Excerpts from ’Fenced In: HIV/AIDS in the US Criminal Justice System’

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HIV in U.S. Correctional Facilities

There are approximately 2.2 million people in jail or prison in the United States. According to the Bureau of Justice Statistics (BJS), about 1.5% of all inmates in state and federal prisons have HIV or AIDS (21,987 persons). That percentage is four times higher than the prevalence rate of HIV in the general population. The BJS reports that Florida (3,626), New York (3,500), and Texas (2,450) have the largest number of inmates

who are HIV-positive. The BJS also reports that the rate of infection for female inmates (1.9%) is even higher than that of their male counterparts (1.5%). The primary routes of transmission are

suspected to be unprotected sexual contact and intravenous drug use (IDU), but precise data on infection and transmission are not available. While numbers remain high for HIV prevalence in prisons, the data may underestimate both HIV prevalence and incidence due to existing stigma and fear. This stigma not only leads to nondisclosure of HIV-positive status, but also places prisoners at an elevated risk of infection.

Healthcare in Prisons and Jails

The fight for proper care and treatment in prisons has been long and difficult and, despite some progress over the years, enormous gaps remain. HIV, tuberculosis and hepatitis are among the most common infectious diseases in U.S. prisons. The CDC reports that up to 41% of inmates have ever been diagnosed with Hepatitis C virus (HCV) and up to 35% are chronically infected. In the un-institutionalized population, HCV prevalence is 1–1.5%.

Disparities in HIV and HCV infection between incarcerated and non-incarcerated populations demonstrate inadequate access to care and treatment. HCV prevalence is also significant because it is linked to HIV. Both infections can be transmitted through unprotected sexual contact and injection drug use. Additionally, HIV-positive individuals are disproportionately affected by viral hepatitis; about one-third of HIV-infected persons are co-infected with hepatitis B virus (HBV) or HCV.

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The onset of the HIV epidemic, coupled with a political and legislative climate that was hostile toward prisoner health, led to deterioration in health care. Prisoners increasingly faced obstacles

to HIV medical care in correctional facilities. In November 1981, the first prisoner in New York State was confirmed to have died from AIDS-related complications. By the early 1990s, two-thirds of all deaths of incarcerated persons in New York were AIDS-related. Some 7.4% of inmates in Northeast state prisons were known to be HIV-positive in 1993, a 22% increase from two years prior. The number of inmates in state and federal prisons with an AIDS diagnosis increased 124% from 1,682 in 1991 to 3,765 in 1993.

Condom Access

Although the prevalence of high-risk sexual behaviors and sexual assault demonstrate the need for proven HIV prevention methods in correctional facilities, only five county jail systems (New York, Philadelphia, San Francisco, Los Angeles, and Washington, DC) and two state prison systems (Vermont and Mississippi) allow prisoners access to condoms. This represents less than 1% of all U.S. jails and prisons. Correct and consistent use of condoms reduces the risk of sexually transmitted infections (STIs) and HIV transmission. Condoms remain the single-most effective prevention intervention and will go a long way towards reducing HIV transmission and other STIs in the corrections system.

HIV Education and Testing

Other than limited knowledge about HIV, specific policies within prisons serve as major obstacles to successful HIV testing. HIV testing strategies vary considerably among correctional facilities and include mandatory, voluntary, and opt-out testing. However, structural barriers largely prevent prisoners from getting tested. Fear of discrimination, lack of confidentiality, and stigmatization of IDU and MSM behaviors hinder access to prevention services and HIV testing and continue to fuel the epidemic in the corrections system.

In order to address these barriers and increase HIV screening, the CDC has recommended routine opt-out HIV testing in all health care settings, including prisons and jails. Under these recommendations, HIV screening is made available as part of the standard medical evaluation and is performed unless the patient declines. The CDC recommendations also include annual testing for persons at high risk for HIV infection, but unfortunately do not require accompanying prevention counseling.

The JUSTICE Act

Without uniform prevention, testing, and treatment programs, incarcerated persons living with HIV and/or other STIs can unknowingly infect others. Often left untreated, incarcerated persons with STIs are frequently in the more advanced stages of their disease, and once released can be even more costly for the public health system to treat. One outcome of the lack of a coordinated response to HIV is that among confirmed AIDS cases in prisons, racial minorities account for the majority. Black prisoners are 3.5 times more likely than white inmates, and 2.5 times more likely than Latino inmates, to die from AIDS-related causes.

In August 2011, Representative Barbara Lee (D-CA) introduced H.R. 2704, The Justice for the Unprotected against Sexually Transmitted Infections among the Confined and Exposed (JUSTICE) Act. This legislation would allow prisons to provide condoms to incarcerated individuals. The

JUSTICE Act also calls for automatic reinstatement or re-enrollment in Medicaid for people who test positive for HIV before reentering communities. This action is of tremendous importance to public health since it would provide a comprehensive response to the spread of sexually transmitted infections in correctional facilities.

Stop AIDS in Prison Act

The Stop AIDS in Prison Act, sponsored by Representative Maxine Waters (D-CA), addresses comprehensive HIV care and prevention in federal prisons on a structural level. The bill calls upon the Bureau of Prisons to take 11 concrete steps to combat HIV in prison, promote awareness, and improve medical care. All testing and medical care would be required to be strictly confidential, with penalties for any breach of confidentiality.

The Act would include HIV testing as a medical service provided with consent during intake and within three months prior to release. Testing would also be provided upon request once per year, or following high-risk exposure or upon pregnancy. Prison personnel would be instructed to encourage inmates who might be at high risk for HIV infection to get tested, and would be prohibited from using any request for testing as evidence of misconduct. Those who tested positive for HIV would have the option of "partner notification services." Inmates would be able to refuse testing at any time, for any reason, without penalty.

Inmates would also be entitled to comprehensive medical care in a timely fashion, with confidential consultations about managing the virus. Upon release, prisons would need to provide information about where to receive treatment and care in the community, as well as 30 days' worth of medication.

In addition, prisons would need to provide educational opportunities for inmates about modes of HIV transmission. This would involve working with a number of organizations, agencies, and well-informed inmates to provide culturally competent and accessible presentations, written materials and audio-visual resources in multiple languages. Within one year, the Bureau of Prisons would need to report to Congress on its policies to enforce the above provisions. Within two years, and every year after, it would also need to report incidence rates of STIs and intravenous drug use.

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