HIV Infection among Prisoners

Judy Greenspan

The fear that HIV infection is running rampant among incarcerated populations has led to a scramble for new prison policies. Federal and state prison systems and county jail administrations in the United States have responded to this perceived threat in different and conflicting ways, often to the detriment of the health and welfare of prisoners. Among the issues state lawmakers and corrections officials most frequently debate are mandatory HIV antibody testing, segregation of HIV-infected inmates, and the appropriate medical care and education programs for prison populations. This article examines these issues.

In the United States, there are three levels of prisons. The Federal Bureau of Prisons operates institutions for those convicted of crimes against the federal government. Each state operates facilities housing prisoners convicted of state crimes. Cities and counties operate hundreds of jails used, in general, for short-term incarceration or pretrial detention. There are over 500,000 men and women incarcerated in U.S. institutions, a disproportionate number of whom are Black, Latino, Native American and poor.

While prisoners lose many of their civil rights when incarcerated, the courts have ruled that the most basic constitutional rights must be preserved, including: the right to live free of cruel and inhuman conditions, the right to adequate medical care and sanitation, the right to communication and free speech, and the right to due process. Many state prison systems, however, are understaffed and unsafe for their growing prison populations.

Incidence of HIV Infection in Jails

The incidence of AIDS is increasing in prisons and jails, but this is not necessarily due to an increase in the transmission of HIV within the inmate population. A 1987 survey by the U.S. Department of Justice, National Institute of Justice (NIJ) shows that seroprevalence in prisons has increased 190 percent since 1985. A 1988 study by the American Civil Liberties Union (ACLU) National Prison Project demonstrates a similar rise in HIV infection.

Both studies suggest that increased testing for HIV antibody in prison populations may be one reason for the apparent rise in seroprevalence. According to the NIJ study, "Incidence rates are predictably higher...because of the concentration in inmate populations of persons with histories of high-risk behavior, particularly intravenous drug use." In addition, the studies note that the rise is consistent with the increased incidence of AIDS in the general population. The largest number of AIDS cases—both inside and outside prisons—is concentrated in the Mid-Atlantic states of New York, New Jersey and Pennsylvania.

Many states have conducted their own seroprevalence studies of incoming prisoners. These results range from 0.2 percent in Indiana to 17 percent in New York, with seroprevalence in most states falling below 1 percent. The rates in a given prison or prison system correspond directly to the rates in the non-prison population that feeds that facility or system.

The big unknown for most corrections and public health experts is the rate of HIV transmission within prisons. The Maryland Division of Corrections recently completed two studies on transmission. The most recent study showed an infection rate of 0.5 percent a year. (See Recent Reports below for information on this study.) This low transmission rate, however, does not mean the AIDS incidence in Maryland prisons will decrease.

The results imply that the high rate of HIV infection among Maryland prisoners is due primarily to exposure to the virus prior to incarceration. Transmission studies in both New York and Florida have yielded similar results and medical experts conclude that the risk of transmission of HIV to seronegative I.V. drug users is likely to be much greater outside than inside prison.

To date, there have been no cases of transmission of HIV from a prisoner to a corrections officer.

Testing Policies

In 1987, the Federal Bureau of Prisons (BOP) conducted mandatory intake testing for all federal prisoners over a six-month period. This testing revealed a low seroprevalence of HIV infection, 2.44 percent, among incoming prisoners. (Note that this represents a high seroprevalence rate among the general population.) At present, the federal system does not test on intake except for occasional 10 percent random samplings. BOP does test 60 days prior to release. Prisoners testing positive must inform their spouses or sexual partners as a prerequisite to release from prison. BOP routinely informs parole and probation officers about the antibody status of ex-prisoners.

There is a growing trend among state departments of correction to conduct forced testing of the prison population. More than 13 states now conduct entry testing on all prisoners. In addition, more than 20 states have mandated HIV antibody testing for people convicted of sex and drug-related offenses. A provision of the recently passed federal Health Omnibus Bill enables the federal government to withhold funding from states adopting testing only of those convicted of sex and drug related offenses. The effect of this bill may be to encourage states to adopt mandatory testing programs for all prisoners.

A shrinking number of states test only prisoners who display certain AIDS-related symptoms or who voluntarily request to be tested. Public health advocates strongly support voluntary testing.

Confidentiality of test results is rarely protected in prisons, even in systems where testing is voluntary. Usually, prison staff are told the names of prisoners who have tested positive. In addition, actions such as quarantine or confinement to a single cell, indicate to staff and other prisoners that an inmate is seropositive.

Housing and Medical Care Policies

In the early 1970s, the substandard medical care of prisons was challenged in the courts. In a landmark case, Estelle v. Gamble, a standard was set whereby prison systems must provide some degree of accessible and adequate medical care for prisoners. In the early 1980s, the courts ruled that prison conditions, including housing, must not constitute "cruel and unusual punishment."

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In prisons across the country, prisoners have begun to develop their own AIDS education curriculum. Corrections administrators have not welcomed these attempts. The National Prison Project substantiated complaints including: prisoners at a New Jersey facility that houses a large number of men convicted of sex-related crimes were denied permission to receive copies of the US Surgeon General’s brochure, “Understanding AIDS”; and prisoners in New York State complain that their attempts to organize AIDS awareness programs have been sabotaged by a reluctant prison administration. A prisoner in Massachusetts who prepared an AIDS course curriculum has alleged that he was abruptly transferred to another institution after submitting this document to the warden.

The AIDS Counseling and Education Program (ACE) at Bedford Hills Correctional Facility, a New York state women’s prison, was established by five prisoners. While the program was approved initially by state prison administrators, administration obstacles forced ACE to suspend operations for about a year. Over the past few months, the program—comprised of peer counseling, a buddy support program, pre-and post-test counseling, and classroom presentations—is in full operation.

Conclusion
It is important to realize that the experience of the AIDS epidemic inside prisons reflects the experience outside prisons. There is isolation, fear, pain, loss and depression, as well as healing, support and community. Many health and legal professionals agree that the medical, educational and testing approaches to AIDS in prisons should reflect the approaches used outside. Oppressive conditions, such as overcrowding, quarantine and substandard medical care, may constitute cruel and unusual punishment and should be a prime concern of health providers, educators and corrections administrators.

AIDS is not running rampant in prisons, but misinformation and discrimination are. Health professionals and AIDS services agencies can play an essential role in developing positive AIDS programs for prisons and jails by offering education and counseling services to prisoners and prison systems. In addition, they can facilitate this effort by devoting money and resources to these issues, especially in situations where prison systems are reluctant to support such programs themselves.

Judy Greenspan is the AIDS Information Director of the ACLU National Prison Project, legal advocates dealing with prison conditions. The AIDS Information program provides information and education to prisoners, prison administrators, educators and the media, and monitors government policy on prisons and AIDS.

References

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Request for Submissions and Comments
We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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Juan Rivera: Emotional Reactions

People who are imprisoned often are overcome with a sense of loss. For most of us, though, it’s more than a feeling: we actually lose our wives and children, and even our parents give us up to the care of the state. Under these conditions, freedom is something we never forget. But, once diagnosed with HIV infection or AIDS, prisoners feel condemned to death. And the reality is that most prisoners with AIDS will die in prison.

It is especially hard for HIV-infected prisoners whose families reject them and refuse to communicate with them. A man like this really hurts, because he believes he is going to die and wants the chance to face his family, to tell them that he loves them and to hear that they love him, to explain his illness and the cause of it, and, if he finds it necessary, to express some of the guilt he feels. When this emotional release is denied, these prisoners are at their most vulnerable. They become overwhelmed with depression, loneliness and despair.

At the Greenhaven Correctional Facility in New York, where I have been incarcerated for five years, many prisoners are losing friends to HIV infection. To deal with this situation and an environment that drives prisoners with AIDS to give up on life, we formed the Health Crisis Action Committee (HCAC). Our objective is to improve living conditions for prisoners with HIV infection. We advocate mandatory AIDS education; peer counseling; expanded and better medical care; social workers assigned specifically to HIV-infected prisoners; family therapy groups; new provisions to allow the release of terminally-ill patients; more risk reduction education and counseling for the general population of prisoners; and anti-discrimination measures to protect prisoners.

HCAC adopted a buddy system, developed by women prisoners at the Bedford Hills Correctional Facility, to provide care and support to prisoners with HIV infection. Volunteers among the prisoner’s population provide practical support, such as writing letters, serving as interpreters, and providing information. But, the most significant contribution we offer is the emotional support of listening. To be a good listener and facilitate emotional release is essential to the mental well-being of these men.

HCAC also organizes weekly support groups for HIV-infected prisoners that meet without administrative involvement. The atmosphere of these meetings is comfortable and open. Men speak honestly about homosexuality or I.V. drug use, for example, without the fear of disciplinary actions from the prison administration. Many prisoners are concerned that since prison staff do not understand the lifestyles of prisoners, administrators would secretly denigrate us at such support meetings where we are at our most vulnerable.

In addition to programs for HIV-infected prisoners, programs must be developed for continuous risk-reduction education for the general prison population. But education must be done with a sensitivity to the prison society. For example, although homosexual relationships are a reality of prison life and may once have been overt, they are now secret occurrences. The fear of being labeled HIV-infected by guards and fellow inmates is as great among prisoners as the fear of contracting the virus itself, since prisoners with HIV may be ostracized. This complicates the job of prison educators trying to reach men who engage in homosexual activities.

Some prisoners who continue to practice high-risk activities believe that fate will determine the outcome of their lives. It is common to hear prisoners say, “If I’m gonna get it, I already have it,” or, “If I haven’t already gotten it, I’m not gonna get it.” Many prisoners believe that a cure for AIDS has been developed, but there is a government conspiracy to keep this secret, particularly from so-called undesirables like prisoners.

David Gilbert: Educating Prisoners

AIDS is now the main cause of death in New York state prisons. Prisoners with AIDS average only one-half the survival time, from diagnosis to death, as people with AIDS in New York City. Yet prison administrators continue to ignore the scope of this problem.

New York state prison officials claim that there is no “apparent” spread of HIV among prisoners, that sharing needles and sex are now rare. We prisoners know differently. These activities are common, and the situation is more serious in prisons than on the streets because condoms, needles, and disinfectants are contraband and rarely found in prisons. Unsterilized needles are widely shared and condoms are seldom used.

Peer education, so successful in the control of AIDS in the gay community in San Francisco, is doubly important in prisons, where there is a gut distrust of authorities and professionals, and where the very activities that must be discussed frankly — sex and drugs — are against prison rules. Peer education is also an effective way to ease fears of casual transmission among prisoners and to promote support among inmates for people with AIDS, who are often ostracized and isolated in prisons.

The motivations for sexual and drug-using practices are strong and deep, and people will go to great lengths to deny the dangers involved in these practices unless they are presented with positive alternatives. Many prisoners however, can change high-risk practices when someone they trust works with them in a detailed and painstaking way over time.

Three key criteria define a program that can reach prisoners and make a change. It must be sponsored by an outside organization whose primary work is AIDS and counseling; it must provide extensive prisoner-to-prisoner education; and it must be ongoing, thorough, and persistent.

More specifically, a successful prison AIDS program must: train inmates as AIDS education counselors; develop seminars directed at existing inmate organizations and coordinate these with substance abuse programs; provide pamphlets and programs in languages other than English; provide pre-release HIV transmission counseling; and provide counseling and support for prisoners already infected with HIV.

Juan Rivera is studying computer science while serving a term of 10 years to life at the Greenhaven Correctional Facility in New York. In addition to his involvement in HCAC, he is a member of Hispanics United for Progress, a prison interest group. David Gilbert is a New York State prisoner who founded the Prisoner Education Project on AIDS at Auburn Correctional Facility in 1987. He believes he was transferred to Clinton Correctional Facility as a result of his proposal for an AIDS education program.
Recent Reports


After a three-day conference on AIDS and prisons, experts from 26 countries recommended a variety of measures including: improvement of the overall hygiene and health facilities of prisons; education of prisoners about the risk of HIV infection from sharing needles during intravenous drug use and high-risk sexual behavior; maintenance of the same level and quality of education, treatment, serological testing, and care inside prisons as exists in the community outside of prisons; use of compassionate release for prisoners with AIDS; guidance for prison staff so that HIV-infected prisoners receive humane treatment; and provision of condoms and, perhaps in lower-security institutions, of sterilized needles.


Two recent studies examined HIV seroprevalence and transmission in prison populations. The first found three of 859 predominantly young, white men (0.3 percent) tested HIV antibody positive upon entrance to the Iowa prison system, despite the fact that over 20 percent reported using I.V. drugs and about 5 percent reported engaging in homosexual behavior.

The study population included 363 prisoners, incarcerated for the first time, 389 prisoners who were returning to prison and 107 forensic psychiatric patients. The Iowa researchers predict that as the presence of HIV increases in Iowa, HIV seroprevalence among prisoners will increase.

In the second study, Maryland researchers found that two out of 393 prisoners (0.5 percent) seroconverted while incarcerated over a two-year period. The researchers conclude that while this number is low, the results provide the strongest evidence to date that transmission of HIV does occur in prisons.

In 1985 and 1986, blood samples for HIV analysis were taken during routine blood drawing of all male prisoners entering the Maryland prison system. Of the 2,286 prisoners initially sampled, 422 were still incarcerated in 1987, had completed a demographic survey, and were willing to provide another blood sample at that time. Twenty-nine (6.6 percent) of the 422 were found to be HIV seropositive at the time of incarceration and were not included.


Incarcerated drug users are fairly knowledgeable about HIV infection and transmission; and those who take the most effective steps to avoid transmission are likely to perceive external influences, such as chance or powerful others, rather than themselves as having control over their lives.

Fifty-eight drug-using inmates of a medium-security prison participated in a survey including three scales: an AIDS knowledge profile, a drug-related behavior profile and a test of a person's expectations of locus of control (sense of whether the control in a person's life is external or internal). Researchers classified 27 inmates as intravenous drug users and 31 inmates as nonintravenous drug users. The two groups did not differ significantly by age, educational level or race.

Members of both groups responded correctly to about 60 percent of the factual items relating to AIDS knowledge, including the principal modes of transmission. Fewer than half, however, knew the length of the HIV incubation period or the fact that individuals need not be symptomatic to transmit the virus. Only 26 percent of the I.V. drug users knew that asymptomatic individuals could transmit HIV by sharing contaminated needles.

The researchers classified as maximal risk reduction the substantial changes made by I.V. drug users to avoid contracting HIV: no longer sharing needles or shooting drugs. They classified other changes—cleaning needles, avoiding shooting galleries and reducing I.V. drug use—as partial risk reduction. A higher percentage of partial risk reducers reported daily drug use. The researchers warn that use of partial risk reduction measures, which are not completely effective, may create a false sense of safety and decrease motivation to engage in more appropriate risk reduction.

Finally, the researchers found that maximal risk reducers were more likely to rely on external influences to make decisions than were partial risk reducers, who tended to rely on internal influences.

Next Month

Although the sexual behaviors of bisexual men and gay men may be similar, bisexual men differ in their concerns about their sexuality and HIV infection, and in their reactions to AIDS education and counseling. In the June issue of FOCUS, Jay Paul, PhD, a researcher at the University of California San Francisco and a faculty member of The Institute For Advanced Study of Human Sexuality, offers insights into bisexual identity and AIDS prevention strategies.

In some cultures, bisexual behavior may occur among people who do not identify themselves as either gay or bisexual. In the June issue, Ernesto de la Vega, an AIDS trainer and a staff member of the Brooklyn AIDS Task Force, explores AIDS and bisexuality among Latino men.

FOCUS Changes. We have instituted some major changes to better serve our readers. Our new name more accurately reflects our commitment to exploring relevant counseling issues. We have redesigned our layout to allow for easier reading, and to continue to provide the depth of information our readers have come to expect. We have added a box on page 2 that encourages readers to communicate with us. Larry Cichosz and Joseph Wilson executed these changes.

We have also instituted changes in staffing. Michael Helquist, Editor of FOCUS since its inception in December 1985, is now Founding Editor and Advisor. He will continue his work as a Program Officer for AIDSCOM, a Washington, D.C. group providing AIDS education and training in developing countries. Robert Marks, formerly Assistant Editor, is now Editor.