue fragmented, reactive approaches to the public health crisis occurring in prisons.

J Skirrow. Lessons from Krever – a personal perspective. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 35-41. Discusses nine lessons that emerge from the Krever Report. At www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/krever.htm.

Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). **Ce feuillet d'information est également disponible en français.**

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Essential Resources

There is a vast amount of literature on HIV/AIDS in prisons. This info sheet provides information about a number of selected, essential resources – articles, books, reports, and newsletters that provide crucial information and/or recommendations on HIV/AIDS in prisons.

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Canadian Resources

Canadian Centre on Substance Abuse & Canadian Public Health Association. *HIV, AIDS and Injection Drug Use: A National Action Plan.* Ottawa: The Centre & The Association, 1997.

The national action plan on HIV/AIDS and injection drug use emphasizes that “Canada is in the midst of a public health crisis concerning HIV and AIDS, and injection drug use,” and that “[i]mmediate action is required at all levels of governmental and community leadership.” With regard to HIV/AIDS in prisons, it states that “conditions in correctional settings must be improved” by increasing access to methadone treatment and conducting “pilot programmes of needle exchange in federal and provincial correctional settings.” Available at the website of the Canadian Centre on Substance Abuse (www.ccsa.ca) or through the Canadian HIV/AIDS Clearinghouse (tel: 1-877-999-7740; email: aids/sida@cpha.ca).

Canadian Public Health Association. *Report from the Round Table Meeting on Communicable Diseases Within and Outside the Correctional Community.* Ottawa: CPHA, 2000.

For a copy, contact CPHA at info@cpha.ca.

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

One of the most comprehensive reports on issues raised by HIV/AIDS and by drug use in prisons. It contains 88 recommendations on how to prevent HIV transmission in prisons and on care for prisoners with HIV/AIDS. Still extremely relevant, but must be read together with Jürgens, 1996, *infra*. Also available: *HIV/AIDS in Prisons: Summary Report and Recommendations* (the summary version of the report); and *HIV/AIDS in Prisons: Background Materials* (includes a review of Canadian legal cases dealing with issues raised by HIV/AIDS in prison, a summary of the prison policies of Canadian provinces and territories and of selected foreign countries, and an analysis of the legal and ethical issues raised by protecting confidential medical information pertaining to prisoners).

Correctional Service Canada. *1995 National Inmate Survey: Final Report.* Ottawa: CSC (Correctional Research and Development), 1996, No SR-02.

The results of a CSC survey of 4285 inmates, confirming that a high proportion of inmates engage in high-risk behaviours.

R Elliott. *Prisoners’ Constitutional Right to Sterile Needles and Bleach.* Appendix 2 in R Jürgens. *HIV/AIDS in Prisons: Final Report.* Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996.

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Do prisoners have a right to the means that would allow them to protect themselves against contracting HIV and other diseases in prisons? Can prison systems be forced to provide condoms, bleach, and sterile needles? Can and should the law be used to achieve change in prison HIV/AIDS policies? The article discusses these questions. In particular, it analyzes whether denying prisoners access to sterile needles is a violation of their constitutional rights. Available at www.aidslaw.ca/Maincontent/issues/prisons/APP2.html.

R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996.

A comprehensive 150-page report, summarizing the history of HIV/AIDS in prisons in Canada and internationally. Includes sections on prevalence of risk behaviours in prisons, HIV transmission behind bars, needle-exchange programs, methadone maintenance treatment, and more. Argues that prison systems have a moral and legal obligation to act to reduce the risk of further spread of HIV behind bars, and to provide appropriate care, treatment, and support. Includes hundreds of references and a substantial bibliography. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse.

Prisoners with HIV/AIDS Support Action Network. *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy*. Toronto: PASAN, 1998.

Discusses the risk of HIV infection for transsexual and transgendered prisoners, summarizes the major issues confronting male-to-female transsexual and transgendered prisoners, and makes recommendations for action in the following areas: prevention of HIV transmission; injection drug use and HIV; medical and support services; human rights and confidentiality; and aftercare. For copies, contact PASAN (email: pasan@interlog.com).

International Resources

American College of Physicians, National Commission on Correctional Health Care, and American Correctional Health Services Association. The crisis in correctional health care: the impact of the national drug control strategy on correctional health services. *Annals of Internal Medicine* 1992; 117(1): 72-77.

A joint position paper pointing out how existing problems in prisons in the US have been exacerbated by the war on drugs. The paper recommends that the drug-control strategy, with its emphasis on incarceration, be reconsidered; that correctional

health-care budgets reflect the growing needs of the inmate population; that correctional health care be recognized as an integral part of the public health sector; that correctional care evolve from its present reactive "sick call" model into a proactive system that emphasizes early disease detection and treatment, health promotion, and disease prevention.

P Bollini (ed). *HIV in Prison. A Manual for the Newly Independent States*. Médecins Sans Frontières, Prison Reform International, World Health Organization, 2001 (forthcoming).

A manual for prison staff in the countries of the former Soviet Union. Extremely useful for other prison systems as well.

RL Braithwaite, TM Hammett, RM Mayberry. *Prisons and AIDS: A Public Health Challenge*. San Francisco: Jossey-Bass, 1996.

Provides information about the frequency of sexual contact, drug use, needle sharing, and tattooing in prisons in the US; analyzes existing educational and prevention efforts; and recommends strategies for developing improved prevention programs, including for young offenders and for ethnic-minority inmates. Includes a guide to education and prevention resources in the US.

K Dolan, A Wodak. An international review of methadone provision in prisons. *Addiction Research* 1996; 4(1): 85-97.

Few papers have appeared documenting the provision of methadone in prison systems. This is probably the most comprehensive review, based on correspondence with prison authorities in a number of countries.

NN Dubler, VW Sidel. On research on HIV Infection and AIDS in correctional institutions. *The Milbank Quarterly* 1989; 67(2): 171-207.

The article discusses the problems involved in conducting research on prisoners. It concludes that, although a prison setting precludes voluntary and uncoerced choice, prisoners should be permitted to choose to participate in research, including therapeutic trials with no placebo arm that hold out the possibility of benefit.

European Network on HIV/AIDS and Hepatitis Prevention in Prisons. *Final Report on the EU Project European Network on HIV/AIDS Prevention in Prisons*. Bonn and Marseille: The Network, 1997.

The proceedings of the first seminar of the European Network for HIV/AIDS and Hepatitis Prevention in Prison, held in Marseille on 20 June 1996, contain a review of literature on HIV risk behaviours in prisons and an overview of the situation

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in six European countries: Germany, Scotland, France, Italy, the Netherlands, and Sweden. For a copy, contact WIAD e.V., Godesberger Allee 54, 53175 Bonn, Germany. The French report, *L'infection à VIH en milieu carcéral: épidémiologie, prévention, aspects éthiques et juridiques*, can be ordered from: Service d'étude de l'O.R.S., 23 rue Stanislas Torents, 13006 Marseille, France. Tel: (33-4) 91-59-89-00; fax: (33-4) 91-37-48-24. See also: **European Network on HIV/AIDS and Hepatitis Prevention in Prisons. 2. Annual Report – European Network on HIV/AIDS Prevention in Prisons. Bonn and Marseille: The Network, 1998** (the second report by the European Network, with detailed information regarding HIV/AIDS and hepatitis in prisons in 16 European countries and an updated European bibliography on HIV/AIDS in prison).

TM Hammett, P Harmon, L Maruschak. 1996-1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities. Washington, DC: US Dept of Justice, National Institute of Justice and US Department of Health and Human Services, Centers for Disease Control and Prevention, 1999. Summarizes the situation with regard to HIV/AIDS, STDs, and TB in prisons in the US. Updated every few years. Available at www.ojp.usdoj.gov/nij/pubs-sum/176344.htm.

Joint United Nations Programme on AIDS. Prisons and AIDS: UNAIDS Technical Update. Geneva: UNAIDS, 1997; and Prisons and AIDS: UNAIDS Point of View. Geneva: UNAIDS, 1997. An extremely useful pair of documents on HIV/AIDS and drug use in prisons around the world, with basic information about the issues, challenges, responses, resources, and UNAIDS' point of view. This is probably the best summary available on HIV/AIDS and drug use in prisons. Available at www.unaids.org and in English, French, Russian, or Spanish from a UNAIDS Information Centre (for more info, contact UNAIDS at unaids@unaids.org; tel: 41-22 791-4651).

Joint United Nations Programme on HIV/AIDS. United Nations Commission on Human Rights (Fifty-second Session, item 8 of the agenda). HIV/AIDS in Prisons – Statement by the Joint United Nations Programme on HIV/AIDS (UNAIDS). Geneva, April 1996.

This statement by UNAIDS to the Commission on Human Rights argues that the treatment of prisoners in many countries constitutes a violation of the prisoners' human rights. UNAIDS urges all govern-

ments to use the World Health Organization's guidelines on HIV/AIDS in prisons (see *infra*) in formulating their prison policies and offers assistance to any government wishing to implement the guidelines. Available at www.unaids.org.

J Nelles, E Fuhrer (eds). Harm Reduction in Prison: Strategies Against Drugs, AIDS and Risk Behaviour. Berne: Peter Lang AG, 1997.

A summary of the proceedings of a symposium on harm reduction in prisons, held in Berne, Switzerland, in March 1996. At the symposium, the initial results of the first scientifically evaluated needle-exchange project in prison were presented and discussed to "prepare a scientific basis for subsequent political decisions." Articles in English, French, and German.

J Nelles, T Harding. Preventing HIV transmission in prison: a tale of medical disobedience and Swiss pragmatism. The Lancet 1995; 346: 1507.

Describes how Dr Franz Probst, a part-time medical officer working at Oberschöngrün prison in the Swiss canton of Solothurn, began distributing sterile injection material without informing the prison director: the world's first distribution of injection material inside prison began as an act of medical disobedience.

S Rutter et al. Is Syringe Exchange Feasible in a Prison Setting? An Exploration of the Issues. Technical Report No 25. Sydney: National Drug and Alcohol Research Centre, 1995.

A study conducted to consider the issues raised by syringe-exchange programs in prison and to assess their possible benefits, adverse consequences, and the feasibility of implementing them. The study found that needle and syringe exchange is feasible in Australian prisons.

D Shewan, JB Davies (eds). Drug Use and Prisons: An International Perspective. Amsterdam: Harwood Academic, 2000.

Provides a comprehensive account of patterns of drug use and risk behaviours in prisons, and of the different responses to this feature of prison life. Contains articles from Europe, North and South America, Africa, and Australia. A must-read.

H Stöver. Study on Assistance to Drug Users in Prisons. Lisbon, European Monitoring Centre for Drugs and Drug Addiction, 2001 (EMCDDA/2001).

A very up-to-date and comprehensive study on HIV/AIDS and drug use in prisons. For copies: info@emcdda.org.

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World Health Organization. WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: WHO, 1993 (WHO/GPA/DIR/93.3).

This 10-page article written from a public health perspective proposes standards for prison authorities in efforts to prevent HIV transmission and provide care to those with HIV/AIDS in prisons. Available at www.aidslaw.ca/Maincontent/issues/prisons.htm.

Newsletters

AIDS Policy & Law

A US biweekly newsletter on legislation, regulation, and litigation concerning AIDS. Contains short summaries of US developments, mainly lawsuits. For info, contact *AIDS Policy & Law* (tel: 215-784-0860).

Canadian HIV/Policy & Law Review

Required reading for all those working on, or interested in, HIV/AIDS in prisons. Provides regular updates and feature articles on policies and programs from around the world. Bilingual (English and French). For info, contact the Canadian HIV/AIDS Legal Network – email: info@aidslaw.ca. Also available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm.

HIV/AIDS Legal Link

Regular updates on HIV/AIDS in prisons in Australia. For info, contact the HIV/AIDS Legal Link (tel: 61-2-9281-1999; email: afao@rainbow.net.au).

Hepp News

Provides HIV updates designed for practitioners in the correctional setting. Targets correctional administrators and HIV/AIDS care providers, with up-to-the-moment information on HIV treatment, efficient approaches to administering such treatments in the correctional environment, and US and international news related to HIV in prisons. Published monthly and distributed by fax. For info, see www.hivcorrections.org/

Spectra

The quarterly newsletter of the Swiss Federal Office of Public Health. Regularly carries updates on the

many innovative approaches to HIV prevention in prison implemented in Switzerland (such as needle-distribution programs). Trilingual (German, English, French). For a free subscription, contact GEWA, Tannholzstrasse 14, PO Box CH-3052, Zollikofen.

Websites

www.aidslaw.ca

The website of the Canadian HIV/AIDS Legal Network. Nowhere will you find more info on HIV/AIDS in prisons than on this site.

www.catie.ca

The Community AIDS Treatment Information Exchange website, an essential source for treatment information.

www.prisonpoz.org

For HIV and hepatitis activism. Parts are still under construction, but promising.

www.thebody.com/whatis/prison.html

The Body is one of the HIV/AIDS “super-sites.” Their prison reference page provides links to a number of articles and publications.

<http://hivinsite.ucsf.edu/topics/prisons/>

HIV Insite is another HIV/AIDS “super-site.” Their prison site links to prison-related info in the “AIDS Knowledge Base” online textbook, as well as other documents and sites. Also a useful tool for searching recent news documents about HIV/AIDS and prison.

For More Resources ...

consult *Legal and Ethical Issues Raised by HIV/AIDS: Literature Review and Annotated Bibliography*. Montréal: Canadian HIV/AIDS Legal Network, 2nd edition, 1998. Contains a section on HIV/AIDS in prisons with many additional resources. The web version, available at www.aidslaw.ca/Maincontent/otherdocs/biblio/c-20.htm, is bilingual (English and French) and updated regularly.

Second, revised and updated version, 2001. Copies of this info sheet are available on the Network website at www.aidslaw.ca/Maincontent/issues/prisons.htm and through the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca). Reproduction of the info sheet is encouraged, but copies may not be sold, and the Canadian HIV/AIDS Legal Network must be cited as the source of this information. For further information, contact the Network (tel: 514 397-6828; fax: 514 397-8570; email: info@aidslaw.ca). Ce feuillet d'information est également disponible en français.

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