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Social Policy, Imperiled Communities, and HIV/AIDS Transmission in Prisons: A Call For Zero Tolerance

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Abstract

HIV/AIDS and African-American male imprisonment contribute to the destruction of African-American communities. African-American men and HIV/AIDS are disproportionately represented throughout all sectors of the criminal justice industry, including the juvenile justice system. The criminal justice system contributes to unacceptably high African-American male imprisonment rates and HIV prevalence directly via the 'war on drugs' and lax enforcement of institutional policy among other things, and indirectly through perpetuation of economic hardship which further exacerbates imprisonment rates, thus closing the loop of a vicious cycle of revolving prison doors and HIV contraction. This article briefly introduces surrounding socio-political issues that contextualizes the ensuing discussion. It then considers the State of Georgia to explore issues of incidence and how HIV transmission occurs in prisons, uses Prison Rape Elimination Act data to shed light on accountability issues and the degree to which the nature of sex in prisons is romantic or violent, and concludes by offering overarching solutions and encouraging action in response to the myriad associated problems.

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Introduction: social context leading to incarceration and HIV contraction

African-American communities have been damaged historically in the United States by health, economic, corrections, and other social policies that have severely compromised the ability of families living at low or minimum wage to survive, thrive and remain united [1,2]. These policies have affirmatively excluded the poor, most significantly poor, single adults that are disproportionately African-American men, and have had a cumulative effect on individual and family poverty [3]. African-American families with children have a 29% poverty rate, 3.5 times higher than white families. In addition to economic policies that lead to high poverty rates, and public housing regulation restrictions related to felony convictions that effectively bar family reunification, on which elaborate discussion of both are beyond the scope of this paper but worth mentioning, incarceration is another form of family separation which also directly contributes to HIV contraction [4]. While African-Americans comprise 17% of the national youth population, African-American youth represent 27% of all drug violation arrests, and comprise 48% of youth detained for drug offenses [5]. Yet no evidence exists that suggests African-American youth possess drugs at higher rates than other youth, except the tautological argument that if African-American youth are being arrested at higher rates, then they must possess drugs at higher rates. Indeed, the system (the disproportionate imprisonment of African-American men) of segregation from family and community begins early and continues throughout adulthood [6].

Complicit in the destruction of African-American families and communities are the systems of human bondage now seen in jails

and prisons in the United States[1]. Incarceration has yielded enormous financial gains for the criminal justice system in the US, despite the lack of funding available to government systems, such as education and labor, which may help to prevent individuals from entry into the penal system. With the advent of the War on Drugs[2] [7,8], a prohibition campaign undertaken by the US government with the assistance of participating countries, and mandatory sentencing laws, African-American men have finally found affirmative inclusion but unfortunately it is within the confines of a cellblock. The War on Drugs has become the *de facto* war on African-American communities, and poverty may be the driving factor. The arrest rates for drug violations dramatically rose from 661,000 in 1983 to 1,126,300 in 1993; and those who were adversely affected were people of color, especially African-American men [9]. Thus, during this same time frame, the number of white prison inmates rose 163%, whereas the number of African-American inmates increased 217% [9]. Currently, similar trends continue to occur as incarceration rates increase and the latest and perhaps most severe health threat to the very survival of African-American families and communities has arrived in the form of HIV/AIDS.

This system of segregation has interpersonal side effects: interrupted sexual partnerships [10] and increased levels of sexually transmitted infections (STIs), among other things [5]. Research indicates that lower gender ratios of men to women in African-American communities may be a result of prison sentencing, which increases rates of teenage pregnancy, syphilis, and gonorrhea [11]. While no studies currently explore the explicit relationship between lower gender ratios of men to women and an increase in the transmission of HIV, the increasing rates of other STIs in African-American communities is suggestive [12]. Research does support the contention that the loss of African-American men from communities has lowered the ratio of African-American men to women, and has disrupted sexual partnerships and networks in ways that exacerbate STI transmission and likely HIV infection [13,14]. AIDS is the leading cause of death among 25–44 year old African-American men and HIV rates are rapidly rising among heterosexual African-American women [15].

These sociocultural, historical, and political issues have been given some attention before focusing on HIV in prisons specifically, in order to accurately represent the complexities of HIV transmission and related matters. Much of the HIV/Corrections discourse to date attempts to address HIV contraction outside of a necessary sociopolitical context that is vitally important for clearly and comprehensively understanding how and why HIV transmission occurs. To consider transmission issues in a silo fashion oversimplifies the challenges faced in reducing morbidity and mortality resulting from HIV/AIDS. What is missing from the literature is a comprehensive discussion of sero-conversion in prisons that takes into account and considers, simultaneously, the pre and post prison conditions, policies, and issues that lead up to contraction, and the aftermath that puts others at risk [16]. It is not the intent of the authors to provide an elaborate and detailed explanation of every factor that comes into play when considering HIV in marginalized communities. Many of these factors have been considered in great detail elsewhere. Rather, it is the intent of the authors to present a much needed holistic perspective that centers on the description and characterization of HIV transmission in prisons without ignoring the integral surrounding issues.

HIV transmission: issues of incidence and the case of Georgia

There have been increasing investments in the study of HIV/AIDS incidence and transmission among inmates in jail and/or prison, where incidence refers to the risk of seroconverting from negative to positive within a specified period of time and is distinguished from prevalence, which is the total number of HIV cases in a population at a given time. While the true incidence of HIV among inmates is unclear due to the inability to access reliable data, it is

[1] In the USA, jail is the term commonly used for a place for the confinement of persons in lawful detention, especially persons awaiting trial under local jurisdiction, while prisons are a place for the confinement of persons convicted of crimes.

[2] Intended to reduce the illegal drug trade – to curb supply and diminish demand for certain psychoactive substances deemed 'harmful or undesirable' by the government.

known that the incidence is high and that any transmission of HIV infection is unacceptable. Additionally, a focus on incidence may be misleading, as known seroconverters in correctional systems probably underestimate the actual number of incident cases of HIV for a number of reasons, primarily that both testing prompted by symptomology and voluntarily requested testing tend to underestimate actual cases.

Symptomatic seroconversions, which might prompt HIV testing in a medical setting, occur in only about half of all seroconversion episodes. Onset of AIDS-defining illness or other symptoms of more advanced HIV infection pertains only to chronically infected persons and is likely to manifest, on average, between 5 and 15 years after infection occurs, which is apt to be longer than the period of continuous incarceration for a majority of inmates. Similarly, voluntary testing is probably even less appealing to the incarcerated than to the general population, for which a large fraction (25%) [17] of people estimated to be HIV-infected have not been tested. The discrepancy between known seroconversions and actual seroconversions might be estimated if a similar correctional setting implemented periodic, mandatory HIV screening, as is performed, for example, among military populations.

Furthermore, prevalence may be of greater importance [18] than incidence or transmission rates as, even when prevalence is low, social structures and mixing patterns become relatively more important determinants of incidence rates, particularly in settings where ulcerative STIs are not treated quickly. Where access to care is compromised, the risk of infection from relatively few exposures to a chronic carrier of HIV is exacerbated. There is grave concern over the potential for transmission of HIV in prisons and tremendous resources are being invested in providing testing for the virus among those incarcerated. Incidence data from the State of Georgia analyzed by the Centers for Disease Control relative to HIV/AIDS recently appeared in the Morbidity and Mortality Weekly Report [19].

In the Georgia study, two or three facilities account for more than two-thirds of the transmission episodes from among 73 facilities in the system, including 31 facilities in which the inmates who became infected were housed at the time the study was conducted. While the Georgia Department of Corrections concluded that the findings should prompt concern, not complacency, CDC's commentary makes no mention of the clustering of cases by facility even though it could be an informative clue about the factors associated with correctional facility transmission and, therefore, might have motivated thorough investigation or analysis of the unique characteristics of those high-risk settings. Instead, a part of the solution proposed by the Georgia Department of Corrections is to provide separate housing for HIV-infected inmates as an HIV prevention strategy for reducing 'other sexually transmitted, opportunistic, and blood borne infections.' The failure to analyze and explain a grossly inequitable distribution of transmission episodes belies the whole discussion of 'separate housing' as a prevention strategy since the situations in which transmissions occur are already 'separately housed'. The strategy itself is questionable given the strict and authoritative control that prisons are supposed to provide on a daily basis. By inference there may be some implicit admission that sex occurs in prisons and that the Department is incapable of monitoring these occurrences. Possibilities for such foci of infection include: environmental factors that facilitate sex, unusually lax enforcement of prohibitions on sex between inmates and all others, purposefully tacit tolerance, encouragement of sexual activity for the instrumental purpose of helping to maintain order, or a small number or cluster of predatory 'core transmitters'.

With regard to inmates, the prevalence of rape and the tolerance of highly predatory individuals or ritualized gang rape is a readily-investigated anthropological question, given the restriction to a small number of unique facilities. However, the prevalence of stable, pair-bonded quasi-marriage relationships as a basis for self-organized sociopolitical stability within and among male inmate populations argues against a small number of sexual predators, especially among the 'long-termers'. Additionally, it seems unsurprising that sex with staff receives no attention in the discussion of results or analysis of their implications, even though sex between staff and inmates is almost equally prevalent (reported, respectively, by 54% and 59% of the cases and 15% and 12% of controls). Moreover, staff are not tested for HIV as a correlate of employ-

ment; and nationwide data discussed in the accompanying notes on non-consensual sex in prison show that staff and inmates play equal roles as sexual predators in correctional facilities.

Accountability and the nature of sex in prisons and jails

Constitutionally, residents in criminal justice facilities are protected from 'cruel and unusual punishment' and this should cover freedom from unintended infection since inmates do not have complete control over their bodies and they are not permitted to protect themselves. No other 'total institution' besides prison and jail has equal potential to control all the environmental and behavioral correlates of sexual transmission of agents such as HIV and HCV/Hbv. That capability transforms every episode of HIV transmission into evidence of the failure of the State to provide for the safety and security of its totally dependent charges. Guidelines, practices, and structure can be so thoroughly managed as to control virtually all aspects of the physical and psychosocial environment.

Despite the capacity to curb unsanctioned behavior and mitigate evident risks to health and safety, correctional facilities, in their custodial role, tolerate conditions, rules, and practices that permit or even sometimes sanction preventable harm. To illustrate this failure, consider the best available data on non-consensual sex in correctional facilities from the US Bureau of Justice Statistics (BJS), using data from routine reporting under the Prison Rape Elimination Act (PREA). The most recent (September 2006) report (based on data from 2005) [20] shows that despite equal responsibility for sexual violence and misconduct shared by staff and inmates, responses to and interpretations of the same sorts of incidents differ depending on whether the perpetrator is a staff member or an inmate.

The level of staff involvement in perpetrating rather than curbing sexual violence and misconduct is radically at odds with the asymmetrical role of staff and inmates. About 38% of the reported allegations of sexual violence involved staff sexual misconduct; 35% inmate-on-inmate nonconsensual sexual acts; 17% staff sexual harassment; and 10% inmate-on-inmate abusive sexual contact. Most substantiated incidents of staff sexual misconduct and harassment involved correctional officers – 57% of the incidents in prisons, 89% of those in jails. In prisons, nearly 16% of perpetrators of staff misconduct were maintenance and other facility support staff, including groundskeepers, janitors, cooks, and drivers. An additional 10% of perpetrators in prisons were medical or health care staff, including counselors, doctors, dentists, nurses, psychologists, psychiatrists, social workers, and medical assistants.

The former are charged with affecting the minimal institutional responsibility of equitably protecting the health and safety of residents over whom they exercise virtually total and arbitrary authority. Behavior at variance with the role and responsibility of the institution's official agents is compounded by every departure from equitable management of, and responses to, the same sorts of incidents, depending on whether the perpetrator is a staff member or an inmate, which is evident in the operational definitions of associated terms and designations. Perhaps no asymmetry better – and more bizarrely – underscores the absence of just, equitable, and humane principles and practices than the government's discrepant interpretation of the 'romantic' significance of inmate–inmate and staff–inmate sexual interactions.

Equivalent rates of physical force imposed by inmates and staff are viewed differently: when an incident is staff perpetrated, absence of physical force by staff is associated with 'romance' – a motivation implicated in two thirds of incidents of substantiated staff sexual misconduct reported in 2005. This categorization is interpreted by prison systems based on guidelines outlined by the BJS with authorization from the PREA. Although legally all sexual relationships between staff and inmates are considered nonconsensual, fewer than 15% of the substantiated incidents involved physical force, defined as 'abuse of power or pressure by staff'. Likewise, however, in most substantiated incidents of inmate-on-inmate sexual violence, victims were not physically injured (85%). Nevertheless, staff–inmate sex is considered 'romantic', whereas inmate–inmate sex is considered, by definition, coerced. If anything, this contradicts the unavoidable power discrepancy inherent in staff–

inmate relationships, but is not necessarily a component of inmate–inmate sex.

Medical or mental health services are asymmetrically provided to most victims of inmate–inmate nonconsensual sex, but only to a minority of victims of staff sexual misconduct. In most substantiated incidents of staff sexual misconduct (74%), victims received no medical follow up, counseling, or mental health treatment. In contrast, victims received medical attention, counseling or mental health treatment in more than two-thirds of the incidents of inmate–inmate nonconsensual sexual acts. Additionally, staff sexual misconduct represents white perpetrators preying on victims of color, where the majority of prisoners in jails and prisons are overwhelmingly persons of color. In prisons, 69% of the perpetrators of sexual misconduct and harassment by staff were white, 25% black, and 3% Hispanic. In jails, 74% of the perpetrators were white, 21% black, and 4% Hispanic. In contrast, of all state and federal prisoners, 40% are white, 41.6% are black, and 15.5% Hispanic [21]. Moreover, emphasizing the failure of systems to protect inmates and their tacit or purposeful facilitation of illicit sexual encounters, inmate perpetrators most often commit incidents in the victim's cell or room, raising the question of how they gain access while under surveillance or other forms of controlled movement.

A call to action: moving toward solutions

Imprisonment, in many cases a result of crushing poverty and continued unemployment or underemployment, further economically disenfranchises releasees as they witness significant barriers to reintegration into their families, difficulty in securing profitable jobs (or even the same jobs that they held), and many other obstacles [22]. Also, such high imprisonment rates drain men out of communities, thus potentially contributing to increased numbers of un-incarcerated men who have multiple sexual partners, which increases their risk of HIV contraction and transmission [23,24]. Prisons and jails offer criminal justice administrators, public health professionals, community institutions, and other key stakeholders an opportunity to fulfill their duty to reduce the burden of HIV/AIDS on African-American communities and the country as a whole by instituting prison policies that provide an environment in which inmates can protect themselves and are protected; through the implementation of HIV prevention programs that offer education and practical risk reduction strategies; by critically examining and addressing the disparities in arrest, prosecution, and incarceration rates that fall so heavily on black communities; by making healthcare accessible to all poor and indigent people; and through economic policies that substantively and in real time, alleviate poverty in black communities [22,25]. These contextual challenges promote health disparities, including HIV that then circulates in communities, on to prisons, and back out again [26]. Many countries around the world have already instituted prevention policies [27,28] and some such programs have already shown promise in moving toward best practices models, like the New South Wales condom distribution in prisons program.

Insofar as prisons have the capacity to implement policies and procedures that preclude transmitting behaviors, every transmission event measures their failure to discharge their essential and most fundamental ethical and social responsibilities. Consequently, there must be an insistence on zero tolerance for HIV transmission in jails and prisons.

Prisons and those that set policy must develop systems that provide inmates with the means to protect themselves if they have sex, use drugs, or engage in tattooing (condom distribution, needle exchange). Otherwise, prisons need to securely police inmates to enforce their own proscriptions against sex, drug use, and tattooing. Furthermore, prisons must police themselves and weed out practices and individuals not proven to protect inmates and the greater society. National standards would provide assistance in evaluating and removing individuals and practices that perpetuate the problems currently faced by corrections institutions.

All interventions and standards aside, prison rape, the spread of infectious diseases, and the transmission of HIV/AIDS, are reflections of the very worst that a society can become when it isolates individuals in prison and then alienates them from every source of support that they could use. Infection with

HIV/AIDS may well be a sentence to enhanced morbidity and even early death without adequate early access to treatment. But simply returning to a community without a home, access to affordable healthcare, employment at a livable wage, and other social necessities, inflicts tremendous morbidity and ultimately mortality not only to the individual but to children, families and communities [29,30]. The destruction of hope, the death of dreams, and subsequent risky behavior borne out of despair compromises not only the inmate. A bitter irony exists in a nation where no health care is affirmatively guaranteed for poor men in communities unless and until they become afflicted with life threatening diseases such as HIV/AIDS. There are some strategies that are targeted to ameliorate HIV/AIDS among high risk populations, such as Project Unshackle: Confronting HIV and Mass Imprisonment [31], which is a groundbreaking effort to launch educational campaigns at the intersection of HIV/AIDS and mass imprisonment in the United States and which includes formerly incarcerated people, grassroots leaders, researchers, HIV policy advocates, prison reform and social justice organizers, coalition-building veterans and other allies working together to bridge the nexus between HIV and incarceration. However, given that prisons are the sites where so many African-American men receive health care it is reasonable to conclude that prevention of the transfer of disease would be a joint venture between the Departments of Criminal Justice (jail and prison) and Public Health, and that efforts equal to the $1.1 billion recently allocated by the Department of Health & Human Services be invested in the health of poor men before any contact with the criminal justice system to prevent poor health, including infectious diseases.

The historical, underlying, and persistent effects of racism, discrimination, and economic hardship in many ways mediate increased imprisonment of poor African-American men in part due to the advent of the 'war on drugs' and the negative outcomes that have resulted. The likelihood of not having been afforded prevention healthcare, coupled with subsistence in ill-suited environments increases the possibility that upon arrival to jail or prison, these men may indeed already have HIV/AIDS and should be tested at the door using an opt out system like the one proposed in the Stop AIDS in Prison Act of 2007 recently approved by the House Judiciary Committee [32]. Once there, if not infected, the inability of corrections institutions to protect its patrons, and police itself, along with its proscription of prisoners from protecting themselves puts these men at further risk for HIV or other disease contraction. Once released, barriers to reentry, including separation from family due to public housing regulations, prior records preventing suitable job attainment, and other factors, exacerbates economic hardship which increases the likelihood of a return to the criminal justice system [33].

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