

HIV in U.S. jails and prisons: Building a national dialogue for change

HIV in Prisons: Overview of the Problem

There are currently 2.2 million people in jail or prison in the U.S. 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).¹ This is 4 times the prevalence rate of HIV in the general population. The BJS reports Florida (3,626), New York (3,500), and Texas (2,450) have the largest number of inmates who were HIV-positive or had confirmed AIDS.² The BJS also reports that the rate of infection for female inmates (1.9%) is higher than that of males (1.5%).³ The primary routes of transmission include sex 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, which leads to nondisclosure of HIV-positive status and places prisoners at elevated risk of infection.

In addition to HIV, inmates living in U.S. prisons report higher rates of disabling health conditions than the general population. They also have poorer perceptions of their health status and lower usage of primary health services.⁴ At present, the prison population is disproportionately by African Americans, intravenous drug users, and individuals with serious health issues related to socioeconomic status. Most incarcerated individuals come from medically underserved populations. Factors such as drug addiction, poverty, substandard nutrition, poor housing, and homelessness

can contribute to their increased risk of HIV and other diseases.⁵ Even within the inmate population, health disparities exist along racial and social lines.

The elevated rates of HIV infection found in prisons are not solely a concern for prisoner populations. This public health crisis reaches beyond the confines of prisons and to the communities where inmates live upon completing their sentences. In 2009, 729,295 prisoners were released from state and federal prisons and into communities across the country.⁶

Unfortunately, many former inmates find it increasingly difficult to successfully reintegrate into society. A criminal record can lead to removal of voting privileges, lack of employment and housing opportunities, and burdensome financial obligations resulting from incarceration, all of which create barriers to reintegration and increase the likelihood of re-incarceration. Many states have adopted laws, such as “Three Strikes” laws, which hand down mandatory and extended sentences to persons whom have committed a serious offense on three or more occasions, thus adding to the difficulty of reintegration.

While great advancements have been made in identifying methods of transmission, risk factors, and social contexts behind the spread of HIV over the last 30 years of the epidemic, the larger social perception of the epidemic remains fraught with fear, stigma, and anxiety. These issues are exacerbated by structural barriers in

State or federal prison inmates reported to be HIV positive or to have confirmed AIDS, 2006–2008

	Total HIV/AIDS cases ^a			Percent of custody population ^b		
	2006	2007	2008	2006	2007	2008
U.S. total						
Comparable reporting ^c	21,985	21,615	21,462	:	:	:
Reported ^d	21,985	21,644	21,987	1.7%	1.5%	1.5%
Federal ^e	1,530	1,679	1,538	0.9	0.9	0.8
State	20,455	19,965	20,449	1.8	1.6	1.6

“Note: For jurisdiction-level data see appendix table 1. :Not calculated. ^aCounts published in previous reports may have been revised. ^bThe custody population is defined as all inmates held in state or federal public prison facilities, inmates held in privately operated facilities, and inmates held in local jails regardless of length of sentence and state holding jurisdiction. ^cExcludes data from Illinois, Indiana, Alaska, and Oregon for all 3 years due to incomplete reporting. ^dExcludes inmates in jurisdictions that did not report data. ^eCounts for 2008 may not be comparable to previous year counts due to implementation of a new record-keeping system.”

Source: U.S. Department of Justice

prison settings. This includes denial from prison officials of the existence of sex and drug use in prisons.

HIV Infection Rates in Prison

In 2010, New York State Department of Correctional Services (DOCS) released the results of a Department of Health review of HIV/AIDS and Hepatitis C care in New York State prisons. The review only referenced official DOCS policies, without much investigation into how these policies were being implemented. According to this review, DOCS facilities scored extremely high on a survey of quality of HIV care.⁷ This was received with a great deal of skepticism by many HIV/AIDS organizations that cited anecdotal evidence of uneven rates of care and inadequate access to certain medications.

The estimated rates of infection in New York State prisons – 3.0% for men and 10.7% for women – are among the highest in the country.⁸ A common perception is that many inmates contract HIV while in prison, due to unprotected sex (both consensual and otherwise) and shared needle use (for substance use and tattooing). However, recent data reports a greater infection rate before inmates are ever incarcerated. The true danger of living with HIV in prisons is not, after all, the risk of infecting another inmate, but the stigma and abuse that accompanies a disclosed diagnosis.

According to a CDC study published in 2006, 780 out of 856 HIV-positive inmates in Georgia Department

of Corrections facilities were infected prior to incarceration. From July 1988 to February 2005, Georgia implemented mandatory testing upon entry into prisons and voluntary testing by request or by clinical indication after entry. Beginning in July 2003, voluntary testing was also offered to inmates on an annual basis. After reporting the results of these tests, it was found that 88 of the 856 inmates tested negative upon entry and later tested positive during their incarceration. Of those who were found to be HIV positive in Georgia prisons and jails, 91% were positive upon entry.⁹ It should be noted that this was just one state’s study, albeit the most extensive one to date, and statistics will vary across the US. Comparable large scale surveillance programs should be encouraged and funded by the CDC.

Sexual Assault

The frequency in which sexual assault occurs in male correctional facilities is difficult to estimate. Victims of sexual assault whom report the offenses face a high probability of retaliation from the accused, leading to further harassment and injury. A study from the Federal Bureau of Prisons reported that 9–20% of federal inmates, especially new inmates or those perceived gay, were victims of rape.¹⁰ A report from the Bureau of Justice Statistics on sexual victimization in prisons also identifies specific subgroups—including women, gay and bisexual people, and individuals who had been sexually victimized in the past—as more vulnerable than others to sexual victimization and hence HIV infection.¹¹

Prevalence of sexual victimization, by type of accident, inmate sexual history, and orientation, National Inmate Survey, 2008–09

Sexual orientation and history	Prison inmates reporting sexual victimization ^a			Jail inmates reporting sexual victimization ^a		
	Number of inmates ^b	Inmate-on-inmate	Staff sexual misconduct	Number of inmates ^b	Inmate-on-inmate	Staff sexual misconduct
Sexual orientation						
Heterosexual	1,316,000	1.3%	2.5%	706,000	1.1%	1.9%
Bi-sexual, homosexual, or other	114,300	11.2**	6.6**	52,900	7.2**	3.5**
Number of sexual partners						
0–1*	229,800	1.4%	2.4%	121,600	1.20%	1.30%
2–4	181,500	2.3**	2.1	108,800	1.6	1.6
5–10	248,500	2.5**	2.0	141,700	1.5	1.5
11–20	227,600	1.8	2.5	125,200	1.1	1.6
21 or more	509,200	2.2**	3.6**	247,000	1.8**	3.1**
Prior sexual victimization						
Yes	177,000	11.0%**	8.7%**	100,100	7.4%**	6.1%
No*	1,280,400	0.8	2.0	676,900	0.6	1.4

“*Comparison Group. **Difference with comparison group is significant at the 95%-confidence level. ^aPercent of inmates reporting one or more incidents of sexual victimization involving another inmate or facility staff in the past 12 months or since admission to the facility, if less than 12 months ^bEstimated number of inmates at midyear 2008 in prisons and jails represented by NIS-2, excluding inmates under age 18. Estimates have been rounded to the nearest 100.”

Source: U.S. Department of Justice

The Prison Rape Reduction Act of 2002 provides an estimate of the percentage of individuals who are sexually attacked at least once during their incarceration at a national median of 13.6%. Qualitative data gathered from the Human Rights Watch confirms that sexual assault and rape can often be violent, causing abrasions, and tears to the anus, increasing vulnerability of contracting HIV.¹²

The CDC study conducted in the Georgia Department of Corrections facilities also asked an equal number of HIV-positive and HIV-negative inmates questions about sexual activity, injection drug use, and tattooing. Of those who reported having male-male sex during incarceration, 72% reported that it was consensual, and 89% reported having sex with other inmates (as opposed to having sex with officers and staff). Of those reporting consensual sex, 30% reported using a condom or “other improvised barrier methods” (like rubber gloves or plastic wrap). Amongst those who reported exchanging sex for money, food or cigarettes, 21% reported using “improvised barrier methods”, while none reported using a condom. Of those who reported being involved in rape, no barrier methods were used.¹³

Medical Confidentiality

In an April 2006 study, a University of California, San Francisco researcher reported that medical confidentiality in the prison system was “virtually impossible to maintain.” Medical records, especially the results of HIV tests, could be handled by a number of prison staff members including non-medical personnel. A 1988 California Proposition required physicians in correctional facilities to provide lists of inmates known or suspected to have an HIV infection to custodial staff members (e.g., prison guards). Because prison is a closed community, information travels quickly. Those diagnosed with HIV are often segregated or quarantined, or have been denied visiting privileges or certain work assignments such as kitchen work.¹⁴

Segregation

In the early days of the epidemic, the majority of state and federal prison systems segregated HIV-positive inmates as a method of protecting other inmates from infection.¹⁵ Over time, policies regarding HIV-positive inmates changed as advances were made in our knowledge of HIV transmission. Currently, integration of HIV-positive inmates is practiced in the majority of states and considered a best practice in correctional health. However, Alabama and South Carolina have maintained segregation policies. Furthermore, they also enforce mandatory HIV testing of all inmates.¹⁶ If an inmate tests positive, they are immediately segregated, and most will wear an arm badge or other marker signifying their HIV status for the entirety of their sentence.¹⁷

Segregation policies for HIV-positive prisoners present a number of discriminatory practices and human rights violations. These include: involuntary disclosure of HIV status to family, staff, and other inmates; assignment to higher security prisons where segregated HIV units are housed, and at a greater cost to taxpayers; denial of work-release opportunities, which allow prisoners to earn credits to shorten their sentences; and denial of re-entry opportunities, such as employment, which have been shown to reduce recidivism.¹⁸

HIV, Prisoners, and Community Contexts

It is important to recognize that HIV transmission and prevalence in prisons is not an isolated issue, but that linkages exist between prisons, communities and the overall HIV epidemic. As inmates are released back into their communities, they stand to impact the overall health and well-being of entire communities. As more and more inmates are susceptible to HIV infection in prisons, the communities into which they return are also placed at risk. Many inmates return ill-prepared for reintegration and experience great difficulty with health, substance abuse, family, and lack of employment and housing. However, public health and corrections officials are beginning to recognize the tremendous opportunities within corrections to aid in a more successful reintegration process and help communities to better absorb this population. Many have begun to recognize that a comprehensive approach, one that includes early detection and assessment, health education, prevention and treatment, and continuity of care, is critical to reducing the incidence and prevalence of HIV in correctional facilities and our Nation’s communities.¹⁹

Also important is the need for a multi-level, integrated approach in targeting behavioral and institutional issues while addressing structural aspects of problem. Barriers to adequate HIV prevention and care exist on various levels, and all must be addressed in order to effectively combat the problem. On a structural level, reintegration difficulties and hurdles faced by ex-prisoners in receiving benefits or gaining employment (especially true for those with felony convictions), force them into a cycle of recidivism and eventually lead them back into the prison system. Existing health disparities are also deepened as a result of a criminal justice system that reinforces poverty and exclusionary practices that disproportionately affect poor African-American communities.²⁰ Policy-making, therefore, must seek to close the gaps and holes in the system while reducing health disparities that place certain communities and populations at increased vulnerability.

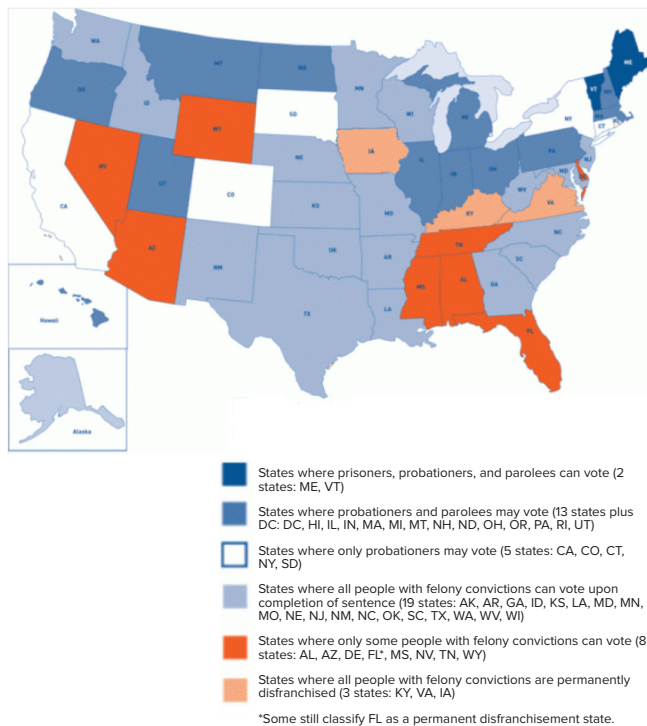
On an institutional level, resistance by correctional facilities to acknowledge and document the problem hinders progress and stifles prevention and education

efforts. Behavioral programs such as sexual health education and condom distribution, therefore, must be matched by institutional changes within correctional facilities, including increased efforts at raising awareness of HIV in prisons and communicating the extent of the problem to inmates and their affected communities.

Barriers to Re-entry

Employment, housing, voting, and even public assistance become increasingly difficult to access following incarceration. In fact, after being convicted of any drug-related offense, students are ineligible for any federal loan, grant, or work assistance for higher education, and all states must abide by this ban.²¹ If a person living with HIV is trying to care for themselves following incarceration, they will confront a number of hurdles in doing so. Aside from the fact that it is still legal to deny employment to formerly incarcerated people in most states, or deny voting to those with felony convictions in some states, those living with HIV face other barriers that can threaten their physical health.²²

Voting rights of former prisoners by state:



Source: ACLU

Though formerly incarcerated people display a diverse set of needs, finding suitable housing often provides the largest obstacle to re-entry.²³ There is currently no national surveillance system to monitor homelessness among people leaving correctional facilities. However, figures from some states provide information on the scope of the problem. In 1997, the California Department of Corrections issued a report that estimated as many as 10% of the state's parolees are homeless on any given day. Furthermore, in areas like Los Angeles and San Francisco the number may be as high as 50%. In 2011, a study conducted by Metraux and Culhane reported that 11% of inmates released from New York State prisons to New York City between 1995 and 1998 entered a homeless shelter within two years of their release.²⁴ Of those former prisoners who do obtain housing, it is likely they are living in impoverished neighborhoods where employment opportunities are limited and crime is abundant.²⁵

Most states prohibit anyone with certain drug felony convictions from federally funded public assistance and food stamps. Since 2004, nine states have dropped this ban, but many will still confront significant challenges in accessing public assistance with their HIV care. Public housing, which allows many low-income people living with HIV to adhere to treatment and stay alive, is not guaranteed to anyone with a criminal record and is completely denied to them in New Mexico and Wyoming. Most states can even deny public housing based on an arrest that never led to a conviction.²⁶

Employment can also be difficult to obtain upon re-entry for a host of reasons, including lack of education or skills, and resistance from employers to higher persons with criminal records. A 2004 study on education level among prison populations reported that over 40% of incarcerated adults have not graduated from high school or completed their GED, compared to only 18% of the general population.²⁷ Furthermore, a survey of more than 3,000 business in four cities (Atlanta, Boston, Detroit, and Los Angeles) found that a large portion of employers were unwilling to hire people with a history of incarceration. Of those surveyed, only 38% would consider hiring ex-offenders; 32% stated they consistently utilized background checks; and another 17% utilized background checks on an inconsistent basis.²⁸

Drug felon ban on TANF and Food Stamps

Adopted federal ban	Opted out of federal ban entirely	Opted out of food stamps and modified ban on TANF	Modified ban by requiring treatment	Modified ban by requiring completion of sentence or treatment	Other modifications*
Alabama Alaska Arizona California Georgia Indiana Kansas Mississippi Missouri Montana Nebraska North Dakota South Dakota Texas Virginia West Virginia Wyoming	Idaho Maine Michigan New Hampshire New Mexico New York Ohio Oklahoma Oregon Pennsylvania** Utah Vermont	Illinois Massachusetts	Colorado Hawaii Iowa Kentucky Nevada South Carolina Tennessee	Connecticut	Arkansas Delaware Florida Louisiana Maryland Minnesota New Jersey North Carolina Rhode Island Washington Wisconsin

*Limiting ban to distribution or sale offenses or requiring submission to drug testing. **The new statute opting out specifically requires the department to follow pre-existing procedures for referral for assessment and treatment if available and appropriate.

Source: The Legal Action Center

User-fees

Many states impose financial obligations, or “user-fees,” on formerly incarcerated people. This debt, and the collection practices associated, creates a series of barriers for former inmates who seek to rebuild their lives post criminal conviction. A few examples include:

- **Florida:** has added more than 20 new categories of financial obligations to the criminal justice process since 1996 and has increased existing fees in both of the last two years. It recently increased court costs for felonies by \$25, required costs of prosecution to be imposed on convicted persons regardless of their ability to pay (minimum \$50 for misdemeanors and \$100 for felonies), and set minimum mandatory recoupment fees for persons who use public defenders at \$50 for misdemeanors and \$100 for felonies.²⁹
- **New York:** has been increasing the size and number of fees since the 1990s.³⁰ In 2008, the Legislature introduced new surcharges for various driving offenses, ranging from \$20 to \$170 dollars.³¹ It also increased existing surcharges, some by as much as \$50.³²
- **North Carolina** in 2009 instituted a \$25 late fee for failure to pay a fine or other court cost on time and a \$20 surcharge to set up an installment payment plan. It also doubled the fee for a failure to appear in court (to \$200), and the fee imposing lab costs on defendants (to \$600).³³

A publication released by the *Brennan Center for Justice at New York University School of Law* analyzed the 15 states with the highest prison populations, which account for 60% of all state criminal filings (Alabama, Arizona, California, Florida, Georgia, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, Texas, and Virginia). The report found: eight of the 15 states suspend driving privileges for missed debt payments, a practice that can make it impossible for people to work and that can lead to new convictions for driving with a suspended license; seven of the states require individuals to pay off criminal justice debt before they can regain their eligibility to vote; in all 15 states, criminal justice debt and associated collection practices can damage credit and interfere with other commitments, such as child support obligations; and, thirteen of the fifteen states also charge poor people public defender fees simply for exercising their constitutional right to counsel, a practice that can push defendants to waive counsel, raising constitutional questions and leading to wrongful convictions, over-incarceration, and significant burdens on the operation of the courts.³⁴

In some states, local government fees and state-wide fees add to “user-fee” burdens.³⁵

Inability to obtain employment also has consequences on a formerly incarcerated person’s ability to repay debts accrued as a result of their incarceration. Lack of a consistent and/or sufficient wage forces many former

inmates to default on debt repayment. This leads to a violation of their parole, and increases the likelihood of re-incarceration.

Conclusion

GMHC will stimulate national discussion about HIV in prisons, the prison-community nexus, and alternative actions that can be pursued to address the problem through brief policy reports and the convening of a national symposium on HIV in prisons. This and subsequent policy reports will highlight different issues and angles involved with HIV in prisons and also focus on the specific activities of GMHC's Prison HIV Prevention Project, a multi-level approach to HIV prevention in America's prisons that addresses the behavioral, institutional, and structural contexts of the problem.

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Notes

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- 3 Ibid.
- 4 Health Resources and Services Administration & Centers for Disease Control and Prevention. (2007). Opening Doors: The HRSA-CDC Corrections Demonstration Project for People Living with HIV/AIDS. Ibid.
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- 9 Centers for Disease Control and Prevention. (2006). HIV Transmission Among Male Inmates in a State Prison System — Georgia, 1992–2005. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5515a1.htm>.
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- 31 Center for Community Alternatives. (2008). Increased Mandatory Surcharges and Crime Victims Assistance Fees. Retrieved from <http://www.communityalternatives.org/pdf/fees%20chart.pdf>; see also N.Y. Veh. & Traf. Law § 1809-e.
- 32 Center for Community Alternatives. "Increased Mandatory Surcharges and Crime Victims Assistance Fees." (2008). <http://www.communityalternatives.org/pdf/fees%20chart.pdf>; see also N.Y. Veh. & Traf. Law § 1809(1)(b)(i) (surcharge for felony conviction increased from \$250 to \$300); § 1809(1)(b)(ii) (surcharge for misdemeanor conviction increased from \$140 to \$175); N.Y. Penal Law § 60.35(1)(a)(iii) (surcharge for conviction of a violation increased from \$75 to \$95).
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- 34 Brennan Center for Justice. (2010). Criminal Justice Debt: A Barrier for Re-entry.
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