Male Prisoners and HIV Prevention: A Call for Action Ignored

US prison inmates are disproportionately indigent young men of color. These individuals are severely affected by HIV/AIDS, largely owing to the high-risk behavior that they engage in prior to incarceration.

Researchers and practitioners have issued a call for the importance of offering HIV prevention services in prison settings. However, this call has largely been ignored.

In this article, we outline reasons why these recommendations have been largely ignored, discuss innovative HIV prevention programs that are currently being implemented in prison settings, and offer recommendations for securing support for HIV prevention services in correctional settings. (*Am J Public Health.* 2003;93:759–763)

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IT IS WELL DOCUMENTED that health disparities in disease status between people of color and Whites exist outside of prison walls.[1–3] In the case of HIV/AIDS, epidemiological data clearly show a heavier burden of illness among African American and Latino males than White males.[4] Given the legal mandates on prisons to provide inmates with the same quality and standard of health care available in the community, the potential for equity in access to HIV prevention services is greater in prison than in most local communities where African Americans and Latinos live.

Some practitioners argue that for those infected with HIV, this is a benefit of prison life. These individuals tend to be poor, to lack formal education, to be unemployed prior to incarceration, and to have inadequate legal representation.[5,6] For far too many African American and Latino inmates, prison affords a first-time opportunity to experience a complete medical and dental examination as well as access to HIV prevention, treatment, and care by certified health providers. This demographic profile, together with research that suggests that many men of color engage in HIV risk behavior prior to incarceration,[7] has prompted numerous authors to argue that incarceration offers an ideal opportunity for the delivery of health education programs and especially HIV prevention messages that focus on high-risk behaviors.[7–12]

The purpose of this article is threefold. First, it outlines the reasons why HIV prevention services continue to be underused despite repeated calls for an increase in the availability of these services. Second, it discusses innovative HIV prevention programs that are currently being conducted as part of the federally funded Corrections Demonstration Project. Third, it offers recommendations for generating the necessary support to implement HIV prevention services for men in prison.

HIV/AIDS AMONG MALE PRISONERS

At the close of 2001, 1.4 million individuals were incarcerated in US federal or state adult prison systems.[13] This excludes the approximately 700 000 jail inmates and the 4.6 million additional individuals who were in some form of protective custody via probation (a sentence of correctional supervision in the community given to criminal offenders) or parole (a period of

conditional supervision in the community after a prison term).[14–16] The correctional population has grown almost fourfold in the last 20 years,[16] largely owing to the US government's "War on Drugs" and mandatory sentencing laws for drug-related offenses. The dramatically increasing inmate population has important implications for US prison systems as they seek to provide medical and mental health services for this population.

It is well known to the general public that prison populations comprise a disproportionate number of disenfranchised individuals, the overwhelming majority of whom are young African American and Latino men.[9] In both the free world and within the microcosm of society that prisons represent, these individuals disproportionately experience poor health outcomes as well as a high prevalence of HIV/AIDS and other infectious diseases, owing to numerous barriers and structural constraints. Among African American men aged 25 through 44 years, AIDS is the single largest cause of death, and over one half of these deaths are due to drug-related transmission of the virus.[17,18]

Although it is clear that most of these infections occurred in the community prior to incarceration, the lack of implementation of risk reduction programs in these settings is a missed opportunity. It is estimated that 25% of those living with HIV pass through correctional facilities each year.[19] The seriousness of the problem of HIV/AIDS among incarcerated populations is reflected in the confirmed AIDS case rate among prison inmates (0.52%), which is 4 times the rate in the US general population (0.13%).[20] Moreover, the number of confirmed AIDS cases varies greatly by prison system, with 56% of inmates with AIDS residing in 4 states: New York, Texas, Florida, and Maryland.[20] Given the demographic characteristics of those who are incarcerated, it is not surprising that many of the inmates who are infected with HIV/AIDS are young men of color. These numbers exceed the number of Black and Latino males in undergraduate colleges and universities. This is a sad commentary for African Americans and Latinos seeking to live the American dream.

In the free world, despite their relatively poor health status, men of color have been noticeably absent from the use of health care services, perhaps owing to a lack of access to care, a lack of adequate health insurance, distrust of the medical establishment, competing priorities, environmental stress, stoic attitudes, or a combination of these factors. Moreover, racial discrimination certainly serves as a barrier to health care, not only in the community but also in correctional facilities. Anecdotal evidence suggests that White inmates receive more favorable response to "sick call" requests and less strenuous prison work details than do African American inmates. Despite inmate claims of racial discrimination, inmates are the only segment of the US population with a constitutional right to adequate medical care.[21] Thus, the period of incarceration offers a unique opportunity for men of color to access HIV prevention services and other medical services that they might otherwise find difficult to obtain.

LIMITED ACCESS TO HIV PREVENTION SERVICES IN PRISON

It is well understood that many offenders engage in high-risk behavior before they are incarcerated. The lifestyles of many inmates prior to incarceration include unprotected sexual intercourse, drug and alcohol abuse, poverty, homelessness, undereducation, and unemployment—all of which are associated with risk of HIV/AIDS. For example, Wohl and colleagues[7] found that among men with a history of incarceration, high-risk behaviors are more common in the community than during incarceration.

Nevertheless, research with ex-offenders supports the contention that high-risk behavior occurs inside prisons as well.[7] However, Black and White inmates may ascribe different meanings to the sexual encounters that occur during incarceration, and these meanings have important implications for their risk taking. For example, for many Black inmates, same-sex encounters during incarceration are defined as situational in nature and therefore not an indication of sustained sexual orientation. Often, these individuals do not consider themselves to be gay or bisexual and may not respond to HIV prevention messages that target men who are openly gay or bisexual. Conversely, for White inmates, having sexual encounters in prison often is an acknowledgment of being either gay or bisexual, even upon release. If these provocative perceptions are accurate, different intervention strategies are needed to reduce the harm associated with risky sexual encounters.

Supporting this contention is research that suggests that African American men who have sex with men tend to be less open about their sexual orientation and to have more female sexual partners than White men who have sex with men.[22] Compounding these interactive dynamics is the issue of sexual encounters without protective barriers. Only 2 state prison systems (Mississippi and Vermont) and 5 city/county jail systems (New York, Philadelphia, San Francisco, Los Angeles, and Washington) make condoms available to their male inmate population. Although the use of harm reduction strategies (e.g., condom and bleach availability) in correctional facilities is increasingly endorsed worldwide and by the World Health Organization (WHO), US jail and prison systems continue to offer only minimal endorsement for such policies and practices.[23] Specifically, the WHO advances the following position:

> Since penetrative sexual intercourse occurs, in prisons, even when prohibited, condoms should be made available to prisoners throughout their period of detention. In countries where bleach is available to injecting drug users in the community, diluted bleach (e.g. sodium hypochlorite solution) or another effective veridical agent, together with specific detailed instructions on cleaning injecting equipment, should be made available in prisons housing injecting drug users or where tattooing or skin piercing occurs. In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this.[23]

Numerous prevention scientists have suggested that correctional facilities offer an ideal opportunity for implementing HIV

prevention interventions.[7–12] In contrast to when they were in the community, incarcerated individuals are logistically easier to reach with prevention and education programs; they are supposedly encountering fewer situations of risk (e.g., sex while under the influence of drugs or alcohol, anonymous sex); they are sometimes reevaluating their life choices; they have access to medical and mental health services for little or no cost; and they have fewer demands being made on their time. Nevertheless, systematically evaluated HIV prevention programs in correctional settings have been slow to develop over the past 2 decades.

The relatively slow development and implementation of HIV prevention programs in prison settings has occurred for several reasons. First, there is a duality and cultural divide between public health and corrections. The culture of corrections focuses on promoting the custody and security of inmates; among some correctional officials there is apathy toward inmates' health and well-being. Even when there is an interest in medical treatment and care, prevention services are often at the bottom of the list of priorities. Public health, on the other hand, holds dear its focus on primary, secondary, and tertiary prevention of disease. In the face of budget constraints and the existence of competing programs, it is clear how correctional officials may not consider HIV prevention programs to be important enough for funding, although public health professionals remain adamant in support of such programs.

Additionally, many prison officials are slow to embrace HIV prevention messages (e.g., the consistent use of condoms, the use of sterile syringes) that they perceive as directly contradicting policies that prohibit anal sex, condom use, and injection drug use in prisons. However, this concern can be addressed by delivering HIV prevention messages that increase knowledge and awareness surrounding HIV/AIDS in the context of discussions of *postrelease* high-risk behavior.

Additionally, there continues to be stigma associated with discussing HIV/AIDS, particularly in correctional settings where many HIV risk behaviors (e.g., injection drug use, unprotected anal intercourse) are disallowed. Inmates may fear that by expressing an open interest in learning about HIV prevention strategies or requesting testing, they are openly admitting to engaging in homosexual or drug use behavior, which may cause others to think negatively of them. Moreover, inmates may fear being tested because of the stigma associated with having a positive test result. Confidentiality is very difficult to protect in a closed system such as a prison, which might prompt an inmate to choose to learn of his HIV serostatus only after his release.

Many prison officials contend with a lack of resources for implementing HIV prevention programs even though there is an awareness that such programs are needed. As mentioned earlier, departments of corrections are facing budget cutbacks, which means that "nonessential programming" such as HIV prevention programs are the first to be eliminated. Moreover, programs that interfere with security procedures (e.g., lockdowns and the need for staff escorts) may seem cumbersome to prison officials who are seeking solutions to budget shortfalls. Developing programs that consider the logistical constraints of correctional settings is therefore of the utmost importance. Despite these barriers, some prison officials recognize the value of delivering HIV education programs and have welcomed these services into their facilities. Several examples of this are illustrated below.

INNOVATIVE HIV PREVENTION PROGRAMS IN US PRISONS

One national initiative that addresses the dearth of HIV prevention services in prisons is the Corrections Demonstration Project of the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration. One city and 6 state departments of public health (Chicago, California, Florida, Georgia, Massachusetts, New Jersey, and New York State) were awarded funding under this initiative. In addition, an Evaluation and Program Support Center at Emory University's Rollins School of Public Health in Atlanta, Ga, in collaboration with Abt Associates Inc of Cambridge, Mass, was funded by the Health Resources Services Administration. The 7 grantees partnered with individual jails, prisons, juvenile facilities, and transitional facilities and contracted with local evaluators and community-based organizations to develop and evaluate programs for HIV-infected inmates on the basis of local circumstances, existing services, and established relationships between the collaborators.[24,25] The Evaluation and Program Support Center was charged with documenting the services provided by the grantees and the process of program development and implementation by overseeing the design of a scientifically sound cross-site evaluation of these projects on the basis of shared instruments.[26]

Under the Corrections Demonstration Project, 4 state grantees (California, Florida, New Jersey, and New York) are implementing new HIV prevention/peer education programs in prison settings (see Table 1). These services, primarily delivered by community-based organizations, range from weekly new inmate orientation to describe the available HIV prevention services (New Jersey) to prerelease health education sessions for inmates who are returning to the community (California). Three of the grantees (California, New Jersey, and New York) are offering peer educator training to inmates in the area of HIV prevention; the services offered target both HIV-positive and HIV-negative inmates. This demonstration project offers an opportunity for grantees to build new relationships with correctional officials and medical staff and to implement the needed services in prisons without placing a burden on correctional budgets.

GENERATING SUPPORT FOR HIV PREVENTION IN PRISONS

Bold and progressive risk reduction policy action is required by correctional policymakers to advance the health and well-being of incarcerated populations and, ultimately, the community at large. Examples of such policy initiatives are as follows.

1. Adoption of mandatory HIV testing by state prison systems. Although this position runs

TABLE 1—Centers for Disease Control and Prevention/Health Resources Services Administration Corrections Demonstration Project: HIV Prevention/Peer Education Programs in Prisons

State Grantee	Services Provided	No. of Male Facilities	Contracted Providers
California	Prerelease health education via single sessions and multiple-session series	1	Centerforce
	Peer educator training		
Florida	HIV prevention education via single sessions and multiple-session series	7	University of Miami AIDS Clinical Research Unit
	HIV pre- and posttest counseling		
New Jersey	Weekly new inmate orientation sessions to describe available services	11	AIDS Coalition of Southern New Jersey Hyacinth AIDS Foundation
	Multiple-session series on HIV, sexually transmitted disease, and tuberculosis prevention, treatment, and risk reduction		North Jersey AIDS Alliance South Jersey AIDS Alliance Visiting Nurses Association of New Jersey University of Medicine and Dentistry of New Jersey
	Support group for HIV-infected inmates		Henry J. Austin Health Center Inc
	Peer educator training		New Jersey Association on Corrections
New York	Single sessions and multiple-session series of HIV prevention education	5	New York State Department of Health, AIDS Institute The Altamont Program
	Peer educator training		The AIDS Council of Northeastern New York

counter to the WHO's support of voluntary testing,[23] it is highly recommended. It is of paramount importance that this testing only be offered to inmates in a nonprejudicial setting by health personnel who can ensure medical confidentiality. Currently, only 16 states and the federal prison system have such mandatory testing. Mandatory testing will reveal numerous undiagnosed cases and facilitate case finding and subsequent treatment. The surfacing of new cases will, however, have budgetary implications as it relates to the provision of treatment. Many state departments of corrections have external health care providers servicing the prison population. These providers often have a capitation formula for health care services rendered and fear that the identification of new cases will have a negative financial impact on their "bottom line." State legislatures must be taught that prevention is more cost-effective than medical intervention. The legislatures must increase funding support to state departments of corrections to accommodate the new HIV cases that will result from a mandatory testing policy.

2. An increase in initiatives that reinforce continuity of care for HIV-infected inmates returning to community settings. Some correctional systems supply released inmates returning to their community with only 5 days' medication. This is woefully inadequate. Continuity of care for African American and Latino offenders is especially daunting, given their low rates of health insurance. Deliberate policy action is needed to extend the responsibility for medical treatment from the prison to community settings. Most state correctional systems are divorced of this responsibility once the inmate is released, and parole departments typically do not have strong articulation agreements with local and county health departments. Interagency collaboration between departments of corrections and municipal health providers will need to be legislated to ensure such articulation.

3. Improved opportunities for community-based organizations and AIDS service organizations to gain access to incarcerated populations for delivery of HIV/AIDS education and prevention programs. Many state departments of corrections and local jails allow these organizations to offer prevention programs, but prevention specialists are frequently humiliated and negatively stereotyped by correctional officers for the positive service they provide. There is thus an apparent need for increased staff training and education designed to modify attitudes about HIV among correctional personnel. Such in-service training should be required of all correctional staff and administrators as a certification for employment.

CONCLUSIONS

The lack of consistent, effective HIV prevention education targeting male prisoners of color is merely a symptom of the larger problem of incarcerated men of color having relatively poor health status. The onus of responsibility is shared among the inmates, correctional officials, public health officials, and community service providers who must work collaboratively to establish a seamless system of prevention and treatment services that transcends prison walls. This type of collaboration faces barriers such as the competing missions of health professions and corrections officials, apathetic attitudes toward inmate health, lack of resources, and many logistical barriers (e.g., inmate movement within a correctional facility). Despite these barriers, there is a need to heed the call for action issued by researchers and practitioners alike for the delivery of effective HIV prevention education behind prison walls. ■

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Contributors

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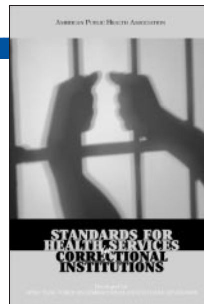

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