Encyclopedia of PRISONS & Correctional Facilities

SAGE reference

Hiv/Aids

At the end of 2000, around 2.2% of all state inmates (24,000 people) and 0.8% of all federal inmates (1,000 people) were infected with **HIV**. Among state and federal inmates, 0.6% and 0.2%, respectively, had AIDS. According to the Bureau of Justice Statistics (BJS), the rate of confirmed AIDS cases among the nation's prison population in 2000 was about four times the rate in the general population of the United States. Thirteen in every 10,000 persons in the United States general population had confirmed AIDS compared to 52 in every 10,000 prison inmates.

HIV INFECTION AND AIDS

The human immunodeficiency virus (**HIV**) does not kill a person directly. Instead, it destroys the immune system and makes people infected with **HIV** vulnerable to infections that are rarely seen in people with normal immune systems. After a person becomes infected with **HIV**, it may take years for symptoms to develop. During this latency period, many people are unaware they are infected but can still transmit the virus to others. Acquired immunodeficiency syndrome (AIDS) is diagnosed by a physician using certain clinical criteria (e.g., blood test results, AIDS indicator illnesses).

HOW HIV IS AND IS NOT TRANSMITTED

HIV can be spread by oral, vaginal, and anal sex with an infected person. The risk of **HIV** transmission through oral sex is much smaller than that associated with vaginal and anal sex. **HIV** is also transmitted by sharing needles or syringes with someone who is infected. Babies born to women infected with **HIV** may become infected before or during birth, or after birth through breast-feeding. Health care workers may be infected with **HIV** after being stuck with needles containing **HIV**-infected blood, or after infected blood gets into a worker's open cut or a mucous membrane (e.g., the eyes or inside of the nose). There has been one case of **HIV** transmission from acupuncture.

Most **HIV**-positive inmates became infected prior to their incarceration. **HIV** transmission through sharing injection equipment and unprotected sex does occur within correctional facilities, although not very frequently. A 1997/1998 article published in *The Canadian* **HIV***/AIDS Policy & Law Newsletter*, for example, described a 1993 study of an **HIV** outbreak in a Scottish prison, which revealed that 13 inmates who engaged in extensive syringe sharing had become infected in prison. A study of an Australian prison found that at least four injection drug-using inmates had become infected in prison.

Correctional officers and inmates are often afraid of **HIV** being transmitted through a bite or a sneeze. Neither a small amount of blood being exposed to intact skin nor exposure to sweat, tears, saliva, or airborne droplets has ever been shown to result in **HIV** transmission. Biting or needlestick injuries pose a low threat of **HIV** transmission. According to the Centers for Disease Control and Prevention (CDC), 99.7% of needlestick/cut exposures do *not* lead to infection. Biting presents even less of a risk of **HIV** transmission than does a needlestick. Typically, a biter is more likely to come into contact with the victim's blood than vice versa. The medical literature has reported cases in which **HIV** appeared to have been transmitted by a bite but all of these cases involved severe trauma with extensive tissue tearing and damage, and the presence of blood. The CDC knows of cases where the hepatitis B virus has been transmitted through tattooing or body piercing, but no instances of **HIV** transmission through these practices. In the United States, blood is routinely screened for **HIV**

antibodies. Consequently, **HIV** is very rarely transmitted through transfusions of infected blood or blood clotting factors. **HIV** is not spread by insects nor through casual contact such as sharing food utensils, towels and bedding, telephones, or toilet seats.

HIV AND AIDS IN PRISONS AND JAILS

The number of **HIV** infections and AIDS cases dropped from 1999 to 2000; however, this trend was not present in all states. The decrease in the number of confirmed AIDS cases was the first since data collection began in 1991. During 2000, 18 states reported a decrease in the number of **HIV**-infected inmates while 29 states reported an increase. Nearly one in four inmates known to be infected with **HIV** are incarcerated in New York; at least 6,000 inmates are infected with **HIV** in New York. New York also has the highest percent of the custody population that is infected with **HIV** (8.5%) followed by Maryland (with 4.3% or 998 inmates infected), Florida (with 3.7% or 2,640 inmates infected), and Texas (1.9% or 2,492 inmates infected).

The quality and effectiveness in **HIV**/AIDS care has improved with the introduction of protease inhibitors and highly active antiretroviral therapy (HAART). As a result, AIDS-related death rates in state prisons have been dropping, from 100/100,000 inmates in 1995 to 14/100,000 in 2000. AIDS-related illnesses are now the third leading cause of death in state prisons (after natural causes and suicides), having been the second leading cause of death since 1991. Death rates vary widely from state to state, however. For example, in 2000, the District of Columbia, Florida, New Jersey, Connecticut, New Hampshire, Pennsylvania, South Carolina, and Alabama all had AIDS-related death rates at least twice the national prison average of 14 deaths/100,000 inmates.

At mid-year 1999, 1.7% of jail inmates (8,615 inmates) were reported to be infected with **HIV**. Jails in the South and the Northeast account for 80% of all jail inmates known to be infected with **HIV**. The south held the largest number of inmates infected with **HIV**, followed by those in the northeast (3,822 and 3,105, respectively). Forty-three of the 50 largest jail jurisdictions held nearly 4,000 inmates who were known to be **HIV**-positive. Of these, almost one-third were held in New York City jails.

HIV/AIDS raises a number of issues for correctional administration, including those related to testing, housing, education, medical care, confidentiality, and the greater rates of **HIV** infection among women. Each of these issues is discussed briefly below.

HIV *Antibody Testing*

HIV infection is diagnosed by an ELISA test that is confirmed by a Western Blot test. Both of these tests detect **HIV** antibodies rather than **HIV** itself. It may take as long as several months for antibodies to develop to detectable levels. During this time, an infected person may still pass the virus on to others. All correctional systems provide **HIV** antibody testing on some basis. In 2000, the most common circumstances under which jurisdictions test inmates are: upon inmate request (46 jurisdictions), upon clinical indication of need (46), upon involvement in an incident (41), or upon intake (41). Fifteen states test inmates in specific "high risk groups," and a handful of states test inmates upon their release, test all inmates currently in custody, or test inmates selected at random.

Housing

In 1985, 16% of state and federal facilities segregated prisoners with **HIV** and 75% segregated inmates with AIDS, on the grounds that it would reduce rates of **HIV** transmission. No reliable studies support this assertion. By 2003, Alabama was the only state to isolate inmates infected with **HIV** from all other prisoners in both its housing and its prison programs. Most states integrate inmates with **HIV** infection with the rest of the prison population and permit them to access some, if not all, prison programming. Some states house prisoners throughout the system until their medical condition warrants their transfer to a clinic that provides specialized care. Others—including programs in California, Texas, Florida, and South Carolina—group prisoners known to be infected with **HIV** into a single facility in an effort to provide state-of-the-art medical care. Some experts are

concerned that a quarantine model may give prisoners in the general population a false sense of security and lead to greater transmission within the facility. Also, even in states with special **HIV** units, the demand for beds may exceed the supply, resulting in a lack of uniformity of care and expertise.

Education and Prevention

Incarceration provides an important opportunity to educate inmates about **HIV**, sexually transmitted diseases (STDs), and other communicable diseases. A 1997 National Institute of Justice/Centers for Disease Control and Prevention (NIJ/CDC) study found that **HIV**/STD education and prevention programs were becoming more common in correctional facilities. Few systems, however, had implemented comprehensive and intensive **HIV** prevention programs in all of their facilities. For example, while over 85% of prison and jail systems provided basic **HIV** information and explained the meaning of **HIV** test results, less than half offered education on more controversial topics such as how to negotiate safer sex or engage in safer injection practices. The NIJ/CDC study found that only 10% of state and federal prison systems and 5% of jail systems offered comprehensive programs in correctional facilities that included instructor- and peer-led programs, pre- and post-test counseling, and multisession prevention counseling.

Correctional administrators in the United States have resisted measures such as condom distribution that might reduce the spread of **HIV** and other STDs in the facility, citing concerns that condoms might be used as weapons (by filling them with sand or using them to strangle someone) or to conceal contraband. Another concern is that condom distribution implies that sexual activity is permitted when, in fact, it is prohibited behavior. In 2001, only 4% of U.S. jails and 10% of U.S. prison systems permitted condom distribution. Most other industrialized countries (including Canada and most European prison systems) make condoms available to inmates and report few problems.

Medical Care

The introduction of protease inhibitors and HAART in 1996 revolutionized the treatment of **HIV**/AIDS. These new **HIV** therapies have reduced morbidity and mortality in the general population, and they are widely available in correctional systems. Still, the treatment of **HIV** in a correctional setting presents many practical challenges as well as legal and ethical questions.

Barriers to Medical Care

Barriers to medical treatment of inmates remain such as high medication costs; inmate reluctance to seek testing and treatment out of fear, denial, and/or mistrust; and uneven medical competence and treatment standards. Features of correctional facilities such as strict schedules, definitions of "contraband," inmates' extremely limited ability to self-treat even minor medical ailments without reporting to sick call, and the need to constantly balance security concerns over the medical needs of inmates pose several challenges to the delivery of medical services to inmates. Many inmates who are not adequately warned about the complicated drug regimens and the potential side effects may discontinue the treatment. Prison regulations and routines may interfere with inmates' attempts to comply with instructions regarding when and how to take the medication. If an antiretroviral regimen is pursued but fails, it may lead to resistance to other drugs of the same class thus limiting future treatment options and adding to the economic burden **HIV** imposes on society. Inmates with **HIV** infection often seek access to therapeutic clinical trials in hopes of obtaining good-quality care from knowledgeable university staff. Because of past abuses, federal regulations discourage—but do not prohibit —research conducted on inmates. Inmates seeking access to clinical trials may be accommodated by research protocols that recognize the importance of voluntary and uncoerced consent for research taking place in a prison setting. To determine the best treatment for the **HIV**-positive inmate, a clinician must take into account what will work best biologically, what will be most tolerable to the inmate-patient, and what will gain his or her maximum adherence to the treatment plan.

Legal and Ethical Considerations

The U.S. Supreme Court ruled in *Estelle v. Gamble* that inmates have a right to be free of "deliberate indifference to their serious health care needs" under the provisions of the Constitution's Eighth Amendment. According to the National Commission on Correctional Health Care (NCCHC), "deliberate indifference" often takes the form of denied or unreasonably delayed access to a physician for diagnosis and treatment, failure to administer treatment prescribed by a physician, and the denial of a professional medical judgment.

NCCHC identified some specific legal and ethical considerations associated with the provision of medical care. Maintaining rights to privacy has also been proven to be very difficult in a correctional setting where **HIV** infection is still feared and stigmatized; where medical information may be deduced from an inmate's movement, a cell search, or a pattern of scheduled visits; and where differing opinions may exist regarding who has a "need to know" someone's **HIV** status. Correctional staff and inmates have been implicated in breaches of confidentiality in many institutions. These breaches suggest a need to hold prison administrators more accountable for their confidentiality policies. Additional issues relate to the nature of the provider-patient relationship in a prison—the inmate cannot seek treatment elsewhere and the provider cannot refuse to treat the patient-inmate—and the right of a mentally competent adult to refuse treatment.

Women With HIV *Infection*

Factors such as drug use, race, poverty, having a partner who uses drugs, and having a history of sex work or physical or sexual victimization that place women at increased risk for incarceration also put women at increased risk for **HIV** infection. **HIV** infection rates are higher among women prison inmates than men inmates; 3.6% of all female inmates in state facilities were **HIV** infected compared to 2.2% of men. At the end of 2000, around 20,000 male inmates and 2,200 female inmates in state prisons were known to be **HIV**-positive. In six states and the District of Columbia, more than 5% of all female inmates were known to be **HIV**-positive. In two jurisdictions, more than 15% of all female inmates were known to be infected: the District of Columbia (41%) and New York (18.2%). As in the United States as a whole, women of color are overrepresented among those incarcerated who are infected with **HIV**.

Men and women **HIV**-positive inmates face similar problems such as the violation of their privacy rights, discrimination and stigma, unsanitary housing conditions, and difficulty accessing quality medical care. In addition, the **HIV** Education Prison Project reports that women inmates face the additional challenges of receiving **HIV** care from a doctor who not only has expertise but also recognizes the women-specific issues, such as gynecologic complications of **HIV** infections, management of the **HIV**-positive pregnant woman, and monitoring for toxicities of antiretroviral therapy. For example, women who are infected with **HIV** have high rates of STDs and cervical neoplasia; thus physical examinations should include pelvic exams (with Pap smear and STD screening), and laboratory evaluations should include screening for other bloodborne infections (e.g., hepatitis B and hepatitis C, tuberculosis), and other tests. Around one-quarter to one-third of all untreated pregnant women infected with **HIV** will pass the infection to the fetus during pregnancy or birth. If a woman can safely take AZT or Retrovir during pregnancy, labor, and delivery and she has a cesarean delivery, infection rates can be reduced to 1%.

Discharge Planning

In 1996, inmates comprised 35% of the U.S. population infected with tuberculosis and 17% of those infected with **HIV**. Releasing sick inmates—including those infected with **HIV**—with proper treatment and arrangements for follow-up care not only improves their health status but also reduces the potential threat they pose to public health. Inmates with **HIV** benefit most from a "continuum of care" encompassing early detection, effective medical and psychosocial support, prevention and risk-reduction counseling, hospice care and substance abuse treatment when appropriate, prerelease planning, and linkage to community-based services. Ideally, discharge planning for inmates with **HIV** disease and other health problems helps to ensure prisoners will be able to obtain their medications and adhere to their regimens. A 1997 NIJ/CDC study of discharge planning services found that inmates in most correctional systems are given referrals for services. Far fewer systems actually make

appointments for inmates and provide additional support and assistance to ensure that inmates make contact and receive the services they need. For example, although 82% of state and federal systems made referrals for **HIV** medications, fewer than one in three made an appointment. Continuity of care is particularly difficult in jail settings since the time of discharge is often unanticipated and many jail inmates enter and exit the system frequently.

CONCLUSION

HIV/AIDS poses a complex set of legal, ethical, and practical challenges for prisons and jails, particularly in the areas of housing, medical care, education, and discharge planning. While many medical advances have been made in the treatment of **HIV** infection, efforts are still needed to ensure that inmates' privacy rights are protected and that the correctional system's response to **HIV** is based on the best epidemiological information available rather than prejudice and fear.

—Jeanne Flavin

Further Reading

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