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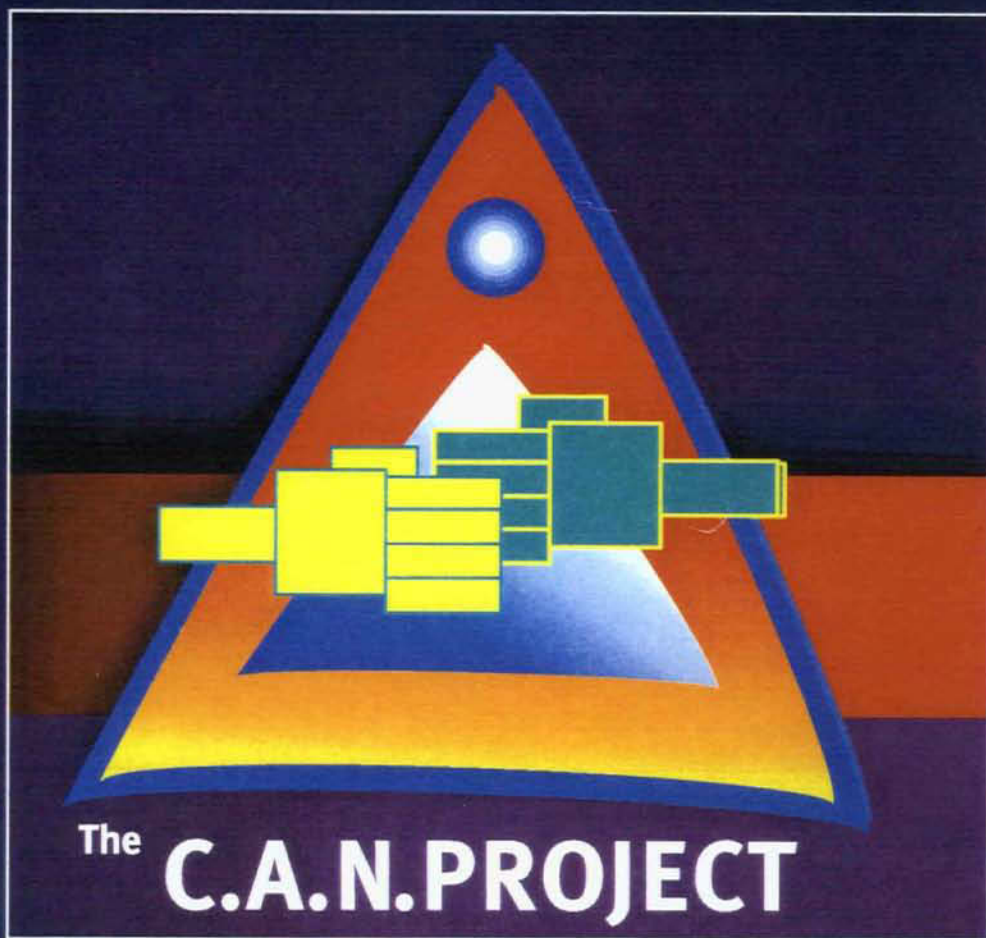
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Correctional Service
Canada



FINAL REPORT

THE C.A.N. NATIONAL PILOT INMATE AIDS PEER EDUCATION PROJECT

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1996

was funded in part by the National AIDS Strategy, Health Canada

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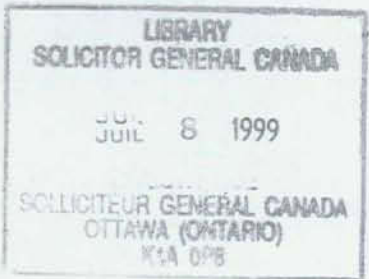
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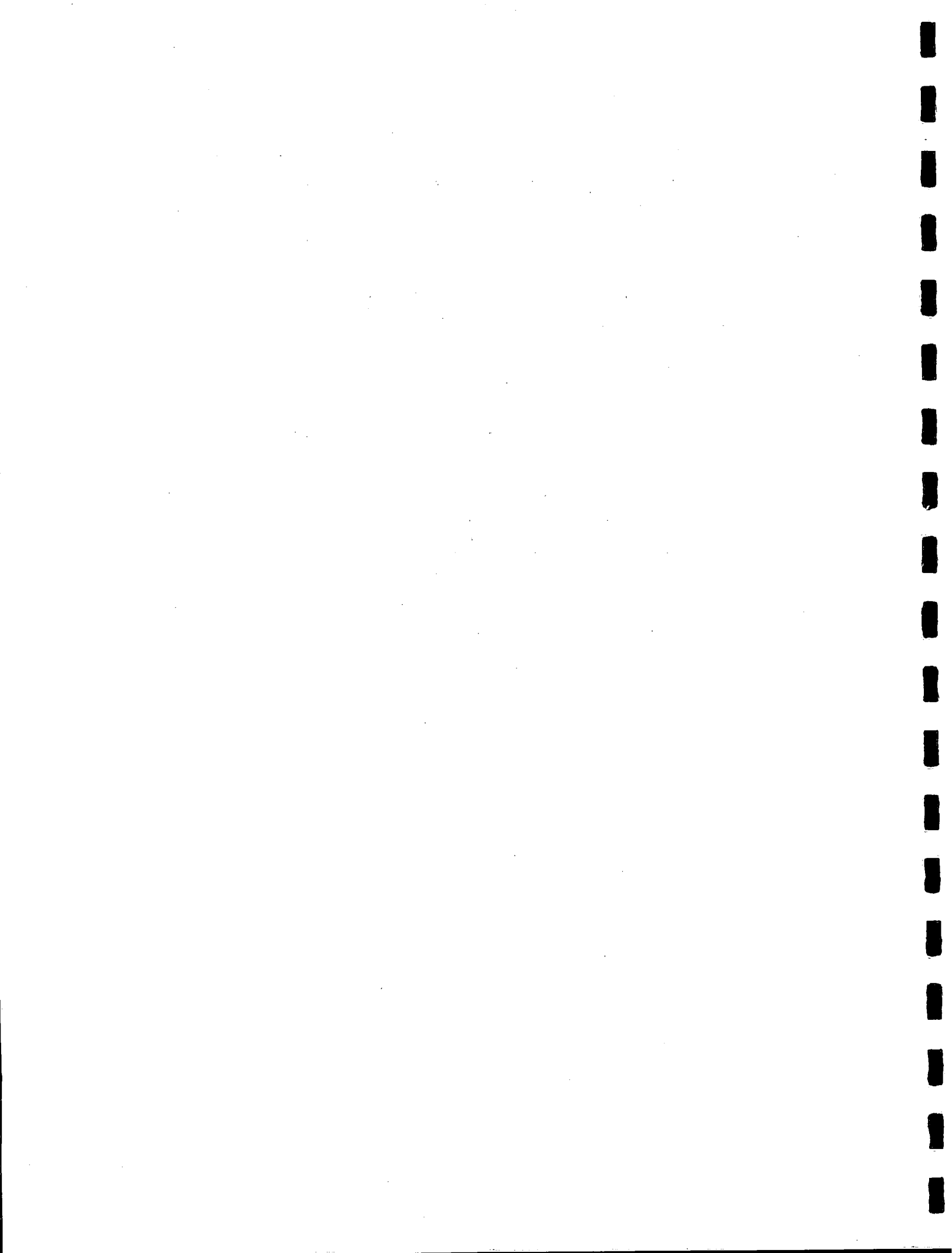
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The author would like to thank the following Advisory Committee members for their input and contributions into various phases of the project.

ADVISORY COMMITTEE

Members at-large

- Anne Malo, Former CSC National AIDS Program Coordinator
- Andréa Riesch Toepell, Research Consultant
- John MacTavish, Kingston AIDS Project
- Gregg Brown, AIDS Vancouver
- Janet Dunbrack, Health Canada, AIDS Care, Treatment and Support Unit
- Betsy MacKenzie, Health Canada, AIDS Education and Prevention Unit
- Elaine Sussey, AIDS/SIDA New Brunswick
- Leslie Reid, John Howard Society of Fredericton
- Ted Gaudet, PLWHIV/AIDS Network of New Brunswick
- Michael Linhart, Prisoners of HIV Group, British Columbia

Dorchester Sub-Committee (Dorchester Penitentiary)

- Odette Pellerin, Regional Chief, Clinical Services
- Susan Steeves, Nursing
- Natalie Fullerton, Case Management Team
- Sylvie Berubé, Psychology
- Glenn Davis, Inmate, Dorchester Penitentiary
- Eugene Newman, Personal Development
- Robert Poirier, IPSO

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C.A.N. PEER EDUCATORS

- ♦ William Taylor, **Coordinator**
- ♦ Steve Bovair, **Assistant Coordinator**
- ♦ Orell
- ♦ Garfield
- ♦ Ray
- ♦ Thane
- ♦ Darryl
- ♦ Neil
- ♦ Israel
- ♦ Kevin

EXECUTIVE SUMMARY

The critical need for enhanced HIV-related education and support services within the prison setting is evident, given that reported rates of HIV-infection among federal inmates continue to increase across all regions of Canada, and that the reported number of cases is more than 10 times higher than that in the general population.

The "C.A.N." (Cons AIDS Network) Project was a national pilot inmate peer education and support project conducted at Dorchester Penitentiary, a medium-security federal prison for men in New Brunswick. The overall goal of this project was the development, implementation and evaluation of a sustainable peer education model in which inmates provide others with the necessary information, motivation and skills to prevent HIV and other communicable diseases (particularly Hepatitis and TB), as well as to provide support to those already infected.

Following the successful completion of a comprehensive and prisoner-centred 120-hour train-the-trainer program, implemented over a course of four weeks, participants were assessed in terms of their interest and suitability for being peer educators or one of the two program coordinators. The inmates hired as coordinators then received five additional weeks of one-on-one support and training to help them develop and launch various peer-led initiatives in conjunction with the other eight peer educators.

In addition to distributing condoms and information by means of pamphlets, books, audiovisual materials, and discussions, the C.A.N. Peer Education Team provided one-on-one HIV/AIDS prevention and support. Group information and interactive workshop sessions were also conducted throughout the prison, utilizing a variety of innovative and prisoner-centred educational and awareness strategies. The coordinators also produced a monthly newsletter, attended a support group for prisoners with HIV/AIDS, corresponded in writing to HIV-positive prisoners in other Atlantic Region institutions, and staffed an office approximately 36 hours/week.

An evaluation of the program has been conducted through the administration of a knowledge, attitudes and behaviour questionnaire (KAB) administered prior to and three months following the implementation of the peer-led program. A total of 113 and 76 inmates completed the pre- and post-test KAB questionnaires, respectively.

The data obtained over the course of this pilot project indicate that inmates can effectively provide education and support to their peers. The first 3 months of the C.A.N. Project were met with a high level of interest and involvement by inmates at Dorchester, and were evaluated as being very useful. In addition, self-reported increases in knowledge, attitudes and safe/safer sex and needle use were found, as were pre- to post-test changes in terms of more objective KAB measures. That is, the results indicated: (1) Increased knowledge scores; (2) Enhanced attitudes toward prisoners with HIV/AIDS; (3) Increased intentions to engage in HIV-related risk reduction behaviours; and (4) Increased incidence of HIV and Hepatitis testing.

In sum, the evaluation of the C.A.N. Project supports the efficacy of inmate peer education models in relation to preventing the spread of HIV and other communicable diseases within prisons, as well as in providing support to those already infected. The C.A.N. Project has generally been very well accepted by inmates, prison administration and staff. Content and process evaluations of the training program strongly support its benefits in enhancing the knowledge, attitudes and skills of all participants. In addition to successfully delivering a variety of proactive initiatives, the C.A.N. Peer Education Team continues to meet the numerous information and support needs of a diversity of inmates.

Peer-led AIDS prevention and support programs are of utmost necessity to prevent the continued spread of HIV among prison populations, and to provide support to inmates infected with the virus. The success and sustainability of such programs requires the integral and continual involvement of credible and "solid" inmates, the establishment of paid coordinator positions, as well as the widespread support of prison staff, administration and inmates. With the support of CSC, community-based organizations can also play an important role in helping prisons implement and sustain such programs.

The implementation of inmate peer education and support programs is an important step toward promoting and protecting the health of inmates and the communities to which they return upon release. The model developed for this project is adaptable for use in other correctional institutions across the country. As a tool to facilitate the implementation of inmate AIDS peer education programs in other institutions, a comprehensive training manual has been prepared to provide other organizations and prisons with guidelines regarding setting up, implementing, and sustaining peer education and support programs within correctional facilities.

1.0 INTRODUCTION

1.1 Background and Rationale

Given the absence of widespread testing, the exact number of inmates with HIV-infection in Canadian correctional institutions is unknown. However, more than 1 in every 100 federal inmates are reported to be living with HIV/AIDS, reflecting a prevalence of more than ten times that reported in the general population.¹ In addition, reported rates of infection among federal inmates continue to increase across all regions in Canada, and there has been a 46% increase in the number of reported cases of HIV/AIDS between April 1994 and March 1996.² Effective and comprehensive inmate AIDS education strategies are clearly needed to prevent the continued transmission of HIV within Canadian prisons.

In the prison environment, a number of behaviours pose particularly high risks for the transmission of HIV: Injection drug needle sharing; unsafe sex; and the sharing of needles/equipment for tattooing, piercing or injecting steroids. Approaches to HIV-related education in federal penitentiaries have traditionally been passive, and have included audiovisual materials, brochures, information sessions, and conversations with Correctional Service of Canada (CSC) Health Care Staff.³ These strategies have frequently been criticized as incomprehensive and ineffective.⁴ Given the illegal nature of most HIV-related risk activities within CSC policy, inmates have been reluctant to discuss these behaviours with correctional staff.

Inmate peer education models offer the most promise in relation to preventing the spread of HIV and other communicable diseases such as Hepatitis within Canadian prisons. A number of reasons have been stated for why peers can be so effective in preventing the spread of HIV/AIDS in prisons: (1) Given that HIV infection in prison often involves illegal activities, it is generally easier to speak openly about HIV-related risk behaviours to other inmates than to staff; (2) Given the frequent mistrust of correctional staff by inmates, HIV-related information from peers is not likely to be viewed with the same suspicion; (3) Peers may be

¹ Correctional Service of Canada. *Reported Cases of HIV/AIDS in Federal Penitentiaries*. Ottawa: CSC, Health Care Services Branch, March, 1996.

² R. Jürgens. *HIV/AIDS in Prisons: Final Report*. Montreal, Quebec: HIV/AIDS Legal Network and the Canadian AIDS Society, September, 1996 at 32.

³ Correctional Service of Canada. *HIV/AIDS and Prisons : Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994 at 42.

⁴ PASAN. *HIV/AIDS in prison systems: A comprehensive strategy*. A Brief from the Prisoners with AIDS/HIV Support Action Network (PASAN) to the Minister of Correctional Services and the Minister of Health. Toronto: The Network, June 1992.

the only ones to truly understand the prison culture and inmate code, along with which strategies are likely to work within the prison setting; and, (4) Because they reside in the same setting, peers are able to respond both formally and informally to educational needs in an ongoing manner.⁵

In February 1995, AIDS New Brunswick/SIDA Nouveau-Brunswick (AIDS/SIDA NB) received funding from CSC to develop, implement and evaluate an inmate AIDS peer education and support program at Dorchester Penitentiary. AIDS/SIDA NB had been involved with Dorchester in the provision of counselling for HIV-positive inmates, and in educational services for inmates, volunteers and staff. The recognition of the critical need for enhanced education and support services within the prison setting led AIDS/SIDA NB in 1993 to begin investigating the possible implementation of a peer education program.

In March 1994, the Expert Committee on AIDS and Prisons (ECAP) released a report on *HIV/AIDS in Prisons*.⁶ This report corroborated the need for inmate peer education programs. A number of the recommendations cited by ECAP had also been included in *HIV/AIDS in Prison Systems: A Comprehensive Strategy*,⁷ a brief prepared in 1992 by the Prisoners with AIDS/HIV Support Action Network (PASAN). Among the many recommendations made by ECAP were:

- "Inmates should be encouraged to develop and should be assisted in delivering their own peer education, counselling and support programs." (p. 50)
- "In each institution, CSC should create or designate one or more inmate job positions as peer health counsellors and provide for appropriate training, support and evaluation." (p. 50)

In response to the ECAP Report, the Correctional Service of Canada agreed to pilot test a program of paid inmate peer health promotion.⁸ This response in combination with AIDS/SIDA NB's prior investigation into the feasibility of implementing such a program led to the submission of a proposal (May, 1994) for a pilot inmate peer education project. Approval for funding from CSC was received in January, 1995 and the project was launched in February, 1995.

⁵ Centre for Education and Information on Drugs and Alcohol and the Prison AIDS Project of the N.S.W. Department of Corrective Services. National Prisons HIV Peer Education Program Training Manual. Sydney, 1991 at 19.

⁶ Correctional Service of Canada, supra note 3.

⁷ PASAN, supra note 4.

⁸ Correctional Service of Canada. *Backgrounder: CSC Response to the Expert Committee on AIDS and Prisons*. Ottawa: Health Care Services Branch, March, 1994.

The following is a report on the results and experiences of the "C.A.N." (Cons AIDS Network) Peer Education Project conducted at Dorchester Penitentiary. The remainder of the present section includes a more detailed review of the incidence and transmission of HIV/AIDS in prisons, intended to set the context for peer education and support work within Canadian federal penitentiaries. It is followed by an outline of the project's primary goals and objectives. Section 2.0 of this report consists of an overview of the methodology utilized, and includes a discussion of the project outline, key players, training program curriculum, C.A.N. Program implementation, KAB questionnaire, and evaluation procedures. The main findings pertaining to the impact of the C.A.N. Project on inmates' HIV-related knowledge, attitudes, intentions, and behaviours are outlined in Section 3.0. The fourth and final section includes a project summary, as well as the personal perspective of the inmates hired to coordinate the C.A.N. Peer Education Program. The report concludes with a discussion of various logistical considerations and recommendations regarding setting up, implementing and sustaining inmate AIDS peer education and support programs.

1.2 HIV/AIDS in Prisons

1.2.1 Prevalence of HIV-Infection. Information regarding the number of HIV-infected Canadian inmates comes from two sources: (1) reported cases of HIV/AIDS; and (2) seroprevalence studies. As mentioned previously, however, the exact number of inmates with HIV-infection in Canadian federal penitentiaries or provincial jails is unknown, as widespread testing for HIV is not carried out.

As of March 1996, 159 federal inmates were reported by CSC to be living with HIV/AIDS.⁹ This indicates that more than 1 in every 100 federal inmates is reported to be living with HIV-infection, a figure more than ten times higher than that reported in the general population. Reported rates of infection among inmates continue to increase across all five regions in Canada. For instance, there were a total of 13, 27, 37, 49, 92, 109 and 138 reported cases of HIV/AIDS in federal penitentiaries for the month of April in each of the years 1989-1995, respectively. These figures must be interpreted with caution, however, in that they represent only the cases among inmates who have been tested and have had this information reported to CSC. Nonetheless, as highlighted in the recently released final report on HIV/AIDS in Prisons, there has been a 46% increase in the number of reported cases of HIV/AIDS in the two years between April 1994 and March 1996.¹⁰

⁹ Correctional Service of Canada, supra note 1.

¹⁰ R. Jürgens, supra note 2 at 32.

According to the ECAP final report,¹¹ five seroprevalence studies have been conducted among Canadian prison populations (1 in a federal penitentiary in Ontario and 4 in provincial institutions in Quebec, British Columbia, and Ontario). Seroprevalence rates ranged from 1% (medium-security federal institution for men in Ontario) to 7.2% (medium-security prison for women in Montreal). A history of injection drug use was found to be strongly correlated with HIV-infection by the studies which gathered data on risk behaviours.

Internationally, higher rates of HIV-infection are generally reported among prison populations. In Southern Europe, for instance, infection rates of 26%, 17%, 13% and 11% have been found among inmates in Spain, Italy, France, and Switzerland respectively. In contrast, low seroprevalence rates have been reported for countries such as Belgium, Finland, and Iceland. Widely varying infection rates have been reported among inmates in the United States. While some states report prevalence rates of less than 1%, New York has reported rates approximating or exceeding 20%.¹²

As noted in the ECAP report, comparing or interpreting these figures must be done cautiously, in that different testing and reporting methodologies are utilized in different prisons/regions. For instance, while some institutions may offer voluntary testing, others may require mandatory testing of all or some inmates. Nonetheless, the data on the rates of HIV/AIDS infections consistently reflect a higher incidence of infection among inmate populations than what is found in the general population.

In response to the ECAP recommendations, CSC indicated that it would more vigorously promote voluntary HIV testing among inmates at reception and during incarceration.¹³ In addition, CSC agreed to pilot test an anonymous HIV testing program in at least one federal institution. In June 1995, however, the former Commissioner of CSC announced a decision not to wait for the results of the anonymous testing pilot, and agreed to make anonymous testing available to federal inmates. This decision was expected to enhance the accuracy of the data collected regarding infection rates in Canadian federal correctional facilities. While a national working group began the process of developing anonymous testing implementation guidelines, work on this initiative was postponed several months later. Conflict remains surrounding whether and/or when the disclosure of an inmate's HIV status is justified. Although work on the anonymous testing action plan is expected to resume, the working group has not yet reconvened on this issue.

¹¹ Correctional Service of Canada, *supra* note 3 at 15-17.

¹² *Ibid* at 18.

¹³ Correctional Service of Canada, *supra* note 8.

1.2.2 Transmission of HIV-Infection. In the prison setting, a number of behaviours are particularly high risk for the transmission of HIV: (a) Injection drug needle sharing; (b) Consensual sexual activity; (c) Non-consensual sexual activity; (d) Tattooing; and (e) Piercing. As with injection drug needle sharing, the sharing of equipment for steroid or other substance injection is also high risk for the transmission of HIV. Other possible (although much reduced) means of HIV transmission include fighting and accidental injuries involving spilled blood.

Injection Drug Needle Sharing

The exact prevalence of injection drug use and needle sharing among Canadian inmates is unknown. However, as noted by the Expert Advisory Committee on AIDS and Prisons, injection drug use is a reality and is likely to be the greatest risk factor for HIV transmission within correctional institutions.¹⁴

Studies conducted following the release of ECAP's Final Report have since corroborated the high rates of injection drug use and needle sharing among federal inmates. For instance, the results of CSC's *1995 National Inmate Survey* revealed that 11% of the respondents acknowledged having used injection drugs in the prison in which they were currently incarcerated. Further, less than two-thirds of this sample (57%) believed the equipment they had used had been clean. The highest rate of injection drug use was found among inmates in CSC's Pacific Region, where close to one-quarter of the respondents reported this behaviour.¹⁵

The following points highlighted in the ECAP Final Report are of relevance to the transmission/prevention of HIV in prisons:¹⁶

- According to the Computerized Lifestyle Screening Instrument developed by the Ministry of the Solicitor General and CSC, 10% of federal inmates report using drugs every day in the six months prior to being incarcerated, and 64% admitted using alcohol or other drugs on the day of their crime.
- Needles and syringes are classified as contraband, and possessing such injection equipment is considered an institutional offence.

¹⁴ Correctional Service of Canada, *supra* note 3 at 74.

¹⁵ Correctional Service of Canada. *1995 National Inmate Survey: Final Report*. Ottawa: The Service (Correctional Research and Development), 1996 at 138.

¹⁶ Correctional Service of Canada, *supra* note 3 at 63-78.

- Methadone, a drug used as a treatment for opiate dependence, is not available in Canadian prisons.
- There is general consensus that injection drug use is common in Canadian prisons, and that the scarcity of needles invariably results in needle sharing.

Also highlighted in ECAP's final report was that bleach, classified as contraband and possession of it deemed an institutional offence, should be made available in correctional institutions. They also pointed out that while bleach was not officially available in federal prisons, some inmates did have covert access through kitchens or laundries.¹⁷

In response to ECAP's recommendations, CSC agreed to pilot test a bleach distribution program in an institution in British Columbia (1994). In their response to the ECAP report, however, CSC stated: "We are continuing to vigorously pursue our current policies stressing interdiction of drugs, urinalysis testing, and the treatment and rehabilitation of inmates with substance abuse problems. This response recognizes the need to try new approaches while maintaining the existing strong prohibitions against drug use in federal institutions."¹⁸

In June 1995, however, the former Commissioner of CSC conferred that he agreed to widely implement bleach distribution in federal institutions, rather than waiting for the completion of the pilot bleach distribution project. All federal institutions are expected to be implementing bleach distribution by the end of September 1996. Greater availability of bleach is likely to reduce a significant barrier to harm reduction practices among inmates.

Consensual and Non-consensual Sexual Activity

As with injection drug use, consensual and non-consensual sexual activity is a reality of prison life. A total of 6% of the respondents to CSC's Inmate Survey, for instance, reported having had sex with another inmate since coming to the prison in which they were currently serving their sentence. The results of this survey also point to the prevalence of unsafe sexual activity, in that only approximately one-third of the respondents who acknowledged sexual activity with another inmate reported having used condoms.¹⁹

Consensual sexual activity among inmates occurs either as a consequence of true sexual orientation or situational homosexuality (heterosexual men who engage in sex with men while incarcerated). Condoms have been available in federal institutions since January 1992. A few

¹⁷ Ibid at 63.

¹⁸ Correctional Service of Canada, *supra* note 8.

¹⁹ Correctional Service of Canada, *supra* note 15.

provincial systems have also made condoms available to their inmates. However, there has been little consistency in the methods institutions use for distributing condoms, as well as in the availability of lubricant. Dental dams are not available in male facilities. Despite the availability of condoms within federal penitentiaries, determining the best means for their distribution and encouraging their use remains a challenge. While condoms are readily accessible in some institutions, condoms are not discreetly obtainable in others. In some facilities, for instance, inmates are required to go to Health Care to get condoms.

Furthermore, consensual sexual activity between inmates remains an institutional offence. In addition to discouraging inmates from obtaining condoms, the illegal status of consensual sexual activity may actually encourage unsafe sex in that inmates may fear reprimand if they make the effort required to engage in safer sex.

In addition to recommending discreet and easy access to condoms and lubricant, ECAP's report made the following recommendation:

"...in order to discourage unsafe sexual activity in federal correctional institutions, consensual sexual activity between inmates not be considered an activity that is likely to jeopardize the security of the institution, and be removed from the category of institutional offenses."²⁰

In response to the ECAP recommendations, CSC agreed that condoms, dental dams and lubricant be more accessible to inmates (i.e., through various institutional venues) and that a health kit be distributed upon entry, release, and in family visiting units. However, CSC continued to support its policy against consensual sexual activity between inmates, and this behaviour remains an institutional offence.²¹

Non-consensual sexual activity includes sexual assault, as well as sexual acts performed on the basis of fear or intimidation or in return for certain favours -- e.g., protection, drugs, etc. This has often been referred to as semi or quasi-consensual sexual activity. The prevalence of non-consensual sexual activity is difficult to estimate, and its occurrence may be under-reported. Some prisoners may also be more vulnerable to being sexually exploited or abused (e.g., mentally disabled, transsexuals, homosexuals). Non-consensual sexual activity is a means by which sexually transmitted diseases including HIV can spread within correctional institutions -- the risk becoming even greater in situations of violent sexual assault where blood to blood contact is probable.

²⁰ Correctional Service of Canada, *supra* note 3 at 60.

²¹ Correctional Service of Canada, *supra* note 3.

Preventing the occurrence of sexual assault and other non-consensual sexual activities amongst inmates must be a priority. To this end, ECAP's report recommended that inmates receive education about non-consensual sex (preferably from their peers) and about the fact that such behaviours will not be tolerated within institutions. It also recommended that efforts be made to: identify sexual predators and vulnerable inmates; prosecute and remove sexual predators from the general population; and closely supervise and protect vulnerable inmates from predators. The provision of single-cell accommodations for all inmates was recommended as a long-term goal.²²

Tattooing and Piercing

Tattooing and piercing -- prevalent activities in many facilities -- also pose serious risks for the transmission of HIV within correctional institutions. In fact, 45% and 17% of respondents to the National Inmate Survey reported having had a tattoo or piercing done in prison.²³ Due to the prohibition of tattooing and piercing within federal penitentiaries, these behaviours are frequently performed covertly without the sterilization of equipment. As noted by PASAN in their 1992 brief to the Ontario Ministers of Correctional Services and Health:

"Even though the risk for HIV-infection in this practice can be high, tattooing is an art form in which many inmates engage. It can be practised safely if new needles are used for each tattoo and if safety guidelines are followed. Expert tattoo artists should be brought into the prisons to help inmates learn to tattoo safely".²⁴

The ECAP final report similarly emphasized the need to reduce the harms caused by tattooing and piercing and presented a number of recommendations: (1) authorizing the use of tattoo/piercing equipment and supplies; (2) providing inmates with educational materials on how to perform safe tattooing/piercing; (3) prohibiting inmates from tattooing/piercing until they have been instructed on and proven their understanding of safer tattooing/piercing practices; and (4) consider providing inmates with access to outside professionals who can provide safe tattooing/piercing.²⁵

In response to these recommendations, CSC agreed to permit inmates access to professional tattooing/piercing services at the inmates' expense, while continuing the policy of prohibiting inmates from possessing such equipment or providing these services.²⁶ The utility and realism of permitting inmates to pay for professional tattoo/piercing services must be questioned, however, given that the average prison wage approximates \$20 per week.

²² Correctional Service of Canada, supra note 3 at 62.

²³ Correctional Service of Canada, supra note 15.

²⁴ PASAN, supra note 4 at 17.

²⁵ Correctional Service of Canada, supra note 3 at 80.

²⁶ Correctional Service of Canada, supra note 8 at 3.

1.3 Goals and Objectives

Goals

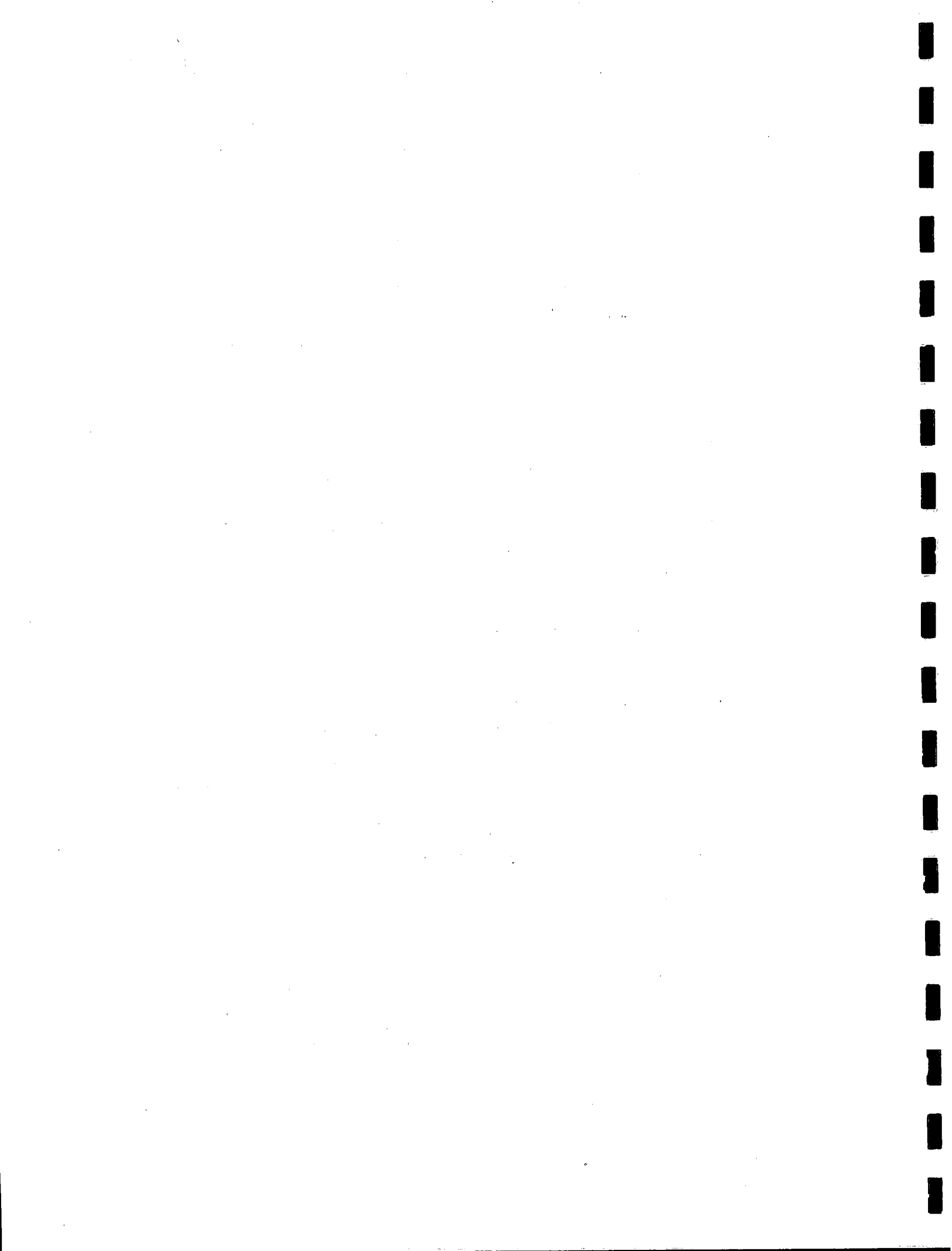
- To develop, implement, and evaluate an effective and sustainable model of inmate AIDS peer education resulting in: (1) increased knowledge, (2) improved attitudes toward risk reduction behaviours and persons living with HIV/AIDS, and (3) increased rates of HIV risk-reduction practices and health promoting behaviours.

Objectives

The objectives were outlined as follows:

- Develop an AIDS-related training curriculum for inmate AIDS peer educators.
- Train inmate volunteers to provide AIDS peer education.
- Select and train at least one inmate to become the AIDS Peer Education Program Coordinator.
- Evaluate the effectiveness of the program through the administration of a knowledge, attitude and behaviour (KAB) study.
- Prepare a manual/guide to be used for other prisons wishing to establish a prison AIDS peer education program.

The more specific goals and objectives of the training program are delineated in Section 2.3.2.



2.0 METHOD

2.1 Project Outline

The project was carried out in seven phases over a 15-month period (February, 1995 - May, 1996). Several phases were carried out concurrently, as the completion of all previous phases was not necessarily required in order to begin work on subsequent phases. The approximate time frames for each of the project's seven phases and their main components are outlined below.

PHASE I: Research Design and Methodology (5 weeks)

- a. Establishment of Advisory Committee
- b. Conducting of research toward the project's design and methodology
- c. Consultation with the Advisory Committee and other key players for input into the research design and methodology
- d. Defining of criteria for participant selection
- e. Development of job descriptions for key players
- f. Development of the communication strategy

PHASE II. Development of Curriculum and Evaluation Strategy (25 weeks)

- a. Development of the curriculum
- b. Development of the KAB Questionnaire
- c. Development of the evaluation design for training program participants
- d. Development of the evaluation strategy for the training curriculum
- e. Development of evaluation tools for assessing peer-led educational sessions

PHASE III. Pre-test KAB Questionnaire Administration (2 weeks)

PHASE IV. Training Program Implementation (9 weeks)

- a. Module 1— AIDS Prevention Education Training
- b. Evaluation of Trainees
- c. Module 2— Peer Support Training
- d. Hiring and Training of Inmate C.A.N. Project Coordinators

PHASE V. C.A.N. Program Implementation (12 weeks)

PHASE VI. Post-test KAB Questionnaire Administration and Analyses (4 weeks)

PHASE VII. Program Evaluation and Final Report (15 weeks)

- a. Revision of curriculum
- b. Production of final report
- c. Establishment of a dissemination strategy for project results

2.2 Key Players

2.2.1 Overview. A critical component of the C.A.N. Peer Education Project was the involvement of a variety of key players. The main key players are depicted in Figure 1.1. A description of their respective roles is provided on the following page.

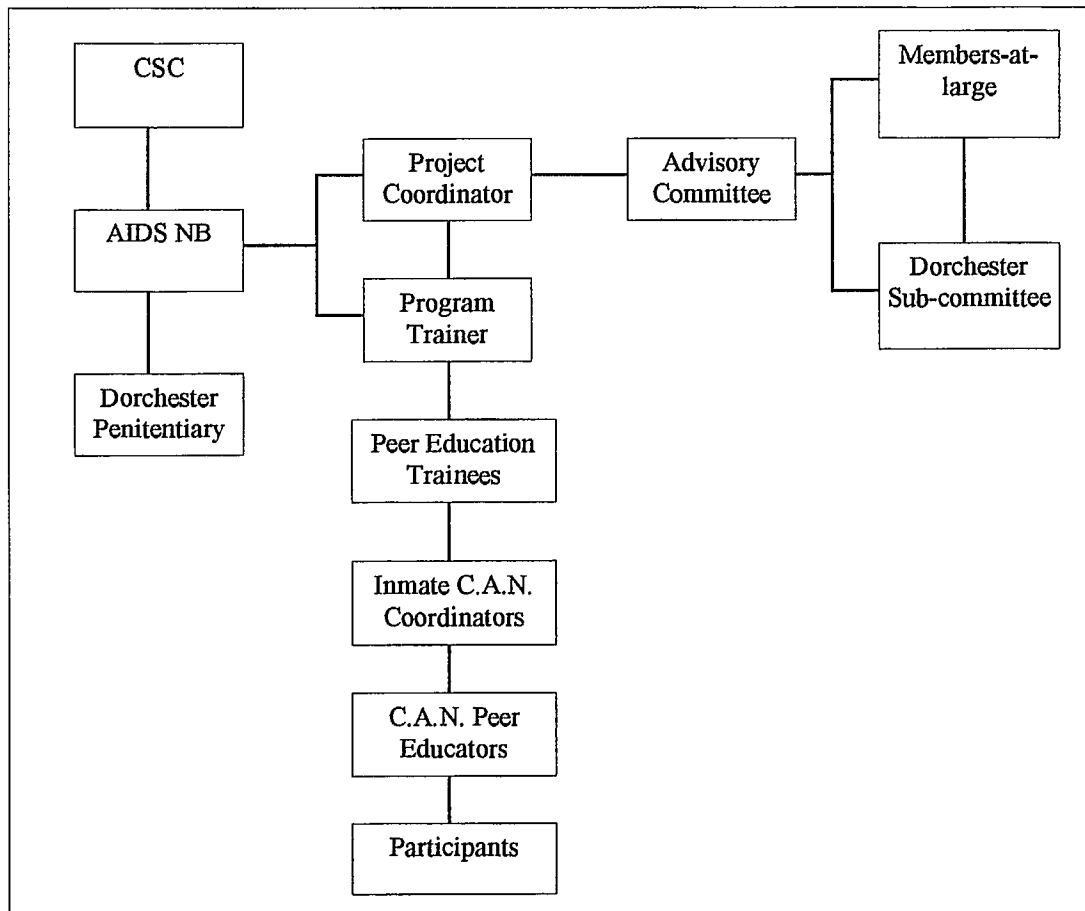


Figure 1.1 Organizational Structure of the C.A.N. Project

2.2.2 Advisory Committee. As depicted in Figure 1.1, a national advisory committee was established for the purpose of this project. This committee consisted of broad representation from CSC, Health Canada, John Howard Society, various community-based AIDS Service Organizations, inmates, persons living with HIV/AIDS, as well as individuals and organizations across Canada with experience working within the prison setting. A Dorchester advisory sub-committee was also formed, and included representation from Health Care, Case Management, Psychology, Personal Development, IPSO (i.e., security) and inmates. Inmates— infected and affected by HIV/AIDS— played an instrumental advisory role throughout all phases of the project.

2.2.3 Roles of Key Players. During the project's initial phase, role descriptions for the project's key players were clearly delineated and articulated. Consultations with prison administration, staff, inmates, and other members of the Advisory Committee were held toward the establishment of realistic and fair criteria for selecting participants interested in the C.A.N. Peer Education Training Program, as well as toward the development of reality-based role descriptions for the other key players. The lines of decision making, reporting and responsibility between the various players were also clearly defined.

Job descriptions were also drafted for each of the following key players: Project Coordinator; Program Trainer; Advisory Committee Members; AIDS Peer Educators; and the C.A.N. Program Coordinators. Each job description included a detailed description of the purpose, duties/responsibilities, qualifications, and time frames.

Correctional Service of Canada

- Funder

Dorchester Penitentiary

- Medium-security federal correctional institution selected as the pilot project site. It is located in Dorchester N.B., and has a population of approximately 400 male inmates.

AIDS New Brunswick/SIDA Nouveau-Brunswick

- Provincial community-based AIDS Service Organization which served as "Contractor" for the pilot project. Responsible for the selection and hiring of the Project Coordinator and Program Trainer.

Project Coordinator

- Responsible for the overall planning, management, coordination and evaluation of the program. Working with an advisory committee, was responsible for the research design and methodology; development of the peer education curriculum and evaluation strategy; developing and piloting a KAB questionnaire; coordinating the hiring of the AIDS Peer Education Program Trainer; overseeing the administration of a pre- and post-test KAB questionnaire; as well as the implementation of the program. This role also involved program evaluation and the production of a guide for other prisons wishing to establish inmate AIDS peer education programs. The Project Coordinator worked in conjunction with an HIV/AIDS education consultant and researcher at Brock University toward the development of the KAB questionnaire and the analytic strategy. Data coding, entry and computer analyses were conducted by the researcher at Brock University.

Advisory Committee

- Consisted of representation from CSC, Health Canada, Community-based ASO's, inmates, persons living with HIV/AIDS, various staff at Dorchester Penitentiary, as well as individuals and organizations across Canada with experience working within the prison setting. This committee's role was primarily consultative, its main purpose being to provide input and consultation into various phases of the project.

AIDS Peer Education Program Trainer

- Responsible for the delivery of the Inmate AIDS Peer Education Training Program at Dorchester Penitentiary. This role also involved administering the pre- and post-test KAB questionnaire; evaluating peer education trainees in relation to their suitability as Inmate AIDS Peer Education Coordinators, and/or AIDS Peer Educators; and, training/supervising the Inmate AIDS Peer Education Coordinators.

AIDS Peer Education Trainees

- Selected according to specified criteria and procedures. Inmates interested in becoming either the Inmate AIDS Peer Education Coordinator (or Assistant Coordinator) or volunteer AIDS Peer Educators were required to attend and complete Modules 1 and 2 of the AIDS Peer Education Training Program. Following the training program, trainees were evaluated in relation to AIDS knowledge, attitudes, as well as presentation and interpersonal skills to assess their suitability for either of the positions.

Inmate AIDS Peer Education Coordinators (C.A.N. Coordinators)

- A Coordinator and an Assistant Coordinator were hired for coordinating the delivery of the AIDS peer education and support program utilizing volunteer inmate peer educators. These roles also involve supervising the volunteer peer educators, providing opportunities for the ongoing education of peer educators, and ensuring the maintenance of a corps of peer educators. These are ongoing paid positions.

AIDS Peer Educators (C.A.N. Peer Educators)

- Responsible for planning and delivering various AIDS education and support initiatives to fellow inmates (e.g., condom distribution, information distribution, one-on-one AIDS prevention and support, peer education workshop sessions, etc.). The role also involves working with the Inmate AIDS Peer Education Coordinators to coordinate and schedule various peer education and support initiatives.

Participants

- Refers to the Dorchester inmates who participated in one or more of the C.A.N. peer education and support initiatives. The extent of involvement in the project varied greatly ranging, for example, from one visit to the C.A.N. office to extensive participation in all initiatives (e.g., multiple visits to the C.A.N. office, attendance at several workshop sessions, speaking one-on-one to a peer educator, obtaining HIV-related information through literature and audiovisual materials, etc.).

2.3 Training Program Curriculum

2.3.1 Development. A curriculum was developed on the basis of research and consultations conducted during the initial phase. The draft curriculum was circulated to all Advisory Committee members for input, suggestions and approval.

The curriculum developed for the C.A.N. Peer Education Training Program consisted of two Modules: (1) AIDS Prevention Education Training and (2) Peer Support Training, which were themselves subdivided into 18 units, ranging from basic facts about HIV/AIDS and other communicable diseases, to more complex information on medical aspects of HIV/AIDS and on providing peer education and support. The central premise of the curriculum was harm reduction, and it was intended to be delivered in a very interactive and prisoner-centred format over a period of approximately 120 hours.

A more detailed discussion of the curriculum can be found in Section 2.4. It should also be noted that the entire curriculum is included in an extensive facilitation manual prepared on the basis of this project (see *Facilitation Manual: The C.A.N. National Pilot Inmate AIDS Peer Education Project*). The facilitation manual is available in both English and French, and its purpose is to provide other community-based organizations and prisons with guidelines regarding setting up, implementing, and sustaining peer education and support programs within correctional facilities. In addition to suggested facilitation strategies, the manual includes a number of overheads, hand-outs and exercises developed specifically for this project.

2.3.2 Program Goals and Objectives. The overall goal of the Inmate Peer Education Program was to implement and evaluate an effective and sustainable model of inmate AIDS peer education which would result in: (1) increased knowledge, (2) improved attitudes toward risk reduction behaviours and persons living with HIV/AIDS, and (3) increased rates of HIV risk-reduction practices and health promoting behaviours.

There were 15 overall objectives for the participants of the C.A.N. Peer Education Training Program. Participants were to:

- (1) Gain a comprehensive, relevant, and up-to-date knowledge base regarding HIV-infection (definition, epidemiology, virology, transmission, stages, etc.).
- (2) Acquire extensive information about HIV-antibody testing and the issues thereof.
- (3) Identify and explore their own knowledge and attitudes pertaining to sexuality and safer sex, including non-consensual sex.
- (4) Identify and explore their own attitudes toward homosexuality, injection drug use, and persons living with HIV/AIDS.
- (5) Identify and examine the issues pertaining to drug use, tattooing, piercing, and steroids.
- (6) Develop skills needed to practice safer sex, drug use, tattooing, piercing, etc.
- (7) Examine infection control guidelines (aims, procedures, and barriers).
- (8) Examine the principles of behaviour change in relation to HIV-related risk taking practices.

- (9) Review and practice the skills required to develop and provide peer education sessions within the prison setting.
- (10) Examine the fundamental principles of providing one-on-one peer education and support.
- (11) Review and practice the skills needed to conduct an HIV-related risk assessment.
- (12) Review and practice the skills required to provide one-on-one peer education and support in various situations.
- (13) Examine and explore the medical aspects of HIV/AIDS and various related health promotion strategies.
- (14) Examine health promotion and maintenance strategies both in and out of prison.
- (15) Examine and explore HIV-related issues "on the outside".

2.3.3 Program Outline. The following is an overview of the content of the C.A.N. Peer Education Training Program. As outlined below, the AIDS Prevention Education Training module consisted of 10 units, while the Peer Support Training module consisted of 8 units.

Module 1— AIDS Prevention Education Training

Unit 1: Introduction to the Program

This unit provided an opportunity for peer educator trainees and the training facilitator to meet and discuss:

- goals and objectives of the program
- utilizing program skills outside of prison
- roles of the key players
- pre-training knowledge and attitudes
- ground rules for the program (e.g., confidentiality, honesty, and respect)
- HIV/AIDS in prisons (i.e., the Canadian scene, the International scene)
- participants' hopes, fears and expectations

Unit 2: Basic Facts About AIDS and Other Communicable diseases

This unit offered participants an introduction to HIV/AIDS and other communicable diseases, particularly Hepatitis and Tuberculosis. Information about other sexually transmitted diseases was also covered briefly. More specifically, this unit provided basic information regarding:

- definition, epidemiology and virology of HIV/AIDS
- stages of HIV-infection
- modes of transmission of HIV (myths vs. facts)
- prison-related transmission issues
- Hepatitis and Tuberculosis within the prison setting

Unit 3: HIV-Antibody Testing

This unit provided trainees with information pertaining to HIV-antibody testing, including:

- what the test is; how the test works
- what a positive, negative and indeterminant result means
- other tests to determine HIV-infection
- the importance of informed consent
- types of HIV testing (compulsory, mandatory and voluntary testing; nominal and non-nominal; confidential vs. anonymous)
- where to go for testing (options available both in and out of prison)
- prison-related HIV-antibody testing issues
- process of testing for HIV (options available both in and out of prison)
- the pros and cons of taking a test
- the importance of pre- and post-test counselling

Unit 4: Sexuality and Safer Sex

This session covered:

- an exploration of one's knowledge and attitudes toward sexuality
- homophobia/heterosexism
- sexual orientation vs. sexual behaviours
- HIV and sexual activity (levels of risk)
- sexual activities and other STD's
- making sex safer (including condom/dental dam demonstrations)

- safer sex communication/negotiation
- consensual and non-consensual sex
- safe/safer sex options in consensual and non-consensual relationships
- prison-related sexual behaviour and safer sex issues

Unit 5: Drug Use, Tattooing, Piercing and Steroids – Risks and Prevention

This unit explored:

- possible reasons why people engage in these activities
- levels of risk involved in drug use, tattooing, piercing and steroids (Hepatitis and HIV)
- constraints to changing behaviours
- concept of harm reduction
- making these activities safe/safer (options available both in and out of prison)
- cleaning works demonstration (with/without bleach)
- tattooing/piercing safely
- prison-related issues

Unit 6: Infection Control Guidelines

This unit examined infection control guidelines (i.e., universal precautions) mainly in relation to HIV/AIDS, although their relevance to Hepatitis, TB, and other communicable diseases were also addressed. The unit included:

- definition and aims of infection control
- body fluids which can transmit HIV
- body fluids which can transmit other diseases (e.g., Hepatitis, Tuberculosis)
- procedures for infection control
- infection control scenarios within the prison setting
- barriers to infection control within the prison setting

Unit 7: Principles of Behaviour Change

This unit provided an overview of behaviour change principles in relation to HIV-related risk taking practices, including:

- a review of HIV-related risk taking behaviours
- an examination of prison-related risk-taking scenarios and barriers to change

- how knowledge, motivation, skills, and environment impact on behaviour/behaviour change
- implications of behaviour change principles for peer educators

Unit 8: Review of AIDS Prevention Education Module

Prior to moving to the unit on peer education skills, this unit reviewed the main elements covered in units 1-7:

- basic facts about AIDS and other communicable diseases
- HIV-antibody testing
- sexuality and safer sex
- drug use, tattooing, piercing and steroids -- risks and prevention
- infection control guidelines
- principles of behaviour change

Unit 9: Peer Education Skills

This session covered:

- review of adult learning principles
- group work basics
- education and literacy
- dealing with conflict, anger and other reactions
- public presentation tips
- confidentiality
- review of the role of peer educators
- planning a peer education program

Unit 10: Role Playing and Feedback

During this unit, participants:

- role played a 1 1/2 - 2 hour basic AIDS presentation
- participated in self and peer evaluation
- co-ordinated with the appropriate people to conduct a presentation to other inmates
- prepared and conducted one presentation which was evaluated by the participants and attended by other trainees.

Module 2-- Peer Support Training

Unit 11: Overview of Peer Support

This unit included fundamental principles of providing one-on-one peer support, including:

- overview of peer support training module
- what is a peer?
- what is a peer relationship based on?
- characteristics of a peer support provider
- foundations of peer support (code of ethics, guiding principles)

Unit 12: Conducting a Risk Assessment

This section covered:

- review of all HIV-related risk behaviours
- review of risk levels
- skills involved in risk assessment

Unit 13: Pre-test Peer Education and Support

This unit included a review of the testing process for HIV, as well as the pros and cons of being tested. A number of role playing and skills-building exercises around the provision of education and support to a peer before and after the testing process were also included. The session was outlined as follows:

- review of the testing process for HIV (both in and out of prison)
- pros and cons of being tested for HIV
- peer educator's role before and after an inmate is tested for HIV
- what to include in a pre-test education and support session
- how to discuss HIV testing with peers
- role playing and feedback

Unit 14: Post-test Peer Education and Support

In this unit, trainees explored the feelings and emotions following HIV negative and positive test results, as well as the education and support needed. It included:

- review of what a positive, negative and indeterminant test result mean
- testing HIV-negative: feelings and emotions

- testing HIV-positive: feelings and emotions
- stages of grief (e.g., denial, guilt, anger)
- resources and services available for people who test HIV+ (both in and out of prison)
- issues surrounding the decision to disclose one's HIV status (pros and cons, fear and discrimination, who to tell? how to tell?)
- peer education/support following negative and positive results
- role playing and feedback

Unit 15: Medical Aspects of HIV/AIDS

This unit covered:

- an overview of the immune system
- stages of HIV-infection
- AIDS-related illnesses
- medical treatments
- clinical drug trials
- complementary/alternative therapies
- importance of good health care
- referral resources

Unit 16: Health Promotion

This section provided information on health promotion and maintenance strategies both in and out of prison. It covered:

- nutrition
- alcohol, drugs and smoking
- safe/safer sex
- safe/safer needle use
- stress reduction
- emotional/social support
- rest and sleep
- exercise
- hygiene
- spirituality
- other health promotion ideas

Unit 17: HIV/AIDS "On the Outside"

This unit provided an overview of the HIV-related issues inmates or their peers may have to deal with upon release.

- preparing for release
- pre-release stressors
- remaining HIV negative "on the outside"
- living with HIV/AIDS "on the outside" (diet and nutrition, accessing good medical care, infection control, living with pets)
- helpful community resources [e.g., AIDS Hotlines and Organizations, John Howard/Elizabeth Fry Societies, Hemophilia Societies, Needle Exchanges, Parole Offices, Alcoholics/Narcotics Anonymous, Human Rights Offices, Legal Aid, Counselling Centres/Help Lines].

Unit 18: Support Skills: Bringing it all Together

This unit provided an opportunity for more practice and roleplaying of the skills involved in providing one-on-one education and support to peers who wish to seek personal information on risk assessment, testing, safe/safer sex, needle use, tattooing, etc. It also reviewed the skills needed to be a source of information and support to those who are HIV+. Roleplay scenarios also addressed situations from "the outside".

- reflections on the program
- a review of adult learning and peer support principles
- roleplaying and feedback: one-on-one education
- roleplaying and feedback: one-on-one support
- self-care for peer educators
- review of peer educator's roles
- program planning

2.4 C.A.N. Peer Education Training Program

2.4.1 Implementation. A high level of interest in the C.A.N.'s Peer Education Training Program was expressed by the inmates at Dorchester. Twenty-five inmates applied to take part in the training program to become AIDS peer educators. Eleven fulfilled the recruitment criteria, and were accepted as trainees. One declined the training due to a scheduling conflict with a Personal Development Program he was required to attend.

Scheduling the month-long training program was challenged by the fact that the majority of inmates were working or attending education programs through the week and were being paid for doing so. As such, motivating and recruiting participants required that inmates holding prison jobs not be financially penalized for participating. To address this issue, the prison administration at Dorchester agreed to continue paying inmates, and to hold their prison jobs until the completion of the training. The duration and length of the program precluded the participation of inmates taking part in other education programs.

The C.A.N. Training Program (described in Section 2.3) was implemented over a period of 120 hours over a course of 4 weeks (November 7 - December 8, 1995). Full-day sessions took place Tuesdays through Thursdays, with Mondays and Fridays being half-day sessions. Sessions were held in a small, comfortable and private meeting room. Although structured by the content and suggested strategies developed for this pilot project, sessions were as informal as possible, with an atmosphere encouraging openness. Given the diversity in participants' backgrounds, and the fact most lived on different units, participants needed time to get to know one another. The program was delivered in a very interactive and prisoner-centred manner, encouraging active participation, comments, questions, and feedback.

The individual who facilitated the C.A.N. training program was hired through AIDS/SIDA NB. As a nurse, her HIV-related experience included working in hospital as well as community-based AIDS Service Organization settings. She had extensive knowledge about HIV/AIDS and HIV-related prison issues, and had excellent presentation, teaching, problem solving and team-building skills.

Given that inmates frequently mistrust correctional staff, it was paramount that the trainer come from an "outside" agency or AIDS Service Organization. This facilitated the ability to establish credibility and trust with the participants early in the course of the training program. None of the sessions were attended by CSC staff. The success of the training program was also dependent on establishing a sense of trust among participants, and an assurance that what they discussed within the training program remained within the group.

The following is a list of “ground rules” for the training program established and agreed upon by all participants during the initial session:

- ◆ No offensive language (within reason)
- ◆ Be on time (2 chances— 1 warning, 1 more = out!)
- ◆ No food during sessions (coffee is allowed)
- ◆ Confidentiality (“What is said here stays here”)
- ◆ Courtesy (“Don’t interrupt someone when they are speaking”)
- ◆ Respect
- ◆ Use language everyone can understand (“street” vs. “textbook” language)
- ◆ Bring supplies
- ◆ Honesty
- ◆ No aggression toward each other
- ◆ Stay on topic (within time frames)
- ◆ Give notice for absences
- ◆ Everybody gets time to speak
- ◆ **Break in Confidentiality = Grounds for not finishing the program**

The level of interest, enthusiasm and commitment among the group was obvious. Attendance was excellent, and none of the participants dropped out. All ten inmates successfully completed the month-long training program, and received a “Certificate of Achievement” during a “graduation” ceremony scheduled following the completion of the Peer Support Training Module.

2.4.2 Evaluation. All 10 peer educators gave the curriculum very positive evaluations. All indicated that they had learned much new information, and that the information had been very well presented. The following is a representative sample of comments made by the participants at the end of the training program:

- *“I felt rewarded in taking this program.”*
- *“I thought that this program was very informative and useful and I hope to get hired so I can help others with their questions and concerns.”*
- *“The four weeks that I was here were very educational for me because I got to learn a lot about HIV and AIDS ... I hope that the project gets off to a good start and keeps running for a long time because there are a lot of people out there who need help.”*
- *“I hope to see that a program like this one goes into all the prisons across Canada.”*

- *“I learned a lot of information during the last month that I am sure would be helpful to others if they had the chance to take part. I will be able to relay the things I have learned for many, many years to people I will come in contact with.”*
- *“Not only has this program increased my knowledge, but it has really changed the way I look at people with AIDS. It has helped me realize the difficulties they can face and how important support is. I can also honestly say that I will protect myself and others in the future by being safer.”*

2.4.3 Selecting the Inmate AIDS Peer Educators and Coordinators. Following the completion of the training curriculum, trainees were evaluated in relation to their AIDS knowledge, attitudes, as well as presentation and interpersonal skills to assess their suitability and interest in either of the two positions. The development of job descriptions which included clear, objective, and measurable criteria facilitated a smooth and fair selection process.

The following criteria were included in job descriptions designed for selecting both the inmate C.A.N. Peer Educators and the Coordinators. These were developed in consultation with various inmates, prison administration and staff, as well as the project's Advisory Committee.

- Successful completion of the Peer Education Training--Modules 1 and 2.
- Good communication, interpersonal, and organizational skills.
- Team-playing skills.
- Ability to establish functional and positive relationships with prison staff and inmates.
- Ability to create support for and commitment to the goal of preventing HIV in prisons.
- Ability to communicate comfortably and non-judgementally about homosexuality, sexuality, drug use, and tattooing/piercing.
- Respect of confidentiality is essential.
- Must have the credibility and respect of other inmates.
- Must not be scheduled for release for at least 6 months.
- Low-risk for segregation.

The individuals selected as the C.A.N. Coordinator and Assistant Coordinator had to fulfill the above criteria, in addition to demonstrating strong organizational, leadership and team-building skills, as well as the potential to develop teaching and presentation skills.

2.4.4 Training the C.A.N. Coordinators. On the basis of the aforementioned criteria, two inmates were hired in paid positions as full-time coordinators of the C.A.N. program. They received an additional five weeks of one-on-one training and supervision to help them launch the peer-led AIDS education and support program. Given the ongoing support required during the actual C.A.N. Program implementation (i.e., Phase V), this additional training and supervision component was interspersed over a period of five months (December, 1995 - May 1996). During the first 3 weeks, the coordinators received daily training and supervision; weekly sessions were subsequently scheduled until May, 1996. In addition to helping them establish the C.A.N. office, the Program Trainer worked with the Coordinator and Assistant Coordinator toward the design, promotion, scheduling, coordination and delivery of the program.

2.5 C.A.N. Program Implementation

2.5.1 Overview. During the C.A.N. Program's implementation phase, the coordinators, in conjunction with the peer educators, developed and launched various prison AIDS prevention and support initiatives. In addition to distributing condoms and information by means of pamphlets, books, audiovisual materials, and discussions, they provided one-on-one HIV/AIDS prevention education and support. Group information and interactive workshop sessions were also conducted throughout the prison, utilizing a variety of interactive and prisoner-centered education and awareness strategies, including games and contests. The coordinators also produced a monthly newsletter, attended a support group for prisoners with HIV/AIDS, corresponded in writing to HIV-positive prisoners in other Atlantic Region institutions, and staffed an office approximately 36 hours/week. The C.A.N. Team was also involved in a number of advocacy issues (e.g., advocating for access to latex gloves for inmate janitors; advocating on behalf of an inmate who had been refused HIV-testing), and provided input toward the implementation of bleach distribution at Dorchester, which was slated to officially commence September 30, 1996.

2.5.2 Staff/Community Liaison. Maintaining support from prison administration and staff during the implementation of the C.A.N. peer-led program was of paramount importance. As such, a liaison officer position between prison staff and inmate peer educators/coordinators was established. Monthly meetings between the staff liaison officer and the peer education coordinators were deemed necessary in order to keep staff updated and informed about the program, and to provide a venue to voice and address program-related concerns and/or issues.

Regular support from AIDS/SIDA NB was also provided during the 3-month C.A.N. implementation phase. That is, weekly meetings were held between the C.A.N. Program Coordinators and the AIDS Peer Education Program Trainer during the period of February - May, 1996. Meetings were very informal in nature, and involved the discussion of workplans, brainstorming around peer education and support initiatives, and addressing program-related concerns and/or questions. These meetings also provided a venue for ongoing education and training in relation to new information and documentation related to the roles of the C.A.N. Peer Educators. The C.A.N. Coordinators were also able to access information and support from AIDS/SIDA NB through contacting the organization by telephone. The Project Coordinator or Program Trainer were available to answer questions and/or concerns.

2.5.3 Components. The following is a summary of some of the C.A.N. HIV-related education and support initiatives and highlights undertaken between February and April, 1996. As of this writing (September, 1996), most initiatives are ongoing and additional ones have been launched.

C.A.N. Office

- The C.A.N. office officially opened its doors to Dorchester's population on February 1, 1996. The office is located in the main dome of the prison, is open 6 hours/day Mondays through Saturdays, and is both easily accessible and private. In addition to being furnished with the basics (e.g., desks, chairs, tables, etc.), the C.A.N. office is equipped with a computer, television and VCR. Printed and audiovisual resource materials are available on a variety of topics related to HIV/AIDS and other communicable diseases (i.e., particularly Hepatitis A, B and C and TB). Documentation is available on such topics as prevention, transmission, epidemiology, medical/health promotion aspects, and legal issues surrounding HIV/AIDS and other communicable diseases.

Inmates visiting the office can obtain a one-on-one consultation with a project coordinator, receive written documentation, and/or view educational videotapes. A "video lounge" area, separated from the main section of the office by a partition and equipped with a couch, is available for the purpose of reading or watching videos.

A total of 116 visits were made to the C.A.N. office by inmates during the first 3 months of the project (February 1 - April 31, 1996). Over the course of these visits, 194 presenting questions/concerns were addressed by the C.A.N. office. The majority of questions/concerns dealt with HIV/AIDS (51%). A total of 28.4% of the questions/concerns related to Hepatitis B and C; 11.3% related specifically to issues around testing

procedures for HIV/AIDS or Hepatitis. The remaining questions/ concerns regarded Tuberculosis transmission or testing (2.6%) or were not specific to the prevention, transmission, epidemiology, medical/health promotion aspects, and legal issues surrounding HIV/AIDS or other communicable diseases. Of the 116 visits, 65 (56%) also involved the viewing of one or more HIV-related educational videotapes.

One-on-one peer education and support

- In addition to being offered through the C.A.N. office, one-on-one peer education and support was provided more informally through conversations on living units/ranges, as well as through such venues as the gymnasium, cafeteria, work sites, etc. The C.A.N. Coordinators received open passes to move throughout the institution as required to fulfill their duties. Although not authorized for open passes, the other peer educators also provided one-on-one education and support on their own units, at their work sites, as well as through their everyday activities.

Condom Distribution

- C.A.N. Peer Educators also took on the responsibility of ensuring that the condom machines installed on several of the units at Dorchester were stocked. Condom machines were checked regularly by several of the peer educators, and restocked on an as-needed basis.

"Did You Know?" Bulletin

- As part of the project's information dissemination strategy, the C.A.N. Coordinators produced and distributed a monthly newsletter bulletin, titled "Did You Know?" In addition to being a useful promotional tool, this publication included information about the C.A.N. Project (e.g., goals and objectives, available resources, upcoming HIV-related educational initiatives) as well as basic information regarding the prevention, transmission, and epidemiology of HIV/AIDS and other communicable diseases. The C.A.N. Peer Education Team ensured that all inmates received this information by distributing "Did You Know?" to every cell.

Prisoners with AIDS (P.W.A) Support Group

- The Coordinator of the C.A.N. Project was asked by several of the P.W.A. group members to sit in on the monthly support group meetings for prisoners with HIV-infection. This group, consisting of 3-5 inmates, has been established for several years with the support of SIDA AIDS Moncton, a local community-based AIDS Service Organization.

Participation in the P.W.A.Group has provided the C.A.N. Peer Education Team with a structured opportunity to work in conjunction with HIV-positive inmates toward the fulfillment of their information and support needs. In addition to increasing the Coordinator's awareness pertaining to the issues/concerns facing the P.W.A. group members, this participation provides the opportunity to disseminate information regarding the C.A.N. project, as well as to offer HIV-related information and support to their peers.

Educational Workshops/Presentations

- A total of 8 educational workshops/presentations were conducted throughout the prison during the C.A.N. Program's implementation phase. Originally, interactive workshops/presentations focusing on the basic facts about HIV/AIDS and other communicable diseases were scheduled to be held on each of 5 units/ranges during the work/school day. However, scheduling the sessions during this time slot was not widely approved, given the logistics of excusing inmates from their regular work or school programs. Consequently, only one workshop was held on a living unit, and the remainder were held in the classroom or workplace setting. Workshop participation was on a voluntary basis, and was attended by approximately 100 inmates. Feedback received from the participants, as well as the instructors was very positive. Pre- and post-test scores on a quiz developed by the Coordinators also indicated increases in knowledge and enhanced attitudes. The data revealed average post-test scores exceeding 95%, with a pre- to post-test increase of approximately 15%.

Video Presentations

- Between February and April, 1996, AIDS-related video presentations were held in the common rooms of two ranges. Presentations were held in the evenings and participation was on a voluntary basis. Video nights were also held on a weekly basis in the C.A.N. office during the month of March, 1996. A variety of HIV-related educational videos were shown, reaching a total of 28 inmates.

Pamphlet Distribution

- Members of the C.A.N. Peer Education Team distributed educational brochures/pamphlets to all of the inmates' cells. One of these pamphlets, "HIV/AIDS and Hepatitis: Am I at Risk in Prison?", was developed by the C.A.N. Coordinators and dealt specifically with issues surrounding prison life and communicable diseases. More than 2000 flyers were distributed over the course of the 3-month evaluation period.

“Family Feud” Style Quiz Night

- A “Family Feud” style debate night was developed, coordinated and implemented by the C.A.N. Peer Education Team. This interactive initiative involved a round-robin tournament between six teams (each comprised of a peer educator plus 4 other inmates). More than 100 questions relating to HIV/AIDS and other communicable diseases were developed by the C.A.N. Coordinators for the purpose of this event, and most team members studied for the competition. A total of 31 inmates, 2 health care staff, and 2 AIDS/SIDA NB staff members participated in this event. Approximately a dozen inmates took part as members of the audience. Feedback regarding the event highlighted the utility of such events for motivating and educating inmates about HIV/AIDS and other communicable diseases.

2.6 KAB Questionnaire

2.6.1 Overview. A pre- and post-test knowledge, attitudes and behaviour (KAB) questionnaire was developed for the purpose of the present project. It was designed to evaluate the impact of the C.A.N. Peer Education Program on the HIV-related knowledge, attitudes and behaviours of inmates at Dorchester. Several questions were also included to assess knowledge around Hepatitis and TB.

The vast majority of questions were “close-ended”— i.e., asking respondents to select from various specified response categories. When the response categories were not exhaustive, respondents had the option of indicating and specifying an “other” choice. A few “open-ended” questions were included to enable participants to clarify and/or expand on certain issues. Given education and literacy considerations of federal inmates, the questionnaire was designed to read at a Grade 7-8 level. The option of completing the questionnaire in English or French was provided.

The questionnaire consisted of 84 questions divided into 6 main sections: (1) “Things About You” — designed to gather basic demographic and background data [e.g., age, educational level; length of sentence(s) served in provincial/federal correctional institutions; sources of HIV-related information]; (2) “Information”— designed to assess basic knowledge about HIV and other communicable diseases (e.g., epidemiology, disease progression, testing, transmission, universal precautions, safer sex, safer needle use/tattooing/piercing); (3) “What Do You Think?”— designed to assess participants’ attitudes toward persons living with HIV/AIDS, as well as various HIV-related issues [e.g., testing and confidentiality, harm reduction policies in prison]; (4) “Testing and Risks”— designed to gather information about

participants' experiences with HIV and Hepatitis testing, as well as about the incidence of various risk-related behaviours [e.g., unsafe sex, injection drug use, tattooing, piercing, etc.]; (5) "Activities"— designed to assess the incidence of various risk-related behaviours in the past 4 weeks; and (6) "In the Future"— developed to gather information regarding intentions to participate in the C.A.N. Program, get tested for HIV/Hepatitis, as well as intentions to engage in safe/safer behaviours in the upcoming 4 weeks. Four of the questions included in the section titled "Testing and Risks" were adapted from the questionnaire developed for the 1995 *National Inmate Survey*.²⁷

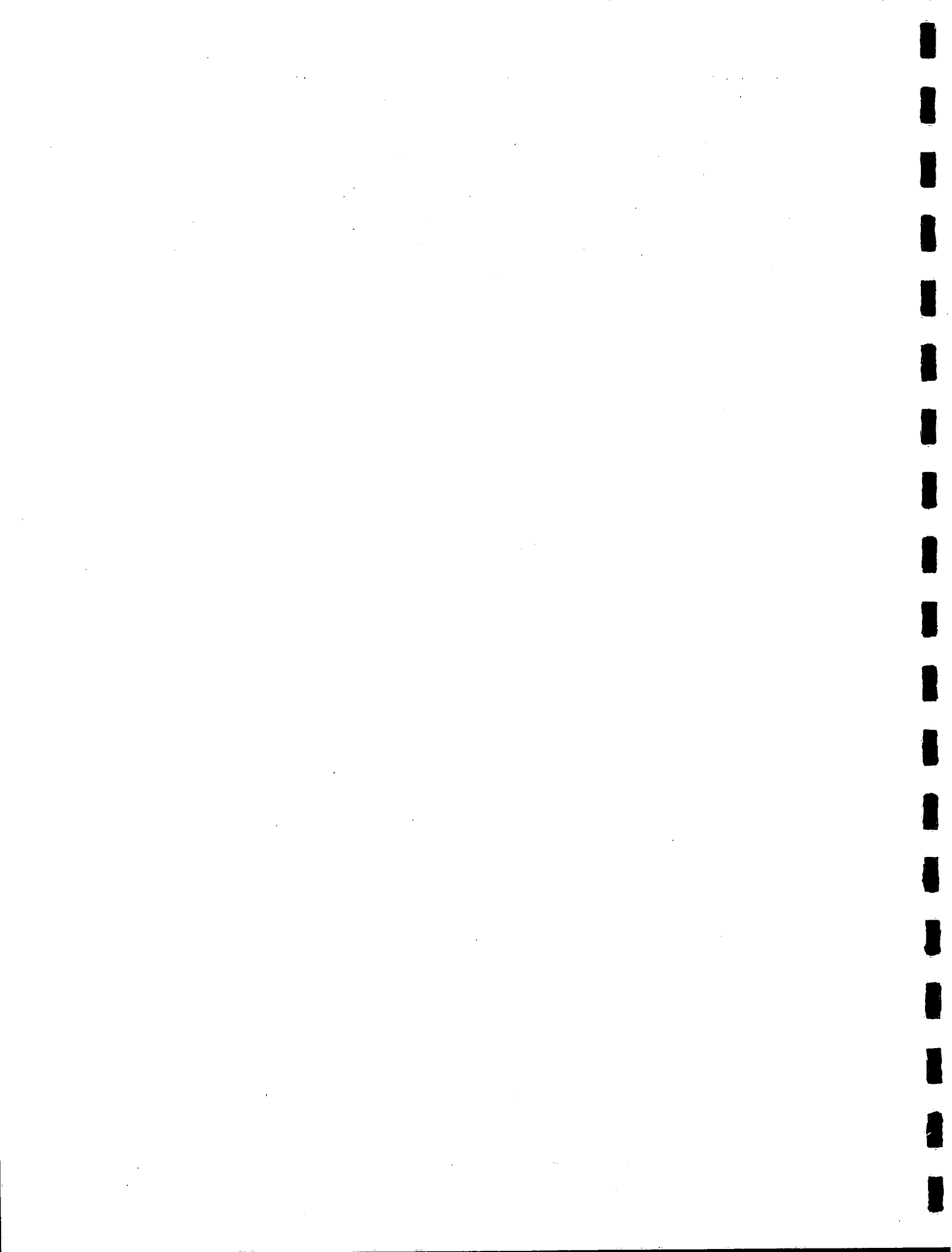
The pre-and post-test questionnaires were identical, except that a seventh section was added to the latter questionnaire to assess participants' involvement in and perceptions of the C.A.N. Project (e.g., perceived impact on one's knowledge, attitudes, and sexual or needle using behaviours; perceived usefulness of various C.A.N. prevention education and support initiatives).

2.6.2 Administration. The pre- and post-test KAB questionnaires were administered three months prior to and following the implementation of the peer-led C.A.N. Program. A total of 113 and 76 inmates completed the pre- and post-test KAB questionnaires, respectively. The methodology developed for administering the questionnaires was developed on the basis of extensive consultation, and took into consideration such factors as literacy rates, available resources, need for anonymity, and the prison culture. In order not to single-out inmates with lower literacy levels, the questionnaires were administered verbally in small groups or individually by the Program Trainer and/or C.A.N. Peer Educators, who had received training in administering the KAB questionnaires. Individuals who preferred to complete the questionnaire on their own had the option of doing so. A manila envelope was provided with each questionnaire as an added safe-guard to anonymity.

An attempt was made to reach as many inmates as possible through all of the ranges/units (i.e., except the Psychiatric Units), as well as through the Adult Basic Education Program. Both pre- and post-test questionnaires were administered over 2-week time periods, using the same methodology. Completion of the questionnaires required informed consent, and was done both voluntarily and anonymously. In order to match the pre- and post-test questionnaires, participants were asked to select their own anonymous codes. No one from CSC had access to the coded questionnaires. Participants were repeatedly assured that their answers would remain completely anonymous, and that no-one from CSC would see their responses.

²⁷ Correctional Service of Canada, *supra* note 15 at 185-186.

2.6.3 Data Analyses. Following the administration of the post-test KAB questionnaires, the pre and post-test data were coded and entered into a computer database. The statistical package utilized for the analyses of the data was *StatView 4.1*. *Microsoft Excel 5.0* was used for manipulation of the data. Frequencies, cross-tabulations, chi-square, t-tests, and regression analyses were conducted with the data. All statistical tests for group differences were two-tailed, with the significance level set at $p < .05$.



3.0 RESULTS

3.1 Participant Characteristics

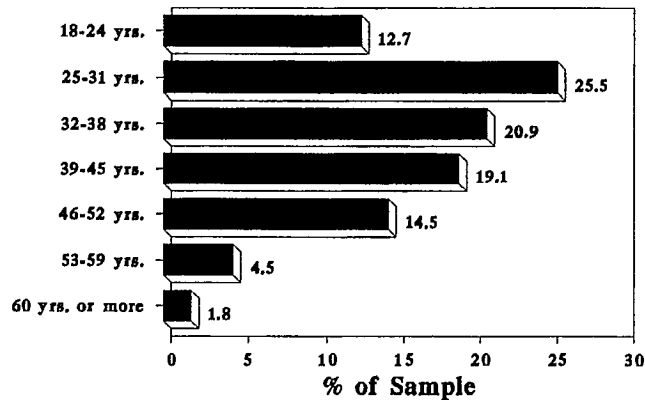
3.1.1 Overview. A total of 113 participants completed the pre-test KAB questionnaire, representing approximately one-third of Dorchester Penitentiary's non-psychiatric inmate population (i.e., approximately 350 inmates were residing on non-psychiatric units at the time of the pre-test). Seventy-six inmates took part in the post-test KAB questionnaire, and did not differ significantly from the pre-test sample in terms of basic demographic and background variables (e.g., age, educational level, incarceration history, incidence of sexual/injection activities, HIV/Hepatitis status, etc.). Six inmates (5.3%) chose to complete the pre-test questionnaire in French, while only one participant (1.3%) chose to do so at post-test.

3.1.2 Demographic Information. As shown in Figure 3.1, a wide range of ages was represented by the participants who completed the pre-test questionnaire. Representative of Dorchester's inmate population, respondents ranged in ages from 18-74 years, with approximately two-thirds between the ages of 25 and 45 years. The mean age of participants who completed the pre-test questionnaire was 36.3 years ($SD = 10.7$ years). While younger respondents (i.e., 18-24 year-olds) comprised close to 13% of the sample, very few participants (6.3%) were 53 years of age or older.

The data regarding the highest level of education completed by the participants are presented in Figure 3.2. As evident in this graph, a diversity of educational levels was also found among participants, ranging from the completion of Grade 1 through to some university courses (*Median* = the completion of Grade 10). Approximately one-third of the sample had not gone beyond the eighth grade, and an additional one-quarter listed the tenth grade as their highest level of completed education. Although 10% of the participants had attended college and/or university, none reported having received a college diploma or university degree.

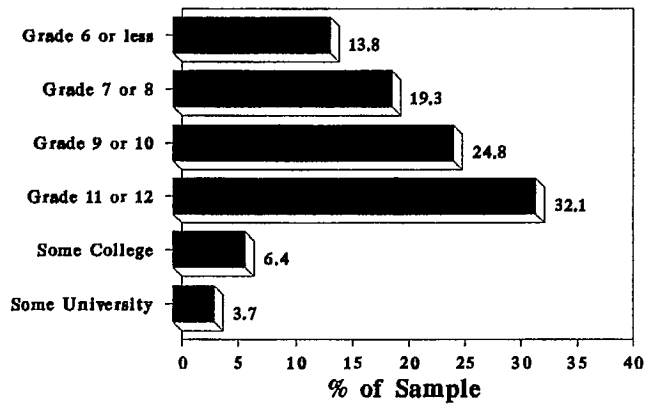
3.1.3 Incarceration History. As illustrated in Figure 3.3, the length of time served in a Federal prison varied greatly, with a range of less than 1 month to a maximum of 25 years (*Median* = 2.5 years). On average, however, participants reported having served close to 5 years ($M = 4.6$; $SD = 5.4$) in a Federal prison. Also shown in Figure 3.3, a total of 79.2% of participants had also served time in a provincial correctional facility. Participants reported having served an average of 15.4 months ($SD = 20.7$ months) in a provincial prison, and the length of these sentences ranged from a low of less than 6 months to a high of 9 years.

Figure 3.1 Respondents by Age



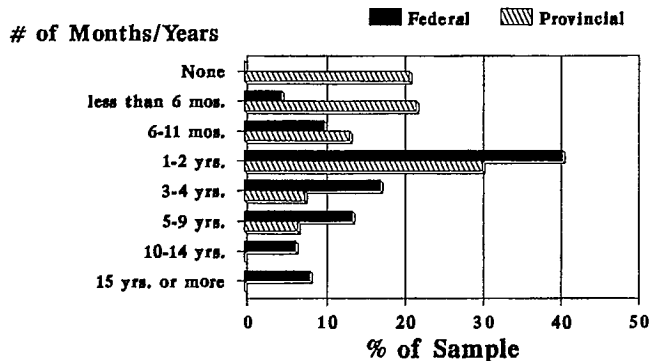
Note. $M = 36.3$ years ($SD = 10.7$).
Range = 18-74 years.

Figure 3.2 Respondents by Education



Note. Represents highest level of education completed.

Figure 3.3 Total Time Served in Federal and Provincial Prisons



Close to 80% of all respondents reported that they were currently serving their first Dorchester Penitentiary sentence, and approximately one-half of the sample indicated that they began serving their current sentence in 1995. Figure 3.4 depicts the number of months or years respondents had remaining to serve at Dorchester. While participants reported a widely varying range of sentence time remaining— i.e., less than 1 month through to “life”— they had, on average, slightly more than 3 years ($M = 3.3$; $SD = 3.9$) remaining at Dorchester Penitentiary.

3.2 Testing for Communicable Diseases.

Participants were asked to indicate whether they had ever been tested for HIV/AIDS, Hepatitis B, and Hepatitis C. Questions also centred around the results of their last tests, the HIV testing site, and their reasons for having been tested. As shown in Figure 3.5, a substantial number of inmates reported having been tested for one or more of the diseases listed. That is, 63.3% of all respondents reported having been tested for Hepatitis B; 43.4% had been tested for Hepatitis C; and 38.2% had been tested for HIV/AIDS. Rates of infection among those who had been tested ranged from 2.7% (Hepatitis B) and 3.5% (Hepatitis C) to 3.9% for HIV/AIDS. It should also be noted, however, that approximately 12%, 16% and 23% of participants reported not knowing their most recent Hepatitis B, HIV/AIDS, and Hepatitis C test results, respectively (see Figure 3.6). These data reflect infection rates for each of these communicable diseases of approximately 2% in relation to the entire pre-test sample surveyed (i.e., including participants who had not been tested).

As illustrated in Figure 3.7, the most common testing site among the participants who reported having been tested for HIV-infection was prison (52.9%). Less than one-third of all those tested had done so outside of prison, and 15.7% reported having been tested both while in prison as well as on the outside. When asked what had prompted them to seek HIV-antibody testing, more than two-thirds of the respondents indicated that it had been their own idea. A number of other sources were named by participants as having suggested HIV-testing: CSC Health Care Staff (12.1%); friends on the outside (12.1%); sexual or needle sharing partners on the outside (7.6%); a doctor on the outside (6.6%); and another inmate (4.5%). One participant reported that HIV-testing had been the idea of a non-medical CSC staff member.

Figure 3.8 depicts the results of an open-ended question asking participants to list their reasons for having been tested for HIV/AIDS. Of the 39 individuals responding to this question, more than one-third (35.9%) provided a vague reason or reported a non-specific risk— e.g., “to know”, “to be on the safe side” or “past behaviour”. Unsafe sex, injection

Figure 3.4 Sentence Time Remaining at Dorchester

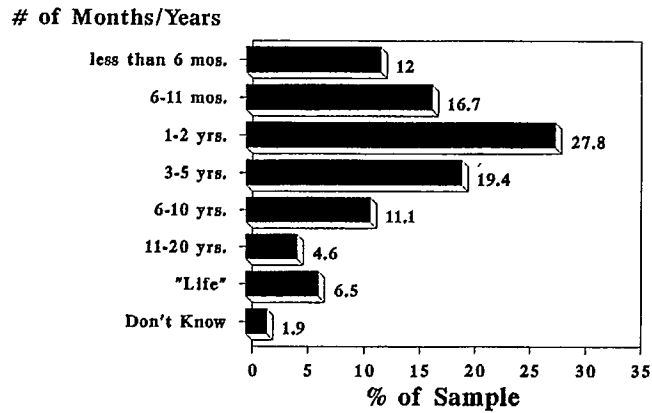


Figure 3.5 Testing for Communicable Diseases

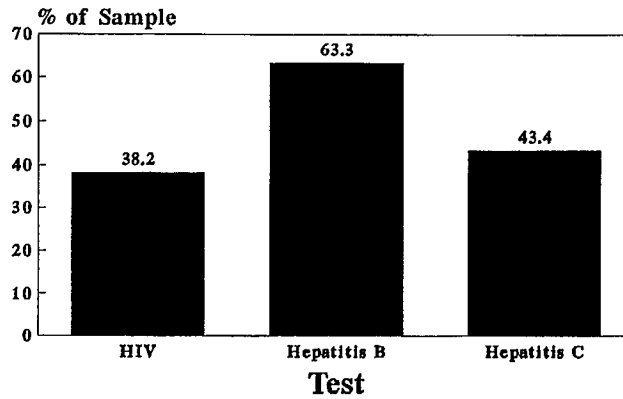
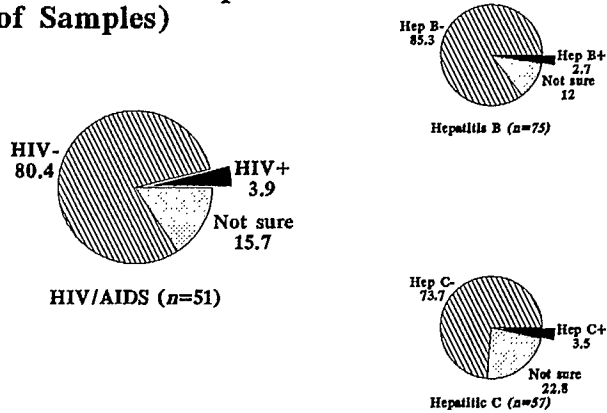
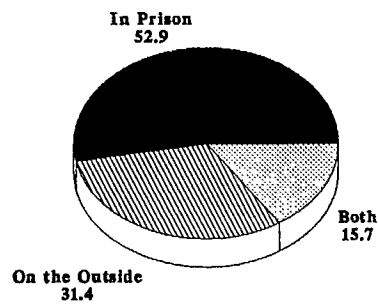


Figure 3.6 Results of Last HIV/AIDS, Hepatitis B and Hepatitis C Tests (% of Samples)



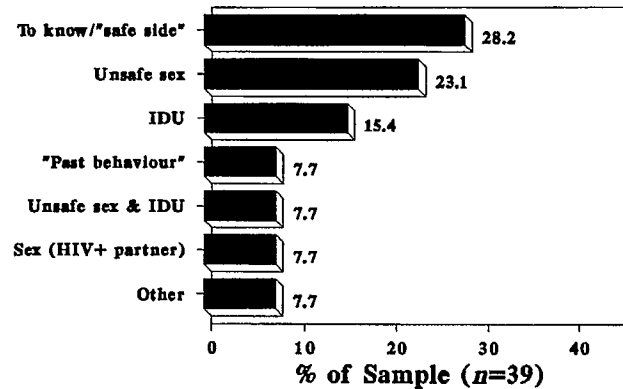
Note. Based on the respondents who reported having been tested.

**Figure 3.7 Site of HIV-testing
(% of Sample)**



Note. Based on the 51 respondents who reported having been tested for HIV.

**Figure 3.8 Reason for Getting Tested
for HIV**



drug use, a combination of unsafe sex and injection drug use, and having had sex with an HIV-positive partner were cited as reasons by 23.1%, 15.4%, 7.7% and 7.7% of the respondents, respectively.

3.3 HIV-Related Knowledge

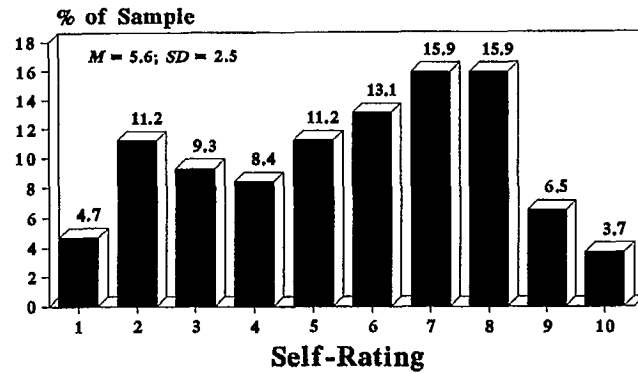
3.3.1 Self-Ratings. Figure 3.9 depicts the results of a question asking participants to rate themselves on a 10-point HIV-related knowledge scale, where 1 represented “knowing nothing”, and 10 represented “knowing everything”. As illustrated in this figure, participants provided widely varying self-ratings on the HIV/AIDS knowledge scale. That is, these ratings ranged from 1-10. On average, however, participants rated themselves as having a mediocre level of HIV-related knowledge (i.e., $M = 5.6$; $SD = 2.5$).

3.3.2 Sources of Information. An assortment of individuals and organizations were identified by the respondents as being sources of AIDS-related information. As shown in Figure 3.10, the five most frequently cited sources of information listed by individuals prior to the onset of the C.A.N. Project were: television/radio programs; (59.3%); newspapers/magazines (49.6%); pamphlets/videos (46.9%); books (44.2%); and other inmates (44.2%). Friends and relatives were also cited as sources of HIV/AIDS information by more than one-third of the sample. Other potential sources of information— CSC Health Care, school, sexual/needle sharing partners, AIDS peer educators, AIDS organizations, and prison reception— were identified by fewer than one-quarter of pre-test participants. Since the C.A.N. Project was not officially underway at the time of the pre-test, it should be noted that the 17 participants (15%) who replied that they received information from AIDS peer educators were likely referring to several inmates who were enrolled in the C.A.N. Peer Education Training Program, but who had not yet undergone the training, and were not yet officially fulfilling their roles as peer educators.

3.3.3 Knowledge Quiz. The knowledge quiz developed for the present study was designed to assess basic knowledge about HIV and other communicable diseases. The quiz was divided into two parts, the first consisting of 33 true-false items assessing general knowledge regarding epidemiology, disease progression, testing, transmission, universal precautions, safer sex, as well as safer needle use, tattooing, and piercing. A “not sure” response option was also provided to reduce the possibility of guessing. The second part of the quiz consisted of 8 items assessing participants’ knowledge of risk (none, low, and high) associated with various sexual activities. Participants were awarded 1-point for each correct response, for a total possible score of 41. The present section examines the knowledge levels of the pre-test sample. A pre- to post-test comparison of knowledge levels can be found in Section 3.7.2 of this report.

Figure 3.11 depicts the mean raw AIDS knowledge scores (and their percentage score equivalents) of the total pre-test sample. As shown, pre-test knowledge scores ranged from a

Figure 3.9 Self-Ratings on HIV/AIDS Knowledge



Note. 1="Know Nothing"; 10="Know Everything"

Figure 3.10 Pre-test Sources of Information on AIDS

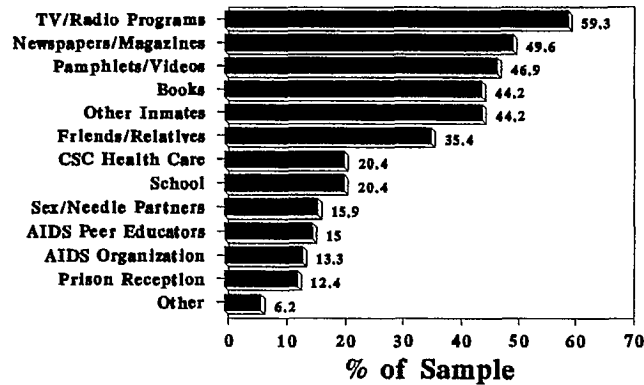
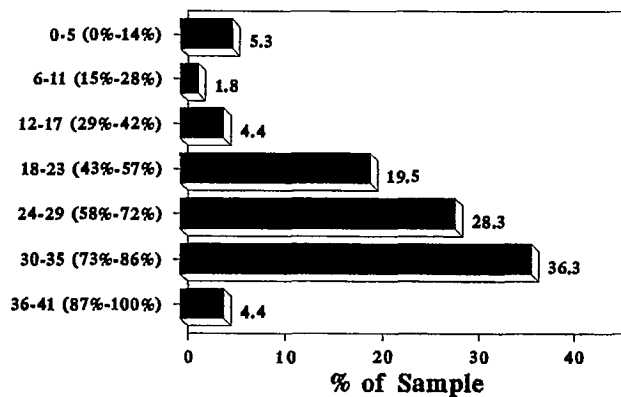


Figure 3.11 Pre-test AIDS Knowledge Quiz Score (and Percentage Equivalent)



Note. Range = 1-37; *M* = 25.8; *SD* = 8.1

low of 1 to a maximum of 37 ($M = 25.8$, $SD = 8.1$). This reflects an average total pre-test knowledge score of 62.9%. Also evident in this figure, more than two-thirds of the sample received a pre-test score between 58% and 86%, and an additional one-fifth of this sample scored between 43% and 57%. A more detailed examination of individual knowledge items is provided below.

Figures 3.12 to 3.19 illustrate the percentage of the total pre-test sample answering each of the 41 knowledge items correctly. For the purpose of the present section, items have been grouped into the following themes: Miscellaneous basic facts (5 items); Common AIDS transmission myths (4 items); HIV testing (6 items); Safer needle use: general items (5 items); Safer needle use: cleaning instructions (3 items); Communicable diseases (5 items); and, Safer sex (5 items). The eight risk rating items have been grouped together under the umbrella “sexual activity risk ratings”.

As shown in Figure 3.12, participants generally did very well in terms of answering the five miscellaneous basic facts about HIV/AIDS. In fact, three-quarters or more of the pre-test sample correctly answered all five items correctly. As such, most pre-test participants (75.2% - 91.1%) knew that: There were not only 1000 Canadians infected with HIV; HIV must enter the body in order to infect; there is no cure for AIDS; you cannot tell if a person has HIV/AIDS by looking at them; and that HIV damages the immune system and makes it difficult to fight off diseases.

In contrast, Figure 3.13 illustrates that, prior to the C.A.N. Project, inmates harbored several myths surrounding the transmission of HIV/AIDS. For instance, approximately one-quarter to one-third (22.5% - 34.9%) of these participants maintained that HIV could be transmitted through: sneezing/coughing; sweat or tears; and insects and animals. In addition, the vast majority (85%) incorrectly classified fighting and biting as high risk behaviours for the transmission of HIV.

Knowledge levels regarding HIV testing varied considerably at pre-test, and the data point to much confusion related to various testing issues (see Figure 3.14). While three-quarters or more of all participants knew that a person testing “positive” can transmit HIV to others and that an inmate at Dorchester can go to Health Care Services for an HIV test, fewer participants (i.e., anywhere from 36.9% - 63.1%) correctly answered the questions relating to confidential/anonymous testing, the “window” period, and false negative results. Furthermore, only one-quarter of all pre-test respondents correctly disagreed with the statement “The HIV test tells you if you have AIDS.”

Figure 3.12 Knowledge Quiz: Miscellaneous Basic Facts (% Correct)

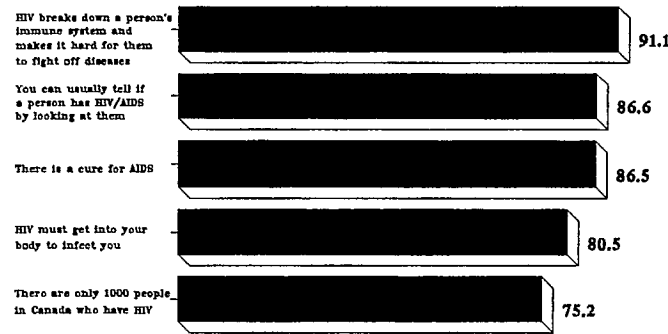


Figure 3.13 Knowledge Quiz: Common AIDS Transmission Myths (% Correct)

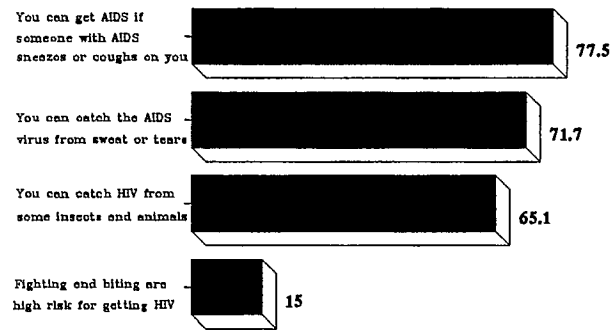
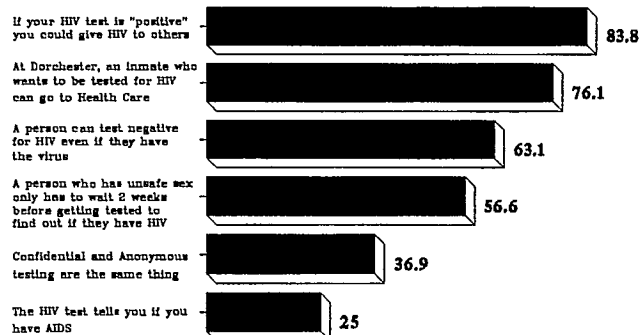


Figure 3.14 Knowledge Quiz: HIV Testing (% Correct)



The percentage of the pre-test correctly responding to each of the 8 items on safe/safer needle use are presented in Figures 3.15 and 3.16. As shown, participants were more likely to correctly answer the general items pertaining to safer needle use than the more specific ones regarding cleaning instructions. That is, four out of five of the general items on safer needle use were correctly answered by 73.0% - 87.3% of the pre-test sample, whereas none of the cleaning instruction items were correctly answered by more than 57% of this sample.

As presented in Figure 3.15, approximately three-quarters or more of this sample correctly refuted the statements: "It is safe to share your needles/works with friends who look clean"; "Washing needles/works with hot water and soap is as safe as using bleach for killing HIV and Hepatitis"; and "Orange juice or brew can be used to clean needles/works." In addition, 87% knew that using a new needle every time one injects is preferable to cleaning one's needles. However, a substantial proportion of pre-test participants (46.9%) incorrectly answered the item addressing the fact that bleach may not always be 100% effective against HIV/AIDS (i.e., "If people always clean their needles/fits, they can still get HIV/AIDS."). The data in Figure 3.16 point to much confusion and misinformation among the pre-test respondents regarding specific needle cleaning instructions— e.g., leaving bleach in a syringe for a minimum of 30 seconds; flushing equipment with clean cold water at least twice before and after using bleach. In addition, less than one-half of the pre-test participants knew that washing needles/works only once with bleach was insufficient for killing HIV and Hepatitis.

As evident in Figure 3.17, substantial variation in pre-test knowledge levels regarding communicable diseases and universal precautions was found. While the vast majority (84.9%) of respondents knew that a mask and gloves are not always necessary when in contact with a person with AIDS, very few (35.7%) knew that Hepatitis B is more easily transmissible than HIV. The remaining three questions were correctly answered by 58.4%, 64.3% and 69.9% of the participants, indicating some confusion surrounding when to use universal precautions, the transmission routes of Tuberculosis, and the fact that special infection control precautions are not needed for washing dishes and laundry of persons with AIDS.

Figures 3.18 and 3.19 illustrate some of the safer-sex related misinformation and misconceptions held by significant numbers of pre-test participants. For instance, while most participants (82.4% - 94.4%) correctly identified unprotected anal and vaginal sex (including withdrawal) as high risk activities, less than one-half (23.1% - 41.1%) of the pre-test sample provided correct risk ratings for deep kissing, cunnilingus and fellatio. Further, only approximately two-thirds of respondents correctly answered the questions pertaining to proper condom use (i.e., using condoms made of latex; pinching the air out of the tip of the condom prior to unrolling).

Figure 3.15 Knowledge Quiz: Safer Needle use--General Items (% Correct)

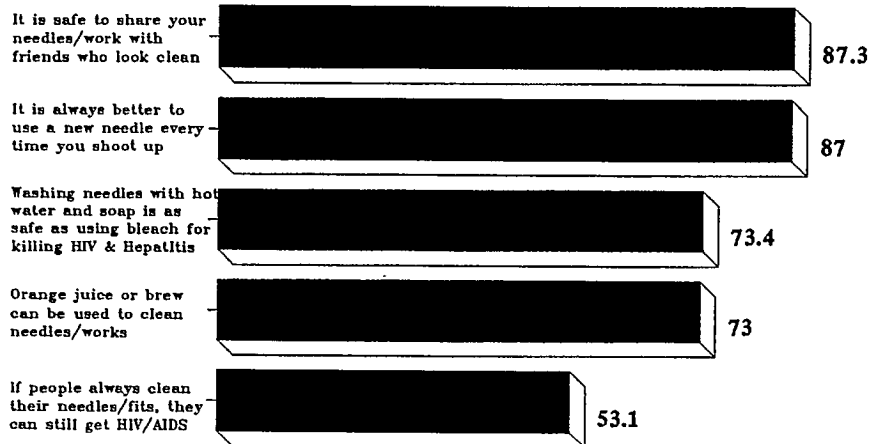


Figure 3.16 Knowledge Quiz: Safer Needle Use--Cleaning Instructions (% Correct)

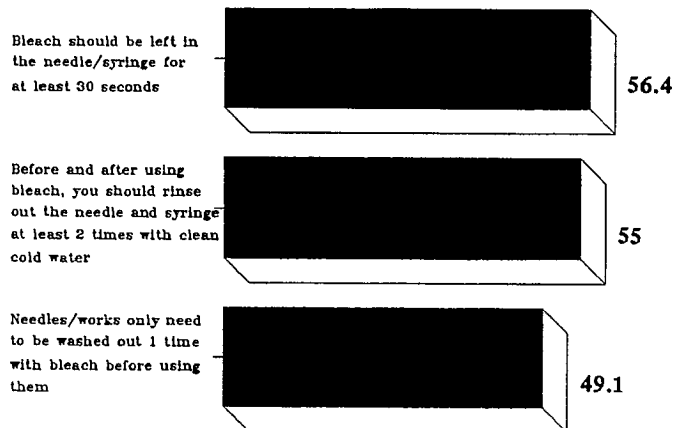


Figure 3.17 Knowledge Quiz: Communicable Diseases (% Correct)

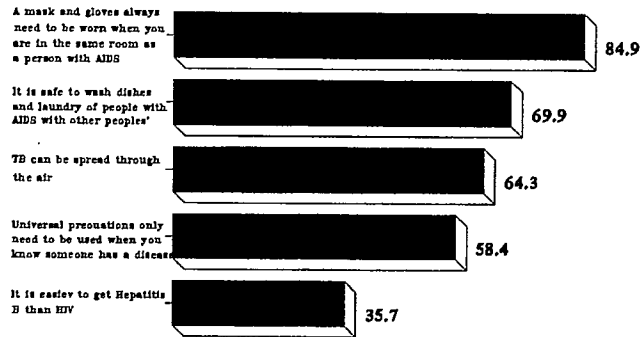


Figure 3.18 Knowledge Quiz: Safer Sex (% Correct)

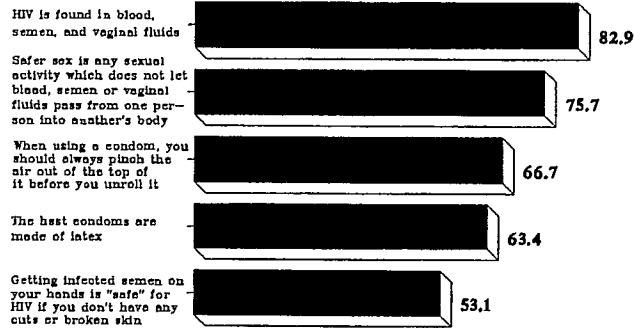
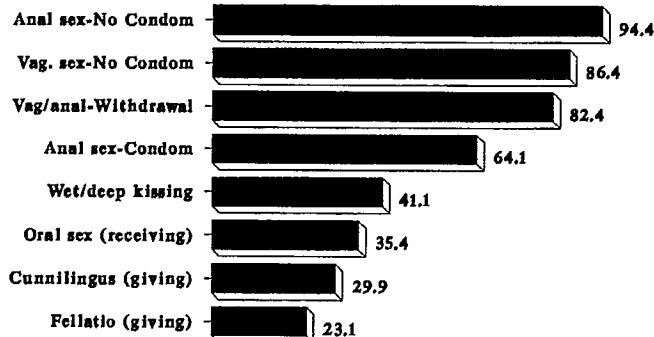


Figure 3.19 Knowledge Quiz: Sexual Activity Risk Ratings (% Correct)



3.4 HIV-Related Attitudes

Seventeen HIV-related attitudinal items were developed in order to assess participants' attitudes toward persons living with HIV/AIDS (PLWHIV/AIDS), as well as various HIV-related issues (e.g., confidentiality; prison harm reduction strategies). Participants were asked to read each of the items and to indicate whether they agreed, disagreed or were undecided. They received 3-points for each positive attitude, 2-points if undecided, and 1-point for each negative attitude, yielding a possible range of scores from 17-51, with higher scores reflecting more positive HIV-related attitudes. For the purpose of analyses, items were grouped into the following themes: (1) Attitudes toward PLWHIV/AIDS: general items (4 items); (2) Attitudes toward PLWHIV/AIDS: rights and freedoms (3 items); (3) Confidentiality issues (3 items); and (4) Prison harm reduction strategies (6 items).

Eight additional items pertaining to testing were designed to assess respondents' attitudes toward the compulsory testing of the following groups: (a) homosexuals/gays; (b) drug users; (c) women; (d) men who have sex with men and also have female partners; (e) prostitutes; (f) inmates; (g) correctional staff; and (h) everyone. Participants received 1-point if they agreed with the compulsory testing of a given group, 2-points if undecided, and 3-points if they opposed compulsory testing. As such, this scale yielded a possible range of scores from 8-24, with higher scores reflecting greater opposition to compulsory testing.

Widely varying attitudes toward HIV-related issues were found among pre-test participants. That is, scores on the 17-item scale ranged from 18 to 49 ($M = 39.6$; $SD = 7.4$), and those on the compulsory testing scale ranged from 8 to 24 ($M = 13.8$; $SD = 6.4$). Interestingly, the distribution of compulsory testing scores indicated that many pre-test participants were either totally in agreement of or totally opposed to compulsory testing. That is, approximately one-quarter (28%) of all participants agreed with compulsory testing for all of the groups listed, and one-quarter (25%) did not agree with the compulsory testing of any group.

The percentages of respondents who agreed with the various attitudinal statements at pre-test are displayed by theme in Figures 3.20 - 3.24. The present section provides a descriptive overview of the HIV-related attitudes of pre-test participants. A comparison of pre- to post-test attitudes is provided in Section 3.7.3.

Negative attitudes toward prisoners with HIV/AIDS were not uncommon among the pre-test sample. As illustrated in Figures 3.20 and 3.21, only slightly more than one-half (51.8%) to three-quarters (79.5%) of pre-test participants indicated positive attitudes toward persons living with HIV/AIDS. As evident in these two figures, the most negative attitudes related to

Figure 3.20 Attitudes Toward Persons With HIV/AIDS: General Items (% Agree)

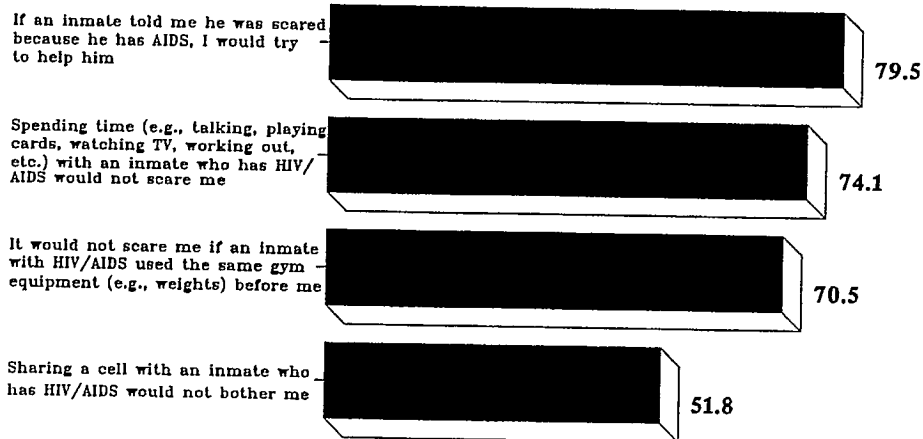
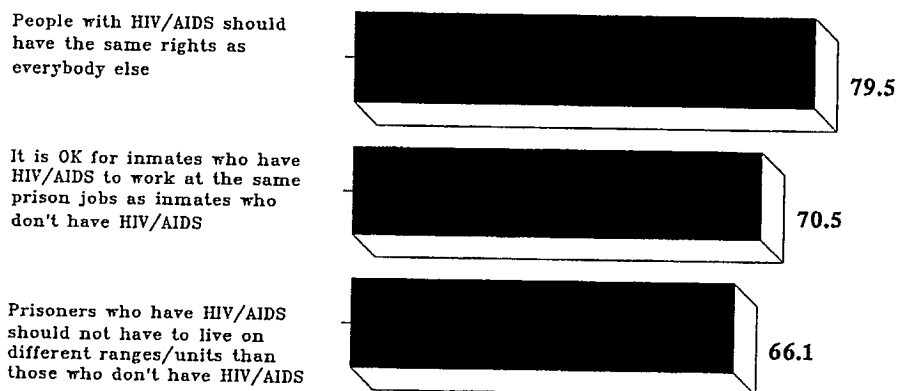


Figure 3.21 Attitudes Toward Persons With HIV/AIDS: Rights and Freedoms (% Agree)



sharing a cell with an HIV-positive inmate and to the mandatory segregation of HIV-positive inmates on different ranges or units than those who do not have HIV-infection. That is, approximately one-half of the pre-test sample indicated that sharing a cell with an HIV-positive inmate would bother them; and only two-thirds disagreed with the mandatory segregation of HIV-positive inmates on different living units than the remainder of the prison population.

Differing opinions toward the confidentiality issues were found among the pre-test sample (see Figure 3.22). Whereas the vast majority (91%) of participants agreed with the availability of anonymous testing, only one-third of the sample indicated that there was no need for inmates to be told about their peers who have HIV/AIDS. Similarly, only approximately two-thirds of the pre-test sample disagreed with the statement "If an inmate told me he had AIDS, I would have to tell other inmates about him." It should be noted, however, that this apparent discrepancy may be a reflection of the misinformation regarding the types of HIV testing. As discussed previously, for instance, only 36.7% of the pre-test sample knew that confidential and anonymous testing were not synonymous (refer to Figure 3.14).

As displayed in Figure 3.23, the majority of inmates indicated opposition to various prison harm reduction strategies. For instance, less than one-half supported the legalization of tattooing (48.2%), and less than one-third supported the legalization of body piercing (33%). Further, many maintained that inmates found having sex together should be punished, and that those found with injection equipment should be punished. However, more than three-quarters of all participants endorsed the availability of condoms (85.7%) and bleach (79.3%) within correctional facilities. It is interesting to note that these seemingly contradictory attitudes are analogous to current Correctional Service of Canada policy. That is, condoms and bleach are to be made available, yet sex between inmates and the possession of injection equipment continue to be classified as institutional offenses.

As shown in Figure 3.24, support for widespread compulsory testing was common among the pre-test sample. That is, more than two-thirds agreed that testing should be compulsory for: prostitutes, men who have sex with men and also have female sexual partners, and drug users. In addition, more than one-half also agreed that homosexuals/gays, correctional staff, as well as inmates be forced to undergo HIV testing. Although participants were least likely to state that all women should be tested, 40.5% of the pre-test sample did nonetheless agree with the compulsory testing of women. Also evident in Figure 3.24, close to 43% agreed with requiring "everyone" to be tested.

Figure 3.22 Attitudes Toward Various Confidentiality Issues (% Agree)

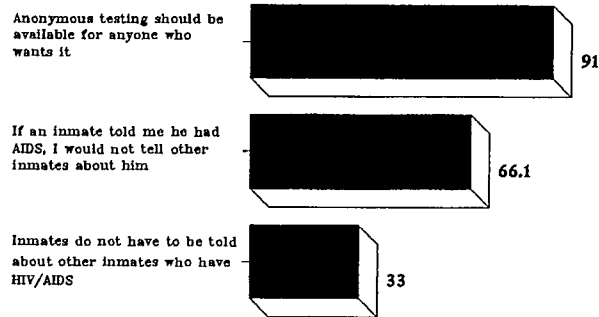


Figure 3.23 Attitudes Toward Prison Harm Reduction Strategies (% Agree)

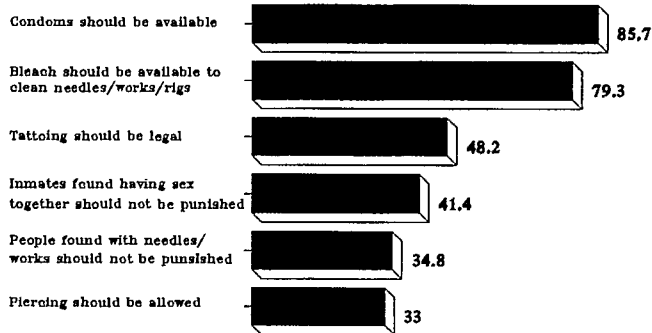


Figure 3.24 Attitudes Toward Compulsory Testing for Various Groups (% Agree)



3.5 HIV-Related Risks in Prison

3.5.1 Incidence of Risk Activities. In order to assess the incidence of various HIV-related risk taking behaviours while in prison, participants were asked whether they had ever engaged in: tattooing/body piercing; injection drug use (i.e., illegal drugs, steroids, or “something else”); and sexual activity with another inmate while at Dorchester Penitentiary. They were also asked to report on the frequency with which they practiced safe/safer sex and needle use behaviours.

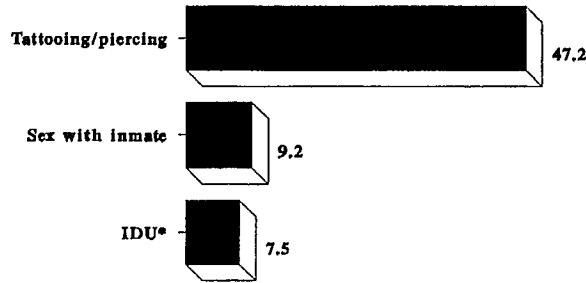
As illustrated in Figure 3.25, participants reported having engaged in several risk behaviours since being incarcerated at Dorchester Penitentiary. For instance, 47.2% reported having had a tattoo or piercing done; 9.2% acknowledged sex with another inmate; and 7.5% cited the use of injection drugs.

The data also highlight the frequency of unsafe practices. For instance, inmates who had been tattooed or pierced were asked whether they thought the equipment used had been clean and safe. Only three-quarters of all participants who reported having engaged in tattooing/piercing thought the rigs had been clean and safe to use. The remaining 25% of these individuals reported that the rigs had not been clean or that they were not certain. For the purpose of clarification, inmates who indicated that the rigs had been clean and safe were asked to specify their reasons for their belief. The data revealed that substantial numbers of respondents who thought the equipment was clean/safe to use thought so inaccurately. For example, more than one-half (19/37) of these participants reported thinking the equipment was clean/safe for one of the following reasons: they were *told* it was clean; they *assumed/took it for granted*; they had *since been tested*; they had *injected in the 1970's*; or they thought the rigs *looked* clean.

A high incidence of unsafe sexual activity was also evident among the pre-test sample (see Figure 3.27). First, respondents who acknowledged sex with another inmate reported having had a range of 1-25 sexual partners since being incarcerated at Dorchester Penitentiary (*Median* = 3.5). Further, none of the participants reported consistent condom use; 25% reported the occasional use of condoms; and, 75% indicated that they “never” used condoms.

Inmates reporting the use of injection drugs also acknowledged high rates of unsafe activities. For instance, 43% of those who reported having injected at Dorchester Penitentiary also indicated having shared injection equipment. In addition, one-third of participants who shared injection equipment at Dorchester Penitentiary reported “never” cleaning it prior to use. Furthermore, participants who reported cleaning their equipment revealed the use of a variety

Figure 3.25 Incidence of Risk Activities While in Dorchester (% of Sample)



* 43% reported sharing equipment. 1/3 reported "never" cleaning it prior to use.

Figure 3.26 Tattooing/Piercing in Prison (% of Sample)

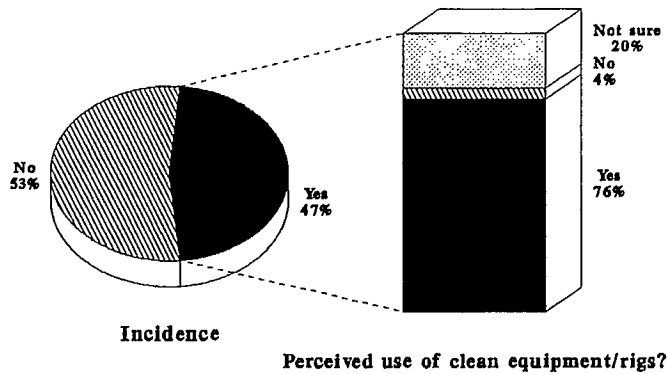
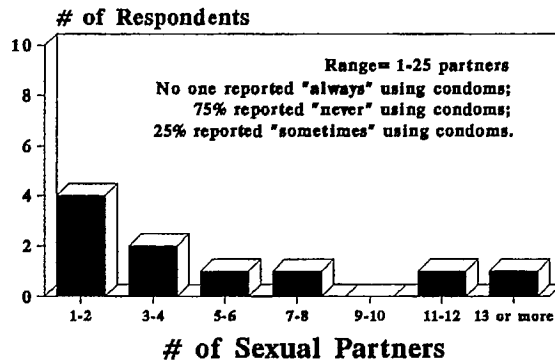


Figure 3.27 Number of Sexual Partners Since at Dorchester



Note. Based on the sample reporting sex with another inmate at Dorchester (n = 10).

of ineffective substances (e.g., hot water and soap, shine/brew, and saliva). Participants were also queried as to whether they had ever shared injection equipment while in another prison. A total of 7.5% of the sample reported having done so.

3.5.2 Perceptions of HIV-Related Risk. Participants were asked whether they perceived inmates to be in: (a) more danger than; (b) less danger than; or (c) about the same danger of contracting HIV as their counterparts “on the outside”. As shown in Figure 3.28, very few inmates contended that inmates were in less danger of contracting HIV/AIDS than those on the outside (5.7%). In contrast, the vast majority of participants believed that inmates were either at greater risk (40%) or approximately the same risk (54.3%) as those on the outside.

Figure 3.29 illustrates the results of questions inquiring as to whether respondents had heard of any inmates at Dorchester (and, if so, how many?) who were living with HIV/AIDS. As evident in this figure, the vast majority of participants (96%) were aware of inmates at Dorchester who were living with HIV/AIDS. As also shown in Figure 3.29, most reported knowing of between one and four HIV-positive inmates (*Mode* = 4 inmates). It should be noted that this modal figure accurately represents the number of HIV-positive inmates on record at Dorchester Penitentiary at the time of the pre-test.

When asked about their own sense of perceived vulnerability of contracting HIV/AIDS while in Dorchester Penitentiary, only 54.5% of the total sample responded that they did not think they were at risk. In contrast, 25% responded that they felt personally vulnerable for contracting HIV/AIDS during their incarceration at Dorchester Penitentiary, while 20.5% were uncertain of their risk.

Inmates who reported having sex and/or using needles in prison were asked in a separate question whether they were worried about contracting HIV/AIDS. Despite high levels of unsafe practices, 52.9% responded that they were not worried. A total of 38.2% of these participants responded that they were worried about contracting HIV/AIDS while in prison, and 8.8% were not sure.

3.6 HIV-Related Intentions

Ten items were included in the KAB questionnaire to assess participants' intentions to engage in various HIV-related behaviours in the upcoming four weeks. The data pertaining to these intentions are presented in Figure 3.30. Pre- to post-test comparisons of these behavioural intentions are provided in Section 3.7.4.

Figure 3.28 Perceived HIV-Related Risk for Inmates (relative to those on the "outside")

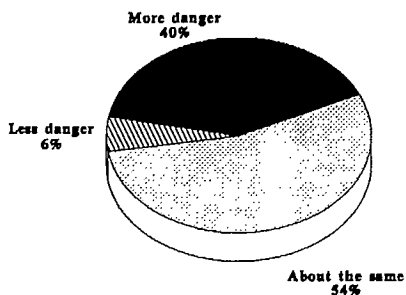


Figure 3.29 Awareness of HIV+ Inmates at Dorchester

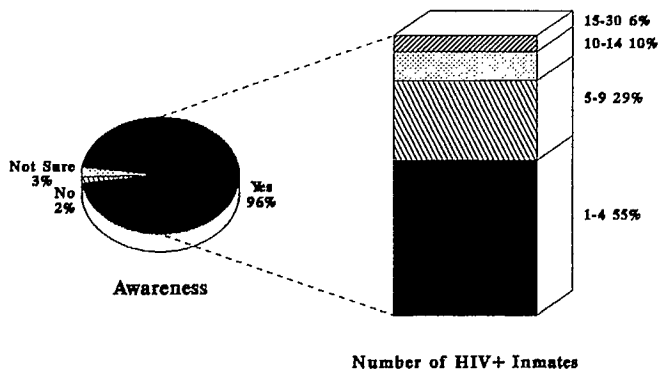
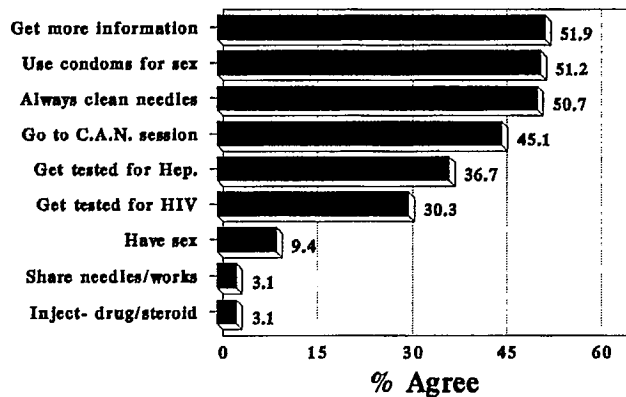


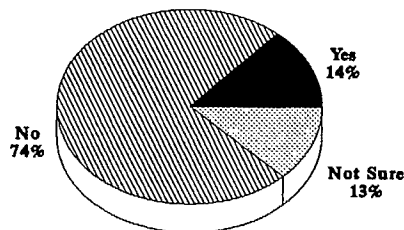
Figure 3.30 Intentions to Engage in Select Behaviours in the Next 4 Weeks



As shown in Figure 3.30, relatively few respondents acknowledged intentions to engage in HIV-related risk behaviours— e.g., injection of drugs/steroids (3.1%); sharing injection equipment (3.1%); and sexual activity (9.4%). Although not necessarily in the majority, greater proportions of respondents reported intentions to engage in various risk-reduction strategies. For instance, approximately one-third to one-half of the total sample reported intentions to: obtain HIV testing; obtain Hepatitis testing; attend C.A.N. sessions; and, if they were to use needles or have sex, to always clean their needles or utilize condoms, respectively. A total of 51.9% of this pre-test sample reported plans to obtain additional information about protecting themselves or others from HIV/AIDS and other communicable diseases.

The results of a more general question asking participants whether they had plans to modify their sexual or needle use behaviour in any way due to the threat of HIV/AIDS, Hepatitis, or any other disease are presented in Figure 3.31. As illustrated in this figure, only a minority of participants (i.e., 14%) reported intentions to change their sexual/needle use behaviours due to the threat of communicable diseases. In contrast, close to three-quarters of this sample denied any plans to modify these behaviours. This data is not surprising, given the absence of any formal HIV-related peer education program at the time of the pre-test. Thirteen percent of the respondents were not certain about their intentions.

Figure 3.31 Intentions to Change Sexual or Needle Use Behaviours in the Next 4 Weeks.



3.7 C.A.N. Project Evaluation

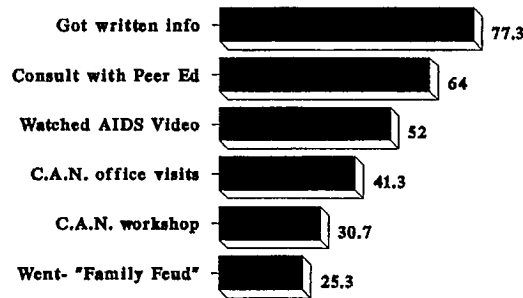
3.7.1 Perceived Usefulness and Impact. The post-test KAB questionnaire included several items designed to assess participants' involvement in and perceptions of the C.A.N. Project. As shown in Figure 3.32, a high level of involvement in the C.A.N. Project was reported among Dorchester's inmate population. That is, 66/76 of the total post-test sample (i.e., 86.8%) reported involvement in at least one activity during the evaluation period. As illustrated in Figure 3.32, more than three-quarters of the respondents had received written information from the C.A.N. office (77.3%); approximately two-thirds had received a one-on-one consultation with a peer educator (64.0%); and more than one-half had viewed an HIV-related video (52.0%). In addition, approximately 41% had visited the C.A.N. office, and roughly 31% of the total sample had attended a C.A.N. workshop/ presentation. The fewest number of participants reported having been involved in the "Family Feud" quiz event. It is not surprising that only one-quarter of the respondents had attended, in that "Family Feud" was a special event organized by the C.A.N. Peer Education Team. It took place on only one occasion during the evaluation period, and was attended by a total of 43 inmates.

As shown in Figure 3.33, the C.A.N. Project received high ratings from inmates. First 86.4% of the participants rated the C.A.N. Project as "Very useful" for inmates at Dorchester. Very few provided ratings of "A little bit useful" or "Not at all useful" — i.e., 10.6% and 3.0%, respectively. A closer examination of the data revealed that a number of C.A.N. activities were rated as useful by the vast majority of participants. For instance, one-on-one consultations with peer educators, workshops/presentations, the C.A.N. office, videos, and written material were rated as useful by anywhere from 81.8% - 93.9% of the total sample. While the "Did You Know?" bulletin and "Family Feud" events were rated as useful by a smaller percentage of respondents, these two initiatives were nonetheless perceived as useful by more than one-half of these participants. Responses to open-ended questions asking participants to comment on the utility of the C.A.N. Project and/or provide additional comments can be found in Section 3.7.5 of this report.

Figure 3.34 depicts the perceived impact of the C.A.N. Project on one's knowledge, attitudes and behaviours. As shown, participants indicated that the peer-led AIDS education and support program had an impact in terms of their own knowledge, attitudes and behaviours. More specifically:

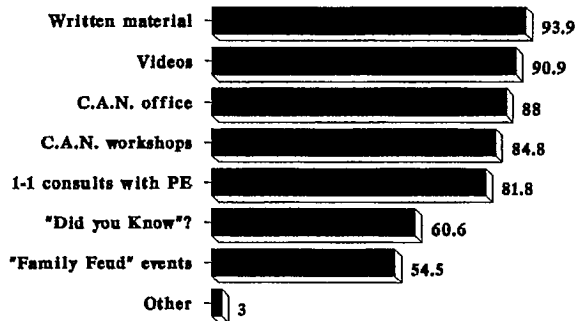
- more than three-quarters of the sample (75.8%) reported that their knowledge about HIV/AIDS and other communicable diseases had increased since the beginning of the C.A.N. Project;

Figure 3.32 Involvement in the C.A.N. Project (% of Sample)



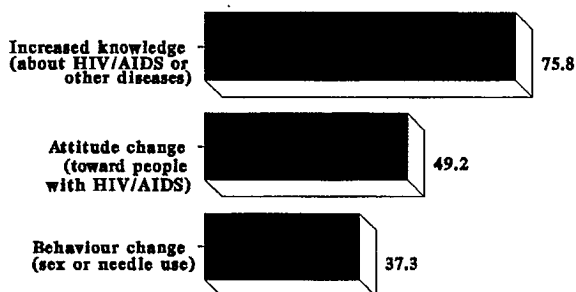
Note. Based on the post-test sample (N=76). 86.8% of the total sample reported involvement in at least one activity.

Figure 3.33 Perceived Usefulness of Various C.A.N. Activities (% of Sample)



Note. 86.4% rated the C.A.N. Project as "Very Useful" for Inmates.

Figure 3.34 Perceived Impact of the C.A.N. Project on One's Knowledge, Attitudes and Behaviours (% of Sample)



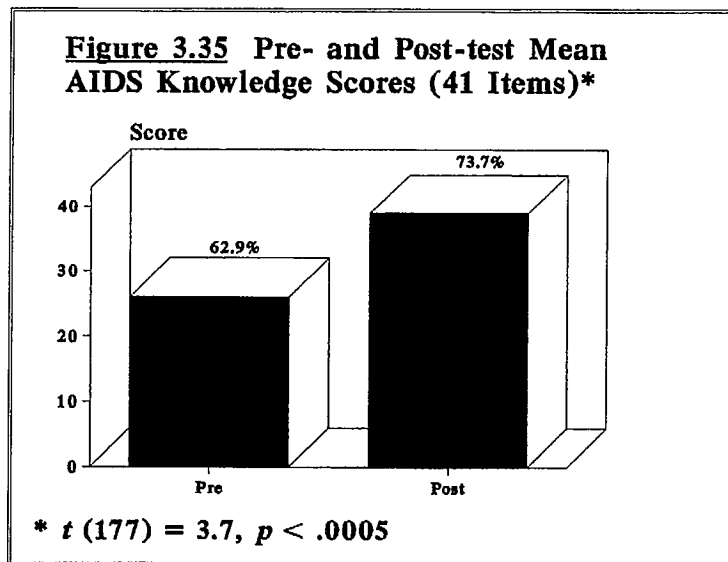
- approximately one-half (49.2%) reported that their attitudes toward people living with HIV/AIDS had been enhanced; and
- more than one-third (37.3%) indicated that their sexual or needle use behaviours had become safer since the onset of the C.A.N. Project.

The inmates who indicated that the peer-led AIDS education and support program had an impact in terms of their own knowledge, attitudes and/or behaviours were asked by means of open-ended questions to explain their responses. An examination of these data revealed that the majority of those who elaborated on the way in which their knowledge about HIV/AIDS or other diseases had increased focused on their greater understanding and awareness of the risks involved in various behaviours, and the ways to make these behaviours safer. A few individuals commented that the C.A.N. Project helped to dispel the myths they had held regarding casual contagion. The vast majority of participants who reported on the ways in which their attitudes toward people living with HIV/AIDS had been enhanced specified that their fears toward persons with HIV/AIDS had been reduced (59%); that they could be more sympathetic and understanding toward PLWHIV/AIDS (29%); or that they no longer stereotyped AIDS as being a gay disease (12%).

A variety of responses were provided by the sample when asked to specify the ways in which their sexual or needle use behaviours had changed since the onset of the C.A.N. Project. Some indicated a change toward consistent condom use (25%) and safer needle use (17%), while others cited changes toward both safer sex as well as safe/safer needle use (25%). The remainder of the participants were vague and reported that were simply more “careful” (25%) or that they and their partner had since been tested (8%).

3.7.2 Impact on HIV-Related Knowledge. The pre- and post-test mean AIDS knowledge scores (out of 41 items) are displayed in Figure 3.35. A comparison of these data revealed a significant increase from a pre-test mean knowledge score of 62.9% ($M = 25.8$; $SD = 8.1$) to a post-test mean knowledge score of 73.7% ($M = 30.2$; $SD = 7.1$); $t(177) = 3.7$, $p < .0005$. Significant increases in knowledge scores were found for both sections of the quiz. That is, significant pre- to post-test increases in mean scores were found on the 33 general items, as well as the 8 sexual activity risk rating items [i.e., $t(177) = 3.4$, $p < .001$; and $t(177) = 3.2$, $p < .005$, respectively]. Thus, post-test participants scored significantly higher on the AIDS Knowledge Quiz than their pre-test counterparts.

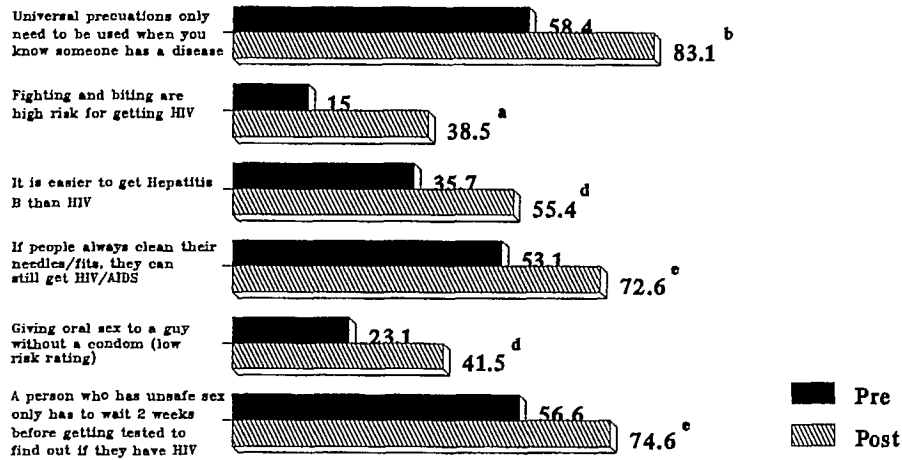
While an analyses of individual items revealed a pre- to post-test percentage increase in correct responses in all but two knowledge items, statistically significant pre- to post-test



increases were found for 11/41 items. These data are presented in Figures 3.36 and 3.37. As shown, significant increases were found for items pertaining to a diversity of themes as described in Section 3.3.3: Common AIDS transmission myths; HIV testing; safer needle use: general items; safer needle use: cleaning instructions; communicable diseases; and, safer sex. Figures 3.36 and 3.37 depict the percentage of the pre- and post-test samples correctly answering each of the 11 knowledge questions, whereas Figure 3.38 presents the pre- to post-test percentage increase in the 11 quiz items on which the post-test participants scored significantly higher than their pre-test counterparts.

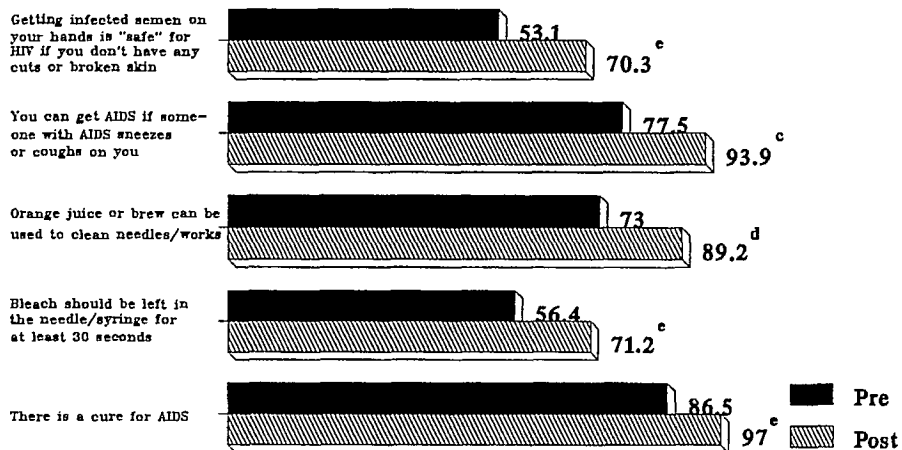
As shown in Figure 3.38, the three greatest pre- to post-test increases were found for items addressing: (1) when universal precautions are to be used; (2) the HIV-related risk involved in fighting and biting; and, (3) the higher transmissibility of Hepatitis B over HIV. These three items showed approximately 20% - 25% increases in correct responses. Although slightly lower, pre- to post-test increases in correct responses of approximately 11% - 20% were evident for the remaining eight items. Following the implementation of the peer-led C.A.N. Project, participants were more likely to know that: cleaning needles/fits is not a guarantee against HIV/AIDS; performing fellatio is considered a "low risk" activity; the window period for HIV testing extends beyond 2-weeks; infected body fluids must enter one's bloodstream in order to infect; HIV is not transmitted through sneezing or coughing; cleaning needles/works with orange juice or homemade alcohol is not effective against HIV; bleach should be left in the needle/syringe for at least 30 seconds; and, that a cure for AIDS has not been found.

Figure 3.36 Pre- to Post-test Increases in AIDS Knowledge (% Correct)



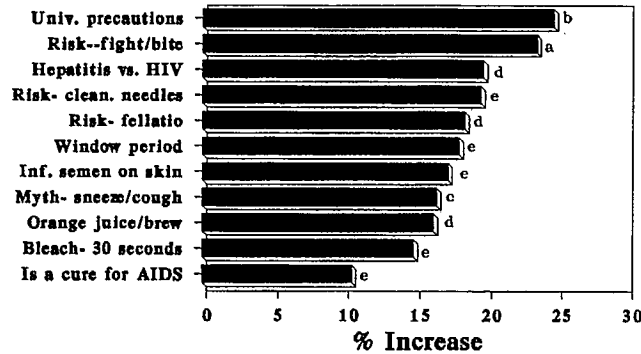
Note. a= $p<.0005$; b= $p<.005$; c= $p<.001$; d= $p<.01$; e= $p<.05$

Figure 3.37 Pre- to Post-test Increases in AIDS Knowledge--Continued (% Correct)



Note. a= $p<.0005$; b= $p<.001$; c= $p<.005$; d= $p<.01$; e= $p<.05$

Figure 3.38 Pre- to Post-test Increases in Correct Responses on AIDS Knowledge Quiz



Note. a= $p<.0005$; b= $p<.001$; c= $p<.005$; d= $p<.01$; e= $p<.05$

Figure 3.39 Post-test Sources of Information on AIDS

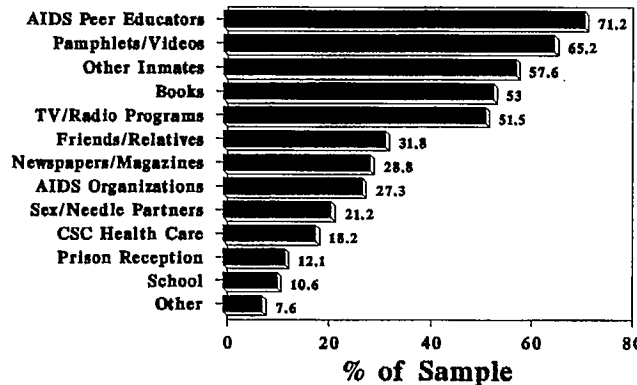


Figure 3.39 depicts the sources of AIDS-related information cited by the post-test respondents. It is clear from this graph that AIDS peer educators played a significant role in terms of enhancing the HIV-related knowledge of the post-test sample. That is, 71.2% of post-test participants reported that they received their HIV-related information from AIDS peer educators at Dorchester Penitentiary. In contrast, only 15% of the pre-test sample had cited peer educators as sources of HIV-related information. At pre-test, TV/radio programs (59.3%); newspapers/magazines (49.6%); pamphlets/videos (46.9%); books (44.2%); and other inmates (44.2%) were the five most frequently cited sources of information. At post-test, pamphlets/videos (65.2%); other inmates (57.6%); books (53%); and TV/radio programs (51.5%) remained as four of the top five sources of information. AIDS peer educators, however, were listed as the source of HIV-related information by the greatest proportion of participants.

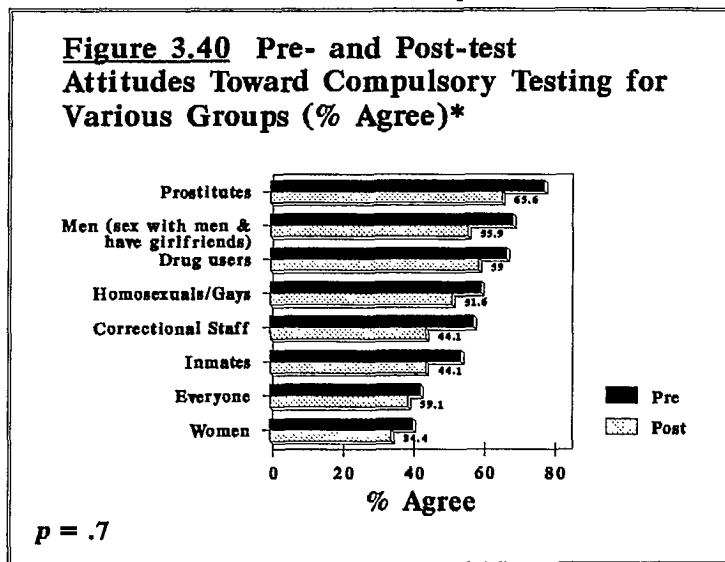
Despite significant increases in knowledge following the implementation of the C.A.N. Project, it is evident that the dissemination of information must continue. First, a comparison of self-ratings on the 10-point HIV-related knowledge scale revealed that, while post-test participants provided higher self-ratings ($M = 6.2$; $SD = 2.3$) than those at pre-test ($M = 5.6$; $SD = 2.5$), the post-test sample continued to acknowledge the need for additional information. Second, participants were asked whether they needed help (and, if so, what type of help) to protect themselves from HIV/AIDS at Dorchester. While almost two-thirds (65.5%) of the pre-test sample reported a need for information and one-third (31.9%) cited a need for risk counselling, the data revealed that substantial proportions of the entire post-test sample also reported a need for additional information (51.5%) and/or risk counselling (18.2%).

Third, although significant increases in knowledge quiz scores were found from pre- to post-test, the scores on the post-test knowledge quiz also indicate a need for the continued dissemination of HIV-related information. For instance, three-quarters or less of the entire post-test sample knew that: the window period for HIV extends beyond two weeks (75%); Tuberculosis can be spread through the air (74%); condoms should be made of latex (74%); cleaning injection equipment is not 100% safe (73%); bleach should be left in a syringe for a minimum of 30 seconds (71%); injection equipment should be flushed out at least twice with clean cold water before and after using bleach (69%); a person can test negative for HIV even if they have the virus (68%); injection equipment should be cleaned with bleach more than one time (62%); and that Hepatitis is more easily transmitted than HIV (55%).

3.7.2 Impact on HIV-Related Attitudes. As discussed in Section 3.4, a 17-item scale was developed to assess attitudes toward persons living with HIV/AIDS, as well as toward various confidentiality issues and prison harm reduction strategies. Eight additional items were included to assess participants' attitudes toward compulsory testing for various groups (i.e., homosexuals/gays; drug users; women; men who have sex with men and also have female partners; prostitutes; inmates; correctional staff; and everyone.) The scoring of these scales was such that higher scores reflected more positive HIV-related attitudes, and greater opposition to compulsory testing.

As shown in Figure 3.40, while a smaller proportion of post-test participants agreed with compulsory testing, a statistically significant pre- to post-test difference was not found in relation to the total score on the compulsory testing scale, $t(177) = .42$, $p = .67$. Thus, participants were no more likely to oppose or support compulsory testing following the implementation of the C.A.N. program than they had been prior to the program.

Figure 3.40 Pre- and Post-test Attitudes Toward Compulsory Testing for Various Groups (% Agree)*

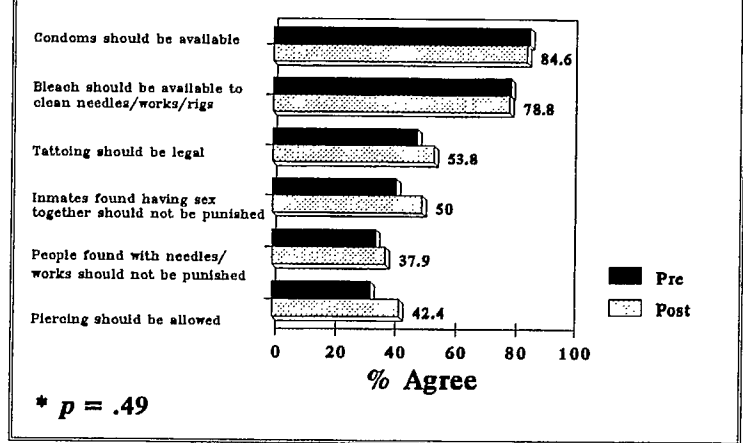


Substantial numbers of post-test participants continued to agree with widespread compulsory testing. For instance, approximately one-half to two-thirds of the post-test sample agreed that testing should be compulsory for homosexuals/gays, drug users, men who have sex with men and also have female sexual partners, and prostitutes. In addition, more than one-third also agreed that correctional staff, inmates, as well as “everyone” be required to undergo HIV testing. As with the pre-test sample, participants were least likely to agree with the compulsory testing of women.

In contrast to the data pertaining to attitudes toward compulsory testing, participants scored significantly higher on the 17-item attitudinal scale at post-test than they had at pre-test, $t(177) = 2.2$; $p < .05$. In order to gain a more thorough understanding of which types of attitudes were more positive following the C.A.N. program, pre- to post-test comparisons were conducted for each of the four themes: (1) Attitudes toward PLWHIV/AIDS: general items; (2) Attitudes toward PLWHIV/AIDS: rights and freedoms; (3) Confidentiality issues; and (4) Prison harm reduction strategies.

A pre- to post-test difference was not found in relation to attitudes toward prison harm reduction strategies (see Figure 3.41). As such, as compared to pre-test respondents, post-test participants were no more likely to hold positive or negative attitudes toward such harm reduction strategies as the legalization of tattooing and body piercing; removing consensual sexual activity between inmates from the category of institutional offences; and the legalization of the possession of injection equipment. In addition, a pre- to post-test change

Figure 3.41 Pre and Post-test Attitude Toward Prison Harm Reduction Strategies*

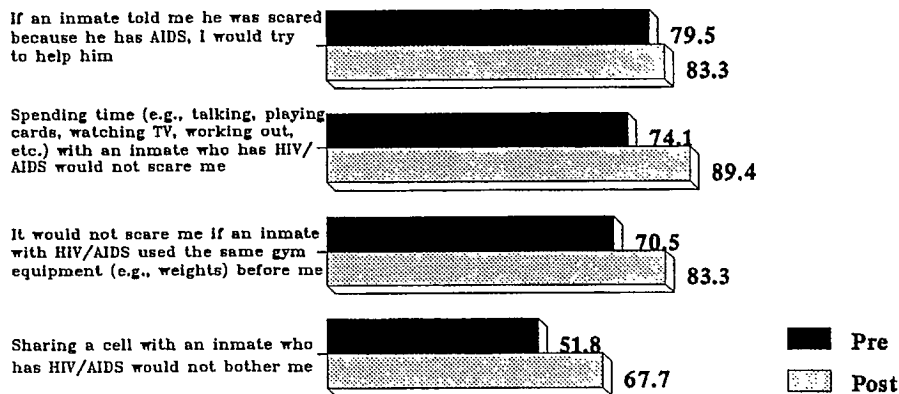


was not evidenced in relation to attitudes toward the availability of condoms and bleach. As such, attitudes toward these harm reduction strategies were similarly positive (i.e., more than three-quarters of both samples agreed that condoms and bleach should be available in prison). As previously mentioned, these attitudes are consistent with CSC policy. That is, while condoms and bleach are to be available, sexual activity between inmates and the possession of injection and tattooing/body piercing equipment are considered institutional offenses.

The analyses revealed significant effects for the first three themes. Thus, following the implementation of the C.A.N. project, participants held more positive attitudes toward persons living with HIV/AIDS in terms of: (1) the general items; and (2) the items assessing attitudes toward the rights and freedoms of PLWHIV/AIDS— i.e., $t(177) = 2.5; p < .05$, and $t(177) = 2.1; p < .05$, respectively. In addition, inmates were more likely to hold more positive attitudes towards various confidentiality issues at post-test than they were at pre-test, $t(177) = 2.1; p < .05$. All of these data are presented in Figures 3.42-3.44.

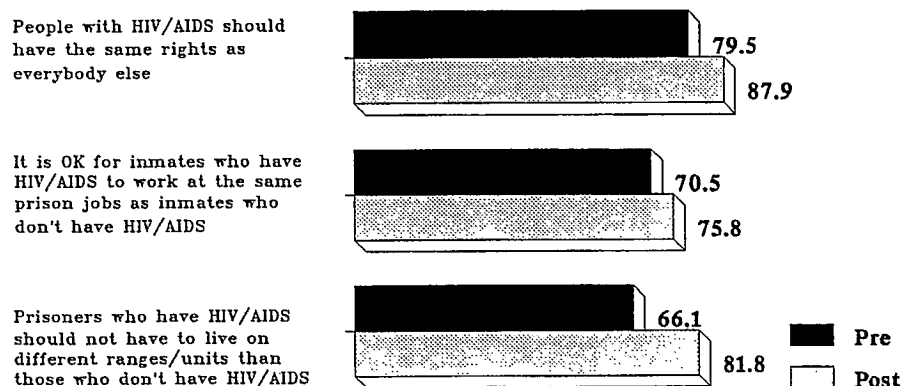
An examination of individual items was conducted in order to assess which attitudinal items were most affected. As depicted in Figure 3.45, significant differences between pre and post-test participants were found in relation to five attitudinal items. In comparison to those at pre-test, post-test participants were more likely to hold positive attitudes toward spending leisure time with an HIV-positive inmate; sharing a cell with an inmate who has HIV/AIDS; and using the same gym equipment as a prisoner with HIV/AIDS. They were also less likely to believe in the mandatory segregation of HIV-positive inmates on different living units/ranges than other inmates, and more likely to indicate that they would respect the confidentiality of HIV-positive inmates who disclosed their HIV status to them.

Figure 3.42 Pre- to Post-test Changes in Attitudes Toward Persons With HIV/AIDS: General Items (% Agree)*



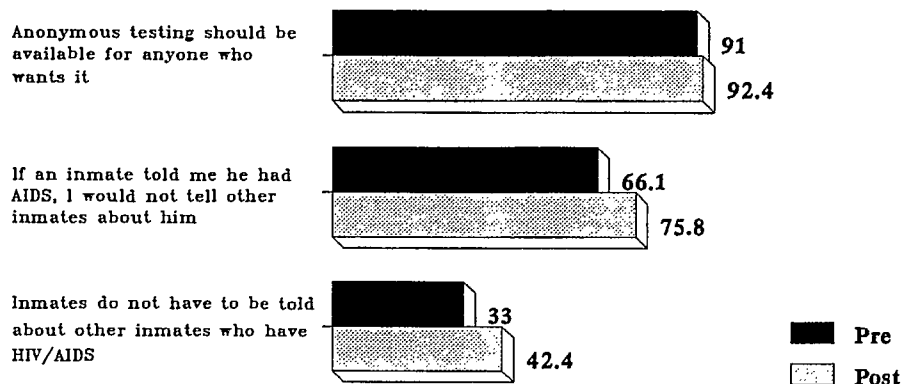
* $t(177) = 2.5, p < .05$

Figure 3.43 Pre- to Post-test Changes in Attitudes Toward Persons With HIV/AIDS: Rights and Freedoms (% Agree)*



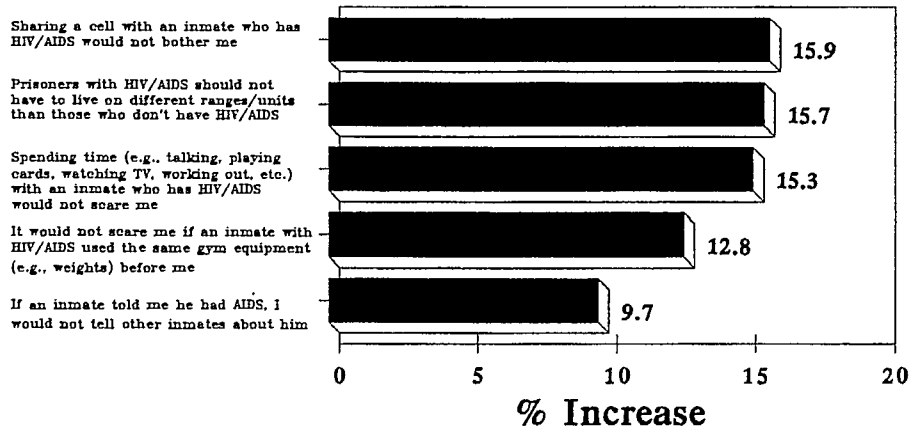
* $t(177) = 2.1, p < .05$

Figure 3.44 Pre- to Post-test Changes in Attitudes Toward Various Confidentiality Issues (% Agree)*



* $t(177) = 2.1, p < .05$

Figure 3.45 Pre- to Post-test Percentage Increase in Positive HIV-Related Attitudes



Note. $p < .05$ for all pre- to post-test differences.

3.7.4 Impact on HIV-Related Behaviours and Intentions. In an attempt to assess the behavioural impact of the C.A.N. Project, participants were asked how often they had engaged in various sexual and needle use behaviours over the previous 4 weeks. Questions centred around the incidence and frequency of injecting illegal drugs, steroids, or any other substance, as well as the frequency of sharing and cleaning injection equipment. Participants were also asked to report on the frequency of sexual activity (i.e., oral, vaginal and anal), number of different sexual partners, as well as the use of condoms.

A question was also included in the post-test questionnaire to assess whether participants had been tested for HIV/AIDS or Hepatitis since the launching of the C.A.N. Project. The data revealed that one-third of the entire post-test sample had been tested for HIV/AIDS or Hepatitis in the pre- to post-test interim. This figure is substantiated by reports of Health Care staff at Dorchester, who noticed a marked increase in requests for HIV testing following the onset of the C.A.N. Peer Education Program.

A pre- to post-test comparison in relation to sexual and needle use activities was not possible due to the relatively small sample size reporting these behaviours. That is, statistical tests could not be conducted since there were only 9 reported cases of injection behaviours and 12 individuals reporting sexual activity in the 4 weeks prior to the pre-test. At post-test, 5 individuals reported having injected illegal drugs, steroids, or "something else", and 7 participants acknowledged having engaged in sexual activity during the 4-week evaluation period. Although participants were repeatedly assured that their answers would remain completely anonymous, and that no-one from CSC would see their responses, the possibility remains that rates of HIV-related risk taking behaviours were under-reported. This is especially likely given the fact that injection drug use and sexual activity between inmates are considered institutional offenses.

Although pre- to post-test comparisons in terms of actual sexual and needle use behaviours were not possible, data are available regarding general intentions to change one's sexual or needle use behaviours in any way due to HIV/AIDS, Hepatitis, or any other disease, as well as regarding intentions to engage in specific HIV-related risk behaviours during the 4 weeks prior to and following the pre-test.

A comparison of the pre- and post-test results of a question asking respondents whether they had intentions to modify their sexual or needle use behaviour in any way in the upcoming 4 weeks because of the threat of HIV/AIDS, Hepatitis, or another communicable disease revealed an increase in the percentage of participants reporting such intentions from 14% at pre-test to 27% at post-test.

Figure 3.46 depicts the percentages of the pre- and post-test samples who reported intentions to engage in a variety of HIV-related risk taking and risk reduction behaviours. Although pre- to post-test changes in intentions to engage in several HIV-related risk reduction strategies were anticipated, it was not expected that the C.A.N. Project would impact on intentions to engage in risk taking behaviours, since a relatively small percentage of the respondents had reported such intentions at pre-test. Not surprisingly, therefore, none or very few of the post-test respondents reported intentions to engage in HIV-related risk behaviours— i.e., sharing injection equipment (0%); injection of drugs, steroids or other substances (3.2%); and sexual activity (9.2%).

A pre- to post-test difference in relation to intentions to be tested for HIV or Hepatitis was not found. Overall, intentions to be tested for these communicable diseases ranged from 30.3% to 36.5%. The impact of the C.A.N. Project on testing behaviour cannot be discounted, however, in that a substantial proportion of the post-test sample had recently been tested. As previously mentioned, one-third of the post-test sample reported having been tested for HIV/AIDS or Hepatitis in the pre- to post-test interim. Furthermore, 59.4%, 67.7% and 48.4% of all post-test participants indicated that they had been tested for HIV/AIDS, Hepatitis B and Hepatitis C, respectively, at some point in their lives. Thus, while a significant pre- to post-test increase in intentions to be tested was not found, these data— as well as reports of Health Care staff— point to the C.A.N. Project's impact in relation to the actual number of tests conducted in the 4-week interim between the pre-test and the post-test.

As expected, significant increases in key risk reduction intentions were found from pre- to post-test. That is, in comparison to those at pre-test, a greater percentage of the post-test sample reported plans to attend peer-led C.A.N. sessions (+22.1%), as well as to obtain additional information about protecting themselves or others from HIV/AIDS and other communicable diseases (+16.9%). In addition, post-test participants were more likely to report intentions to always use condoms (+ 16.0%) or always clean needles with bleach (+14.1%) if they were to have sex or use needles, respectively. The majority of post-test participants (i.e., 64.8% - 68.8%) indicated plans to engage in each of these four HIV-related risk reduction behaviours.

In order to further assess the impact of the C.A.N. Project on respondents' intentions to engage in HIV-related risk reduction strategies, a risk reduction intentions scale was derived on the basis of participants' answers to questions regarding plans to: attend C.A.N sessions; get more information about protecting themselves or others from HIV/AIDS and other communicable diseases; always use condoms if they were to be sexually active; and, to always clean their equipment prior to needle use. Participants received 3-points for each risk reduction intention, 2-points if undecided, and 1-point for indicating that they did not plan to engage in a given risk

Figure 3.46 Pre- to Post-test Changes in Intentions to Engage in Various HIV-Related Behaviours

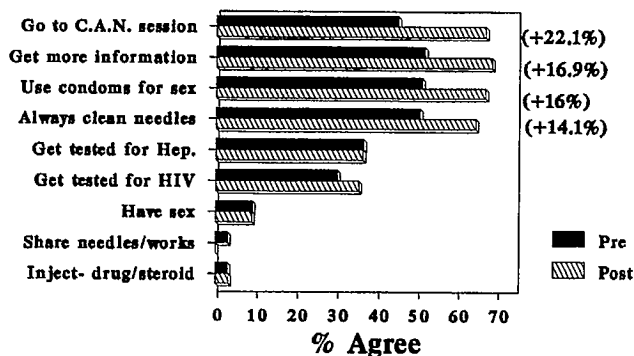
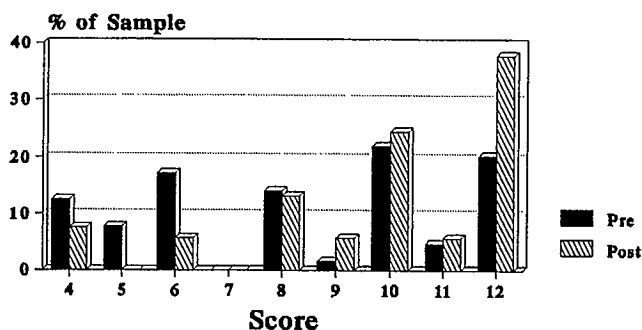


Figure 3.47 Pre- and Post-test Scores on HIV-Related Risk Reduction Intentions Scale



Note. The possible range of scores was 4-12, with higher scores indicating a greater number of intentions.

reduction strategy. As such, the scale yielded a possible range of scores from 4-12, with higher scores reflecting intentions to engage in a greater number of HIV-related risk reduction behaviours.

The pre- and post-test scores on the HIV-related risk reduction intentions scale are presented in Figure 3.47. As shown, participants were more likely to report intending to engage in a greater number of risk reduction behaviours at post-test than they were at pre-test. In fact, approximately 40% of post-test respondents (i.e., versus 20% at pre-test) indicated that they intended to engage in all 4 of the risk-reduction behaviours in the following month. A comparison of the pre- and post-test mean scores revealed a significant pre- to post-test increase, $t(115) = 3.0, p < .005$.

An examination of individual items was conducted in order to assess which items pertaining to intentions were most affected. Statistically significant differences between pre- and post-test intentions were found in relation to: attending C.A.N. sessions [$t(164) = 2.3, p < .05$]; obtaining more information about protecting themselves and others from HIV/AIDS and other communicable diseases [$t(166) = 2.0, p < .05$]; as well as intentions to always use condoms for sexual intercourse [$t(137) = 2.1, p < .05$].

3.7.5 Additional Comments. Thirty-eight inmates (57.6%) who had taken part in the C.A.N. Peer Education Program responded when asked to comment on the utility of the C.A.N. Project and/or whether they had any additional comments regarding the project. As shown below, the vast majority of respondents provided praise for the work done by the C.A.N. Peer Educators. The main variants of this theme centred around the usefulness and necessity of the project, as well as the need for the project to be ongoing. A substantial number of participants encouraged the C.A.N. Peer Education Team to “keep up the excellent/good work”, while others focused on the impact of the project on their own or others’ knowledge, attitudes and/or behaviours.

The following are the verbatim quotes provided by the respondents. Necessary clarifications are provided in parentheses (i.e., < >).

“Keep up the excellent work!” (35 years of age)

“It helps people who can’t read!” (23 years of age)

“<The C.A.N. Project> helps inmates that want information.” (23 years of age)

“I have obtained a wealth of information about HIV/AIDS ...I am not as afraid and ignorant of the disease... I think it is very useful and much-needed.” (33 years of age)

“More people <now> know about the virus...40 months from now when I get out, I will always use a condom...Keep up the good work!” (25 years of age)

“It is useful to know that if I need to talk to someone and I can get the gumption to do so, someone will be there.”(29 years of age)

“Keep up the good work. I like it! Should have more <projects> like this project and everyone should get one in jail and out!” (21 years of age)

"It does educate people about high risks and safety precautions." (28 years of age)

"C.A.N. has opened other cons' eyes... Needed it sooner!" (28 years of age)

"C.A.N. must continue and any improvements deemed necessary be approved." (35 years of age)

"I believe that the C.A.N. project should hold seminars on a quarterly basis. Faces change daily in prison, so even if only one person attends a seminar it would be worth the effort." (35 years of age)

"I know more and feel safer. I didn't know anyone with AIDS before prison. But now I have 2 friends with it... I think it's great for educating people. I had no knowledge before coming to jail." (29 years of age)

"It's very good for inmates and staff and people from the street to know the information available... I will be more careful/wear condoms if I have trailer visits." (31 years of age)

"Keep up the good work. Maybe in time people will realize it is their life you are trying to save." (60 years of age)

"I wasn't sure about all the ways a person could pass it on, now I am... <CAN is> very useful for the safety of all persons here...I hope it continues forever. AIDS is a life threatening disease." (44 years of age)

"<C.A.N.> helps." (24 years of age)

"<C.A.N. is> a very good thing to have. Educators should be more free to travel on units." (50 years of age)

"I think that they <the peer educators> are doing a real good job here in prison." (35 years of age)

"I think that it was a real good idea when they brought the peer educators to Dorchester. Now inmates can learn more about AIDS and other diseases. And I am glad to help any way that I can." (46 years of age)

"<The peer educators are> good guys to talk with, lots of good material for reading." (23 years of age)

Results

"Excellent, keep it up!" (35 years of age)

"<C.A.N. helps inmates> learn things they did not know before." (41 years of age)

"<C.A.N. is useful> but we need more education." (29 years of age)

"The two individuals running the office are very informative and care about others." (25 years of age)

"Keep up the good work!" (50+ years of age)

"I know much more now... I try to use condoms and clean needles... <CAN> is needed here for people like me." (43 years of age)

"Inmates now know what their risk factors are." (47 years of age)

"C.A.N. helps inmates learn precautions." (37 years of age)

"The education <provided by the C.A.N. Project is very useful>." (30 years of age)

"I'm going to make sure my wife and myself are clean. <C.A.N.> teaches a lot on precautions." (28 years of age)

"<C.A.N. is useful because it involves> inmates teaching inmates." (38 years of age)

"If I ever went back to using needles for any purpose, I'd no longer share them, and make sure that they are looked after." (32 years of age)

"Keep up the good work." (44 years of age)

"<C.A.N. is useful because it has raised> awareness!" (21 years of age)

"... If anyone wants condoms, they should just be able to go to the C.A.N. office." (38 years of age)

"<C.A.N. should be> more public about events." (25 years of age)

"The information <provided by the C.A.N. Project is very useful.>" (40 years of age)

4.0 CONCLUSIONS AND RECOMMENDATIONS

4.1 Summary

The "C.A.N." (Cons AIDS Network) Project was a national pilot AIDS peer education and support program developed by AIDS New Brunswick (AIDS/SIDA NB) for Dorchester Penitentiary. The project was funded by the Correctional Service of Canada (CSC) in response to recommendations made in 1994 by the Expert Committee on AIDS and Prisons (ECAP) in their *Final Report on HIV/AIDS in Prisons*. Among the many recommendations made by ECAP were that "inmates be assisted in delivering their own peer education, counselling and support programs" and that "in each institution, CSC should create or designate one or more inmate job positions as peer health counsellors and provide for appropriate training, support and evaluation."²⁸

The overall goal of the C.A.N. Project was the development, implementation and evaluation of a sustainable peer education model in which inmates provide others with the necessary information, motivation and skills to prevent HIV and other communicable diseases (particularly Hepatitis and TB), as well as to provide support to those already infected. Five main objectives were outlined for the project: (1) Development of an AIDS-related training curriculum for inmate AIDS peer educators; (2) Implementation of the training program; (3) Selection and training of at least one inmate to coordinate the peer-led program; (4) Evaluation of the program's effectiveness through the administration of a knowledge, attitude and behaviour (KAB) study; and (5) Preparation of a manual/guide to be used for other prisons wishing to establish a prison AIDS peer education program.

The C.A.N. training curriculum consisted of two modules, Prevention Education Training and Peer Support Training, and was based upon principles of harm reduction. Inmates were selected according to specific criteria and procedures, and participated in the training program which was implemented over a period of approximately four weeks (120 hours), and delivered in a very interactive and prisoner-centred format. Content and process evaluations of the training curriculum by the 10 participants strongly support its benefits in enhancing their knowledge, attitudes and skills.

Following the training, participants were assessed in terms of their interest and suitability for being peer educators or one of the two program coordinators. The inmates hired as C.A.N. Coordinator and Assistant Coordinator then received five additional weeks of one-on-one support and training to help them launch the peer-led initiatives in collaboration with the other peer educators.

²⁸ Correctional Service of Canada, *supra* note 3 at 50.

Conclusions

During the C.A.N. Program's implementation phase, the coordinators, in conjunction with the peer educators, developed and launched various prison AIDS prevention and support initiatives. In addition to distributing condoms and information by means of pamphlets, books, audiovisual materials, and discussions, they provided one-on-one HIV/AIDS prevention and support. Group information and interactive workshop sessions were also conducted throughout the prison, utilizing a variety of innovative and prisoner-centred educational and awareness strategies. The coordinators also produced a monthly newsletter, attended a support group for prisoners with HIV/AIDS, corresponded in writing to HIV-positive prisoners in other Atlantic Region institutions, and staffed an office approximately 36 hours/week. Inmates visiting the C.A.N. office could obtain a one-on-one consultation, receive condoms, get written documentation on a variety of topics, or view educational videotapes.

An evaluation of the program has been conducted through the administration of a knowledge, attitudes and behaviour questionnaire (KAB) administered prior to and three months following the implementation of the peer-led program. A total of 113 and 76 inmates completed the pre- and post-test KAB questionnaires, respectively.

The data obtained over the course of this pilot project indicate that inmates can effectively provide education and support to their peers. These results are particularly noteworthy given that the project had only been underway for several months. The first 3 months of the C.A.N. Project were met with a high level of interest and involvement by inmates at Dorchester, and were evaluated as being very useful. For instance, approximately 87% of the total sample reported involvement in at least one activity during the evaluation period, and 86% of the participants rated the C.A.N. Project as "Very Useful" for inmates at Dorchester. Further analyses revealed that a number of C.A.N. activities were rated as useful by the vast majority of participants. That is, one-on-one consultations with peer educators, workshops/presentations, the C.A.N. office, videos, and written material were rated as useful by anywhere from 82% - 94% of the total sample, respectively.

Participants also indicated that the peer-led AIDS education and support program had an impact in terms of their own knowledge, attitudes and behaviours. More specifically, more than three-quarters of the sample reported that their knowledge about HIV/AIDS and other communicable diseases had increased since the beginning of the C.A.N. Project; approximately one-half reported that their attitudes toward people living with HIV/AIDS had been enhanced; and more than one-third indicated that their sexual or needle use behaviours had become safer since the onset of the C.A.N. Project.

The data obtained during the evaluation period also showed significant increases in terms of more objective KAB measures. That is, the results indicated: (1) Increased knowledge scores; (2) Enhanced attitudes toward prisoners with HIV/AIDS; (3) Increased intentions to engage in HIV-related risk reduction behaviours; and (4) Increased incidence of HIV and Hepatitis testing.

First, a comparison of mean AIDS Knowledge Scores revealed a significant increase from a pre-test mean knowledge score of 62.9% to 73.7% at post-test. An analyses of individual items pointed to significant knowledge increases in terms of: Common AIDS transmission myths; HIV testing; safer needle use; communicable diseases; and, safer sex. For example, post-test participants were more knowledgeable about: when to use universal precautions; the level of risk involved in fighting, biting, and fellatio; the transmission of Hepatitis B; the fact that cleaning injection equipment is not a guarantee against HIV; the length of the "window" period for HIV testing; the principles and body fluids involved in HIV transmission; specific cleaning instructions for injection equipment; and the fact that a cure for AIDS has not been found.

Significant pre- to post-test changes were also found in relation to HIV-related attitudes. That is, following the implementation of the C.A.N. Project, participants held more positive attitudes toward persons living with HIV/AIDS, as well as toward various confidentiality issues. For instance, in comparison to those at pre-test, post-test participants were more likely to hold positive attitudes toward spending leisure time with an HIV-positive inmate; sharing a cell with an inmate who has HIV/AIDS; and using the same gym equipment as a prisoner with HIV/AIDS. In addition, they were less likely to believe in the mandatory segregation of HIV-positive inmates, and were more likely to indicate that they would respect the confidentiality of inmates who disclosed their HIV-positive status to them.

Although pre- to post-test comparisons to determine the impact of the C.A.N. Project on participants' actual sexual and needle use behaviours over the previous 4 weeks were not possible due to the inadequate sample size required for the statistical analyses, significant increases in key risk reduction intentions for the upcoming 4 weeks were found from pre- to post-test. In comparison to those at pre-test, post-test participants were significantly more likely to report plans to attend peer-led C.A.N. sessions; obtain additional information about protecting themselves or others from HIV/AIDS and other communicable diseases; and, to practice safer sex. In addition, the percentage of participants who reported intentions to always clean their their equipment with bleach if they were to use needles increased from 51% at pre-test to 65% at post-test. The majority of post-test participants (i.e., 65% - 69%) indicated plans to engage in each of these four HIV-related risk reduction behaviours.

An increased incidence of HIV and Hepatitis testing was also found from pre- to post-test. One-third of the entire post-test sample had been tested for HIV/AIDS or Hepatitis in the pre- to post-test interim. This figure is corroborated by reports of Health Care staff at Dorchester, who noticed a definite increase in requests for HIV testing following the onset of the C.A.N. Peer Education Program.

4.2 Inmate C.A.N. Coordinators' Perspective

4.2.1 Importance of C.A.N. Project. We, the coordinators of the C.A.N. Project here at Dorchester Penitentiary, feel that the greatest importance of this project is the fact that we are able to successfully reach almost all walks of life inside the Penitentiary in respect to education and prevention of communicable diseases, in particular HIV/AIDS. The implications of this education can be far-reaching, and will inevitably include all the people that these inmates come into contact with on the street, when they are released. It has already been established that inmates run a higher risk of contracting HIV and other communicable diseases, therefore this project enables them to be able to make decisions regarding their own safety and well-being based on facts rather than on speculation and myths.

The fact that this is a pilot project is very important to us, in that, if it is successful it can be implemented in prisons across Canada. We feel that not only is this an important addition to the prison system, but a necessary one, given the increase of HIV and Hepatitis seroprevalence. The benefits towards inmates who are already HIV+ are tremendous, as this project enables a change in some of the negative attitudes towards HIV+ inmates, and allow them to live in the prison environment without fear of repercussions from other inmates. We are able to do this through education and by dispelling the myths that unfortunately surround this disease.

In our opinion, the fact that this is a peer education project, is the mainstay of its feasibility and accords it the highest chance of success. There is no doubt in our minds that this is an important project for all inmates, but also for the communities that they will be returning to.

4.2.2 Feelings Toward the Project. We feel that the success of this program is a very big accomplishment, in that it shows that prisoners can be responsible for themselves and achieve success with the cooperation of CSC. We also feel that protecting ourselves while in prison is a right, and we respect the fact that CSC is allowing us to do that. We feel that this is a giant step forward for prisoners' rights and things have certainly come a long way.

From what we can see, from behind the prison walls, society in general seems to be taking the right direction towards education and prevention of communicable diseases. The attitudes of

people toward PLWHIV/AIDS also appears to be changing and we feel it is thanks to organizations such as AIDS NB who care enough to take the time and expend the energy to try and make a difference. We feel that this disease has had a “bum rap” since its inception and it's about time that things change and people see it for what it really is— i.e., a life threatening disease that can happen to anyone. We are more than happy with the success of this program so far and the acceptance of the C.A.N. Project office into the prison society.

4.2.3 Our Experiences. Our experiences with this project since it began for us, in December 1995, have been rewarding to say the least. We have seen inmates' attitudes change in front of our own eyes and watched as the knowledge levels increased by leaps and bounds around us. We were very hesitant at first about doing presentations in front of the inmates, but that changed dramatically when we realized that they were genuinely interested in learning the facts about HIV/AIDS and being able to protect themselves from communicable diseases. We expected criticism and opposition to the project in the beginning but these ideas proved to be unfounded. We have been accepted by most inmates and by most levels of staff and administration as well. Of course there have been some roadblocks and also some people that oppose what we are doing but, when weighed against the support and acceptance we have received, they are mere irritations as opposed to being major problems.

4.2.4 Challenges. There have been many challenges involved in making this project a success. Acquiring the knowledge and getting over our own fears surrounding this disease was a challenge in the first place. Trying to get the message out to the population in general was a challenge also at the beginning.

In our experience, since this is a pilot project and never before been attempted, the whole thing feels like one challenge after another, as we are being forced to build bridges that have never been tried before. When you start talking about condoms, bleach and needles etc. in prison, it is definitely a challenge to try and change views which have been deep-rooted for years and years. To our benefit, CSC, in particular the Warden of this prison and the staff, have kept very open minds and made our jobs much easier to accomplish. This could be the greatest challenge a lot of prisons will face in making this program work, for without the cooperation of CSC staff, this project would surely fail.

Another challenge we face is presenting the information in terms that all inmates can understand. With the broad range of literacy levels in this prison, and I assume in most prisons, it is a challenge to be able to deliver the presentations so that all inmates can gain from them. We feel that we have been able to overcome this challenge with the help of different mediums, such as video displays.

4.2.5 Sustaining the Program. We feel that the biggest prerequisite to sustaining this program is continued support from outside agencies such as AIDS NB, without whose help we would never have been able to set up and deliver such a program. The connection to the outside world is very important to the success of the program inside.

Continued help and support from CSC is also necessary for the program to survive. The corps of volunteers (inmates) must also be maintained and there must always be people ready to step in and take over the coordinators' jobs at any time due to the nature of transfers, releases, etc. As long as the people involved in the program remain active and interested in making this program work, we feel that it will continue to be a success.

As for new programs that will be developed in other prisons across the country, it is essential that they try to enlist inmates from all walks of the prison culture so that they can reach as many inmates as possible. Any involvement by outside agencies across the country would be beneficial to such programs in any prison.

4.2.6 Conclusion. In conclusion we would just like to say that we feel very privileged that we have been given this opportunity to protect ourselves and to help our fellow inmates protect themselves from communicable diseases. We also take great satisfaction from knowing that we are in some small, but genuine way, helping to prevent the spread of HIV and other communicable diseases in this prison as well as the communities at large.

We can't finish this summary without acknowledging the enormous support that we have received from the key people involved with this project from the very beginning. They are: from AIDS NB, Lynn McNutt and Caroline Ploem; and from CSC staff, Odette Pellerin, Sylvie Berubé, and Susan Steeves. These people have been paramount in the success of this program and have gone above and beyond the call of duty in support of this program. We hope that the other programs across the country can have as helpful and supportive contributors as we have had. If they do, they will surely be a success.

Bill Taylor
Steve Bovair
Coordinators, C.A.N. Project

4.3 Logistical Considerations and Recommendations

Numerous logistical issues and challenges were faced during the various phases of the C.A.N. Project. A number of these issues (i.e., support from CSC; literacy levels; recruiting a diversity of inmates; support from outside agencies; and challenges to sustainability) have already been mentioned by the Inmate C.A.N. Coordinators in Section 4.2. The following is a synopsis of these, as well as some of the other most important logistical considerations and recommendations stemming from the C.A.N. Project in relation to setting up, implementing and sustaining peer-led inmate AIDS education and support programs.

Empowering Inmates to Own the Education and Support Process

Traditional approaches to HIV-related inmate education have been passive, and have not empowered inmates to own the education/support process. Peer education models, in contrast, provide an optimal opportunity to build upon and reinforce prisoners' ability to manage their own health. Empowering inmates to own the process of HIV prevention and support requires that programs be developed and implemented *by inmates for inmates*. As previously noted by the C.A.N. Coordinators:

"... the success of this program is a very big accomplishment, in that it shows that prisoners can be responsible for themselves and achieve success with the cooperation of CSC."

Involvement of Credible and "Solid" Inmates

The integral and continual involvement and support of a diversity of credible and "solid" inmates is paramount throughout all phases of such projects. Without the involvement of inmates that are credible and respected— i.e., particularly in the eyes of other inmates— success is virtually unattainable.

Gaining the Credibility and Trust of Inmates

Motivating and recruiting participants for the C.A.N. training program and the completion of the KAB questionnaires highlighted the necessity of gaining the credibility and trust of inmates. Although facilitated by the fact that the individual primarily responsible for promoting the project and recruiting participants was from an "outside" AIDS Service Organization, it was also paramount to enlist the assistance of several inmates who were respected and "solid" in the eyes of their peers.

Maintaining credibility and trust is also crucial during the implementation of such training programs. Individuals who facilitate inmate AIDS peer education training programs must be credible in the eyes of prison administration, staff, as well as inmates. Given the frequent mistrust of correctional staff by inmates, it is generally easier for a program facilitator/trainer to establish his/her credibility and trust with participants if he/she is from an outside agency or AIDS organization. Since much of an HIV-related peer education training curriculum necessitates discussions of sensitive issues and illegal practices, the facilitator must also assure participants that what they discuss within the training program remains within the group.

Other Recruitment Considerations

Recruiting participants for the C.A.N. peer education training program was challenged by the fact that the majority of Dorchester inmates were working or attending educational programs through the week and were paid for doing so. During the project's planning stages, it became evident that motivating and recruiting participants would be extremely difficult, if not impossible, should participation be equated to loss of employment and income. This issue was addressed by ensuring that inmates holding prison jobs would not be penalized for participating in the C.A.N. Training Program. It is recommended, therefore, that other institutions considering the implementation of such training programs also agree to continue paying inmates, and to hold their prison jobs until their completion.

Establishing Realistic and Effective Criteria for Selecting Participants

In setting up the C.A.N. peer education program, it was crucial to consult with prison administration, staff, and inmates toward the establishment of realistic and fair criteria for selecting a diversity of inmate peer educators. First, as previously stated by the C.A.N. Coordinators, a peer education program's ability to reach a wide segment of an inmate population requires obtaining a diverse and representative sample of inmates. As such, attempts should be made to consider factors such as race, language, sexual orientation, length of sentence, etc.

The C.A.N. experience also highlighted the importance of other participant selection criteria: Team playing skills; ability to establish functional and positive relationships with prison staff and other inmates; ability to create support for and commitment to the goal of preventing HIV in prisons; respect of confidentiality; having the credibility and respect of other inmates; and the ability to communicate comfortably and non-judgmentally about sexuality, drug use, and tattooing/ piercing. Although the level of skills (e.g., literacy, interpersonal, communication, and presentation) varied considerably among the participants, it was important to acknowledge

the contributions each individual could make to the goal of AIDS prevention and support within the prison culture. Strong organizational, leadership and team-building skills, as well as the potential to develop teaching and presentation skills, are recommended as additional qualifications for selecting inmate project coordinators.

Support from Prison Administration and Staff

Obtaining widespread support from prison administration and staff is crucial, given that inmate AIDS peer education programs can be viewed as threatening (i.e., especially when harm reduction is a central theme). As the C.A.N. Coordinators asserted:

“CSC, in particular the Warden of this prison and the staff, have kept very open minds and made our jobs much easier to accomplish. This could be the greatest challenge a lot of prisons will face in making this program work, for without the cooperation of CSC staff, this project would surely fail.”

The involvement and support of a variety of prison personnel is a necessity throughout such programs. As noted by the inmate coordinators, the C.A.N. Project has generally been very well accepted by prison administration and staff at Dorchester Penitentiary. A strong contributor to this support has been the establishment of a strong Advisory Committee from within the prison, as well as from the “outside”.

Maintaining support from prison administration and staff during the implementation of peer-led AIDS programs can be facilitated through the establishment of a liaison officer position between prison staff and inmate peer educators/coordinators. The C.A.N. Project experience underscored the benefits of monthly meetings between the staff liaison officer and the inmate coordinators in terms of keeping staff updated and informed about the program, as well as in relation to providing a venue to voice and address program-related concerns and/or issues.

Support from Community-Based Organizations

Community-based organizations can play an important role in terms of the implementation and sustainability of inmate AIDS peer education programs. Regular support from AIDS/SIDA NB was provided during the 3-month C.A.N. Program implementation phase. Weekly meetings between the C.A.N. Coordinators and the AIDS Peer Education Program Trainer provided a venue for the discussion of workplans, brainstorming around peer education and support initiatives, and addressing program-related concerns and/or questions. In addition, these meetings provided opportunities for ongoing education and training in relation to new

information and documentation related to the roles of C.A.N. Peer Educators. The inmate C.A.N. Coordinators were also able to access information and support from AIDS/SIDA NB through contacting the organization by telephone.

Additional Infrastructure Considerations

Given the responsibilities inherent in coordinating peer-led HIV-related education and support initiatives, the creation of two paid inmate positions (i.e., Coordinator and Assistant Coordinator) is strongly recommended. An assistant can be invaluable in terms of: Helping the coordinator fulfil the project's objectives; filling-in should the coordinator become ill; and providing a smoother transition should the coordinator be released. Giving the coordinators access to units beyond their own (i.e., "open passes") is also important in facilitating the provision of education and support to inmates throughout a prison.

Office space for the inmate peer educators and program coordinators is paramount to the success and sustainability of an inmate AIDS peer education program. Given the sensitive nature of HIV/AIDS work, such an office must be accessible and foster a "safe" environment for inmates. A computer is also recommended in order to produce materials related to the program; access to a photocopier is required to copy pamphlets, brochures, and other AIDS education materials, as well as information regarding peer education sessions and meetings. As also noted by the Inmate C.A.N. Coordinators, a television and VCR are crucial educational tools given the low literacy rate of many inmates.

Other Sustainability Issues

Even when prison peer education program are well underway, sustainability continues to be an ongoing challenge. Peer educators and coordinators need to remain motivated and updated in regards to new information related to their roles. Sustainability is also related to attrition—loss of peer educators due to institutional offences, drop-out, transfers, or release from prison. To this end, recruiting, training and supporting peer educators must be an ongoing process. The responsibility for maintaining such programs must be shared among a number of key players: Correctional Service Canada; the program's prison advisory committee; and, the inmate peer education coordinators. As the C.A.N. Coordinators assert, "Continued help and support from CSC is also necessary for the program to survive"; and "The connection to the outside world is very important to the success of the program inside." As such, AIDS service organizations, and other community-based organizations can also play an important role in helping prisons sustain such programs.

4.4 Final Recommendations

The critical need for enhanced HIV-related education and support services within the prison setting is evident. Inmates continue to be at high risk for contracting and transmitting HIV while in prison and once released. While the exact number of infected inmates is unknown, we do know that the reported number of cases is more than 10 times higher than that in the general population, with more than 1 in every 100 federal inmates reported to be living with HIV/AIDS. We also know that the reported number of cases continue to increase across all regions in Canada. As recently highlighted in *HIV/AIDS in Prisons: Final Report*,²⁹ there has been a 46% increase in the number of federal inmates known to be infected with HIV/AIDS over the past two years (i.e., April 1994 - March, 1996).

As corroborated by the present study's KAB questionnaire data, injection drug needle sharing; unsafe sex; and the sharing of equipment for tattooing, piercing and injecting steroids are the behaviours posing the highest risk for the transmission of HIV with the prison setting. In light of these behaviours, and their illegal classification within current CSC policy, effective, comprehensive, and innovative peer-led AIDS prevention and support programs are of utmost necessity to prevent the continued spread of HIV and other communicable diseases among prison populations, and to provide support to inmates already infected.

In addition to successfully delivering a variety of proactive initiatives, the C.A.N. Peer Education Team continues to meet the numerous information and support needs of a diversity of inmates. In fact, as of this writing (i.e., four months following the official completion of the project's evaluation period), the C.A.N. Team continues to launch various innovative and prisoner-centred prevention and support strategies. For instance, they recently organized and coordinated a walk, in which approximately 80 inmates participated, as part of the 1996 AIDS Walk Canada. This event was the first of its kind in Canada, and Dorchester Penitentiary was recognized by the Canadian AIDS Society as the most unique walk site in the country. Two AIDS Walk T-Shirts were designed by the C.A.N. Project's Assistant Coordinator, and sold to inmates and staff at Dorchester Penitentiary for the purpose of raising funds for HIV-related prevention, health promotion and support programs throughout New Brunswick.

A number of upcoming initiatives are also in the works. For instance, the C.A.N. Team will be playing an instrumental role in the distribution of bleach once this national initiative is officially underway at Dorchester Penitentiary (i.e., scheduled for September 30, 1996). A video on safe/safer needle use, tattooing and piercing involving the C.A.N. Team has already

²⁹ R. Jürgens; supra note 2 at 32.

been produced in preparation for the launching of this initiative. Further, by the end of September, the C.A.N. Coordinators will be meeting with all incoming inmates at prison reception, provide them with information on protecting themselves and others from HIV/AIDS and other communicable diseases, and discuss the role of the C.A.N. Project.

In sum, the evaluation of the C.A.N. Project supports the efficacy of inmate peer education models in relation to preventing the spread of HIV and other communicable diseases within prisons, as well as in providing support to those already infected. The data collected over the course of the project substantiate the recommendation made in the recently released *HIV/AIDS in Prisons: Final Report*:

The results of and lessons learned in the pilot inmate peer health promotion project undertaken at Dorchester Penitentiary should be widely distributed and applied to other institutions: wherever possible, inmates should be encouraged and assisted in delivering peer education, counselling and support programs, and inmate job positions as peer health counsellors should be created.³⁰

The national implementation of inmate peer education and support programs is an important step toward promoting and protecting the health of inmates and the communities to which they return upon release. The model developed for this project is adaptable for use in other correctional institutions across the country.

As a tool to facilitate the implementation of inmate AIDS peer education programs in other institutions, a training manual has been prepared to provide other organizations and prisons with guidelines regarding setting up, implementing, and sustaining peer education and support programs within correctional facilities. Although developed primarily for male facilities, much of the training program could also be adapted for use in women's prisons, providing the inclusion of additional material pertaining specifically to the needs of female inmates. In addition to suggested facilitation strategies, the manual includes a number of overheads, hand-outs and exercises developed for the C.A.N. Project. This document, titled *Facilitation Manual: The C.A.N. National Pilot Inmate AIDS Peer Education Project*, is available in both English and French and can be obtained by contacting the Correctional Service of Canada.

³⁰ Ibid. at 104.

5.0 REFERENCES

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