

Prison HIV Peer Education

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Report of the
National Prison HIV Peer Education Project

JUDITH ROBINSON

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Preface

The National Prison HIV Peer Education Project was funded by the Commonwealth AIDS Workforce Information, Standards and Exchange (CAWISE) Program of the Commonwealth Department of Human Services and Health.

The Project Manager was Ms Jennifer Norberry, Criminologist, Australian Institute of Criminology. The steering committee established the aims and objectives of the project and employed a Project Officer, Judith Robinson, who commenced work in August 1993.

The following people served on the steering committee:

Mr David Biles, Deputy Director, Australian Institute of Criminology;

Ms Tracey Cross, Strategy and Co-ordination Unit, Department of Human Services and Health;

Ms Susan Hayes, Manager of Professional Development, Centre for Information on Drugs and Alcohol;

Mr David McDonald, Senior Criminologist, Australian Institute of Criminology;

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Mr Chris Shanley, Manager, Education, Training and Development, Centre for Information on Drugs and Alcohol;

Ms Jenny Williams, Director, Strategy and Co-ordination Unit, Department of Human Services and Health.

The work of the Project Officer was completed in August 1994.

Canberra
August 1994

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Thanks are also due to those who attended the national seminar conducted by the project (their names are listed in Appendix IV), and those who presented papers to the seminar. The combined understandings of these people was of great value in the analysis presented here.

The Steering Committee, whose members are listed in the preface, established the clear objectives of the project and provided continuing guidance throughout. Special thanks are due to Jennifer Norberry and David McDonald for their help during the project, and in particular in the writing of this report.

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Recommendations

Prison HIV peer education, which refers to the process of prisoners educating other prisoners, is recommended as the most effective and efficient means of providing HIV education in prisons. It goes beyond the provision of information to motivating prisoners to change practices which place them at risk.

The investigations of this project reveal that HIV peer education is most effective when it is supported by the policies and practices which are recommended here. The following recommendations are a distillation of major findings in the chapters which follow. The text of the report also contains numerous detailed recommendations for the delivery of HIV peer education programs in prisons.

1. Corrections departments should recognise that their responsibility with regard to HIV includes support and management of HIV positive prisoners *and* prevention education. The need for prevention education is not dependent upon the presence of HIV positive prisoners in the system, but reflects the prevalence of practices conducive to the transmission of HIV within prisons.
2. Corrections departments should ensure that HIV education is an integral part of their service and not an ad hoc fringe activity. This means providing a permanent staffing structure with clear lines of responsibility and a specific budget allocation.
3. Jurisdictions should provide all prisoners with basic information on modes of transmission of HIV and other communicable diseases and the protective measures available to them in prison. This information should be provided soon after admission and should be in a culturally appropriate form which is accessible to all prisoners.
4. Corrections departments should provide all prisoners with ongoing HIV education opportunities, along with strong encouragement to participate.

5. The peer approach to HIV education is recommended to corrections departments as the most effective and efficient means of motivating prisoners to change practices which place them at risk.
6. It is essential that corrections departments provide regular HIV education to all prison officers so that they are able to take action to protect themselves against HIV transmission; provide a supportive environment to prisoners in their efforts to educate themselves and other prisoners about HIV; and be part of a non-discriminatory environment for HIV positive prisoners.
7. It is essential that those responsible for HIV education establish good working relations with prison officers' unions so that mutually beneficial education initiatives may readily be implemented.
8. Monitoring and evaluation of programs must be implemented by all jurisdictions to ensure the effectiveness of the educational approaches adopted.
9. Special attention should be paid to peer and other HIV education programs for minority groups (such as women, HIV positive prisoners, those with intellectual disability, and those from non-English speaking background) to ensure that their needs are met.
10. Special peer HIV education programs for Aboriginal and Torres Strait Islander prisoners should be developed and implemented by, or in close consultation with, Aboriginal and Torres Strait Islander people.
11. HIV education should be broadened to include Hepatitis C and B, and other sexually transmissible diseases. Programs which reveal a broader concern for the immediate health needs of prisoners have greater credibility with both prisoners and prison management than those which deal only with HIV.
12. HIV education in prisons should be a joint responsibility of health departments and corrective service departments. Prisoners are not permanently housed in prisons; they have lives in the community before after and between sentences. Thus health departments should view HIV education for

prisoners as a permanent part of their public health funding responsibility.

13. Annual national meetings of corrections staff involved in HIV program delivery and policy development should be facilitated at the Commonwealth level. The provision of HIV education in prisons is a complex issue, with workers meeting constraints unique to the prison system. An annual national meeting will enhance educational outcomes for prisoners and officers, particularly in those jurisdictions where educators are isolated and marginalised.
14. The review of the National HIV/AIDS Strategy 1993-94 to 1995-96 should pay particular attention to the important role of peer education in prisons. The review should build upon the work of this project, placing it in the broader context of the National Strategy. HIV peer education in prisons should receive greater prominence in the next National HIV/AIDS Strategy than it has in the current strategy.

1: Introduction

The aim, objectives, process and background of the National Prison HIV Peer Education Project are outlined in **Chapter 2**. The structure of this book has been influenced by the objectives of the project, which indicate a need to examine all aspects of HIV education in Australian prisons, while placing the major emphasis on an examination of prisoner peer HIV education.

Prison is a unique setting for HIV education, and it is important to understand the context in which programs are delivered. Earlier in the epidemic there had been fears that HIV would be as serious a problem in Australian prisons as in some countries overseas. The fact that prevalence in our prisons is not alarmingly high needs to be considered in conjunction with evidence that there is a relatively high incidence of risk practices in the prisons. This indicates that without continued vigilance transmission could accelerate rapidly. The high prevalence of hepatitis C and B, as well as sexually transmitted diseases forms part of the context of education in the prisons, and most jurisdictions include education about these under the umbrella of HIV education. The importance of HIV education in prisons is magnified by the fact that the other main means of prevention, condoms and needle exchange, are not available. We now have the benefit of approximately nine years experience of HIV education in prisons upon which to base our practice and some of the major Australian and overseas recommendations are presented. This context is the subject of **Chapter 3**.

Peer education is the approach which has been recommended by most of the international reports on the provision of HIV education to prisoners. **Chapter 4** provides an explanation of prisoner peer education and describes a number of different models of the process which have been implemented overseas and in Australia. This chapter meets the requirements of Objective 1 of the project.

Within Australia prisoner peer education is not the only HIV education occurring in prisons; indeed some jurisdictions do not follow this method at all. A description of the HIV education provided in all jurisdictions (as prescribed by Objective 2 of the project) is the subject of **Chapter 5**, including the education of custodial officers, information for prisoners in the early days of imprisonment, further education for prisoners during sentence, staffing structure for provision of education for inmates and officers, HIV education funding, evaluation of the HIV education program, and plans for future HIV education. As well as this there is an examination of the HIV education provided to special groups within the prisoner population around Australia.

Chapter 6 provides an analysis of HIV education in prisons around Australia (in keeping with Objective 2 of the project), covering peer and other approaches. The analysis uses the ten key elements for HIV education in prisons which were developed five years ago by Heilpern and Egger (1989), and shows to what extent these criteria are being met.

In **Chapter 7** the focus returns to peer education to summarise the findings of the project with regard to the barriers to prison HIV peer education, along with the factors which facilitate its effective and efficient implementation. This chapter is in line with Objective 3 of the project.

Objective 4 of the project involved supporting key people to develop, implement and evaluate prison HIV peer education. This objective was met to some extent through individual contact between the Project Officer and stakeholders in each of the jurisdictions. More particularly, the national seminar conducted by the project met this objective, as does this report, which is intended to be used by the jurisdictions as a resource in the development, implementation and evaluation of HIV peer education in prisons.

It is intended that this book will be distributed widely in order to achieve Objective 5 of the project.

2: The Project

Aim

The aim of the project was to assess the effectiveness of prison HIV peer education and to facilitate its implementation in Australian prisons.

Objectives

The objectives of the project were:

1. To increase stakeholders' knowledge about prison HIV peer education through documenting Australian and overseas experience in prison HIV peer education programs.
2. To describe and analyse what works in relation to prison HIV education, under what circumstances.
3. To identify, analyse and describe:
 - barriers to prison HIV peer education; and
 - factors which facilitate effective and efficient prison HIV peer education.
4. To support key individuals and stakeholders to develop, implement and evaluate prison HIV peer education.
5. To disseminate widely, to key stakeholders and policy makers, new understandings from the project, to further support prison HIV peer education.

Background

The project followed an earlier project funded by CAWISE, the National Prisons HIV Peer Education Program. This program was administered by the New South Wales Corrective Service Department Prison AIDS Project and the Centre for Information on Drugs and Alcohol in 1991. A

training manual was produced and a week-long train the trainer course was conducted in Sydney. The course was attended by two participants from each State/Territory. The aim of the course was to seed the peer approach to HIV education in prisons in jurisdictions other than New South Wales, which had established a program over the previous few years. The evaluation of this earlier project recommended that a further project be set up to continue the process of facilitating HIV peer education in prisons in Australian jurisdictions, recognising that it takes time and effort to build the necessary corrections based infrastructure to ensure programs are taken up and maintained.

The National Prison HIV Peer Education Project, conducted by the Australian Institute of Criminology, was the outcome. As an autonomous national organisation with credibility within corrections departments throughout Australia, the Australian Institute of Criminology was well placed to meet the objectives of this project.

Process

A Project Officer was employed to work at the Australian Institute of Criminology on a one-year contract. At the request of the steering committee each jurisdiction nominated a contact person for the project who was able to facilitate access to key personnel involved in prison HIV education. A review of the literature was conducted by the Project Officer.

The Project Officer attended two peer education courses, one at the Belconnen Remand Centre in Canberra (four days) and one at the Metropolitan Remand Centre at Long Bay in Sydney (three days), in the role of participant observer. As well as this she attended a two-hour information session for new prisoners in Risdon Prison in Hobart, and a meeting of the prisoners' AIDS committee at Belconnen Remand Centre, Canberra.

The Project Officer visited each jurisdiction. The objectives of the visits were to:

- Meet and interview key personnel including HIV education staff, departmental personnel, prison management, custodial officers, and other staff;
- Obtain documentation relevant to the project;
- Meet and interview prisoners who have been involved in education programs;

- Participate in education programs in progress;
- Analyse the needs in HIV education for each State;
- Explain the objectives of the project to key people and obtain a better understanding of the expectations each jurisdiction had of the project.

In each jurisdiction relevant staff at all levels, including the chief executive officer in five jurisdictions, met with the Project Officer for discussions about HIV education. In a number of jurisdictions interviews were also held with personnel from community agencies involved in delivery of HIV services in the prisons, and with representatives from health departments.

The Project Officer also interviewed prisoners from every jurisdiction. The following institutions were visited:

Belconnen Remand Centre, Australian Capital Territory (September and October 1993);

Metropolitan Remand Centre and Special Care Correctional Centre, Long Bay Complex, New South Wales (November 1993);

Wooroloo Prison Farm, Western Australia (December 1993);

Northfield Women's Prison, South Australia (December 1993);

Darwin Prison and Gunn Point Prison Farm, Northern Territory (January 1994);

Numinbah Prison, Queensland (January 1994);

Risdon Prison Complex, Tasmania (February 1994);

Metropolitan Reception Prison and Lodden Prisons, Victoria (March 1994);

Mulawa Women's Prison, New South Wales (May 1994); and

Junee Correctional Centre, New South Wales (May 1994).

The Project Officer organised a two-day seminar on the topic of HIV Peer Education in Prisons which was attended by two officers from each jurisdiction. The objectives of the seminar were to:

- support key individuals and stakeholders in the development, implementation and evaluation of prison HIV peer education (Project Objective 4);
- provide an opportunity for key personnel in each jurisdiction to establish networks for ongoing support and exchange of information (Project Objective 4);
- disseminate widely to key stakeholders and policy makers new understandings derived from the project (Project Objective 5);
- provide an opportunity for key personnel to contribute to the understandings arising from the project (Project Objective 5).

The seminar was the outcome of a series of consultations with all jurisdictions, first to ascertain the principal concerns of those who implement HIV education, and then to ensure that the proposed program met these needs.

During discussions with officers at the executive level of each corrections department the Project Officer sought an in-principle agreement to the attendance of two officers from their department. Such agreement was obtained, with most jurisdictions expressing an intention to send one officer from the HIV education delivery level, and another relevant officer from a more senior policy level.

The seminar was held in June 1994 and was attended by nineteen representatives of the jurisdictions, and four from the Australian Institute of Criminology, with the Project Officer as facilitator. A representative from the Strategy and Coordination Unit of the Commonwealth Department of Human Services and Health was also in attendance for part of the seminar. Details of the program and those in attendance are given in Appendix IV.

As well as sharing information, the participants discussed the value of maintaining contact between jurisdictions in matters relating to HIV. It was agreed that:

- one person from each jurisdiction would take responsibility for liaising with other jurisdictions, particularly in sharing new resources for HIV education; and
- that it should be a recommendation of this project that annual meetings of corrections staff involved in program delivery and policy development should be facilitated at Commonwealth level.

3: The Context of HIV Education in Prisons

Prevalence of HIV in Prisons: Australia and Other Countries

Lack of consistency in testing around the Australian jurisdictions (Walker & Dagger 1993, pp. 20-1) causes difficulty in presenting a full picture of HIV prevalence in Australian prisons. This difficulty is compounded by the fact that the majority of prisoners stay for only very short periods, some re-offend and return to prison, and others move in and out of prisons on programs such as work release, during which time it is possible that they could contract HIV which would not be picked up by testing in many of the jurisdictions.

In a paper delivered at the Fifth World Conference on Prison Health Care, McDonald et al. (1993) provide figures on the number of diagnoses of HIV infection, by year of reception and whether the diagnosis was a new or repeat diagnosis in 1991 and 1992 (*see* Tables 4, 5, 6 & 7, Appendix I.)

McDonald et al. conclude that testing for HIV antibody at reception indicated that the prevalence of HIV infection in Australian prisons remained low during 1991 and 1992, at less than 0.5 per cent. They comment that this prevalence rate was higher than previously documented for blood donors ("0.86 per 100,000 donors over the interval 1985-1990") and post-partum women ("0 out of 10,217 women in 1989"). The prevalence rate for prisoners was lower, though, than the 0 per cent-5 per cent previously documented for injecting drug users (IDUs) who do not practise male to male sex.

Harding (1992) provides information on seroprevalence in prisons around the world and makes the point that:

... the number of HIV-infected prisoners was closely related to the proportion of those injecting drugs prior to

imprisonment and to the rate of HIV infection among injection drug users in the community (pp. 762-3).

Harding reports particularly high rates of seroprevalence in countries in southern Europe, with 26 per cent in Spanish prisons and 17 per cent in Italian prisons. In North America the rates of seroprevalence are highly variable, but in New York City and Washington DC, which have large numbers of injecting drug users, the rate is particularly high.

An issue of potential significance in Australia is that in the USA the rate of HIV infection among female prisoners is higher than that of male prisoners. Dolan (1993) reports studies from New York City gaols showing women prisoners with an infection rate of 26 per cent compared with 16 per cent for men, and in Washington DC rates of 25 per cent and 20 per cent respectively. Similarly, higher rates of infection among female prisoners have been reported in New York State, Connecticut and Maryland. A study conducted in all adult provincial correctional centres in British Columbia in Canada revealed a similar trend there, with women inmates having an HIV-1 prevalence rate of 3.1 per cent compared with 0.9 per cent in men (Rothan 1994, p.162).

Dolan suggests that there have been very few documented and verified cases of HIV transmission in prison throughout the world. Within a study she conducted among ex-prisoners in NSW, six respondents reported that they had become infected with HIV while in prison. Investigation has confirmed this in one case (Dolan et al. 1994) and Dolan is investigating the others. Even though transmission within prison walls currently seems low, research into risk practices inside prisons indicates that the rate of transmission could increase considerably unless preventive measures are taken.

Risk Practices in Prisons

The practices which place prisoners at risk are well known. Connolly & Potter (1990), Wodak (1991), Gaughwin (1992), Gaughwin & Seemark (1994) and Dolan (1993) are among those who have conducted research into risk practices in Australian prisons.

The Australian research, along with international research (ECAP 1994a, p.19), suggests that the major risk practice in prisons is injecting drug use. A sizeable proportion of prisoners have injected drugs at some time, and although a majority of these probably do not inject while they are in

prison (Gaughwin 1992, pp. 116-17), a significant number do. Among the prisoners who do inject, a high proportion share injecting equipment and because needles and syringes are in very short supply, one needle/syringe is likely to be shared between a large number of prisoners. The risk is compounded by the fact that effective cleaning of injecting equipment is made difficult either by the lack of full strength bleach or the need to avoid the scrutiny of the authorities. According to a number of prisoners interviewed by the project officer, a further complication is the practice of urinalysis introduced as a means of reducing the use of drugs in most jurisdictions. Because of their perception that heroin is detectable in the urine for a shorter period than some of the non-injected drugs which a prisoner may gain access to, it seems that fear of a "dirty" urine test result could make injected heroin the drug of choice for some prisoners.

Anal intercourse, whether consensual, quasi-consensual (sex in return for drugs or other favours) or non-consensual occurs inside prisons. Since sexual relations between male inmates are considered illicit in most jurisdictions and stigmatised within the prison culture, the exact extent of this risk practice is not known, although the researchers referred to above provide evidence that it does occur and needs to be addressed for effective prevention. There is little evidence in the literature of research into the sexual risk taking of women prisoners while they are in prison.

Risks associated with injecting drug use and sexual practices are the major concerns for prison prevention programs. There is also, though, risk associated with tattooing and other skin piercing practices which are likely to involve exchange of blood, and concerns about the incidence of violence leading to blood spills in prisons.

Other Communicable Diseases

Other communicable diseases whose modes of transmission are similar to those of HIV form a part of the context of HIV education in prisons. The other communicable diseases of greatest relevance are hepatitis B and C and, to a lesser extent in most jurisdictions, other sexually transmitted diseases. Tuberculosis, although not a large problem in Australia at the moment, is also of relevance because of the susceptibility of HIV positive prisoners, and the fact that conditions in prisons are often conducive to its transmission.

Hepatitis B has been recognised as a possible health problem by correctional departments for some years now, and South Australia and Queensland provide vaccination for all prisoners. Tasmania makes vaccination available for a fee of A\$25. The reason for concern about hepatitis B is that it is transmitted through blood and possibly other secretions, so that risk may be present from so-called household contact as well as from unprotected sexual intercourse and sharing unclean needles (Thompson et al. 1993).

The hepatitis C virus has only recently been identified. It is the virus responsible for what in the past has been called non-A non-B hepatitis. It is transmitted efficiently by the sharing of unclean needles for injection, and less efficiently by unprotected sexual intercourse (Crofts et al. 1993). The Victorian study reported by Crofts et al. has indicated that for men factors other than duration of drug use which independently increase exposure to hepatitis C are "the reported use of opiates as first or primary current injected drug ... and a history of having been in prison" (p. 24). This study is continuing and its results will be significant for those concerned with providing health education for prison inmates.

The presence of other sexually transmitted diseases is a recognised cofactor in the transmission of HIV. In the Northern Territory recent statistics collected by the Disease Control Centre of the Department of Health and Community Services indicate that the gaol in Alice Springs has the highest absolute number of reported sexually transmitted diseases of any community in the Territory (personal communication, January 1994, Dr Frank Bowden, Coordinator, STD/AIDS Programs, NT). The issue of sexually transmitted diseases is not so prominent in other jurisdictions, but it is a part of the whole picture to be considered in HIV education programs in all States and Territories.

Prevention Measures

Outside correctional institutions, education has been just one of a number of HIV prevention measures which have been part of the national response to the HIV epidemic. Condoms have been made readily available through a wide variety of retail outlets, as well as via a number of community organisations which have been funded by governments to supply them free to those whose practices place them at risk. Perhaps the most radical, and effective, prevention measure

which was introduced in Australia early in the epidemic is needle exchange. Those who use needles to inject illicit drugs have been able to attend designated needle exchanges with impunity. In the absence of new injecting equipment, users have information about and access to sterilising agents such as full-strength bleach.

These prevention measures are part of the harm reduction approach which has been embraced by Commonwealth and State/Territory health departments and others viewing HIV from a public health perspective. Researchers respected in the public health arena have also ventured into the area of law and law enforcement by suggesting that a further part of an effective harm reduction approach should be to consider ways of reducing the number of drug users in prisons. The means suggested to achieve this include decriminalising the use of certain drugs, and changing the sentencing policy for those who are convicted on charges relating to drug use so that they are punished by means other than imprisonment, or diverted into treatment programs.

A harm reduction measure which would be less far reaching in its consequences is the availability of condoms in prisons. Condoms are available to detainees in the Belconnen Remand Centre in the Australian Capital Territory. In February 1994, fifty-two New South Wales prisoners were granted leave to begin Supreme Court action against the State Government's policy of not supplying condoms in gaols (*Sydney Morning Herald*, 2 January 1994). Condoms are available in prisons in a number of other countries. The Canadian Expert Committee on AIDS and Prisons (ECAP 1994a) reports that, according to the World Health Organization's network on HIV/AIDS in prison, twenty-three of the fifty-two prison systems sampled allow condom distribution (p. 55). The Committee further notes that no country that has adopted a policy of making condoms available in prisons has reversed the policy. In Canada condoms have been available in federal penitentiaries since the beginning of 1992 and dental dams have also been available to women inmates. Methods of distribution range from distributing condoms to every inmate and leaving supplies of them in living units to restricting supplies to prison health services (ECAP 1994a, p. 55).

The ready availability of full-strength bleach in prisons is also seen as part of a harm reduction approach. Currently bleach is available for inmates to use in a number of jurisdictions, in some cases in sachets specifically designed for

use with needles and syringes, in others as general purpose liquid household bleach.

While those who view the HIV epidemic from a public health perspective tend to advocate a harm reduction approach in the prisons, the perspective of those whose primary role is the containment of offenders is often different. Wodak (1992) clearly enumerates the difficulties faced by prison authorities in dealing with HIV issues:

They manage complex institutions with little understanding or interest from the community, have extremely limited budgets, contend with considerable disagreement about the objectives of correctional facilities and are required to manage many individuals with a propensity to violence in crowded and often outmoded conditions. AIDS has made an already difficult job even harder (p. 35).

It is because of this difference of perspective between public health and corrections that education in prisons comes to prominence. Education is an acceptable option for all stakeholders in this debate, and it is therefore essential that those who are responsible for education of inmates make it as effective as possible in the prison setting.

Australian and International Recommendations for HIV Education in Prisons

AIDS in Australian Prisons—Issues and Policy Options (Heilpern & Egger 1989) provides a distillation of the key elements of effective education within prisons. These elements derive largely from the work of Hammett (1988) and Norton (1988). They are:

1. Education should be timely. AIDS education should be instituted before there are significant numbers of HIV positive prisoners....
2. Education should be mandatory for inmates and staff....
3. AIDS training should be regularly presented and regularly updated....
4. AIDS education should include mechanisms which involve inmates and staff in the development and presentation of the education programs. ... Behavioural change, which is the primary goal of AIDS education, requires a whole range of new strategies that may include tailoring the format to the group; including the target group in the delivery of the information; using the

informal but powerful prisoner hierarchy; making each gaol responsible for its own AIDS prevention strategies; devising an effective form of evaluation; and linking the education strategies with community programs.

5. AIDS training and education should be live. ... It is also often recommended that a person with AIDS should be present because of the powerfully motivating influence of personal testimony.
6. The AIDS educators should be credible. The AIDS educator should understand the prison system and foster credibility. The message should be accurate and straightforward, with no judgmental or hidden ideological content. The education program should be in appropriate language and as non-technical as possible.
7. Live education should be supplemented with video tapes and/or written informational materials.
8. AIDS education should be sensitive to the specific concerns of the institution. In addition to providing basic information on the disease, the education program should address the specific concerns current in the prison no matter how irrational such concerns may be. In prison, AIDS education should address the major risk factors—needle sharing, sexual activities, tattooing and risks associated with fights and other situations where blood may be spilt.
9. There must be a high level of executive commitment. The importance of this is threefold:
 - it enhances the credibility of the program;
 - it emphatically demonstrates the content of the program by way of example;
 - it involves a pragmatic commitment at all levels in the administration of the prison.
10. The AIDS education program should be rigorously monitored and evaluated in order to ensure that the objectives are being met (pp. 56-7).

The National Commission on AIDS report *HIV Disease in Correctional Facilities* (1991) draws together policies and practices regarding HIV in United States prisons. It makes the point that education for the purposes of reducing fear and discrimination against the infected, and to promote inmates' informed participation in their own medical care are important, as well as education for the reduction of risk behaviour. The report commends the following as "elements of a comprehensive AIDS prevention program". Each of these elements is elaborated upon in the report.

1. All inmates should participate in a mandatory AIDS information and education session upon entry into the system.
2. All correctional and prison health staff should be required to participate in AIDS education programs.
3. All inmates should have the opportunity to request confidential HIV counselling and testing.
4. Inmates should have the opportunity to participate in ongoing groups that provide information and support about risk reduction.
5. Peer educators can play an important role in prison AIDS prevention programs.
6. Prisons officials need to create a social environment that supports risk reduction and humane treatment towards those with HIV/AIDS.
7. Inmates need to learn skills that will protect them against HIV infection both inside and outside the correctional system.
8. Prevention programs need to be closely linked to health and social services for inmates with HIV/AIDS.
9. Programs need to address the special needs of female inmates.
10. Prisoners should be included in planning and implementing AIDS prevention programs.
11. AIDS programs should be developed for all institutions in the correctional system.
12. Correctional systems, prison health services, AIDS organisations, prisoners' rights groups and public health professionals need to work together to create effective AIDS prevention programs in correctional settings (pp. 18-21).

The *Final Report of the Expert Committee on AIDS and Prisons* (ECAP 1994a) is the result of consultations within the Canadian corrections system with inmates, prison staff and groups and individuals with an interest in HIV/AIDS and prisons. It also reviews Canadian and international policies and programs in order to make recommendations to Correctional Service Canada on the important issues relating to HIV/AIDS in prisons.

The Expert Committee on AIDS and Prisons (ECAP) concluded that "education about HIV infection and AIDS is the most important effort to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in federal correctional institutions" (p. 61). While

recognising that educational efforts are already in place in Canada, ECAP considered that education could be improved by the following:

1. All inmates should receive written information about HIV infection and AIDS. This could be in the form of pamphlets or of a booklet such as *Get the Facts*, published by the John Howard Society.
2. As part of the reception program, every inmate should be offered educational sessions about HIV infection and AIDS.
3. Educational sessions about HIV infection and AIDS should be available to inmates on a regular basis. External, community-based AIDS, health or prisoner organisations should be encouraged to deliver or supplement these sessions.
4. CSC [Correctional Service Canada] in collaboration with Health and Welfare Canada and others should fund such organisations to provide this education.
5. Inmates should be encouraged to develop and should be assisted in delivering their own peer education, counselling and support programs.
6. CSC in collaboration with Health and Welfare Canada and others should fund such efforts.
7. 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.
8. Participation in educational sessions about HIV infection and AIDS at entry into the prison system should be mandatory for all inmates. Participation in subsequent educational sessions should be voluntary but strongly encouraged.
9. Education should take into account and respond to the needs of prisoners with disabilities, from different cultural and linguistic backgrounds, and with different levels of literacy (p. 50).

Correctional Service Canada, in its response to these recommendations in March 1994 agreed to build on and improve educational programs already in place by emphasising HIV education on entry to prison and on a regular basis during incarceration and by encouraging and supporting community based AIDS, health or prisoner groups to provide education sessions. It will also "pilot test a program of paid inmate peer health promotion workers" (Correctional Service Canada 1994, p.2).

In March 1993 the Global Programme on AIDS released the *WHO Guidelines on HIV Infection and AIDS in Prisons*. These guidelines addressed the issue of standards to which prisons should aspire in the provision of education from a public health perspective. These guidelines closely resemble those already delineated in the separate sets of guidelines above.

In summary, all of the guidelines mention the following elements of effective HIV education in prisons:

- all prisoners should receive information about HIV upon entry into prison, and education should continue during the prison term;
- printed information should be available to all prisoners and should be appropriate to their literacy levels and in a language they understand;
- prison staff should receive education about HIV during their basic training and at regular intervals thereafter;
- HIV education should be live, and supplemented by printed and video material;
- inmates and staff should be involved in the development of programs;
- peer education for both prisoners and staff is recommended as an effective approach to HIV education in prisons.

Approaches to Prison HIV Education

In Australia there has been concern about HIV and AIDS in prisons since about 1985. Often the first education programs were set up as a result of the arrival of the first HIV positive prisoner in a jurisdiction. This report of the arrival of the first HIV positive prisoner at a gaol in Victoria in July 1985 told by Peter Harmsworth, then Director-General of the Office of Corrections, illustrates the nature of the need for education in the prisons.

As arranged an officer escorted the prisoner to Pentridge Hospital. He had been assured that he would be safe from infection, but on arrival at the hospital he and the prisoner were met by a doctor who was fully gowned and masked. The doctor instructed the prison officer not to approach or touch anybody and ordered that the securing handcuffs and the officer's uniform be destroyed. The end result was

that the prison officer undressed, left his uniform in a bag which was later sent to the tip, and went home in a distressed state, wrapped in a blanket. Not surprisingly the incident caused quite a ripple throughout the prison system (Norberry et al. 1991, p.125).

The response to the HIV epidemic in all corrections departments in Australia in the first instance was to provide information to custodial officers and senior management. Such information is now a part of all induction programs for new custodial officers in each jurisdiction.

Education programs for inmates have varied around the different jurisdictions. A widely used approach has been to conduct information sessions, usually delivered by doctors, nurses or other professionals from outside agencies. Time is allotted at the end of a presentation for inmates to ask questions.

Another approach has been for corrective services to employ an AIDS educator who provided information sessions to as many prisoners and officers as possible. Such information programs have often been supplemented by videos and pamphlets, and often the only information offered to inmates has been in the form of videos or pamphlets.

As HIV testing has been introduced at the time of reception in most Australian jurisdictions some departments have made efforts to provide information at this time. The practicalities of the reception process have often proven a barrier to such efforts, however.

In Bathurst, New South Wales, the first peer education program in Australia was established by a group of inmates with the assistance of the drug and alcohol worker. In 1987 this group put together an education program called the Bathurst Inmate AIDS Counselling Course which aimed to "equip inmates to play an ongoing educative role within the institution" and "develop a support structure within the inmate population as an 'opening-bid' in a campaign for the introduction of an anonymous/confidential testing program." (Lyons 1988, p. 3). As well as conducting the course the inmates produced a video called *Miles from Nowhere*, written by one of the group, which is still used in some prison HIV education programs. This group provided the model upon which peer education was later developed in New South Wales.

Another educational approach is the "Lifestyles Changes" course conducted by Corrections Operations in New Zealand (Smith 1993). This course consists of six two-hour modules. It

addresses issues of attitudes and behaviours through active learning workshops which situate safe practices for HIV prevention in a context of individuals making lifestyle changes for better health. It emphasises individual skills like positive "self talk", conflict resolution and stress management as well as addressing the issues of sexuality, sexually transmitted diseases and substance use. This course is for both prisoners and officers, and is conducted in the main by trained custodial officers. A small number of inmates have also been trained to conduct the course.

4: What is Prisoner HIV Peer Education?

HIV peer education in prisons refers to the process of prisoners educating other prisoners. The powerful potential of this process of education has been somewhat ruefully accepted in the community, as revealed by the common saying that prison is the "university of crime". For some time now a peer education approach has been used to good effect in such programs as basic literacy, where prisoners with particular skills act as tutors for other prisoners. The peer approach is also being employed in the education of custodial officers, so that trained officers are providing HIV education to other officers. The focus of this project is inmate peer education, although it is clear that the processes of prisoner and prison staff education are interlinked.

There are two aims in HIV education in prisons and these are also the aims of the Australian *National HIV/AIDS Strategy* (1993). They are to:

- eliminate transmission of the virus; and
- minimise the personal and social impact of HIV infection.

In the prison context this can be expanded to mean elimination of transmission between prisoners or between prisoners and staff; and to minimise the impact of the disease upon those prisoners or staff who are HIV positive. These aims are achievable only by bringing about changes in attitudes and practices, and there is now a large body of research (Ross 1988, Turner et al. 1989, Ottawa Charter 1986) supporting the view that information alone does not bring about changes in attitudes and practices.

Green et al. (1980) make this distinction between health information and health education:

Health education is a process which bridges the gap between health information and health practices. Health education motivates the person to take the information and do something with it—to keep himself healthier by

avoiding actions that are harmful and by forming habits that are beneficial (p.4).

To this could be added that effective HIV education minimises the impact of the disease upon those who are HIV positive by reducing discriminatory practices against them, both at the personal and system level.

On the basis of a wide-ranging review of research Turner et al. (1989) assert that there are two fundamental themes in the principles of behaviour:

1. For behaviour to change, individuals must recognise the problem, be motivated to act, and have the knowledge and skills necessary to perform the action.
2. To increase the likelihood of action, impediments in the social environment must be removed or weakened and inducements for change provided whenever possible (p. 260).

Peer education is one method of taking HIV education that step further than the provision of information, to attempting to change attitudes and motivate people to change practices which place them at risk. It also may remove some of the impediments in the social environment by creating insiders who are well informed and able to support positive health decisions.

According to the *National Prisons HIV Peer Education Program: Training Manual* (CEIDA 1991), the peer approach to HIV education for prisoners is effective for a number of reasons:

- since HIV transmission in prisons often involves illegal practices a peer educator may be the only person to speak candidly to other inmates about HIV transmission;
- peer educators' input is not viewed with the same suspicion as the 'propaganda' from the prison hierarchy;
- peer educators are more able to discuss the alternatives to risk behaviour that are available to inmates, acknowledging the real problems that people face;
- they are more likely to respond to issues as they arise and in an ongoing way, rather than providing a formal service within a limited time and setting;
- they are able to judge which educational strategies would work within their prison and link HIV/AIDS prevention to the existing culture and informal power structure (p. 19).

Models of Prison HIV Peer Education

OVERSEAS *Bedford Hills (USA)*

A prison peer education program whose success has been recognised internationally was started by inmates at the Bedford Hills Correctional Facility, New York State's maximum security prison for women. In 1987, in response to the suffering of inmates who had AIDS, the women established the program which came to be known as ACE, AIDS Counselling and Education. The women's goals were "to save lives and promote prevention; to create more humane conditions for those already suffering from AIDS and HIV-related problems; to provide counselling and support for people dealing with the many problems and questions that AIDS creates in our community; and to build bridges to outside community groups so that women would have the necessary support when they re-enter the community" (Clark & Boudin 1990, p.94).

After receiving training from an outside agency, a core group of women worked in teams which they characterised as "Afro-American, white, Latin, Caribbean, drug users and those who have not used drugs, college educated and those who did not finish high school, gay and straight, PWAs [People With AIDS] and non-PWAs" (ibid p.101). They thus acknowledged the multiplicity of peer groups within the inmate population and tried to provide educators appropriate for many of those groups. The peer educators conducted seminars in which they used a variety of methods to involve women in trying to understand and solve the problems AIDS raised for them.

This group has been a model of achievement, but the inmates make an interesting comment on the nature of their achievement. They say that there is "strong evidence that our work has helped to lessen the stigmatisation of people with AIDS, as well as people's fears of infection through casual contact, and to promote an ethic of care and concern" (p. 106). They also say that the group has been effective in promoting the medical needs and human rights of people with AIDS. However "women have learned about their social reality and about safe and unsafe behaviours, *but most have not changed their behaviors*" (p. 105, emphasis added). It is argued that the prevention of HIV/AIDS cannot rest upon individual strength alone, and that programs concentrating on educating people to take responsibility for their behaviour will be most effective if

they are part of broader action taken to change those social structures which facilitate the transmission of HIV.

Canada

The Expert Committee on AIDS and Prisons (ECAP 1994a) reports that a considerable number of peer education programs are under way in Canadian prisons. In the background papers to the ECAP report (ECAP 1994c) Michael Linhart, an HIV positive prisoner, makes the following comments about peer education efforts in several prisons:

These groups have begun to take the initiative and address the issue of HIV/AIDS in prison through events such as Matsqui's "Family Awareness Seminar" and Mission's "Family HIV Awareness Dinner and Bingo". Some of you may think bingo is a strange thing to hold in relation to AIDS; however, sometimes unusual measures are required to obtain results from resistant groups of people. In this case the lure of bingo prizes brought people in and they listened to what was said (p.172).

In Canada it seems that prisoner HIV peer education and support programs are frequently conducted in close cooperation with a community agency. The Expert Committee considered that education conducted by either peers or external organisations would be better accepted by prisoners than education by Correctional Service of Canada staff.

AUSTRALIA *New South Wales*

The Corrective Services Department of New South Wales has developed and consolidated a prison HIV peer education program which has been recognised internationally as an important model. Following a successful pilot program instigated by prisoners in Bathurst gaol in 1987 (see p.13 above), the Department had put the program in place in all its prisons by the end of 1989.

This model of HIV education provision has been adopted with some modifications by the Queensland, South Australia and the Australian Capital Territory corrections services. A training manual, entitled *National Prisons HIV Peer Education Program—Training Manual*, was developed in 1991 by the Centre for Information on Drugs and Alcohol in conjunction with New South Wales Corrective Services (CEIDA 1991). At the same time a national training course was conducted and it was from this training course that the peer method of HIV education began to be adopted by other jurisdictions. The development of the national training program and the manual

was funded by the Commonwealth Department of Human Services and Health (then known as the Department of Health, Housing and Community Services). The manual is currently being reviewed for use in New South Wales by the Prison AIDS Project and an updated version should soon be available.

The basic idea of the program is to provide training for selected prisoners so that they may become educators of other prisoners. The education provided by peer educators is envisaged in the main as one-to-one, word-of-mouth education provided in an informal manner when the occasion arises. The prisoners who have been trained as peer educators in a four-day training course are identified by a distinctive patch which they are able to sew on their clothing and by the peer educator certificate which they may display in their cells.

Grimsley (1992) provides a clear exposition of the aims of training selected prisoners as peer educators. He writes that the training of peer educators aims to:

- motivate selected prisoners to play an active role in HIV prevention activities with other prisoners;
- develop prisoner peer educators with the ability and the willingness to inform other prisoners about HIV transmission and about safe sexual and safe drug using practices;
- assist peer educators to develop the skills and willingness to actively support other inmates who are HIV positive (p.13).

The video drama, *Dead Set*, produced by the Prison AIDS Project of New South Wales Corrective Services, illustrates the way peer education can work. It tells the story of a young HIV positive prisoner who has been raped, and follows the process adopted by the peer educator to whom he had been referred by the nurse. The peer educator uses the prison network and the sense of camaraderie among drug users to get the message to the sexual predator that his conduct was putting himself (and—less important to the rapist—others) at grave risk. The injecting drug users were able to insist upon safer drug using practices when they were sharing needles, and also had enough influence over the predator to persuade him to have an HIV test. The video emphasised the importance of insider knowledge when trying to instigate change in a person not inclined towards responsible behaviour.

The Prison AIDS Project, a branch of the Inmate Development Service of the New South Wales Department of Corrective Services, administers the peer education program.

The role of the Prison AIDS Project is to provide training for prison officers, liaise with the prison officers' unions about HIV and AIDS matters, provide training for those people who will conduct the peer educator training courses, and to support the continuity of peer education by means of resources, monitoring, and special programs for particular institutions. The Prison AIDS Project ensures that each prison has a well supported prisoners' AIDS committee and a Program Organiser, usually a custodial officer who voluntarily assists the AIDS committee in programs it undertakes. The Prison AIDS Project also provides support and education to HIV positive prisoners.

The prisoner peer education program was evaluated during the latter half of 1993, and a report of the evaluation should be available soon.

Northern Territory

The Northern Territory approach to HIV peer education in prisons is similar to the Bedford Hills approach in that it trains prisoners to conduct formal education sessions for other prisoners. As approximately 75 per cent of the inmates in Northern Territory gaols are Aboriginal people, it was considered necessary to develop an approach to prisoner HIV education that was culturally appropriate.

In a program which began early in 1994, a small number of selected prisoners have undertaken training to provide HIV education for other prisoners, using a package developed and tested within Aboriginal communities in the Northern Territory. This educational package was put together by the Aboriginal Education Unit of the Northern Territory Department of Health and Community Services, and staff at this unit work with Correctional Services to train the prisoner peer educators. The educators are trained to provide sessions based upon a story-telling approach, in which they follow through a person (either "Wayne" or "Carmen") who has symptoms of a sexually transmitted disease. The health decisions with which the person is confronted and the consequences of those decisions become the subject of group discussion. One of the Aboriginal workers who developed the program in the community commented that "the good thing about it is that it's a third person tool, and you can raise issues without getting personal. So there's no blame, and at the end of the session Wayne or Carmen goes and is not left in the group." The issue of HIV is covered within the context of

sexually transmitted diseases because of the extent of this problem in the Northern Territory.

The prisoner peer educators conduct formal sessions once a week for groups of no more than ten prisoners. This does not preclude, however, the probability that the peer educators will also engage in informal, one-to-one education of their peers and the department has plans to provide resources such as pamphlets to assist them in this role. The program has not been evaluated, as it has only been operating for a few months. There are also plans to support prisoners who wish to train as Aboriginal Health Workers through the vocational education program conducted by Education Services of Correctional Services. When this is put in place these prisoners could play an important role in the provision of HIV information in the early days of prisoners' incarceration.

Victoria

A new initiative in Victoria has introduced yet another variation on the theme of prisoner HIV peer education, that of paying prisoners at prisoner rates of pay to provide education to their peers.

Following the training of two officers to provide support, two longer term prisoners in D Division at Metropolitan Reception Prison, where all prisoners go while awaiting classification, have received training to become HIV educators. The aim is to provide basic education to prisoners in those important early days of sentence. The idea of paying prisoners to perform this task is endorsed in the recommendations of the Expert Committee on AIDS and Prisons in Canada (ECAP 1994a, p.50). The Victorian program is a pilot, and will be evaluated.

The Three Tiers of Peer Education

In all the models of peer HIV education outlined there are three levels or tiers in the process to which attention must be paid if effectiveness is to be maximised. These are:

- training the people who will conduct the training of the prisoner peer educators;
- training the prisoner peer educators; and
- education provided by the peer educators to other prisoners.

The first level, training the trainer, requires an emphasis on adult education techniques, and practice in facilitating group processes around the issue of HIV. The pool of people available to become trainers includes nursing staff, custodial staff, general staff from corrections departments and workers from community agencies. There is a considerable difference in the level of expertise that these people have on the issue of HIV, and this difference needs to be catered for in the preparation of training and the resources provided to trainers. The majority of people being trained to be trainers will not have professional expertise in adult education, so it is important that this is not just a short session tacked on to the end of a course. New South Wales is somewhat different in this respect, in that they try to choose people who have already completed a generic train the trainer course and hence have some prior skills in applying the principles of adult education.

The second tier of the process is the training provided to prisoners who have been selected to be peer educators. There is a need for resources which will provide backup in the transfer of information, such as a folder which the prisoner may take away at the end of the course; possibly the attendance of someone who has a particular contribution to make, such as a person who is HIV positive; and a variety of resources which will stimulate discussion and clarification of attitudes. At this level the processes of adult education which emphasise self-responsibility for learning, respect for the experience and informal learning which each participant brings to the course, and recognition that people have different ways of learning, need to be followed. If the model of peer education to be used by the prisoners is the one-to-one approach followed in New South Wales, then the need to provide training in group techniques is not as important as giving an opportunity for the course participants to consider how they might best reach their peers with the HIV message. However if the prisoner peer educators are expected to conduct group education sessions then considerable time would need to be devoted to group facilitation techniques. In both approaches, however, attention needs to be given to skills such as active listening, responding to peers in a non-judgmental manner, and an understanding of such issues as confidentiality and referring a person on to someone else when the issue is beyond the scope of the educator.

The third tier of the process is the primary or core area of education, where it is hoped that the majority of the prisoners,

and in particular those prisoners most at risk, will be in some way reached. This is the underlying reason for the whole process. Obviously it is very important that the prisoner peer educators are very well supported in their role, or the outcome may be that the value of the training is not generalised into the broader prison population. Such support as updating information via a newsletter, providing a focus for special events (the observance of World AIDS Day for instance), ensuring that there is a register of all peer educators, arranging for occasional supervision or peer review, providing opportunities for peer educators to debrief if they have a need to, is essential to the operation of an effective peer education program.

5: Description of Peer and Other HIV Education in Australian Prisons

Overview of the Jurisdictions

Not all jurisdictions use the peer approach to HIV education. This section provides an overview of the current practice of HIV education in each of the jurisdictions. The areas covered are:

- education for custodial officers;
- information/education for prisoners at reception ;
- further education for prisoners during incarceration;
- staffing structure for provision of education for inmates and officers;
- HIV education funding;
- evaluation of the HIV education program;
- plans for future HIV education.

Some background information is also provided for each jurisdiction so that the context in which education programs are offered may be better understood.

NEW SOUTH WALES

New South Wales has the largest prison population of all jurisdictions, accommodated in twenty-nine prisons. The daily average number of prisoners held in custody in March 1994 was 6,344 (Australian Institute of Criminology 1994). Prisoners may be housed in shared cells, single cells, or dormitories. Currently prisoners are HIV tested compulsorily at reception and upon release. HIV positive inmates are integrated into the prisoner population. There is a methadone maintenance (or reduction) program available through the Corrections Health Service for up to 500 inmates.

Education for custodial officers

Officers in primary training receive training in the basics of HIV. This is seen as an introductory session to make all officers aware of the need and methods to reduce their risk and the inmates' risk of infection.

In conjunction with the Corrective Services Academy the Prison AIDS Project conducts an on-site and moduled training program to cover HIV issues including management of HIV positive prisoners for all correctional staff.

An annual seminar is held for correctional centre Program Organisers.

Information/education for prisoners at reception

A one-hour information session conducted approximately fortnightly is being piloted at the Long Bay reception centre. The aim is to conduct a session weekly, but because of the large numbers of prisoners going through the centre, not all prisoners are reached.

Further education for prisoners during incarceration

Peer education is the basic approach used. Each prison has an AIDS Committee comprised of inmates and the Program Organiser (usually a custodial officer). They determine the type and level of HIV education for their prison.

Four-day peer educator courses are conducted in each prison to train selected prisoners to be HIV peer educators.

Educational "events" such as AIDS awareness days are conducted according to decisions of the AIDS Committee.

Informal education of prisoners is provided by the peer educators.

A structured four-month program is run for HIV positive prisoners at the Lifestyles unit at Long Bay. Attendance is voluntary.

Staffing structure for provision of education for inmates and officers

All inmate HIV education is the responsibility of the Prison AIDS Project, a branch of the Inmate Development Service. The Prison AIDS Project consists of the Manager, an Administrative Officer, a Prison Officers' Vocational Branch Representative for liaison with the union and its members, a Prisoner Peer Education Program Coordinator who is responsible for the training of people to conduct the peer educators' course, an AIDS Training Officer who is responsible for training custodial officers who will in turn

train officers in their institutions in matters relating to HIV, and four Regional AIDS Coordinators whose role it is to oversee all HIV issues in institutions in their region.

Each prison has a Program Organiser, a staff member who voluntarily assists in the organisation of any HIV and related policies and programs to be implemented in their institution.

HIV education funding

The 1993-94 budget was \$560,000—half from the NSW Health Department (Commonwealth and State health department funding through the Matched Funding Program) and half from Corrective Services.

Evaluation of the HIV education program

A six-month independent evaluation was conducted in 1993. Results will be published in the near future.

Plans for future HIV education

The prisoner peer education program is currently being updated and in future is likely to consist of a one-day course followed by a three-day course. Those who wish to complete the three-day course will have to re-apply, and prisoners considered to be likely peer educators will be selected.

An Aboriginal prisoner peer education program is to be developed and implemented.

The prisoner peer education program is to be expanded to include more comprehensive treatment of other blood borne communicable diseases such as hepatitis B and C. The Prison AIDS Project is taking on a role similar to a health promotion/education unit.

The development of a pamphlet is planned for distribution to inmates at reception.

A new video targeting female inmates will be produced during 1994.

VICTORIA There are fifteen prisons in Victoria, and the daily average number of prisoners held in custody in March 1994 was 2,419 (Australian Institute of Criminology 1994). There is a mix of single cells, shared cells and dormitory accommodation. The government policy on HIV testing is that it is compulsory. HIV positive inmates are placed in a unit in K Division, Metropolitan Reception Prison (MRP), a maximum security unit, from where they may be re-classified to Loddon which is a medium security facility. There is as yet no low security

accommodation for HIV positive prisoners. Methadone is only available to prisoners who enter the prison system on methadone. This is maintained for unsentenced prisoners or sentenced prisoners in custody for up to three months. Once prisoners are sentenced (excepting pregnant women) they are reduced at a rate appropriate to the individual and eventually withdrawn.

Education for custodial officers

All new recruits have infection control training as part of their basic training course, and all senior and Chief Prison Worker courses also have an infection control component.

Thirty to forty officers have in the past attended a six-day course on HIV conducted by the Centre for Social Health in Melbourne.

The Infection Control Consultant runs training whenever possible in different divisions on infection control, HIV and hepatitis.

In a new initiative two officers from D Division MRP have been trained to provide support to two inmate peer educators who will begin soon in a pilot project. These officers also train other officers as peer educators and take them through infection control issues, with an emphasis on blood spills.

Information/education for prisoners at reception

The video, *Strong & Safe*, is shown at reception in MRP, and an information kit is being developed in a number of languages to be handed to prisoners at reception.

All prisoners received at Lodden also see a video and receive a fifteen-minute talk on HIV and related issues.

A harm reduction video is currently being developed through the Victorian Law Enforcement Drug Strategy made available from the National Drug Strategy funds. The video for prisoners will aim to provide information on ways to minimise harm associated with their drug use and other high risk practices. It will also provide information on drug education and treatment programs in prison and key aspects of the Prison Branch's Drug Strategy. The video will be shown to all male prisoners on reception to prison and a second video will be made for access to prisoners at the time of their release.

Further education for prisoners during incarceration

In the past a variety of educational approaches have been used, the main one being sessions conducted by the Infection Control Consultant. There have been some peer education initiatives, but these have not occurred for about eighteen months on any formal basis. Some HIV positive prisoners, particularly at Lodden Prison have in effect been peer educators on an informal basis.

The Infection Control Consultant is now implementing a pilot peer education program in D Division at MRP, the area where inmates are housed in the early days or weeks of their sentence. Two inmates have been selected to do a two-day training course so that they can become peer educators. For this they will be paid.

Staffing structure for provision of education for inmates and officers

Most HIV education is coordinated by the Infection Control Consultant, who is employed by the Forensic Health Service of the Health and Community Services Department. HIV education sessions are also delivered by Prison Medical Support Officers (specially trained prison officers).

The Communicable Diseases Committee, which consists of representatives of the SPSF (public sector union), Correctional Services, Forensic Health and Health and Community Services, was established in 1988 to oversee all HIV issues. The Committee now only meets on a needs basis.

At Lodden the nurse runs the information program at reception.

HIV education funding

The 1993-94 budget was \$80,000, provided from Health and Community Services Department AIDS funding.

Evaluation of the HIV education program

None to date.

Plans for future HIV education

The Infection Control Consultant's position is for one year only, as there is uncertainty as to future arrangements in view of plans to privatise a number of prisons.

The pilot peer education program in D Division will be evaluated and it is the intention of the Infection Control Consultant to extend it to other prisons. There are plans to train six more custodial officers so that they may provide

training for other officers, and four more inmate peer educators.

Permission has been sought for an ex-prisoner who is HIV positive to be employed as a sessional educator to work for the Infection Control Consultant.

A discussion paper is being prepared by the Infection Control Consultant addressing the issue of HIV and intellectually disabled prisoners.

QUEENSLAND There are twelve prisons in Queensland, and the daily average number of prisoners held in custody in March 1994 was 2,346 (Australian Institute of Criminology 1994). The majority of prisoners have single-cell accommodation, although with increasing pressure of numbers sharing of cells is occurring. Prisoners are tested compulsorily for HIV at reception, at three months, annually and prior to release. HIV positive inmates are segregated, housed in single cells with their own ablutions, but are allowed to work, use library and education facilities, and play non-contact sport with the general prisoner population. Methadone is available to pregnant women only.

Education for custodial officers

There is a half-day HIV component in the basic training course. This is conducted by the HIV educator.

Training for custodial officers in the private prisons is provided by the Corrective Services Commission.

Three train-the-trainer workshops in HIV and infection control were run last year.

Information/education for prisoners at reception

Some information may be given, but this varies from one institution to another.

Further education for prisoners during incarceration

A peer education program based on the NSW model has been operating since 1991. All prisons have peer education programs. Three prisons have prisoner AIDS committees.

Staffing structure for provision of education for inmates & officers

HIV education for inmates and officers is delivered by the HIV Educator who is responsible to the Director of Health and Medical Services.

Queensland Positive People provide volunteers to attend part of the peer educators courses.

HIV education funding

Currently the Queensland Corrective Services Commission pays the salary of the HIV Educator; the Health Department provided \$25,000 program money in 1993-94. This year \$6,000 of program money has been set aside for inmate generated projects, to provide some support for the prisoner AIDS committees.

Evaluation of the HIV education program

The 1991/1992 program was evaluated by the HIV Educator, and a written report was presented.

Plans for future HIV education

The CEIDA manual will continue to be used with some modifications. For example, the pre and post HIV test segments will be modified, and some of the bio-medical aspects will be reduced.

A prisoners AIDS committee will be established in each prison.

A program for Aboriginal and Torres Strait Islander prisoners will be developed.

The possibility of peer educators being part of the reception process to provide information to new inmates will be investigated.

**WESTERN
AUSTRALIA**

There are fourteen prisons in Western Australia. The average daily number of prisoners held in custody in March 1994 was 2,141 (Australian Institute of Criminology 1994). Prisoners may be housed in single cells, shared cells, or dormitory accommodation. Testing is not compulsory, except for those identified by the prison medical service as being at high risk for HIV. HIV positive prisoners are segregated from other inmates. Methadone is available only to pregnant women or HIV positive inmates.

Education for custodial officers

Infection control is part of the basic training course.

There is currently little in-service training.

Information/education for prisoners at reception

Inmates should see a video and receive a pamphlet about HIV at some time during their orientation. This is part of the medical assessment and does not happen for all prisoners.

Further education for prisoners during incarceration

A variety of programs are run by the HIV Coordinator in response to individual need or initiative.

Staffing structure for provision of education for inmates and officers

An HIV Coordinator is employed who has until 1994 been paid by the Department of Health. She is currently employed by the Department of Corrective Services on a one-year contract lasting until the end of 1994.

The HIV Coordinator is responsible to the Director of Prison Operations.

HIV education funding

The salary of the HIV Coordinator comes from Corrective Services. There is no specific budget item for HIV. Funds are sought on a project by project basis from a range of sources such as the Prisoner Programs Branch and Prison Operations.

Evaluation of the HIV education program

There has been no formal evaluation done to date.

Plans for future HIV education

There has been a budget allocation for each prison to receive two three-hour HIV education sessions for prisoners.

Approval is being sought for a number of HIV educational videos to be shown on internal prison video systems.

Approval has been given for a pilot peer education program to be conducted in Wooroloo minimum security prison.

**SOUTH
AUSTRALIA**

South Australia has eight prisons, and in March 1994 the daily average number of prisoners was 1,243 (Australian Institute of Criminology 1994). There is a mix of single-cell, shared cells and dormitory accommodation for prisoners. HIV testing is compulsory at reception for all prisoners serving a sentence of more than seven days, and again at three months. HIV positive inmates are integrated with other inmates and have access to all programs including leave programs. Methadone maintenance is available for a small number of prisoners and strict selection criteria are applied by the Prison Medical Service which administers the program.

Education for custodial officers

HIV is a component of the basic training course for officers. This training is based on the *Communicable Diseases Policy and Procedures Manual*, published in 1992.

In the past two years over 400 officers have attended in-service sessions on HIV.

Information/education for prisoners at reception

Videos, including *The Sentence*, are shown in the holding cells at reception.

Information is given by the nurses at the time of testing, both at reception and after three months

Further education for prisoners during incarceration

Pilot peer programs were conducted in three prisons in 1992 using educators from the AIDS Council of South Australia. The peer education program is now in place, using a modified version of the CEIDA manual produced for South Australian Correctional Services.

For six months in 1993 an Aboriginal project officer was seconded to provide education for Aboriginal prisoners and find appropriate approaches for HIV education for these prisoners.

A pilot course was conducted in the Adelaide Remand Centre for prisoners under protection. The course, entitled 'Sex, Violence and Staying Safe', was conducted by a psychologist and documented in a draft manual.

The Health Project Officer produces a newsletter for prisoners on HIV/AIDS and related issues called *Short Fuse*.

Staffing structure for provision of education for inmates and officers

HIV education is implemented by the Health Project Officer who is responsible to the Coordinator of Health & Welfare.

Currently the peer education course is conducted by an educator from the Aboriginal Health Council on contract.

In 1993 a custodial officer was seconded for three months to provide training for officers, and this approach is likely to be continued.

In 1993 a project officer was appointed for six months to conduct a needs analysis and educational programs for Aboriginal prisoners.

HIV education funding

Funding is provided for 1.5 positions, for the Health Project Officer, and half a position which has been filled by a number of people on a temporary basis to complete specific projects.

A further \$150,000 was provided in 1993-94, part of which went to vaccinating against Hepatitis B.

Funding is provided through the Matched Funding Program of the Commonwealth Department of Human Services and Health, wherein funds are provided by the Commonwealth for HIV/AIDS education, prevention, treatment, care, training and evaluation and are required to be matched dollar-for-dollar by the States/Territories. In the case of South Australia this money comes to the Department of Correctional Services directly, rather than through the South Australian Health Commission.

Evaluation of the HIV education program

Short-term evaluation of the pilot peer education program for prisoners was conducted and internally reported.

Reports of the officer training project and the Aboriginal education project were submitted to the department.

Plans for future HIV education

The peer education approach is to continue.

It is intended that some non-custodial officers of the department will be trained as peer educator trainers.

The Offender Aid and Rehabilitation Service (OARS) has been funded by the South Australian Health Commission to employ a full-time worker to provide information, education and support with regard to HIV to partners of prisoners. This one-year project will be conducted from a building close to the gates of one of the larger prisons.

TASMANIA Tasmania has five prisons, three of which are part of the Risdon complex in Hobart. Most receptions are at Risdon. The average daily number of prisoners in March 1994 was 231 (Australian Institute of Criminology 1994). All inmates have single cell accommodation. Testing for HIV is compulsory at reception and after three months. There is a policy of integration for HIV positive prisoners; in practice to date the small number of HIV positive inmates have remained in the prison hospital for the duration of their sentence. Methadone is maintained for those on a recognised program when they enter, if the sentence is less than three months. Those

sentenced for more than three months will be put on a reduction regime.

Education for custodial officers

HIV information is a component of the basic training course.

Each officer has attended at least one training session in the use of the safety pouch, including the video, *Just Another Day*.

HIV is a component of the senior officers' exam.

Information/education for prisoners at reception

In November 1993 a program was started to provide HIV information to all inmates within two weeks of reception. This is a two-hour session conducted weekly (sometimes twice weekly). The session covers basic information about HIV and AIDS, as well as providing an opportunity for discussion about safer sex and drug use. The video, *The Sentence*, is shown.

Participation in one of these sessions can be a prerequisite for classification to a medium or low security prison.

To date women prisoners have not participated in these sessions.

Further education for prisoners during incarceration

Pre-release programs which include a segment on safer sex and drug use are attended by a small number of inmates.

Inmates produce a weekly news program for the in-house video program, and on occasions the nurse has appeared and provided a health promotion segment.

Staffing structure for provision of education for inmates and officers

Training for officers is currently conducted by the clinical nurse consultant.

The reception information program for inmates is conducted by the clinical nurse consultant and a representative from Your Place, a community drug and alcohol counselling agency.

HIV education funding

The 1993-94 budget was \$100,000—half from the Corrective Services Division of the Department of Justice, and half from the Department of Health and Community Services (Matched Funding Program).

Evaluation of the HIV education program

The Department of Health and Community Services conducted an evaluation of the program in April 1994.

Plans for future HIV education

The recommendations of the evaluation by the Department of Health and Community Services have recently been accepted by the Corrective Services Division of the Department of Justice. These recommendations included the creation of an independent half-time position to coordinate the education program; the continuation of the current program; the training of prisoner peer educators to extend the reach of education; extension of education programs to include women prisoners, those in outlying prisons, and prisoners with behavioural/psychiatric problems. The introduction of a peer education program for custodial officers was also included in the recommendations.

**NORTHERN
TERRITORY**

The Northern Territory has three prisons, two in the Top End and one in Alice Springs. The daily average number of prisoners held in custody in March 1994 was 493 (Australian Institute of Criminology 1994). Approximately 75 per cent of prisoners are Aboriginal and Torres Strait Islander people. Prisoners may be housed in either single cells, shared cells or dormitory accommodation. Prisoners are HIV tested compulsorily at reception, after three months and twelve months and/or on release. HIV positive inmates are segregated. There is not a methadone program available in Northern Territory institutions.

Education for custodial officers

An HIV education component is included in the prison officer induction program and promotional courses. Audio-visual education programs are presented primarily by personnel from the Disease Control Centre (DCC) of the Department of Health and Community Services. An explanation of the HIV education program for inmates is also provided in the induction program

Staff from the DCC are available for other one-off sessions, for example to coincide with the introduction of AIDS pouches in institutions.

A prison officer in Darwin and another in Alice Springs have been designated as HIV peer educators at the institutions within their specific geographical area.

Information/education for prisoners at reception

All inmates are tested on reception to prison. The departmental policy provides for pre and post-test counselling. The practicalities of the reception process cause some difficulties in implementing the policy.

One of the inmate peer educators is now based in reception at Darwin Prison and is able to provide information to new prisoners.

Further education for prisoners during incarceration

In January 1994 a prisoner HIV peer education program was implemented at Darwin Prison following the completion of a five-day training program undertaken by three prisoners. The training was provided by educators from the DCC. The program provided training in the use of an educational package developed and tested within Aboriginal communities. The peer educators run sessions lasting up to two hours for about ten inmates at a time. (See p. 18 above for further details.) The DCC educators continue to monitor and provide support to the peer educators as the role develops within the prison.

Two prisoners from Gunn Point Prison Farm near Darwin have undergone training and are implementing programs.

Two prisoners from Alice Springs Prison have also completed training, and are likely to be conducting programs in at least one Aboriginal language.

Staffing structure for provision of education for inmates and officers

The Director of Health Services has overall responsibility for the health and well-being of adult and juvenile offenders detained in custody. The Director is also responsible for prison officer health education and training. The role is undertaken in close consultation with staff from the DCC. The DCC provide personnel for the delivery of education and training programs.

Two prison officers have undertaken training in the process of inmate peer education. These officers aim to provide support to the peer educators, and ensure continuity and consistency within institutions.

HIV education funding

There is no budget item for HIV education within Correctional Services. An agreement exists between the Departments of Health and Community Services and

Correctional Services to provide a broad range of health and related services, at no cost to Correctional Services.

Evaluation of the HIV education program

There has been no evaluation of the program to date.

Plans for future HIV education

The implementation of a Territory-wide prisoner STD/HIV peer education program is planned.

Education Services are developing a vocational approach and are well placed to provide support to those prisoners undertaking formal and/or informal training as Aboriginal health workers.

The implementation of an Aboriginal Health Worker Training Program is planned.

Trainee Aboriginal health workers will be placed in correctional institutions for work experience.

A video unit will be placed in the medical room so that new prisoners can view an appropriate HIV educational video at the time of their HIV test.

Prison officer training will be implemented aimed at training prisoner HIV peer educators.

A review of HIV education component of prison officers' training courses will be undertaken.

It is intended that attendance at one HIV education session will become compulsory for inmates, and may influence the classification process.

An interdepartmental committee (Correctional Services and Health and Community Services) will be set up to oversee STD/HIV programs in the prisons. A prisoner STD/HIV peer educator may be invited to participate on the committee.

**AUSTRALIAN
CAPITAL
TERRITORY**

The Australian Capital Territory does not have a prison, but it does have a small remand centre run by ACT Corrective Services. This centre caters for up to 34 detainees, both male and female, in single cell accommodation for all men and a four-bed unit for women. A methadone maintenance or reduction program is available for inmates. HIV testing is available to detainees on request. HIV positive inmates are integrated with other inmates.

Education for custodial officers

A small HIV component is provided in the basic training course, covering principles of infection control. Some outside agencies are involved in this training.

Some custodial officers, as well as other staff, have completed a train the trainer course for peer education. This course was run by New South Wales Prison AIDS Project.

Information/education for prisoners at reception

All detainees are offered a kit on reception. This contains two condoms, sachets of lubrication and bleach, a plastic bottle for diluting bleach and a variety of pamphlets about HIV. At last report these were accepted by approximately 30 per cent of detainees.

HIV testing is voluntary, and all people tested receive pre-test counselling.

Further education for prisoners during incarceration

Peer education based upon the New South Wales model is used. Since 1991 three four-day courses for peer educators have been conducted, two within the past twelve months. There is a prisoners' AIDS committee which includes a custodial officer, and has been facilitated by a worker from ACTIV League a community agency. The committee has lapsed from time to time, largely due to the frequent turnover of detainees at the centre. The AIDS committee has organised several education sessions with outside speakers, and for a brief period produced an in-house newsletter.

Staffing structure for provision of education for inmates and officers

Education for inmates has been the responsibility of the Welfare and Programs Officer, who has completed a train the trainer course run by the New South Wales Prison AIDS Project.

Some custodial and non-custodial officers of the department conduct the peer educator courses.

Training of officers is done by the ACT Housing and Community Services Bureau, with input from community agencies.

HIV education funding

Funding is provided from within Belconnen Remand Centre budget.

Evaluation of the HIV education program

Individual courses are evaluated by detainees but no overall evaluation has been conducted as yet.

Plans for future HIV education

The basic training course for custodial officers is being reviewed. This may involve some revision of the HIV component.

The department plans to continue with the peer education approach.

HIV Education Provided for Special Groups

Within the prison community there are innumerable groups of people which may constitute peer groups or perhaps subcultures. One of the advantages of the peer education approach to HIV education is that peer educators are well placed to reach their own subcultures. Within Australian prisons there are some groups, though, which stand out as requiring particular attention to ensure that appropriate educational programs are provided to meet their educational needs.

Chief among these are HIV positive prisoners, Aboriginal and Torres Strait Islander prisoners, prisoners from non-English speaking background, women prisoners, and prisoners with intellectual disabilities. What efforts are being made to meet these prisoners' needs in Australia?

HIV Positive Prisoners

Currently there is a very small number of known HIV positive prisoners in Australian prisons. As a group, though, they have special educational needs to enable them to maintain good health, cope with the double trauma of being HIV positive and in prison, and to ensure that they have the information, attitudes and skills which are compatible with the prevention of transmission of the virus. A significant number of HIV positive prisoners with whom the project officer has spoken also see that they can play an important part in the education of other prisoners about HIV.

New South Wales, the jurisdiction with the greatest number of positive inmates, has a well developed education program. Known as the Lifestyles Program, the course is conducted in a special unit within the Special Care Correctional Unit at Long Bay in Sydney. The unit is fitted out in a comfortable manner with cells leading off a large

living area with high ceilings which is equipped with a kitchen complete with large communal table, and comfortable sitting areas. The custodial officers are specially trained volunteers who have an interest in the program.

Prisoners attend the sixteen-week residential program on a voluntary basis. The program is "structured and fairly intensive" (NSW Corrective Services 1993) and is taught by departmental staff, professional practitioners and consultants. The emphasis is on practical skills which the inmates can use while inside the prison and upon release. The AIDS Council of New South Wales provides HIV positive support workers as part of the program and this helps to establish links with the community. On the afternoon the Project Officer visited the unit the session just completed had been a lesson in healthy cooking, Chinese style.

The Lifestyles unit is a maximum security unit, so some minimum security prisoners are reluctant to attend, as attendance will involve loss of certain privileges. There is also apparently a perception by some that attending the unit will identify them as an HIV positive person, which they fear may cause problems when they return to the mainstream prison.

In Victoria, where HIV positive prisoners are housed separately from the mainstream in K Division, some HIV education sessions are provided. Workers from community agencies such as needle exchanges attend the unit to provide education and as well as that sessions on such issues as stress management, nutrition and healthy cooking are offered. An HIV positive peer support worker attends the unit once a fortnight, and there are plans for an HIV counsellor to attend once a week.

In South Australia, where HIV positive inmates are integrated with other prisoners, some HIV positive prisoners have completed peer educators' courses. This has proved effective in increasing the impact of the HIV message to the general prison population, and has also had a beneficial impact upon the self-esteem and the skills of the HIV positive prisoners. HIV positive inmates from other jurisdictions with whom the Project Officer has spoken have indicated a willingness to participate in some way in the education of other inmates. This idea is in accord with international recommendations for increasing the impact of HIV education.

As well as special programs offered by corrections departments, State health departments frequently become involved in the provision of services to HIV positive prisoners.

Aboriginal and Torres Strait Islander Prisoners

From the outset there has been acknowledgment of the need to provide HIV education programs which are appropriate for indigenous prisoners. The CEIDA manual (1991) devotes a chapter to the subject and provides a rationale for special education efforts for Aboriginal prisoners. The chapter concludes that:

Aboriginal people themselves are the best equipped to motivate other Aboriginal people to prevent the spread of HIV. They are more likely to be able to develop and initiate culturally appropriate, acceptable and effective methods of changing people's risk behaviours within their own communities (CEIDA 1991, p.67).

In 1990 three pilot peer educators' courses were conducted at Cessnock (sixteen participants), Bathurst (eleven participants) and Grafton (twenty participants). The courses were conducted by Beve Speirs (tribal name Goola Ben), a tribal elder of the Darkinoong Tribe of New South Wales. Her Report and Evaluation of the Aboriginal Program forms Appendix 6 of the CEIDA Prisons HIV Peer Education Program 1989-1990 Project Completion Report (CEIDA 1990). Speirs gives examples of the types of strategies which were well received by the Aboriginal inmates, and underlines the importance of programs being developed by Aboriginal people and endorsed by senior people in the Aboriginal community. She makes the following comments on Aboriginal communication and learning styles:

Oral and visual traditions and interaction between people are the major means by which Aboriginal people use to pass on and share knowledge and values this is their heritage. Story telling, sand drawings, rock paintings, corroboree are prominent among the methods used to educate. The corroboree is like a daily newspaper to us, it tells the story of what happened today in mime. Then as it is passed on the elders tell it as a story. The people listen and watch and our practical skills are acquired through shared experience. By participating—learning by doing (CEIDA 1990, Appendix 6).

Unfortunately this course did not continue but an unknown number of Aboriginal inmates have completed the mainstream peer educators' course. At least two of the nine prisoners who completed the course attended by the Project Officer at the Metropolitan Remand Centre at Long Bay in November 1993 were Aboriginal men. There has not been any

analysis of Aboriginal prisoners' response to the mainstream peer educators' course, though, nor of their approach to reaching their Aboriginal peers in prison or in the community outside.

Currently the New South Wales Prison AIDS Project has expressed a commitment to providing HIV education programs especially for Aboriginal inmates, but their way forward has not been defined.

As noted in the overview above, South Australia employed an Aboriginal project officer for six months in 1993. His brief was to develop and plan HIV education programs, in particular peer education programs, and develop culturally specific HIV prevention initiatives for Aboriginal offenders. A full report of the project was written (Abdullah 1993) after consultation with community agencies and Aboriginal prisoners, and the conduct of education programs in most of the prisons in South Australia. The recommendations of the project indicate the importance of having Aboriginal health workers attending all prisons, and the need to provide more Aboriginal drug and alcohol workers in the prisons because of the clear links of substance abuse with HIV risk factors and offending behaviour.

The South Australian Project Officer expressed some reservations about the use of the New South Wales model of peer education for Aboriginal prisoners. His view was that the formal four-day peer educators' course may not be an attractive option for many of the prisoners and that it could be made more attractive by accreditation through TAFE, so that prisoners may see it as leading to some employment opportunities when they are released. The Project Officer successfully used videos made by and for Aboriginal people, particularly those in Aboriginal languages, and strongly recommended the development of video resources. So while the Project Officer was strongly advocating the use of peer education in the broad sense of the term, he saw a need to develop training which did not depend on a formal classroom model which is reminiscent of an education system which has already failed many Aboriginal prisoners.

As the funding for the Aboriginal Project Officer in South Australia was for six months only, the education that he put in place has not been continued on a systematic basis.

The third jurisdiction to introduce a program particularly designed for Aboriginal inmates is the Northern Territory. The program which they put in place at the beginning of 1994 has already been described. This program is intended to be

ongoing and Correctional Services have put staffing support structures in place which should ensure its continuation.

Women Prisoners

Women are a minority group in Australian prisons. The daily average number of women held in prisons during December 1993 was 679, compared with a daily average of 14,325 men (Australian Institute of Criminology 1994). In a number of jurisdictions this, along with the common perception that HIV is not a problem for women, means that they are overlooked when it comes to the provision of HIV education.

The CEIDA manual devotes a chapter to issues relating to women prisoners and peer education, and is a useful starting point for consideration of the issues of relevance to women. Mulawa, the main women's prison in New South Wales, has an active AIDS committee, most of whom have completed a peer educators' course. The committee conducts special events to raise awareness about HIV, and as well as that women from time to time work in pairs to conduct brief education sessions for other inmates. The committee is also active in raising funds, most of which in recent times have been donated to the Quilt Project which commemorates those who have died of AIDS.

South Australia also has included women in the peer education program, and like New South Wales have found that the peer approach is particularly suited to women's educational needs.

At Fairlea in Victoria there is an active health education program and HIV is an element of this. Workers from the Prostitutes' Collective and the Positive Women's group have attended the prison on occasions to conduct sessions.

Prisoners with Intellectual Disabilities

Providing HIV education for prisoners with intellectual disability, developmental disability or intellectual impairment is a complex issue—one whose complexity is highlighted by the difficulty of even naming the issue with which we are dealing.

Just as in the community at large, there is a wide range of people with an intellectual disability in prisons and their disabilities and needs vary widely. Those within the prison systems who are responsible for HIV education are aware that this group of people need to be targeted for education, as they are often vulnerable to risk.

The CEIDA manual provides a chapter with a six-module program for prisoners with a developmental disability. The program was piloted and evaluated at the Developmental Disability Unit at Parklea Prison in New South Wales. This is not a peer educators' training program, rather a program which will be implemented by people with some training in delivering such programs.

Early in 1994 the Family Planning Association of New South Wales conducted a training course for workers including custodial officers and nurses from the three New South Wales prisons which have a special unit for prisoners with developmental disability. This was a one-off staff training event with the aim of equipping staff to provide education to inmates and also support them in their efforts to change practices which place them at risk.

Currently there are no other HIV education programs implemented in the other jurisdictions for prisoners with intellectual disability.

Prisoners from non-English Speaking Background

The CEIDA manual again devotes a chapter to highlighting the special needs of prisoners from a non-English speaking background ranging over cultural issues, language barriers, and the effective strategies for HIV prevention for these inmates. The chapter finishes with what it calls "a cautionary note" to the effect that providing HIV education to these prisoners often finds its way to the too hard basket because those responsible for education feel they cannot bridge the cultural and language gaps.

This suspected tendency to postpone or avoid programs for inmates from a non-English speaking background seems to be a reality when looking around the jurisdictions to discover what programs have been provided. In those jurisdictions which run peer educator training some prisoners from these groups will be found doing the course, but these tend to be prisoners who have become acculturated to the mainstream prison population. There seems also to be a notable absence of inmates from some of the larger Asian ethnic communities, such as Vietnamese, attending the mainstream peer education programs.

No jurisdiction has a systematic approach to provision of HIV education to inmates from those more difficult to reach ethnic communities.

6: Analysis of Peer and Other HIV Education in Australian Prisons

In March 1989 a report commissioned by the then Commonwealth Department of Community Services and Health was published. Entitled *AIDS in Prisons: Issues and Policy Options* (Heilpern & Egger 1989), the report presented the results of a survey of Australian prisons, including an examination of HIV education policies and practices in each jurisdiction. Using international reports available at the time, and the insights gained from the survey of Australian jurisdictions, the authors identified "the key elements for an [HIV] education program within prisons". These elements have been shown above (pp. 9-10) to be very similar in nature to more recent recommendations made by the Expert Committee on AIDS and Prisons in Canada (ECAP 1994), and the recent *WHO Guidelines on HIV Infection and AIDS in Prisons* (Global Programme on AIDS 1993).

Because of the similarity of the Heilpern and Egger criteria for effective education with recent international criteria, and because they were developed after an examination of Australian prisons, this chapter will use their ten elements (or criteria) as the basis of an analysis of HIV education provision in prisons in Australia five years on.

...should be timely...

Education should be timely. AIDS education should be instituted before there are significant numbers of HIV positive prisoners. Such pro-active programs are able to avert the development of serious concerns among staff and prisoners (Heilpern & Egger 1989, p.56).

Although all jurisdictions have some HIV education for both custodial officers and prisoners, there is considerable discrepancy between them in their commitment of staff and resources. The jurisdiction with the greatest number of HIV

positive inmates, New South Wales, remains the jurisdiction with the most comprehensive HIV education program.

The main criterion upon which a number of corrections departments assess the need for HIV education is the number of HIV positive inmates in their prisons. Compulsory testing at reception has been in place in all jurisdictions except Western Australia, the Australian Capital Territory and until recently Victoria (which has a 99 per cent compliance rate) and this, along with policies of segregation of those who are HIV positive, has contributed to a sense among some that enough has been done to deal with HIV. In a number of jurisdictions this has meant that an infrastructure for permanent provision of HIV education has not been established.

...should be mandatory...

Education should be mandatory for inmates and staff. Whilst mandatory education is expensive and difficult to administer, the importance of AIDS education warrants such measures (Heilpern & Egger 1989, p.56).

HIV education is now a component of basic training for custodial officers in all jurisdictions. The focus is infection control and occupational health and safety, and the time devoted to the subject is approximately two hours to half a day. Usually other communicable diseases such as hepatitis B and C are covered in this session, as well as HIV. One compulsory session at induction, however, is not sufficient education to ensure that officers know enough about HIV to take appropriate steps to protect themselves from infection, that unfounded fears or anxieties will be allayed, that they will be supportive of prisoners' efforts to educate themselves, and that officers will not behave in a discriminatory manner towards HIV positive prisoners. Regular in-service training is required for these objectives to be met, and this aspect of officer education will be discussed below.

Compulsory HIV education for inmates is not as widespread as it is for custodial officers. In those jurisdictions which offer the New South Wales model of peer education—New South Wales, South Australia, Queensland and the Australian Capital Territory—compulsory education is not seen as a priority. This is because it is not in the nature of the approach, as only those prisoners who are suitable receive peer educator training, and their role is to disseminate the education by informal means. The only jurisdiction

implementing a form of peer education which has the intention of making attendance at an HIV education program compulsory for inmates is the Northern Territory. The department has plans to make attendance at an HIV session conducted by a peer educator a pre-requisite for re-classification.

The only jurisdiction which claims to have a compulsory HIV information program in place for the early days of a prisoner's sentence is Tasmania. The two-hour session which all new inmates, according to policy, attend within the first weeks of incarceration is the only HIV education offered to prisoners in the Tasmanian system, apart from a brief component in a pre-release course attended by about 5 per cent of prisoners. The recently completed evaluation, however, showed that in the four months 1 December 1993-31 March 1994 only 21 per cent of new inmates attended the two-hour session. The reasons given for this were the rapid prisoner turnover, compatibility issues between some prisoners, and accessibility problems for inmates in Launceston, Hayes and the Women's Prison.

In those jurisdictions with a much larger number of prisoners, the provision of HIV information in the early days of incarceration is an even more complex matter. A number of jurisdictions do provide videos at reception, some provide pamphlets, and others rely on the medical staff who process the new inmates to provide information. No jurisdiction, however, is able to guarantee that all prisoners receive basic HIV information at reception. Indeed, experience and commonsense make it clear that the traumatic time of reception is not the moment when prisoners are likely to be most receptive to information about HIV. This has resulted in a somewhat hit and miss approach which needs to be reviewed in most jurisdictions. New South Wales and Victoria are currently testing programs which aim to provide information to inmates within the first weeks of incarceration. These have been referred to previously in this report.

Given the circumstances in all Australian jurisdictions, it would seem wise to alter Heilpern and Egger's recommendation on the mandatory nature of HIV education for prisoners, so that it is more specific. A modified recommendation would be that HIV and communicable diseases information within the first weeks of incarceration should be mandatory for all inmates. Participation in subsequent educational sessions should be voluntary but strongly encouraged. This recommendation resembles one

made by the Expert Committee on AIDS and Prisons in Canada which has already been mentioned.

...should be regularly presented...

AIDS training should be regularly presented and regularly up-dated to respond to changing information and the often misleading media coverage of AIDS. Mechanisms for obtaining the latest information and up-dating the message conveyed should be developed (Heilpern & Egger 1989, p.56).

This recommendation remains relevant, with information on HIV continuing to change and new insights available about other communicable diseases, Hepatitis C in particular, which are important for prisons to keep up with. Also the media continues frequently to cause alarm and at times to provide misleading information about HIV and AIDS.

In the area of custodial officer training, some jurisdictions do make provision for ongoing in-service training to ensure that HIV is more than just a brief component in the basic training course.

New South Wales has a train the trainer program complete with a leaders' manual for HIV in-service training to be provided in each institution. The *AIDS Training Program: Leader's Guide* (Bates & Berg 1993) was put together for the NSW Corrective Services Academy in conjunction with the Prison AIDS Project. A full-time AIDS Training Officer, a custodial officer who is part of the Prison AIDS Project, takes responsibility for ensuring that each prison has the resources to provide appropriate in-service training. As well as this the representative from the Prison Officers' Vocational Branch of the NSW Public Service Association conducts education sessions on site at the prisons with an emphasis on occupational health and safety. This structure means that new information can be provided to officers, and any issues causing concern because of media coverage or an event in a particular prison can be discussed in a productive manner.

South Australian Correctional Services also provides in-service training for its custodial officers on an institutional basis. The main resource for this training is the *Communicable Diseases Policy and Procedures Manual* (1992). In 1993 a custodial officer was seconded for three months to provide training on a needs basis at the prisons, and the department has indicated an intention to continue this approach to provision of in-service training.

The Northern Territory has designated and trained two custodial officers as Peer Educators and part of their role is to oversee in-service training of other officers. As yet the main in-service training they have been involved in is organising an introduction to the use of safety pouches which were introduced in the Territory in February 1994.

It is worthy of note that Western Australia, which implements the most rigid segregation of HIV positive inmates has the least provision of in-service training for custodial officers.

When it comes to inmates, the need for regular updating and support is equally important. In those jurisdictions which operate the New South Wales peer education model the prisoners require continuing support and information if they are to be expected to carry out a useful education function in the system.

The main mechanism which the New South Wales Prison AIDS Project has put in place to ensure continued support and up-dating is the prisoners' AIDS committees. Each prison has such a committee and it is through the committee that the regional educator is able to channel new information and receive feedback from prisoners about their needs and concerns. A part of servicing the prisoners' AIDS committees is the provision of support and information to the AIDS program organiser, usually a custodial officer who voluntarily undertakes liaison between the prisoners, prison staff and management and the Prison AIDS Project.

In Queensland and South Australia, which follow a similar peer education model to New South Wales, the prisoners' AIDS committees are not as well established but both departments have expressed the intention of consolidating these committees in their prisons. South Australia has over recent times been using another useful mechanism for supporting the peer educators in prisons, that of a newsletter. Entitled *Short Fuse*, the newsletter is compiled by the Health Project Officer, in consultation with the officers' union and departmental staff, and is then distributed to prisoners and officers with an interest in HIV.

In the Northern Territory an officer at each prison has been given responsibility for supporting the peer educators. It is intended that the officer will receive back-up from the education unit of the Disease Control Centre of the Department of Health and Community Services who provide the initial training for the prisoner peer educators.

A number of the other jurisdictions make use of community agencies or other government department personnel to provide information on an occasional basis. There is, however, a need to ensure that such arrangements are provided systematically, rather than in response to a particular crisis or because a member of staff just happens to have a particular interest in the subject.

...should include mechanisms which involve...

AIDS education should include mechanisms which involve inmates and staff in the development and presentation of the education programs. ... Behavioural change, which is the primary goal of AIDS education, requires a whole range of new strategies that may include tailoring the format to the group; including the target group in the delivery of the information; using the informal but powerful prisoner hierarchy; making each gaol responsible for its own AIDS prevention strategies; devising an effective form of evaluation; and linking the education strategies with community programs (Heilpern & Egger 1989, p.56).

This is the element which gets to the underlying purpose of all HIV education. The sought-after outcome is that people will change the way they *do* things as a result of education: those whose practices place them at risk of HIV will modify those practices so they are no longer at risk, and those who contribute to a discriminatory climate for those with HIV will no longer do so. This is a tall order, and education alone cannot achieve these outcomes, but the most likely way to achieve behaviour change through education is to involve those whose behaviour we are hoping to change in the development and presentation of the programs.

To what extent is this happening in Australian prison HIV education?

HIV training for custodial staff is increasingly conducted following a train the trainer model, where officers will be trained by one or more of their peers who has received special training to carry out this role. This approach is used in the Northern Territory, New South Wales, Queensland, South Australia, and Victoria, again with varying degrees of structural commitment. In the Northern Territory two officers are designated as peer HIV educators, in New South Wales there is a train the trainer structure in place in each institution supported by a training officer within the Prison AIDS Project, and a union representative who provides education

to other union members. South Australia has seconded a custodial officer to provide in-service training for a three-month period, and has expressed an intention to continue doing so.

With regard to inmates, the peer education approach is the main means by which corrections departments are meeting this criterion of effective HIV education.

As already described, prisoner HIV peer education is constituted of three tiers: training the people who will conduct the training of the prisoner peer educators; training the prisoner peer educators; and education provided by the peer educators to other prisoners.

It is only in the latter two levels that the prisoners are involved in the development and presentation of programs.

At the level of training peer educators, the prisoners have input in two main ways. In New South Wales, at least, the prisoners' AIDS committees are involved in the selection of prisoners who will do the course. This is important because it is often only the prisoners who are aware of the nuances of relationships or subcultures within the prisons, and they are in the best position to judge whether a particular prisoner is likely to be acceptable to other prisoners as an educator. In those jurisdictions which use the New South Wales model, but do not have prisoners' AIDS committees in all gaols, the selection process on most occasions will not involve prisoners. Similarly, in the Northern Territory to date those prisoners who are peer educators have been selected by staff.

The other way in which prisoners can be said to be involved in the development and presentation of the training course for peer educators is by means of the adult education approach which is used. The principles of adult education as enumerated by Knowles (1970) and others, and which are now well accepted in a broad range of educational settings, are based upon the ideas of involvement and participation of learners in the whole process of learning. In particular this means that the learners will set the ground rules for learning, such as working out how they will ensure that each member of the group has the opportunity to express their views, and how conflict will be dealt with within the learning process. It also means the establishment of respect for each learner's prior experience and learning, regardless of whether it has been obtained via formal or informal education, and an understanding that the learners will learn from each other as much as from the teacher or trainer. This is particularly relevant when looking at such things as sexual practice or

drug using, and ways these may be changed so that risk of disease is minimised.

In Tasmania's two-hour HIV education session, the limited time available, coupled with the need to convey a large amount of information, means that this kind of approach is harder to follow. Nevertheless, the educator does take time to establish rapport and to make the participants feel that their prior learning and experience is respected and will be of value to the learning of the group.

In the peer education approach the third tier of education is that provided by prisoners to other prisoners. In the New South Wales model this is the area where the education provided is entirely in the hands of the prisoners, provided of course the means used does not fall foul of the authorities. On the majority of occasions it is likely that the education will be in the form of private discussions between two or more prisoners, or perhaps via the sharing of literature received during the course. On other occasions at the initiative of the peer educators or the AIDS committee a video may be shown on the prison network, or a concert may be organised to mark, for example, World AIDS Day. In some prisons peer educators have decided to run small discussion groups, and in some others the peer educators have conducted information sessions for larger groups of prisoners.

In the Northern Territory model of peer education, informal education is allowed for, but the principle role of the peer educators is to run formal sessions. During these formal sessions they follow a set format, but flexibility and room to follow the needs of the group are built into the format. Thus the educator may decide to conduct the whole session in an Aboriginal language, and he will be using the experience and opinions of the group members to build the story upon which the learning will be based.

So it is in those jurisdictions which have set up mechanisms for this kind of education that the criterion of prisoner involvement has best been met.

...should be live...

AIDS training and education should be live. "It is the single most effective format because it allows for interaction and feedback." It is also often recommended that a person with AIDS should be present because of the powerfully motivating influence of personal testimony (Heilpern & Egger 1989, p.56).

All jurisdictions provide live training and education.

From time to time an HIV positive person may attend sessions. During 1993 the Queensland community group Positive People was working in cooperation with the Corrective Services Commission's HIV Educator so that an HIV positive person could attend a part of the peer educators' course. When an HIV positive person does attend, Heilpern and Egger's comment that it is "powerfully motivating" is borne out. It is often the feature of a program which the prisoners will most remember, and if an HIV positive person does not attend it is often noted as an omission by course participants. Discussions which the Project Officer has had with HIV positive prisoners indicate that a number of these prisoners would be willing to play a role in education of other prisoners.

...should be credible...

The AIDS educators should be credible. The AIDS educator should understand the prison system and foster credibility. The message should be accurate and straightforward, with no judgmental or hidden ideological content. The education program should be in appropriate language and as non-technical as possible (Heilpern & Egger 1989, p.57).

The means of addressing the credibility and appropriateness of educators are to ensure that they are well trained and have ease of access in the prison via validation from both unions and management.

An evaluation of the quality of training for each jurisdiction is a large undertaking, beyond the scope of this project, and such an evaluation in New South Wales at the end of 1993 indicated the need for some modification and updating of training for those people who conduct the peer educators' courses. Other jurisdictions do not have a training process as large as New South Wales, and often there are only one or two people within the department who have been trained to conduct HIV courses. Some jurisdictions make use of the expertise of community agencies and use groups such as AIDS Councils, Aboriginal health organisations, or, as in the case of the Northern Territory, health educators from the health department.

The matter of easing access to prisons for educators by establishing good relations with both unions and management is an important one and different jurisdictions

have had very different experiences in this regard. This is discussed further below.

...should be supplemented...

Live training should be supplemented with video tapes and/or written informational materials (Heilpern & Egger 1989, p.57).

All jurisdictions are amenable to the use of videos for HIV educational purposes. Most prisons have an internal video system and videos can be an easy, effective way of providing information to a large number of prisoners. Videos are also used in the HIV component of the basic training course for officers.

A number of departments provide a video for prisoners to view at some time during the reception process. Given that prisoners will be watching the video alone and without the benefit of an organised discussion after the viewing, most jurisdictions which use videos at this time avoid those in which the content is distressing. A video such as *Dead Set*, which contains a slash-up scene and shows the consequences of a prison rape, is used to best effect when there is an opportunity for group discussion. It needs to be stressed that videos are most effective as an educational tool when they supplement group discussion.

There is a limited number of videos produced specifically for prisoners, and some jurisdictions find that those developed in other jurisdictions are not appropriate for them. Up until now there have been no videos about female prisoners, but New South Wales has recently received funding to produce one. Other groups of prisoners, such as Aboriginal and Torres Strait Islander people do not yet have a video made specifically to meet their needs. Of course other videos which do not target prisoners can and should be used.

When it comes to printed material, a number of jurisdictions provide pamphlets at reception. However, once again the practicalities of the reception process seem to make it difficult to ensure that all inmates receive them. Another challenge which has not been met by any jurisdiction is that of providing printed material in languages other than English on a continuing basis.

In 1989, *Gaolwize*, an educational comic on AIDS, was developed for prisoners by Streetwize Comics using a Commonwealth AIDS Prevention and Education grant. The development process involved consultation through

workshops with inmates in New South Wales prisons, and the comic was distributed widely in that State. An evaluation of this project (Mohr 1990) found this comic to be an effective educational medium for prisoners because it

roused their interest enough for most who see it to want to read it; it has engaged them in informed discussion about HIV prevention, and it has inspired some to identify with the characters portrayed and the messages conveyed (p. 14).

This resource has been the subject of much controversy at both departmental and political levels because of its explicit nature, and very few jurisdictions now use it. *Gaolwize* provides an interesting case study of the unique problems involved in developing and maintaining programs and resources for prisoners.

The main source of printed material on HIV in those jurisdictions which use the New South Wales model of peer education is the folder of information which the peer educators receive during their course. This is a comprehensive set of information, which provides the peer educators with an excellent back-up to the learning they have obtained through completing the course.

...should be sensitive to specific concerns...

AIDS education should be sensitive to the specific concerns of the institution. In addition to providing basic information of the disease, the education program should address the concerns current in the prison no matter how irrational such concerns may be. In prison, AIDS education should address the major risk factors—needle sharing, sexual activities, tattooing and risks associated with fights and other situations where blood may be spilt (Heilpern & Egger 1989, p.57).

In the main, education programs do deal with the specific concerns of particular institutions. The main problem for prisons in some jurisdictions is that the programs do not occur regularly or frequently enough, so it may not be until there is a crisis that issues are dealt with. This problem is discussed further below.

The other issue that this point raises is that in a few jurisdictions there remains a mind set which has considerable difficulty in providing education to assist inmates partake safely in practices which are officially proscribed, needle use and sexual relations in prison in particular. This is dealt with

by keeping the discussion at the level of safe practices outside the prison, sometimes with oblique references to how these practices may be translated to the prison situation. This is obviously less than satisfactory if the real concern is prevention of transmission inside prison, where risk taking does occur. Even in those jurisdictions which do openly discuss needle sharing and sex inside prison and provide detailed discussion of needle cleaning, there is inevitably a contradiction arising from the fact that the major means of harm minimisation—condoms and needle exchange—are not available in prisons. When this contradiction is faced openly the session is able to move to the pragmatic consideration of being safe within existing constraints.

...must be a high level of executive commitment...

There must be a high level of executive commitment. The importance of this is threefold:

- it enhances the credibility of the program;
- it emphatically demonstrates the content of the program by way of example;
- it involves a pragmatic commitment at all levels in the administration of the prison (Heilpern & Egger 1989, p.57).

Without a high level of executive commitment in corrections departments to HIV education it is very difficult for those trying to implement programs to make any progress at all.

In those departments in which there is a high level of commitment the most important manifestation is the provision of adequate infrastructure so that HIV education programs are an assured and regular feature of their overall service. This means that there will be permanent members of staff who implement programs, either as their primary function or as a well defined portion of their formal job description. There will also be explicit lines of responsibility, so that the HIV/communicable diseases worker is supported by his or her immediate superiors and there is ready access to policy-making levels. In addition, a budget allocation made to HIV and communicable disease prevention education ensures that planning can be done on the basis of assured funding. A number of jurisdictions do not as yet demonstrate this degree of executive commitment and the result is that education is an ad hoc affair often dependent on a particular crisis or the interest of a member of staff who provides education on top of an already complete work program.

Another feature of those departments which have a high degree of commitment to HIV education is good relations between the unions and those who implement programs. This is because efforts will have been made to set up formal liaison with the unions through a variety of means such as joint committees, or special education programs so that unions understand that HIV education of the prisoners is a priority of the department and that an equally important priority is the proper education of officers so they may have their anxieties allayed and protect themselves from HIV and other communicable diseases.

Departments demonstrate the contents of their HIV education programs by way of example in a number of ways. All jurisdictions issue their custodial officers with a safety pouch, so they are equipped to deal with blood spills and other crises safely. Not all jurisdictions rigidly enforce the wearing of the pouch, however. In the majority of jurisdictions, but not all, inmates have access to bleach agents of some sort which are used as part of general cleaning arrangements. This means that there is bleach to be found if inmates want to use it to clean injecting equipment. The only place where condoms are available to inmates is the remand centre in the Australian Capital Territory. The further steps of providing access to the harm minimising strategies available in the community are still a long way from being taken, and these issues are as much a matter of political as executive decision.

... should be rigorously monitored and evaluated...

The AIDS education program should be rigorously monitored and evaluated in order to ensure that the objectives are being met (Heilpern & Egger 1989, p.57).

This is a predictable and obligatory criterion for any education program today. But what does it mean specifically in the context of HIV education in Australian prisons? To discover this we need to separate prison education into its constituent parts and also consider the different functions of monitoring and evaluation.

Monitoring of programs might be described as keeping track of or recording what is happening. So if a comprehensive and useful record of what is happening with regard to HIV education for both custodial officers and prisoners is to be kept, the answers to the following types of questions need to be collected on a regular basis.

Prisoners: How many courses/sessions are being run? At which prisons? Who is running the courses? Which prisoners are attending—men, women, members of the Aboriginal and Torres Strait Islander community, those from non-English speaking background, those with intellectual disability, HIV positive prisoners, long-term prisoners, short-term prisoners? Are prisoners attending one course or more? How many prisoners who have completed courses are still in prison? What is the content of the program? What is the cost of the education?

Custodial Officers (in-service training): How many courses/sessions have been run? At which prisons? Who is running the courses? What is the content? Which officers are attending—those who had HIV education as part of their basic training, those who did not, those who self-select, those whose superiors selected them? What is the cost of the program?

The same types of monitoring questions need to be answered about the provision of training for those who will conduct the courses or sessions for both officers and prisoners.

Currently in most jurisdictions this monitoring function is not being done in a systematic way, and an important tool for assessing the reach and effectiveness of HIV education is not being produced. If this important function is to be carried out, the role must be supported with staff time and other resources, a further aspect of the need for executive commitment to HIV education.

Monitoring is the first phase of evaluation. Evaluation is broadly concerned with assessing the quality and outcomes of the HIV education. The type of questions which evaluation will be looking to answer in prison HIV education are:

- What is the quality of the training for trainers?
- Does the content of the programs meet the needs of the participant?
- Are the language and style of the educator appropriate for the group?
- Are there appropriate videos and printed materials to supplement the learning?
- Is the knowledge of the general prison population increasing and are attitudes being modified to meet the objectives of the program?

- Are practices being modified so that transmission of HIV and other communicable diseases is a risk for fewer people?

Some of the means of evaluation which can be used are peer review of trainers (by peers within the department, or from community agencies), participant feedback at the end of programs, feedback via prison management or AIDS committees, pre and post course questionnaires on knowledge and attitudes. The compilation of a variety of such evaluations can provide a clear picture of the effectiveness of a program, and these are all activities which can be built into the program at the outset.

The last two questions listed above are of the type which may require an evaluation which can only be provided by a specialist researcher. This type of evaluation is important from time to time and could be funded on a special projects basis.

Again when it comes to evaluation most jurisdictions still need to develop a strategy and *build it in to their regular program activity*. The practice of asking participants for their evaluative comments at the end of a program is fairly widespread, and this is a very important aspect of evaluation, but unless this is part of a broader assessment it can be dismissed as a "feel good sheet". The peer education program as presented in the CEIDA manual includes pre-and post-course questionnaires on knowledge and attitudes, but in many cases these questionnaires have been dropped from the program, often because educators see them as taking too much time, or because they do not see how they are useful in the educational process. Jurisdictions need to look again at the value of this process and consider how they may incorporate it into their practice.

The New South Wales Prison AIDS Project has recently redesigned its pre- and post-course questionnaire in line with a new structure for its education program. Details of the new questionnaires will be given in an evaluation report soon to be released by the Department. The aim is not only to look at knowledge and attitudes, but also to collect some information on the risk behaviours of course participants, and to do some of the basic monitoring of participants through some demographic questions.

The New South Wales evaluation referred to above was a six-month exercise for which a special researcher was employed. Tasmania also had its HIV education program

formally evaluated by independent evaluators employed by the Tasmanian Department of Health and Community Services, which provides half of the funding for the program.

...should meet needs of special groups

One important criterion for assessing the effectiveness of HIV education which was not given prominence by Heilpern and Egger is the *provision of education for prisoners with special needs: Aboriginal and Torres Strait Islander prisoners, those from non-English speaking background, those with an intellectual disability, HIV positive prisoners, and women.* These are areas which require particular attention and the extent to which this is provided in the Australian jurisdictions is discussed in the previous chapter.

7: Effective HIV Peer Education for Prisoners: What are the Barriers and What Factors facilitate it?

The previous chapter looked at the key elements of effective HIV education in prisons, one of which pointed to peer education as an important characteristic of programs which aim to change peoples' practices.

In this chapter the focus is turned specifically to HIV peer education for prisoners, to examine some of the barriers to its effective implementation and the factors which facilitate it. Two different sets of circumstances require examination:

- where the peer approach to prisoner HIV education has not been accepted for use by a jurisdiction, and
- where the approach has been accepted and the need is to maintain it and maximise its effectiveness and efficiency.

Getting Prisoner Peer HIV Education Accepted

Perceptions about the Method

There are a number of perceptions about the nature of HIV peer education which can become barriers to its acceptance in prisons. Some of these perceptions are reported here, along with arguments which have been used to counter them. A more complete case for choosing the peer approach to HIV education has been presented in Chapter Four.

The peer education approach requires giving prisoners "adult" status wherein prisoners are asked to work in partnership with those charged with their custody to achieve a particular educational end. This is not compatible with maintaining authority and good order.

Prisoners are adults and as such need to be considered in the light of accepted principles of adult education which recognise that adults learn best when they are able to take

responsibility for their own learning and when their own prior learning and experience is respected.

Management and good order of the prison is likely to be compromised because prisoners are being given a mandate to empower themselves and others through the dissemination of information.

In jurisdictions where the peer education approach is backed up with thorough training and attention to the needs of custodial officers, it can be seen as a tool of effective inmate management. When prisoners are actively involved in working on health promotion projects this can be, and in some jurisdictions is, seen as a providing positive and productive atmosphere in the prison.

If custodial officers perceive that prisoners are receiving more education than they are they will become suspicious of the process and will not cooperate.

This is a fair observation but the answer is clear. An important part of effective education for inmates is the provision of equally effective education for officers. Officers' training needs to make them aware of the process which is being used for inmate education, and equip them with knowledge and attitudes which will make them partners in the process. It is important to establish that inmates who are better educated about HIV and other communicable diseases are likely to contribute to a safer workplace for the officers.

If we motivate prisoners through peer education to change their practices, then deny them access to condoms and needle exchange or bleach to clean injecting equipment they become frustrated and negative. They hit a brick wall in terms of changing to safer practices.

This argument could be used against all HIV education. If education is to be provided at all the desired outcome is a change to practices which do not place the individual at risk of HIV or other communicable diseases. There are responses to education which do not necessarily require condoms or needle exchange or specially marked supplies of bleach. Among these are abstention from sex and needle use, safer sex practices which do not involve penetration, the use of bleach which should be available in household cleaning agents which are a part of a prison's hygiene regime, and the use of protective equipment if involved with blood spills.

As well as this, most prisoners are in prison for a finite period and they take their learning back to the community. This may prevent them from contracting disease upon

release, and, in the case of recidivists, bringing disease into the prison when they return.

HIV peer education is not realistic because there are not enough prisoners who are HIV positive to act as educators for the entire prisoner population.

This view is heard from time to time in some jurisdictions, but it is based upon a misunderstanding of the term "peer educator". A prisoner peer educator is defined as such because he or she is a prisoner, and it is this characteristic which is important rather than HIV status. This is not to deny that HIV positive prisoners can play an important and special role in HIV education if they are willing and appropriately trained.

Maintaining Peer HIV Education and Maximising its Effectiveness

Training of educators and officers

Effective HIV peer education of prisoners cannot occur without thorough attention to the training of personnel involved at the different levels of the process. These levels or tiers are:

- training the people who will conduct the training of the prisoner peer educators;
- training the prisoner peer educators; and
- education provided by the peer educators to other prisoners.

The type of training required at the first two levels has already been discussed in detail.

The second important aspect of training involves ensuring that custodial officers and those in management positions understand the process of peer education so that they are partners in the process. This will mean that officers' training will result in their knowing how to protect themselves from HIV and other communicable diseases, and also in a corps of officers who provide a supportive environment for prisoners in their efforts to educate themselves and other prisoners.

Support

Once prisoner peer educators have been trained they require continuing support if they are to be effective in their role. The components of effective support for peer educators are:

- structural support such as that provided by a prisoners' AIDS committee, and/or a staff member who takes on a support role and liaises with the prison authorities in all matters regarding HIV and communicable diseases education. Without this support the education process may well come to a standstill;
- updating of resources so that new information gets through to the prisoners, and so that the peer educators have access to such aids to education as new videos or pamphlets;
- opportunities to acquire new skills in the delivery of HIV messages. For example, some prisoners may benefit from a workshop in such areas as presentation skills or active listening;
- opportunities to debrief, should the peer educator have a need after dealing with a difficult matter regarding HIV or communicable diseases.

The second essential aspect of support is that provided to the HIV education program as a whole by the corrections department. The components of this support are:

- permanent staff members who implement programs, either as their primary function or as a well defined portion of their job description;
- clear lines of responsibility so that the HIV/communicable diseases worker is supported by his or her immediate superiors and there is ready access to policy makers;
- a specific budget allocation for HIV/communicable diseases prevention education so that proper planning procedures can be followed;
- a clear understanding with custodial officers' unions that HIV peer education is a priority of the department and in the best interests of officers.

Failure of a department to provide this level of support can be an insurmountable barrier to effectiveness because programs will lack continuity and credibility.

Funding

While it is important for corrections departments to take responsibility for supporting HIV education programs with

an established infrastructure as outlined above, it is equally important that health departments continue to provide funding support. The logic of this is made clear by Harding in his overview of HIV service provision in prisons around the world.

Most AIDS researchers have wrongly conceptualised prisons as a static reservoir. In fact, prisons house people temporarily, often for brief periods, sometimes repetitively, and these people have lives in the community before, after, and between prison sentences. Prison should therefore be regarded as an integral part of the community (p. 763).

Since prisons are potentially a source of increased HIV and other communicable diseases transmission in the community, health departments should see the financial support of education as part of their public health funding responsibility.

At a time of rapidly increasing prison populations (due to truth in sentencing policies) and a decline in per capita funding for prisons, corrections departments in all jurisdictions are stretched to maintain their basic service. A lack of funding support from health departments could lead to HIV education falling off the corrections agenda.

This is not to imply that corrections departments do not have any responsibility to fund HIV education: it is an integral part of their duty of care to those in their custody.

Placing HIV in a broader communicable diseases context

A barrier to the maintenance of effective HIV education programs can be the knowledge that the prevalence of HIV has remained low in Australian prisons, and has even declined in some jurisdictions. This could be seen as an argument for reducing HIV education programs except for the fact that epidemiological evidence shows that without continued vigilance in those groups which are particularly at risk of HIV, transmission can quickly take off.

At the same time as jurisdictions are observing HIV transmission is not increasing they are witnessing a rapid and alarming increase in the prevalence of other blood borne communicable diseases, particularly hepatitis C.

HIV education is being broadened in all jurisdictions to cover prevention education for Hepatitis C and B, and in some jurisdictions to encompass sexually transmitted diseases. Programs which reveal a broader concern for the

immediate health needs of prisoners have a greater credibility with both prisoners and prison managements than those which deal only with HIV, and hence are likely to be more effective.

This approach also makes sense in the management context of making the most efficient use of scarce resources.

Information to all in the first weeks of incarceration

Peer education is a process aimed at motivating prisoners to take action to change any practices which place them at risk of HIV. As an approach it has arisen from a recognition that information alone does not cause people to change their behaviour.

Nevertheless, information is one of the main building blocks of education, and it is important that all prisoners do receive basic information about HIV in the early days of their incarceration. Because prisoners are entering an environment with its own set of risks of HIV, and which does not provide all the protective measures that are available in the community, they have a need and a right to information about transmission which is specific to the prison system. The peer approach as it is practised in most jurisdictions cannot guarantee that everyone will be reached, so as an adjunct to peer education this information must be guaranteed by other means. The moment of reception into the prison is likely to be inappropriate for this purpose so jurisdictions need to settle on another time that is suitable for delivering HIV/communicable diseases information in those early days.

Peer education opportunities will be enhanced if all prisoners are also informed at this time of the existence of peer educators and the role they play in the prison.

Recognition that special groups need special attention

While the peer education approach is a very flexible form of education provision, there are some groups of prisoners which for a variety of reasons have special needs (see Chapter Five). Among these groups are Aboriginal and Torres Strait Islander prisoners, those from non-English speaking background, HIV positive prisoners, women, and those with intellectual disability. Unless there is special recognition of and planning to meet these needs such people are missed by the system.

To meet the needs of these prisoners it is important to involve community groups who are peers or who possess special expertise. In the case of Aboriginal and Torres Strait

Islander prisoners, corrections departments may well find that projects are not only more effective, but also more likely to be funded if they are implemented in conjunction with community groups.

Prisons house a significant number of people with intellectual disability, and their chances of receiving appropriate HIV education will be enhanced if they are first recognised and then linked to community or other governmental organisations which specialise in providing education to these people. This is also the case with non-English speaking background prisoners.

The important role for the corrections department HIV worker is to facilitate the educational role of community organisations. This is likely to involve an orientation program which introduces them to the practicalities of working within the prison system, and ensuring that they have ease of access to their client group.

Monitoring and evaluation

Inadequate monitoring and evaluation of programs is a barrier to effective HIV peer education because there can be no indication or certainty that the program's objectives are being met, and an essential tool for persuading policy makers that the program should continue to be supported is not being produced.

The processes of evaluation and monitoring which will facilitate effective HIV peer education have been discussed in some detail in Chapter Six.

A note about private prisons

There is a growing tendency for jurisdictions to consider the option of contracting out the management of prisons to private companies. This step has already been taken in two states. If a jurisdiction has made a commitment to the peer approach to HIV education, it is important for the agreement made with the contracting agency to explicitly outline arrangements for HIV peer education to continue in the private prison, with all the facilitating features mentioned in this chapter. Without such an agreement, an important part of the effort involved in training peer educators will be lost as they go into private prisons, and the prisoners in private gaols will be disadvantaged.

Summary

There are a number of barriers which need to be overcome in getting the peer education approach to HIV and communicable diseases education established, and then in maintaining the process and maximising its effectiveness and efficiency.

When it comes to establishing the approach, the main barriers may be attitudinal. The argument that all adult education requires a different approach from that of traditional school-room teaching can be brought to bear on those with reservations about HIV peer education, as can the well-researched understanding that education for behaviour change requires more than the transfer of information. Those jurisdictions which have adopted HIV peer education have managed to overcome these attitudinal barriers, and no jurisdiction in Australia which has adopted HIV peer education has ceased using it.

The maintenance of an *effective* HIV peer education program in prisons requires serious commitment from corrections departments. Those jurisdictions which will have the most success in providing effective HIV peer education will ensure that:

- detailed attention is paid to training of educators at all levels and equal attention is given to the HIV training of custodial officers;
- both the prisoner peer educators and those responsible for program delivery and development are supported by means of a firm infrastructure within the department;
- specific funding from both the corrections department and the health department is provided;
- HIV is placed in a broader communicable diseases context;
- basic HIV information is provided to all prisoners in the first weeks of incarceration;
- the needs of special groups within the prison are recognised and provided for; and
- monitoring and evaluating of all HIV education is built into programs and regularly conducted.

These are the factors which the experience of the Australian jurisdictions have shown to best facilitate the delivery of effective and efficient HIV peer education in prisons.

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Appendix I: Testing and Diagnosis of HIV in Australian Prisons, 1991 and 1992

The tables in this Appendix are extracted from a presentation to the 5th World Conference on Prison Health Care, 6-11 June 1993, Brisbane, "Pattern of testing for HIV antibody and diagnosis of HIV infection among individuals entering Australian prisons during 1991 and 1992", by

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Table 4:
Total number and proportion of HIV antibody tests carried out at reception, by State/Territory and year of reception.

State/Territory	1991		1992	
	Number	Proportion of receptions	Number	Proportion of receptions
ACT§	-	-	-	-
NSW	9,506	99.6	8,622	99.9
NT	1,338	60.8	1,169	64.8
QLD	8,520	100.0	5,353	100.0
SA	2,647	57.1	2,437	30.1
TAS§§	739	70.7	585	47.9
VIC	4,399	98.0	3,994	99.9
WA	1,590	24.3	1,847	33.4
Total	28,739	77.0	24,007	73.4

§ Remand Centre only—HIV antibody testing by request

§§ Number of HIV antibody tests carried out at reception not available for the 4th quarter.

Table 5:
Number and proportion of diagnoses of HIV infection, by sex and year of reception

Sex	1991	1992
	Number	Number
Male	69	89
Female	2	6
Total	71	95

Table 6:
Number of diagnoses of HIV infection, by sex, year of reception and whether or not the diagnosis was a new or a repeat diagnosis

Sex	1991		1992	
	New	Repeat	New	Repeat
Male	11	58	19	70
Female	0	2	1	5
Total	11	60	20	75

Table 7:
 Number of diagnoses of HIV infection, by year of reception,
 State/Territory and whether the diagnosis was a new or a repeat
 diagnosis

State/Territory	1991		1992	
	New	Repeat	New	Repeat
ACT	0	3	0	1
NSW	8	38	8	39
NT	0	0	1	0
QLD	0	1	7	4
SA	0	12	0	14
TAS	0	0	0	0
VIC	3	5	3	15
WA	0	1	1	2
Total	11	60	20	75

(Tables reproduced from McDonald et al. 1993, with permission)

Appendix II: What the Prisoners Said

In the course of visiting prisons in each jurisdiction the Project Officer spoke with prisoners about HIV and communicable diseases and their needs with regard to education.

The discussions were not recorded and did not follow a uniform format. In some instances the discussions were with groups of prisoners; in others there was just one prisoner present. The Project Officer took notes which were written up in full from memory after the interviews. Extracts from these notes are presented in this appendix. The prisoners' real names have not been used and editing has been kept to a minimum in an attempt to convey something of the prisoners' voices.

A woman inmate who is a peer educator

After the peer educator's course those who had attended set up monthly educators' meetings where they planned talks. They decided topics, discussed who would speak, and helped each other write talks. These talks were arranged so that all the prisoners who wanted to were able to come. Usually about two-thirds of the prisoners came. Aboriginal women from remote communities did not choose to come.

Officers were not welcome, and did not come in, but the female speakers often felt daunted by the knowledge that officers would have been outside listening.

The educators also arranged videos, which were useful to get discussion going. These came from the AIDS Council.

The monthly meetings slowly ceased as the peer educators moved out of the prison.

The videos in the peer educators' course were not made for females. [Reference was made to a number of videos which had been made for male prisoners, some of which included prisoners in the cast] Females do not speak in that way, neither do they behave like those men.

What do women need in HIV education?

- They need to be made aware that they can get HIV—it's not just a gay men's disease.

- They need to think about their children—the consequences for children if their mother becomes HIV positive.
- They need to know that they can change—that they have the ability to change.

What are the benefits of doing the peer educators course?

- The women learnt through doing course that they could do things like talk publicly.
- Their confidence was built up.
- The course made them feel they were worth something.
- The women doing the course bonded closely—they had not been close before but formed a strong support for each other.

What are the barriers to effective peer education and behaviour change?

- Low self-esteem of women prisoners is kept that way by officers constantly telling them they will be back inside, taking bets on how long it will be before they return once they are released etc.
- Urine testing—females used to use marijuana and other drugs more before this was introduced—now tend more towards heroin as it exits the body quickly.
- Lack of access to needle cleaning materials. They had bleach in bathrooms for a while, then it was removed, then on AIDS Day this year it was back—did not know whether it was there now.

What do peer educators need if they are to be effective?

- Constant refresher courses or sessions.
- Updates via newsletter.
- A peer educators' course should be run every three months to overcome problem of women moving on.

What do you think will actually get women to change to safer practices?

This is the hard one. We must accept that not everybody wants to change. One-to-one discussion is far better in getting the message to hit than is group discussion. Having an HIV

positive person present is powerful in getting the message across.

A male inmate peer educator

Most of the inmates who did the recent peer educators' course have already left the prison. The rapid turnover of prisoners can be a problem. It is better from the point of view of providing peer educators for the benefit of all prisoners if the course is run early in the prisoners' sentences.

What did you like about the course?

- It cleared up a number of mysteries about HIV and AIDS. [Previously he had thought it was nothing to do with him.]
- The presentation was right for the group: the presenter pulled no punches—the language was direct and appropriate for the group; all questions were answered; there was lots of group discussion about matters that would not normally be talked about.
- The presenter gave a phone number to ring if follow-up information was required. He also left a booklet of information.
- Two HIV positive men came and talked to the group.
- The course dealt with hepatitis B and C.

Other comments?

- Would like to do the course again, as a refresher but also for the value of talking the issues through again.
- In prisons where most of the inmates are there for a short time, a course should be run every three months.

Report of a discussion about the needs of male prisoners with regard to HIV education

Frank: Had done the peer education course in its early days. Keen to get HIV peer education up and running in this prison. He chose the men who attended the meeting (to represent different sub-groups in the gaol, he said).

Trevor: Had little to say except when asked. He commented that it would be good to have HIV positive people talking to the prisoners as their presence would have a powerful effect.

Jim: (Aboriginal prisoner) Pointed out that young kids are more knowledgeable about HIV than older people, but despite this they still shoot up. He said it would be valuable for Aboriginal prisoners to have their own education sessions, but to come together with other prisoners for discussion after they had had their own sessions.

Peter: Felt frustrated by the lack of logic in the Department's position with regard to HIV. He thought needle exchange should be introduced and parity of punishment for marijuana and hard injected drugs should be removed. Prisoners would choose heroin in preference to marijuana because it does not stay in the urine as long, and so is less likely to be detected by urine tests.

Bill: Commented that the prison system needed to wake up to the reality that there are drugs inside and that something needed to be done to reduce the risk of disease arising from needle sharing. Felt that there is some curiosity about HIV but most prisoners would prefer to remain in ignorance.

Malcolm: Felt that the educational message should be that injecting drug users should stop using these drugs, but while they are withdrawing safe alternatives like methadone should be allowed in the prisons.

Comments from other prisoners

Colin: Officers' attitudes can be a problem. A number of prisoners had been called to an HIV education session with words along the lines of "You've got AIDS—get down to the AIDS meeting".

Steve (an HIV positive inmate): It is essential to provide education to all prisoners to ensure that HIV positive prisoners are not discriminated against. HIV positive prisoners would be keen to run education programs for other prisoners, perhaps for an hour a week for a six-week period. Prisoners will only listen to other prisoners. First aid courses should also be run for prisoners so that they know what to do if an HIV positive prisoner takes ill suddenly.

**Appendix III:
Summary of HIV Related Policies and Practices in each of
Australia's Jurisdictions**

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT
Testing	Compulsory on entry and exit for all inmates.	Compulsory on entry. Prisoners may request a follow up test at any time during their sentence.	Compulsory on reception, at three months, annually and prior to release.	Voluntary testing except for those identified as having characteristics of "high risk". For these prisoners it is compulsory.	Compulsory for all with a sentence more than seven days - at reception; after three months.	Compulsory on admission and at three months. Discharge testing on request as is hep B & C or STD testing. Small but significant % of remandees never reach testing area. Approx. 80% of prisoners serve three months or less.	Compulsory on reception; after three months, twelve months, and on discharge.	Not compulsory; available on request.
Bleach	Liquid bleach available for all inmates, for hygiene purposes including needle cleaning if necessary. All cells must now be disinfected each week by inmates.	Sachets available via dispensers in unobserved areas in most prisons or on request through medical centres. Prisoner access to bleach is being reviewed to ensure that those who seek it are not targeted as IDUs for management purposes.	Liquid bleach readily available for general cleaning purposes. <u>Not</u> issued specifically for cleaning needles and syringes.	Not made available for cleaning needles and syringes. Bleach is contained in some general purpose cleaning agents used in the prisons.	Not made available for cleaning needles and syringes. Bleach is used for general cleaning.	Not made available for cleaning needles and syringes. Bleach is contained in some general purpose cleaning agents used in the prisons.	Not available.	Available. Powdered bleach in sachets is part of the kit offered to all detainees at reception. Liquid bleach is available in the security block.

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT
Condoms	Not available except in kit offered on release. There is currently a court case in progress that may require the department to provide condoms to all inmates.	Not available within prisons currently. At two prisons where there are residential visit facilities for prisoners and their families condoms are available via dispensing machines inside the visit area.	Not issued. Have been illegally smuggled into the segregation unit on a regular basis.	Not available.	Not available.	Not available. Split kits for inmates at release were recently developed but withdrawn before any were distributed.	Not available.	Available. Offered to all detainees in the kit provided at reception. Extra condoms are available from the nurse.
Methadone	Available through Corrections Health Service for up to 500 inmates - maintenance and reduction.	Available to those who enter the prison system on methadone. It is maintained for unsentenced prisoners and sentenced prisoners in custody for up to three months. Once prisoners are sentenced they are reduced and eventually withdrawn from methadone (unless pregnant).	Not available, except pregnant women. Pharmacologically designed detoxification programs universally available.	Not available unless HIV positive or pregnant.	Available on a limited basis because of resource constraints. Delivered through the Prison Medical Service.	If on a recognised program prior to entry the program will be maintained if the sentence is less than three months. If sentence is longer than three months the prisoner will be reassessed with a view to reduction.	Nil.	Available. Maintenance or reduction for those on a program before they entered. Those not already on a program are assessed by methadone clinic staff on request.

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT
Housing of HIV positive inmates	Integrated, though single cell accommodation provided. Can share a cell if appropriate forms are completed. Four-month voluntary program available at Lifestyles Unit.	A "corridor" approach to segregation: placed in K Division high security prison (MRP) with volunteer inmates undergoing drug & alcohol program; from there they may be reclassified to Loddon (medium security) where housed with volunteer prisoners.	Segregated: -single cell accommodation, own ablutions, etc -are allowed to work -can use library and access education programs (under supervision) -play non-contact sport -work toward their early release - integrated when under supervision of officers	Segregated. [In July 1994 two HIV positive prisoners were awarded compensation by a tribunal of the Equal Opportunities Commission on the grounds of impairment of access to goods and services.]	Integrated with access to all programs including leave programs. Single cell accommodation is provided.	Policy of integration, but all HIV positive prisoners so far have been housed in the prison hospital where there is limited access to programs.	Segregated.	Integrated with other detainees.
Availability of knowledge of inmate HIV status	As prescribed by legislation, i.e. Commissioner, Assistant Commissioner Operations, Governor, Medical Officer, etc.	HIV status is classified as confidential: known to Director, Medical Services and relevant medical staff for treatment purposes. For placement, Supt. Classification also notified.	Segregation implies no confidentiality.	Segregation identifies HIV positive people to a degree. Policy dictates confidentiality, but it is not easily maintained.	Identification of communicable disease status is available but not the nature of the disease. The CEO is advised of the diagnosis and provides this information to assist the assessment process and to the prison manager on a confidential basis.	At present, notification by Medical Officer to Chief Supt. who informs appropriate people. Historically the identity of HIV positive prisoners has been known throughout the prison.	Information on a "need to know" basis.	Confidential to inmates and doctor/medical staff.

Appendix IV: Attendees and Program—National Seminar, 6-7 June, 1994

Attendees

New South Wales

*Gino Vumbaca, Manager, Prison AIDS Project (02) 2891468
Daniel Shakespeare, POVB representative, Prison AIDS Project
Stephen Taylor, Evaluation Project Officer, Prison AIDS Project

Victoria

*Evi Kadar, Senior Project Officer (03) 6986635
Jane Bennett, Infection Control Consultant

Queensland

*Kristine Mihaly, Health Educator (07) 2251423
Dr Bryan Todd, Director, Director of Health and Medical Services

Western Australia

Ron Hutchinson, Assistant Director Prison Management
*Maxine Drake, HIV Coordinator, (09) 2641285

South Australia

Ben Abdullah, Community Corrections Officer
*§Ann Bloor, Policy Adviser, Health and Welfare Services (08) 2269081

Tasmania

Paul de Bomford, A/Clinical Nurse Consultant, Risdon Prison, (002) 438022
*Ian Fox, A/Director of Nursing, Risdon Prison, (002) 438022

Northern Territory

*Pamela Bazin, Director of Health Services (089) 895457
Bob Cope, Prison Officer, Darwin Prison
Trevor Woodhead, Health Educator, AIDS/STD Unit, Centre for Disease Control,
Darwin Hospital

Australian Capital Territory

*Helen Child, A/Senior Community Corrections Officer (02) 2071562
Trevor Parkinson, Prison Officer, Belconnen Remand Centre
Virginia Gray, Welfare and Programs Officer

Australian Institute of Criminology

Jennifer Norberry, National Prison HIV Peer Education Project Manager
David McDonald, National Prison HIV Peer Education Project Adviser
Jane Mugford, Evaluator, National Prison HIV Peer Education Project
Judith Robinson, Project Officer National Prison HIV Peer Education Project

National Drug and Alcohol Research Centre

Kate Dolan, Research Officer

Commonwealth Department of Human Services and Health

Jenny Williams, Director, Strategy and Coordination Unit
Tracey Cross, Strategy and Coordination Unit

* These people agreed to act as contact person for networking purposes
§ No longer in this position. Contact Roger Sweeney, Manager Health Services
(08) 2269152

Monday 6 June

9.00am	Introductions	Judith Robinson
9.15 - 10.00am	Briefing on the current state of HIV infection in Australian prisons	Kate Dolan (National Drug & Alcohol Research Centre)
10.00 - 10.30am	The current state of HIV education around Australia	Each jurisdiction to report
10.30 - 11.00am	Morning tea	
11.00 - 12.00	The current state of HIV education around Australia (continued)	(each jurisdiction to have 10 minutes for this report)
12.00 - 12.30pm	Prison peer HIV education - what is our shared understanding of it? How does it fit within the context of other approaches to HIV education in prisons?	Discussion
12.30 - 12.45pm	Factors which facilitate effective HIV peer education: 1) Funding	Jenny Williams, Commonwealth Department of Human Services and Health (DHS&H)
12.45 - 1.45pm	Lunch	Jenny Williams to be lunch guest
1.45 - 2.30pm	Factors which facilitate effective HIV peer education: 1) Funding (cont)	Discussion of issues: sources of funding and how to access them; whether funding for HIV education should be a corrective services departmental responsibility or be funded in part or totally by health department grants, through the matched funding and other programs; ways of maximimising cost efficiency in prison programs
2.30 - 3.30pm	Factors which facilitate effective HIV peer education: 2) Structures to ensure continuity	Gino Vumbaca- an outline of NSW structure - then discussion of arrangements in other jurisdictions to ensure continuity of programs. Discussion to include some examination of the barriers to establishment of ongoing structures and ways of overcoming these barriers
3.30 - 3.45pm	Afternoon tea	
3.45 - 4.45pm	Factors which facilitate effective HIV peer education: 3) Good relations with unions	NSW union rep on Prison AIDS Project followed by discussion including successes in building good relations in other jurisdictions
4.45 - 5.00pm	Closure for Day 1	

Tuesday 7 June

8.30 - 8.45am	Recap	
8.45 - 9.30am	Ensuring effective information/education is provided to all prisoners at an early stage	Ian Fox - discussion of what can be done at reception, and an examination of education programs offered in the first few weeks of imprisonment
9.30 - 10.30am	Current strategies for prison HIV education: <ul style="list-style-type: none"> • How the CEIDA manual is being used or modified • Aboriginal and Torres Strait Islander prisoners • women prisoners • Prisoners with intellectual disabilities • Complementing HIV education with education about other communicable diseases • For HIV positive prisoners/involving HIV positive prisoners as educators of others 	Discussion of Aboriginal and Torres Strait Islander prisoners to be led by Ben Abdullah (South Australia) and Trevor Woodhead (Disease Control Centre, Darwin)
10.30 - 11.00am	Morning tea	
11.00 - 1.00pm	Continue the above	
1.00 - 1.45 pm	Lunch	
1.45 - 2.45pm	Evaluation: <ul style="list-style-type: none"> • Why? • What? • How? 	Stephen Taylor, NSW Evaluation Project Officer, followed by discussion
2.45 - 3.45pm	Resources: <ul style="list-style-type: none"> • What do we have? • What is needed? • Strategies for getting these 	Discussion/show and tell
3.45 - 4.00pm	Afternoon tea	
4.00 - 4.30pm	Networking between the HIV education units of each jurisdiction: <ul style="list-style-type: none"> • Is it of any worth? • Mechanism for maintaining it 	Discussion
4.30 - 5.15pm	<ul style="list-style-type: none"> • Looking ahead • Closure 	