until it's over AIDS ACTION POLICY FACTS

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Incarcerated Populations and HIV/AIDS

The United States has the second highest rate of incarceration in the world. One in 32 Americans (two million people) is incarcerated. At the end of 1999, nearly 6.3 million adults were incarcerated or on parole. Seventeen percent of people living with HIV/AIDS have spent time in the U.S. correctional system, where the prevalence rate of AIDS is six times higher than in the general public. Incarcerated populations are susceptible to HIV/AIDS as a result of certain high-risk behaviors that are prevalent in correctional facilities. The geographic distribution of HIV/AIDS cases in U.S. prisons is remarkably uneven. Some facilities' HIV rates are as low as one percent, whereas other facilities have rates that approach or exceed 20 percent. In New York City, a voluntary test among incarcerated populations revealed that 22 percent of women and nine percent of men were HIV-positive. Each year, millions of people are released from jails and prisons back into American society. Many ex-offenders do not know their HIV serostatus.

Prisons and jails contain high concentrations of persons living with HIV/AIDS and individuals at great risk of acquiring HIV via injection drug use and sexual activity. Therefore, HIV intervention programs implemented in correctional facilities are among those with the greatest potential to have a substantial impact on the epidemic.

HIV Transmission in Correctional Facilities

The Center for AIDS Prevention Studies at the University of California, San Francisco reports that the majority of HIV-positive prisoners were infected prior to entering jails and prisons. Even so, incarcerated individuals may participate in high-risk activities that can lead to HIV infection during their incarceration. Continued injecting drug use, tattooing, and consensual sexual activity occur in prison settings. Despite the efforts of correctional facility systems to prevent these behaviors, a significant number of people entering correctional facilities continue to engage in high-risk activities that they initiated prior to their incarceration. A history of physical or emotional violence, sexual abuse, or substance dependency increases the likelihood of sexual risk-taking and substance use, behaviors that place incarcerated populations at-risk of HIV transmission. Other high-risk activities, such as rape or coerced sex among inmates, also contribute to HIV transmission inside correctional facilities.

Injection Drug Use

The Office of National Drug Control Policy reports that 60 to 83 percent of inmates have used drugs at some stage of their life—two times the estimated drug use found among the general U.S. population. Sixty-three percent of the individuals entering federal prison in 1997 had been charged with drug-related offenses, and 73 percent reported using illicit drugs during their lifetime. Injection drug use decreases in prison; however, those who continue to use needles are more likely to do so in an unsafe manner. One quarter of prisoners have used needles to inject drugs; nearly half have shared needles. The scarcity of sterile drug paraphernalia leads to needle sharing and increases the likelihood of HIV transmission; however, only 20 percent of jails and prisons make bleach kits available. Risk reduction and HIV education, including providing bleach kits to sterilize injection equipment, are essential to preventing HIV transmission.

Tattooing and Body Piercing

Tattooing also contributes to the spread of HIV in correctional facilities. Incarcerated populations use hollowed out ballpoint pins and pen ink to create tattoos. They may use the same pin to create tattoos on multiple prisoners. A report from California suggests that tattooing was the most prevalent HIV risk-related activity among incarcerated men. Equally risky is body piercing. Similar to tattooing and needle sharing, difficulties arise in obtaining cleaning agents such as bleach to sterilize instruments used in body piercing.

Sexual activity

Sexual activity between inmates, including consensual sex, rape, gang rape, and survival sex, is not uncommon and puts incarcerated populations at exceptional risk of HIV transmission. The Federal Bureau of Prisons reports that up to 30 percent of federal inmates engage in homosexual activity while incarcerated. Recent reports suggest that between one in three and one in 10 inmates is sexually abused in the U.S. prison system. Numerous studies have found that condoms are an essential

component of HIV prevention among all populations. Yet only four percent of jails—specifically the urban jail systems of New York, Washington, D.C., San Francisco, and Philadelphia—make condoms available to inmates. Ten percent of prison systems allow condom distribution.

Populations At-Risk

Communities of color are over-represented in the incarcerated population. Not unlike the communities most affected by HIV, incarcerated people of color are characterized by disproportionate rates of poverty, injection drug use, high-risk sexual activity, and poor access to preventive and primary health care.

Incarcerated women are three times as likely as incarcerated men to be living with AIDS. In the general population, these rates are reversed: men are four times as likely as women to be living with AIDS. One-third of incarcerated women report injection drug use. Additionally, incarcerated women are more likely to have participated in high-risk HIV behavior ranging from unprotected sex to sex work and/or substance use. In a recent study, 57 newly incarcerated women in the rural South were interviewed about their behavior, and almost all of them (97 percent) reported sexual activity with an injection drug user.

In the United States, African-Americans are 10 times more likely than Caucasians to be infected with HIV. Approximately 75 percent of the two million people in prisons and jails are Latino or African-American. African-Americans are almost eight times more likely to be incarcerated in local jails than their Caucasian counterparts. Women of color comprise 60 percent of the female incarcerated population. The Centers for Disease Control and Prevention (CDC) finds that Latino and African-American women of childbearing age now constitute 75 percent of female AIDS cases.

HIV Prevention, Education, and Testing

HIV Prevention and Education
The Centers for Disease Control and Prevention strongly supports HIV prevention education for incarcerated populations and the distribution of both condoms and sterile syringes to individuals in jails and prisons. Currently, condoms and bleach kits are distributed only among a handful of U.S. correctional facilities, while sterile syringes are not distributed at all.

HIV education programs, particularly peer-led programs, are effective because inmates can receive information about HIV transmission and safer sexual and drug using practices from respected members of their community. Recent evidence suggests that peer-led education programs are particularly effective in reaching incarcerated populations with practical information about HIV/AIDS transmission. In 1997, 13 percent of state and federal facilities and three percent of city and county facilities offered peer-led HIV education programs.

Testing and Counseling
Voluntary HIV testing and counseling is a necessary component of any HIV prevention program. The World Health Organization (WHO) supports the provision of voluntary HIV testing for incarcerated populations that includes pre- and post-test counseling. Both the U.S. Department of Justice and WHO oppose mandatory HIV testing of incarcerated populations, finding it unethical, ineffective, and an invasion of privacy. Research has found that incarcerated populations are less likely to participate in HIV testing as a result of their skepticism regarding the confidentiality of test results.

Testing policies for incarcerated populations vary from state to state. Although HIV testing is mandatory upon release from federal prisons, only three state prison systems require testing prior to release. Nineteen states require that incarcerated populations be tested for HIV upon entering prison. State prison systems may also selectively test for HIV according to specific circumstances. In 47 states, tests are performed if there is a clinical indication of HIV/AIDS. In 39 states, HIV tests are administered after an inmate has been involved in a high-risk incident. Routine tests, in which HIV testing occurs unless the inmate refuses, also occur in several locations around the country. Most city and county jail systems have no mandatory testing; while HIV testing does occur, the circumstances vary greatly.

Conclusion

It is challenging to design and implement comprehensive HIV prevention programs for the incarcerated population. Jails and county correctional facilities have a greater number of admissions and discharges than state or federal prisons; therefore, HIV/AIDS services and programs must be flexible and function under significant time constraints.

HIV prevention efforts do require a financial and organizational investment on the part of correctional facilities. Yet HIV prevention with incarcerated populations may save money by minimizing the number of HIV-positive prisoners. Condoms, bleach kits, and clean needles cost much less than the costs of treating HIV-positive inmates. The Correctional HIV Consortium estimates that the cost of caring for an HIV-positive inmate

is $80,396 per year and $105,963 per year for an inmate diagnosed with AIDS.