



# SOLIDARITY

P R O J E C T

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## Welcome to the Solidarity Project

Julie Davids, Executive Director,  
Community HIV/AIDS Mobilization Project (CHAMP)

**What is HIV?** HIV is a virus. AIDS is a disease caused by the virus known as HIV.

But these definitions do little to reflect the realities of HIV/AIDS, a pandemic that tracks along lines of poverty, discrimination and marginalization worldwide.

We now know how to prevent HIV. We know how to treat it. We know how to combat discrimination against people with HIV, or the communities that bear the greatest burden of infection.

But that doesn't mean we do it. Lack of political will means lack of resources means lack of capacity to overcome today's HIV/AIDS challenges, even as we continue the search for a cure.

For over two decades, people living with HIV and their allies have insisted that "AIDS is a political crisis." And the politics of this crisis demand solidarity if they are to be overcome.

**What is solidarity?** Solidarity is defined as a "feeling or condition of unity based on common goals, interests, and sympathies among a group's members."

It can seem like there is little hope of unity among people fighting HIV/AIDS. Over the past year in the United States alone, national struggles over the re-authorization of the Ryan White CARE Act in the face of sustained under-funding, as well as new guidelines on HIV testing that pitted long-standing requirements for counseling and consent against aspirations of expanding HIV testing, have widened the fault lines that divide us by region, background, individual experiences, and level of access to resources.

It can be even harder to build solidarity across national borders. Just at the time in which President Bush announced new funding for global AIDS, the first big wave of funding cuts were starting to



decimate AIDS community efforts in our own nation. It is understandable that many people in the United States who face very real and very growing epidemics in our families, our communities, and in our towns and cities can feel distanced from the global fight against HIV/AIDS that has captured headlines – but we need to also understand that the headlines have not been matched by adequate funding or effective policies.

**The truth of it is, AIDS remains a political crisis.**

Cuts to HIV prevention funding in the US, and a freeze on funds for services despite increasing number of people living with HIV in need of care, did not happen because those funds were moved to global AIDS. Instead, those funds have gone to war.

The United States is funding a ravenous war economy, and all sorts of domestic programs have been slashed in the quest for billions of dollars to fight in Iraq, in Afghanistan, and elsewhere. If we had a fraction of one day's military budget, we could fill all the holes in the Ryan White CARE Act, and quell much of the battle over shrinking resources that has been forced upon our communities.

The Community HIV/AIDS Mobilization Project (CHAMP) is committed to a solidarity approach in the fight against HIV/AIDS. This newsletter will provide information on key HIV/AIDS issues that affect people in the United States and around the world. We will also provide *conversation starters* in the back of each issue to help spur discussion of hard topics on these issues in our own communities.

The Spanish language version of this newsletter should reach you within the next month. In the coming months, we will also be releasing every issue simultaneously in Spanish and English.

**This month's publication** explores the connection between incarceration and HIV/AIDS. Jails and prisons are an epicenter in the AIDS epidemic and globally, as co-factors for HIV infection such as poverty, racism, and drug-use are also co-factors for incarceration. We believe that prison issues should be central to the agenda of HIV/AIDS activists, and hope that this month's newsletter will serve as a useful tool. Specifically, we suggest the following steps:

1. Use the conversation starter (see page 13) in this newsletter to initiate discussion in your organizations and in your communities about the real cost of prison in the HIV epidemic.
2. If you are a part of an organization, sign onto Stop Prisoner Rape's Call for Change to support LGBT inmates and detainees (see page 10).
3. Make a financial contribution to South Africa's Treatment Action Campaign (TAC) to provide much needed support for their ongoing work in support of HIV positive inmates.
4. Contact Sarah Howell at CHAMP Academy ([showell@champnetwork.org](mailto:showell@champnetwork.org) / 401-427-2302 x 10) if you are interested in training and technical support on integrating prison and jails advocacy into the mission and work of your organization.

Please contact us with feedback and to let us know how we can provide additional help. Solidarity will **build the political will to fight HIV/AIDS.**



## Locked Up and Locked Out:

### ***Advocates Join Prisoners in Fight Against Double Epidemic of HIV and Hepatitis C Behind Bars in the United States***

*By Suzy Subways*

An estimated one in four people living with HIV in the United States spends time behind bars each year. Depending on the region, up to a third of incarcerated people may also be living with hepatitis C.

Given these realities, it should be clear that a well-organized effort to address these overlapping diseases behind bars is necessary, and that prisoner health and public health cannot be separated.

Sadly, this sensible conclusion has not been reached by many policymakers or purseholders. Prisoners with HIV and hepatitis C, along with their outside advocates, are left without resources or much organizational support, battling mazes of bureaucracy that vary between cities and states, sharing ideas over the internet and snail mail, and struggling to keep up with the mounting need for advocacy.

As we prepare to enter 2007, there are a handful of efforts – including bills in Congress – that take on the challenge of HIV and hepatitis C in prison. With more eyes finally open to the problems inside prisons and jails, there may be increased opportunities to link and amplify these efforts.

Many activists point out the links between War on Drugs policy and the rate of HIV in the Black community. Between 1982 and 1996, as sentences for minor drug crimes got longer, the percentage of prisoners who were Black increased to well over half. Meanwhile, the National Institute of Justice [reported](#) in 2005 that 1.9% of male prisoners and 2.8% of female prisoners have HIV.

Illinois passed the first law directed at these linked issues – the [African-American HIV/AIDS Response Act](#) – last year. It will expand voluntary counseling and testing in state and county jails, create new leadership positions in state government to coordinate efforts against HIV in the Black community, and research the links between incarceration and HIV. It will even set up re-entry services, says Reverend Doris Green of the AIDS Foundation of Chicago, who has advocated for prisoners for 25 years. There's one catch, though, she says – the law doesn't have any funding yet. "We worked very hard for this bill, and we're going to work twice as hard to get it funded," she says.

#### **Condoms Save Lives – but what about the lives of the incarcerated?**

The Illinois bill stopped short of authorizing one public health measure that Rev. Green says is urgently needed inside: condoms. In April, the Centers for Disease Control (CDC) released [data](#) from interviews with HIV positive male Georgia prisoners, revealing that the vast majority of sex in the prison is consensual. Thirty percent of those who had consensual sex tried to protect themselves and their partners – mostly by crafting makeshift barriers out of latex gloves or saran wrap.



But prisons only provide condoms in Vermont, Mississippi, Philadelphia, Washington, DC, Los Angeles, San Francisco and New York City. Most of these programs are fairly restricted. For example, the LA program is only allowed to serve a small unit of out gay and transgender inmates. Philadelphia's policy purports to offer universal access, but as one former prisoner told ACT UP members who interviewed him, the majority of corrections officers would "order you to go to the hole or confinement...once they come in your cell and find condoms. Then they know you are doing something [illegal]."

A broad coalition of AIDS organizations in Southern California led a powerful effort statewide, winning the support of 70% of the state's voters and both legislative houses to pass a law allowing distribution in all California prisons – but Arnold Schwarzenegger terminated it with a veto in late September. Mary Sylla of the Center for Health Justice says the coalition may decide to push for the bill's re-introduction next year, and/or approach facilities one by one to start condom programs – a step that would be needed even if the law passed. ACT UP activists in [Philadelphia](#) and [Austin](#), Texas, working with CHAMP's Prevention Justice Partnership program, have also initiated condom-in-prison advocacy campaigns in the past year.

Meanwhile, in the federal House of Representatives, Representative Barbara Lee has introduced a [bill](#) to allow community organizations to provide condoms -- along with voluntary counseling, testing and treatment of all STDs, including hepatitis C -- in federal prisons. Her announcement came after fellow California Congress member Maxine Waters announced a different bill at the global AIDS conference in Toronto in August. The Waters bill would require mandatory testing for all new and soon-to-be released federal prisoners. Under pressure from the HIV community, Waters later added an opt-out provision, but the bill does not specifically require that prisoners be *informed* that they have the right to opt out of the test.

The ACLU's [National Prison Project](#) Coordinator for HIV and Hepatitis, Jackie Walker, notes that "one good aspect [of the Waters bill] is that it would mandate comprehensive treatment." Even if prisoners are tested for hepatitis C, it is common to neglect to tell them that they indeed were tested, or give them test results. While Walker has gotten letters from some prisoners who *are* getting hepatitis C treatment, it is far from the norm. Facilities may also impose "residency requirements" that allow the costly hepatitis C treatment to be denied to people who have not been serving lengthy sentences.

### **States of Neglect**

Last year, the *New York Times* ran an expose of Prison Health Services (PHS), the biggest corporation in the country's \$2 billion-a-year for-profit inmate medical-provider industry. The state had faulted PHS in 23 prisoner deaths within a decade. Dr. Bobby Cohen, a federal court-appointed prison health monitor, told [Democracy Now](#) reporters, "There is no room for for-profit health care in prisons.... There's a fixed amount of money, and whatever they don't spend, they keep."

New York state activists won the removal of a 15-month residency requirement for hepatitis C treatment, but have lost ground in a fight to get direct Department of Health oversight of prison healthcare. "The Department of Correctional Services (DOCS) self-monitors and self-governs," says the [Alliance for Inmates With AIDS](#)'s Romeo Sanchez, a formerly incarcerated advocate living with hepatitis C. And the state's



10,000 Spanish-language-dominant prisoners “must turn to their peers who are bilingual for translation. Their confidentiality is breached, omissions of information occur and the potential for misdiagnosis is constant.”

In Alabama, a [Southern Center for Human Rights](#) lawsuit settled in June improved healthcare in the state’s segregated facility for those with HIV. Ironically, one improvement was to ditch the disastrous for-profit provider the state had been paying, NaphCare, and replace it with PHS, raising the standard of Alabama’s prison health care, apparently, to a level tolerated by other states but that may be far from adequate.

### **Cutting to the Root of Bad Prison Policies**

“Somerville wants to add up to 600 jail beds, but half the state detox beds have been cut,” says Susan Mortimer of the [Massachusetts Statewide Harm Reduction Coalition](#), making the connection between prison spending and the lack of services in the community that could keep people out of the lockups. The coalition fights for needle exchange, drug treatment, against racist medical neglect, and for the human rights of queer and transgender prisoners, in addition to organizing grassroots support to demand a moratorium on prison expansion. “We’re working hard to make all the connections,” she says.

Prisons are a huge expense, and states are being forced to react. Demands for humane treatment can sometimes force authorities to change policies at the root of the problem. Alabama’s plan to counter its now-soaring prison health costs, according to the Athens, Alabama, [News Courier](#), “focuses on reversing inmate growth. The system is depending on sentencing reform and community centers to keep offenders out of prisons.”

These openings bring opportunities for AIDS activists to work closely with anti-prison and sentencing activists ([Critical Resistance](#) is one national group). The AIDS community has always been good at linking issues and bringing people together. But even the most caring AIDS service workers find that their funding sources dictate who they can work with, what services they can provide. So *AIDS Treatment News* offers low cost [ideas for ASOs](#): “Host a former prisoner support group; invite your community legal aid organization to do a legal clinic on getting benefits with a record; build connections with job training programs...reach into prisons through letter writing, informational sessions and official visitor programs.”

Anti-prison activists have added energy to ongoing local efforts for standard-of-care treatment in prisons. But they should be ready for a sustained fight. Somerville, MA, activist Susan Mortimer describes an often-frustrating process: “You get any information and paperwork the prisoner can give you, then you start with the first person on the corrections ladder, going up and up – then you try to get the prisoner’s rep in the state house to apply pressure,” she says. “A friend of mine, Tony, died in prison recently. He had paraplegia and HIV. Medical neglect created a bedsore and infection. The sore on his lower back was huge, and deep enough to expose bone. The media covered it, but even when the issues get publicized, correctional healthcare providers don’t do anything about it.”

Jackie Walker lists some of the prisoner complaints she gets from all over the country: “Their meds are not being administered correctly, they’re not receiving their meds, they think an opportunistic infection may be showing up but they’re not getting monitored for it, they’re not getting regular CD4 and viral load tests.”



In some places, activists have carved out a functional grievance process, often by figuring out if there is a person in the chain of command who will respond. In Philadelphia, John Bell, an instructor at [Philadelphia FIGHT](#) and a former prisoner living with HIV, takes individual complaints straight to the current Philadelphia prison commissioner. “The community is invited to give input, and it’s listened to,” Bell says.

To connect as a prison health activist, download a June 30, 2006, [directory](#) put together by the AIDS Treatment Activists Coalition, or get in touch with CHAMP for ideas about becoming involved in the fight.

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## South Africa’s Treatment Action Campaign demands care for HIV+ prisoners

By Lucio Verani , volunteer for Friends of TAC-North America • email: [lucio\\_verani@yahoo.com](mailto:lucio_verani@yahoo.com)

Blending fierce street activism and political organizing with community education and lawsuits, South Africa’s Treatment Action Campaign (TAC) has won significant change, becoming a model for efforts worldwide.

The below piece, written by staff at TAC and the AIDS Law Project, provides an analysis on AIDS treatment in South African prisons. As background, in April of 2006, after unproductive meetings with prison officials, 15 prisoners at Westville Correctional Centre, TAC and the AIDS Law Project (ALP) used their Constitution’s right to health care (including the right of prisoners to adequate medical treatment) to bring a court case against government. On June 2006, the Court ordered government to roll out ARV treatment at Westville. Sadly, one of the 15 prisoners (known as MM) who won the case died this past August. He needed ARV treatment since 2003 but only got it on July 12th, 2006, just three weeks before dying.

TAC has struggled against their own government’s incompetence in responding to AIDS, but as they recently stated:

*“The eight year struggle to end government HIV denialism and confusion has ended. A renewed focus on local and global mobilisation with the prison HIV deaths, the unnecessary appeals in the Westville Correctional Services Centre matter, and, the country’s painful embarrassment at [the] Toronto [International AIDS Conference] created the space where government and civil society are jointly facing up to the challenge of saving lives.”*

In the spirit of co-operation, TAC has offered to settle its pending lawsuits against the government. One of these suits responded to the government’s appeals in the Westville prisoners’ case. Much work remains in building a functional health system, but the government is now on the right path and TAC, along with all of civil society, will play key roles in holding government accountable and in empowering South Africans.

For more information, visit TAC’s website at [www.tac.org.za](http://www.tac.org.za). You can also subscribe to TAC’s e-newsletter, issued around once every two weeks, by emailing [news-subscribe@tac.org.za](mailto:news-subscribe@tac.org.za). Additionally, readers can support TAC politically and financially by getting involved in Friends of TAC-North America.

## Why prisoners with AIDS must be treated

*By Nathan Geffen (TAC), Jonathan Berger (AIDS Law Project) and Cynthia Golombeski (TAC)*

Coughing blood, wasting away from diarrhea, uncontrolled bowel movements, a strange white fungus growing on your tongue and throat that prevents you from eating: this is what tens - if not hundreds - of thousands of people in South Africa experience daily, as they watch their once healthy bodies deteriorate. Dying from AIDS is usually painful, slow and undignified. But it is also avoidable. For the vast majority of people whose HIV infection has brought on AIDS, antiretroviral (ARV) treatment can restore health and dignity.

Since it is both possible and affordable to stop people from dying of AIDS, most people recognize that ensuring access to ARV treatment is a moral imperative. But is this true for prisoners, especially in the context of a society with extremely high levels of violent crime? Are they not the lowest, least deserving of people?

In 1994, we took a decision - as a society - to accept that everyone in South Africa has the rights to life and dignity. In respect of prisoners, we expressly recognized a right to adequate medical treatment. In 1995, the Constitutional Court declared the death penalty to be unconstitutional. When we adopted our final Constitution in 1996, we also included the general right to have access to health care services.

All these constitutionally guaranteed rights apply to prisoners too, no matter how vile the crimes that landed them in prison. Interestingly, treating prisoners decently is not solely a product of our constitutional democracy. As early as 1912, our courts recognized that the state must provide adequate medical care to prisoners. In practice, however, the health care of prisoners under Apartheid was more likely to be imperiled than improved.

The number of people dying in prison has increased dramatically in the last decade. According to the Judicial Inspectorate of Prison, less than two out of every 1000 prisoners died of natural causes in 1995. By 2005, this had risen fivefold to over 9 deaths per 1000 prisoners. This massive increase is due to the HIV epidemic.

Last week, the Durban High Court ruled that the state - with immediate effect - must remove the restrictions that prevent prisoners at Westville Correctional Centre who want and need ARV treatment from accessing it, and must provide ARV treatment in accordance with the public sector policy. By 7 July, the state must also report to the court on how it intends making ARV treatment available to all eligible Westville prisoners.

This court case came about for two reasons. First, the state acted unconstitutionally. Second, fifteen long-term prisoners with AIDS - one of whom has subsequently been released on ordinary parole - bravely decided to put their trust in the legal system. Some of them had previously gone on hunger strike, with one of their demands being access to ARV treatment. The promises made to them in return for abandoning the hunger strike were simply not met.

Whilst not directly binding on other prisons, the judgment clearly has repercussions for them all. A caring government would ensure that the departments of correctional services and health immediately begin making plans to ensure access to ARV treatment in all prisons. Unfortunately the official response to the judgment has been spin, prevarication and misinformation.

For example, a Correctional Services spokesperson stated that the applicants in the case were demanding to receive ARV treatment without having gone through the assessment and counseling required by the national guideline. He went on to say that this could not be done "because that would be putting their health at risk", and that "the manner in which the judgment was made compels ... [the department] to do the opposite of what is required in terms of the national guidelines". (GCIS, 23 June 2006)

This is a misrepresentation of what the court actually ordered. On the basis of the undisputed medical evidence, the Durban High Court simply ordered the state to implement its own policy in a reasonable manner, as required by the Constitution. There is simply no talk of compelling the state to act in conflict with the national guideline. The judgment makes this plain.

A gut reaction some people have to the provision of ARVs in prisons is that many people outside of prison are not yet able to access such treatment. Why indeed should prisoners have access to treatment when approximately 500 000 South Africans need these medicines right now and are desperately struggling to access them?

Prisoners are extremely vulnerable to HIV infection and other illnesses, and are also completely reliant on the state for their medical care. Almost a third of them are awaiting trial, with thousands being released every month without ever standing trial. Many of those awaiting trial are too poor to afford bail. All of those sentenced with the option of a fine are in prison because they are poor. Not all prisoners deserve to be there.

But more importantly, the answer is not to deny people in the care of the state access to life-saving medicines, but to ensure that all reasonable steps are taken by the Minister of Health and her department to implement the public sector ARV treatment policy. These two things are not mutually exclusive - we have enough money to do both. What is lacking is leadership.

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## **Taking Action against Prisoner Rape: PREA as a tool for justice activists**

*By Sonny Suchdev, Community HIV/AIDS Mobilization Project (CHAMP)*

*Rape in prison is an ugly reality that most people have learned to ignore, but prisoner rape is an institutionalized form of cruelty that infringes upon basic human rights, contributes to the spread of disease, and perpetuates violence both inside and outside of prison walls.*

*- Lara Stemple, former Executive Director, Stop Prisoner Rape*



Prisoner rape is a widespread problem in detention facilities across the country, affecting adults and youth of all genders. According to prisoner rape advocates, overcrowding and insufficient staffing are key contributors to prisoner rape; as the criminal justice system locks up more and more people in the nation with the highest rate of incarceration in the world, the problem only gets worse.

A recent study found that approximately one in five male inmates in four different Midwestern prisons reported pressured or forced sex while incarcerated, and one in ten male inmates reported being raped. Women are most likely to be abused by male staff members, and one recent study found a rate of 27 percent of women reporting pressured or forced sex. Young people in facilities with adults are five times more likely to experience sexual assault than youth in juvenile facilities. (SPR, "The Basics on Rape Behind Bars," spr.org).

Often overlooked or [portrayed as a joke](#), prisoner rape should be an issue of concern to all in the fight against HIV/AIDS. Correctional institutions have a rate of HIV/AIDS that is five to ten times higher than in the general U.S. population. While widespread research is not currently available, it is clear that inmates have contracted HIV and other sexually transmitted diseases through prisoner rape.

Stop Prisoner Rape (SPR), the country's only organization that focuses exclusively on prisoner rape, has released the "[Call for Change](#)." (see below) which addresses the fact that gay and transgender persons behind bars are especially vulnerable to sexual violence. CHAMP has signed onto the Call for Change and encourages other HIV/AIDS organizations to do the same.

But what else can local advocates and activists do about prisoner rape? Federal legislation that condemns prisoner rape actually exists, which can serve as a useful tool at the local level. In 2001, SPR joined a bipartisan and very politically disparate coalition (including right wing fundamentalist groups as well as progressive forces) that worked to pass federal legislation to address prison rape in all detention facilities nationwide. They won the passage of the Prison Rape Elimination Act (PREA) in September 2003.

The key provisions of PREA are:

- Establishing a zero-tolerance standard for any kind of sexual assaults within correctional systems;
- Mandating collection of national data on the incidence of prisoner rape;
- Providing funding for research and program development;
- Creating a federal commission to hold hearings and develop standards for states on how to address sexual violence in prisons;
- Creating a review panel to hold hearings to determine the best and worst performing detention facilities in the country.

Most correctional administrators don't take the issue of prisoner rape seriously. But local activists can put pressure on jails and prisons in their areas to adopt pro-active standards to implement PREA's zero tolerance mandate, using the language of PREA as leverage in getting correctional facilities to adopt more specific measures to support survivors of sexual violence, as well as to prevent sexual violence. PREA



provides a powerful way for local groups to say to correctional administrators that stopping prison rape is not only the right thing to do, but it is also the law.

However, PREA is not necessarily always being used in ways that help the fight against HIV/AIDS. It has been used by some people to justify lack of condoms in prisons. In testimony to the state legislature, New York's Health Commissioner Glenn S. Goord stated: "Prison system policies banning condoms are also consistent with the federal Prison Rape Elimination Act of 2003. It requires that the states take the steps necessary to reduce the opportunity for, and incidence of, inmate sexual assault... I'm not certain we should become the second state in the nation to distribute condoms in the face of that law."

But in reality, there is no evidence that availability of condoms in prisons increasing incidence of sexual assault. In fact, SPR supports access to condoms in prisons. It is vital to recognize that not all sex in prisons is coercive and that incarcerated people should have access to condoms to prevent the spread of HIV and other STIs.

Kathy Hall-Martinez from SPR states, "The high incidence of rape behind bars makes access to condoms imperative... Condom distribution is a critically needed public health measure. The availability of condoms lessens the likelihood that rape in prison constitutes an un-adjudicated death sentence."

PREA has created a number of different areas of government intervention into prison rape, mostly focused on research and measuring incidence, training, and on mechanisms for states to get grants. SPR acknowledges that PREA needs to be strengthened, and advocates need to work on many other fronts to end rape in prisons. For example, the legislation does not help survivors of sexual violence to take legal action against correctional officers. Next year, the National Prison Rape Elimination Commission (created through PREA) is releasing specific standards for PREA, which SPR believes will strengthen the law.

### ***Endorsements Sought:***

#### **A CALL FOR CHANGE: Protecting the Rights of LGBT Detainees**

*This is a summary of Stop Prisoner Rape's [Call For Change](#). See the full document at <http://www.champnetwork.org/media/callchange.pdf> & contact Cynthia Totten at [ctotten@spr.org](mailto:ctotten@spr.org) to sign on.*

### **Background**

In an environment in which sexual violence occurs with some frequency, it is well known that being lesbian, gay, bisexual or transgender place a prisoner at heightened risk of torture, sexual assault, rape, and ill treatment. LGBT prisoners have little access to protection from these crimes and generally tend to endure them in silence. This is due to a number of factors including the fact that LGBT inmates may be disliked and feared by some guards, as well as by other inmates. LGBT inmates also fear retaliation and breaches of confidentiality if they report sexual abuse. They may fear triggering more attacks if they become known as someone who was raped.

This *Call for Change* presents proposals that are meant to complement existing standards. If implemented, these policies will significantly decrease the sexual assault of LGBT detainees.



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## A CALL FOR CHANGE: Protecting the Rights of LGBT Detainees

### Summary of Recommendations

#### **1. Inmate Awareness**

All detainees need to know that sexual abuse is never acceptable. All detainees must be given a handbook detailing information about the policies related to sexual conduct at the facility where they are housed.

#### **2. Promoting Safety**

One of the most important tools available to custodial personnel to prevent prisoner rape is the appropriate classification of detainees. While anyone can be a victim of sexual violence behind bars, typical victims are young, nonviolent, first-time offenders who are effeminate, physically small, weak, and/or shy. Gay, bisexual, and transgender detainees or those perceived as such are exceptionally vulnerable to rape. Corrections staff must therefore take special care in determining the housing arrangements for these detainees.

#### **3. Staff Screening and Training**

Proper staff screening is an essential safeguard against sexual violence. Regular staff training – including the development of clear standards for on-the-job conduct and a zero-tolerance policy with respect to sexual violence – sets a tone of institutional seriousness and professionalism.

#### **4. Responding to Sexual Violence**

Taking action in a timely and professional manner to address allegations of sexual assault is an essential component in minimizing harmful consequences to victims and in breaking the cycle of sexual abuse in detention.

#### **5. External Monitoring, Reporting and Services**

A climate of openness and transparency encourages the safer operation of institutions. External, independent monitoring will also help strengthen the public's trust in the commitment of corrections institutions to adhere to required standards. Furthermore, providing detainees with information about resources provided by outside organizations will help survivors of sexual abuse in their healing process.

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## Case Study From Canada: The Prison HIV/AIDS Support Action Network (PASAN)

*By Sean Barry, Community HIV/AIDS Mobilization Project (CHAMP)*

Many United States prison and AIDS activists have been inspired by Canada's relatively long record of providing behind-bars harm reduction and prevention tools. Our Canadian counterparts continue to struggle for the full range of needed interventions, but their victories can offer strategic lessons to activists in other countries.



In 1991, recognizing that the AIDS crisis in Canadian prisons was a result of “government inaction,” activists launched the Prison HIV/AIDS Support Action Network (PASAN). PASAN’s advocacy is driven by the needs of people who are locked up: an informal committee of prisoners identifies campaign issues, while the external “Activist Committee” is made up of prison rights activists and AIDS service providers. Prisoners have actively participated in letter-writing campaigns and utilized a prisoner grievance system that, while not effective at redressing problems, helps “raise the profile” of issues. Prisoner-run health groups, with both formal and informal peer educators, also inform activists of what their constituency needs. Notably, Canada has a comparatively more equitable health care system and more responsive correctional oversight than in the United States, although advocates point out that the prison system remains a fundamentally inhumane place. PASAN and other groups have used meetings with correctional staff, issued reports on current conditions and recommendations for improvement, and supported prisoners taking action on the inside as tactics for improving conditions.

In 1992, PASAN issued *HIV/AIDS in Prison Systems: A Comprehensive Strategy*, a report recommending forty specific steps the Correctional Service of Canada (CSC) needed to take in order to improve prevention and care for people living with and at risk for HIV inside federal prisons. Among the bold but practical recommendations were universal education for prisoners and staff, harm reduction programs, and prevention tools -- including condoms, bleach kits, *and* clean needles.

CSC responded to PASAN’s challenge by forming the Expert Committee on HIV and Prisons (ECAP), whose recommendations looked like much of what PASAN had asked for, and which echoed recommendations from the World Health Organization. Framing its commitment in terms of community health and noting that 80% of prisoners in the federal system returned to the community, CSC started providing anonymous HIV testing and counseling, condoms (even though CSC still prohibited consensual sexual activity among inmates), and bleach kits (first as a pilot program, then approved for nationwide use).

Methadone maintenance treatment was also eventually approved, although it was initially limited to those who had already received it before entering the system. PASAN and other prison rights groups have followed up by monitoring enforcement of these policies, documenting continuing problems, and calling for further advances in improving HIV prevention and treatment inside prisons.

A follow-up report sponsored by the Canadian HIV/AIDS Legal Network in 2002 stated that “the proportion of prisoners with HIV is six to 70 times higher than the proportion of all Canadians with HIV” -- and as many as one-half or more of prisoners have HCV. Thus, a decade later the government had accepted many of the activists’ demands, prevalence of both HIV and HCV had grown. Does this mean that the interventions themselves do not work?

The 2002 report graded the progress of the federal CSCs and each provincial government in meeting ECAP’s recommendations, concluding that a “piecemeal” and uncoordinated response to HIV behind bars persisted, and that basic HIV prevention tools like condoms, bleach, and basic HIV education “continue to be denied to prisoners” in many jurisdictions. Thus, it is the *lack* of full policy implementation – not the policies themselves – that is the problem.



Advocates, who believe jailhouse tats could be a major source of HCV and HIV transmission, have recently won some progress toward safe tattooing. Framing its decision to approve funding for them as a cost-saving measure that will prevent new infections, CSC opened up a limited number of in-house tattoo parlors that use clean equipment. Unfortunately, the pilot sites have been suspended pending an evaluation, and it's unclear whether they'll be re-opened and expanded.

Currently, needle-exchange programs are the number one prevention tool prisoners are pushing for. Although many European countries have started syringe exchanges in prison without incident -- and despite endorsement from a CSC-convened task force in the late 1990s -- not even a pilot program has been approved.

The powerful Canadian prison guards' union has been an active and politically influential opponent of harm reduction, citing common arguments about safety and suggesting that needles or bleach could be used against guards. The current conservative government may make further improvements in prevention and care in prisons even more difficult.

For more information, please visit [www.pasan.org](http://www.pasan.org) and <http://www.aidslaw.ca/EN/issues/prisons.htm>

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## The Real Cost of Prisons on People with HIV/AIDS: *Conversation Starter from the CHAMP Academy*

Incarceration issues are not easy to discuss in the HIV/AIDS community. They tap into deeper debates -- about punishment, of retribution, of penance or forgiveness -- that are rooted in our personal histories, our political beliefs, our faith traditions, or our values as individuals. They may bring up feelings from having friends or family who are locked up, or from having been locked up ourselves. They also can provoke our anger or pain as the victims of crime or violence. Some of us found recovery, education, or faith when incarcerated, while others found only pain, humiliation, violence or isolation.

What is clear is that prisons and jails are a major part of the HIV/AIDS epidemic in the United States, and in many places around the world. Talking about the realities of incarceration in the epidemic -- and the responsibilities, opportunities and challenges that face us as AIDS activist with so many people incarcerated in our nation -- is a necessary struggle on the road to HIV/AIDS justice.

**But we don't have to do it alone.** We encourage you to check out the [Real Cost of Prisons Project](http://www.realcostofprisons.org) ([www.realcostofprisons.org](http://www.realcostofprisons.org)), which provides information, tools and trainings for those who want to have a deeper understanding of the facts and the skills they need to make effective arguments that specifically deal with changing the criminal justice system.



Here's one conversation starter we've developed using tools from the [Real Cost of Prisons Project](#):

**Conversation Length:** 40 minutes or so, depending on size of group

**Materials:** One piece of flipchart paper and 3 markers, for every three to four people  
The Real Cost of Prison's "[Map of Obstacles](#)," one copy for each person  
(download it here: <http://realcostofprisons.org/obstacles.html>)

Before handing out the maps, the conversation facilitator should explain that "criminal justice," or incarceration issues, can bring up feelings for a lot of people. It may be good to ask the group to establish ground rules for the conversation, such as recognizing that this short discussion will not cover broader issues of crime and punishment, and honoring the different experiences and opinions of all in the room.

The maps are in the form of flowcharts that address three common challenges faced by those leaving jail or prison: earning money, reuniting family, and finding housing. They can also be made into powerpoint slides and projected, so all participants can view the maps at once. The whole group can discuss the maps, and people may choose to share relevant personal experiences.

Then, the facilitator can ask **"what would it look like to make a map of obstacles faced by people leaving jail or prison with an HIV diagnosis?"**

Split into small groups of three to four people for this discussion. Each group should appoint a timekeeper, and another person to track the conversation on the flipchart. Groups can choose to draw their own map, or make a list of points to consider. After 10-15 minutes, the small groups rejoin into a whole, and take turns sharing their maps or lists.

A good way to end the conversation is a go-around, in which each person can contribute one new thing they learned in the conversation, or a point that was made that was challenging for them.

Remember, the Real Cost of Prisons Project has comic books, more tools, and information on their website – and they can also do in-depth trainings on these issues. For more information about the [Real Cost of Prisons Project](#), or to schedule a workshop in your community, please contact:

Lois Ahrens, 5 Warfield Place, Northampton, MA 01060 or E-mail: [lois@realcostofprisons.org](mailto:lois@realcostofprisons.org)

CHAMP Academy is developing trainings and resources to help AIDS organizations and activists clarify our perspectives on incarceration and to deepen our role in fighting for a public health response to HIV/AIDS and incarceration, and invite you to contact us as well.



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