Aids in prisons

Introduction

The Aids pandemic has generated a great deal of discussion and controversy regarding:

- the impact on the prison system;
- the proper management (prevention and control) of HIV infection in prison; and
- the risk of transmission to fellow inmates, correctional staff (medical and line personnel and counsellors) and their families.

The purpose of this article is to review and analyse the incidence of the disease in prison systems and some of the management strategies that have been developed to cope with the problem.

Transmission of HIV within prison: two views

Although we stand on the brink of the second decade of the Aids pandemic, there is still relatively little known about the prevalence and transmission of the virus in prison. Conolly and Potter (1990:158) refer in particular to three important questions which have not yet been adequately answered:

- How many prisoners are infected and engage in high-risk behaviour?

* This article is based on a paper delivered at the colloquium ‘Aids in prison’, CSIR Conference Centre, Pretoria – 8 September 1992.
Has Aids education in prison helped inmates to become aware of the dangers and to protect themselves from contracting the disease?

Are prisons ‘incubators’ for HIV?

In addressing these questions, two different schools of thought have emerged.

On the one hand it is argued that prison populations are predominantly drawn from younger, sexually active groups. Correctional institutions contain a disproportionate number of people who are likely to be at risk of HIV infection, for example:

- People who inject drugs in the community may continue to do so in prison, where sterile injection equipment is not always available, and where it is likely that needles and syringes will be shared and not properly disinfected.
- Men who have sex with men outside prison may continue to do so in prison, where condoms are not available in all systems. Men who do not engage in this practice before admission to prison may do so in captivity because of the deprivation of heterosexual relations.
- Prisoners tattooing with improvised and unsterilised equipment run the risk of transmission of HIV.
- There is potential for transmission through spillage of body fluids in violent incidents or otherwise.

Thus it is feared that correctional institutions might become breeding grounds for this disease (Blumberg 1989:1), with more people leaving the system carrying Aids than came in with the disease thereby posing a risk to the general community. This point of view has been labelled the ‘incubator hypothesis’ (LaMarre 1988:100). The long incubation period associated with the disease has created apprehension that the worst is yet to come.

On the other hand, the findings from three consecutive annual surveys (1986-1988) in the USA indicate that the number of Aids cases in prison is increasing, but at a slower pace than in the general population (Hammett 1988:92). Similar research data (Conolly 1989) elsewhere gives rise to the formulation of an alternative hypothesis. It is noted in the ‘Aids Awareness Hypothesis’ that people who have regular IV (intravenous) drug habits and/or numerous sexual partners may come to prison where

- their behaviour is restricted with less opportunity to participate in high-risk activity;
- they are less likely to obtain drugs and are separated from their normal sexual partners;
- they are subjected to Aids information pro-

grams and constantly reminded about the dangers of the disease; and
- they are forced to think about Aids and re-examine their behaviour.

Being confronted in this way, they may be released with a heightened awareness about Aids and may therefore be less likely to catch or transmit the virus during imprisonment (Dwyer 1988).

High-risk behaviour in prison

There are certain common patterns of behaviour observed among inmates who have been identified as being at high risk in relation to HIV infection and Aids.

Table 1 Risk factors* for HIV infection and Aids

<table>
<thead>
<tr>
<th>Risk factor</th>
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<tbody>
<tr>
<td>Needle sharing</td>
</tr>
<tr>
<td>Anal intercourse</td>
</tr>
<tr>
<td>Sharing tattoo equipment</td>
</tr>
<tr>
<td>History of multiple sexual partners</td>
</tr>
<tr>
<td>History of multiple sexually transmitted disease</td>
</tr>
<tr>
<td>Poor physical and/or mental health</td>
</tr>
<tr>
<td>Risk-taking personality/behaviour</td>
</tr>
</tbody>
</table>

* The HIV infection risk factors are listed in their approximate order of importance.


Percentage-wise, inmates generally engage in a greater number of these high risk behaviour patterns (e.g. anal intercourse and needle sharing) and also more frequently than members of the general population (Pagliaro 1991). In addition, their social interaction is limited to a confined prison community – an isolated population that is itself at high risk of HIV infection and Aids.

It should be noted that though anal intercourse has been acknowledged as the major mode of HIV transmission to date, currently in North America (Pagliaro et al 1990:5) and in Europe (Papaevangelou et al 1990:23) the greatest percentage of new cases of Aids is due to sharing needles and syringes. Research data (Greenspan 1988:5-8) indicates that IV drug use among inmates is the key risk factor for developing Aids.

Thus, even though homosexual activities among male inmates is a significant behaviour pattern, it does not seem to be the major risk factor for the spread of Aids in overseas prisons. In fact, higher rates of HIV antibodies are usually found among female as compared to male prisoners (Dixon et al 1990:349).
The incidence of HIV infection and Aids in correctional institutions

Prisons are very diverse institutions and care must be taken when comparing and interpreting data from different countries. Rates of incarceration vary widely, from 36 to 114 per 100 000 of the population within European countries to well above 300 per 100 000 in certain North American states. The characteristics of prison populations also vary, as do regimes and conditions. A lack of uniform regulations and procedures for screening inmates makes it impossible to obtain baseline statistics regarding the percentage (expressed per unit of the population) of prisoners who are currently HIV seropositive in different parts of the world.

The reported incidence in North America ranges from a less than 1 per cent to 10 per cent HIV seropositive rate among inmates, as indicated in table 2:

Table 2 Reported incidence of HIV seropositive status among inmates in North America

<table>
<thead>
<tr>
<th>Incidence</th>
<th>Jurisdiction</th>
<th>Research reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1%</td>
<td>Iowa</td>
<td>Glass et al 1985</td>
</tr>
<tr>
<td>1.2%</td>
<td>Wisconsin</td>
<td>Hoxie et al 1990</td>
</tr>
<tr>
<td>1.4%</td>
<td>Oregon</td>
<td>Andrus et al 1989</td>
</tr>
<tr>
<td>4.1%</td>
<td>Nevada</td>
<td>Horsburgh et al 1990</td>
</tr>
<tr>
<td>7.7%</td>
<td>Philadelphia</td>
<td>Van de Beek 1990</td>
</tr>
<tr>
<td>7.9%</td>
<td>Quebec</td>
<td>Hankins et al 1989</td>
</tr>
<tr>
<td>8.0%</td>
<td>Maryland</td>
<td>Vlahov et al 1990</td>
</tr>
<tr>
<td>17.4%</td>
<td>Rhode Island</td>
<td>Dixon et al 1990</td>
</tr>
<tr>
<td></td>
<td>New York City</td>
<td>Brewer 1989</td>
</tr>
</tbody>
</table>

According to recent statistics (Marcus et al 1992:2) 5 411 confirmed cases of Aids have been reported amongst prisoners in the USA since 1989. Although the incidence of Aids for the general population was 14.65 cases per 100 000, the rate for state and federal prisoners was 202 per 100 000. From 1988 to 1989 there was a 72 per cent increase of reported Aids cases in prisons, whereas at the same time there was only a 50 per cent increase in reported cases in the general population. The greater increase among inmates may be partly due to improved screening and record keeping, but overall, the spread of Aids in prisons is a major concern to both correctional administrators and health professionals.

Currently, Aids is the leading cause of death among inmates in the New York and Maryland correctional institutions (Vlahov 1989:283–290). It is projected that Aids will be the main cause of inmate death across North America by the end of this decade – an expectation based upon

- the high incidence of HIV seropositive status in prison, in comparison with the general population;
- the factors that tend to foster transmission of HIV in prison.

Turnbull et al (1991:4) estimate an overall incidence of HIV in Western European prisons in excess of 10 per cent, but the seropositive rate is reported to be extremely high in some investigations.

Table 3 Reported incidence of HIV seropositive status among inmates in Western Europe

<table>
<thead>
<tr>
<th>Incidence</th>
<th>Country</th>
<th>Research reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.30%</td>
<td>Belgium</td>
<td>Turnbull et al 1991</td>
</tr>
<tr>
<td>2.10%</td>
<td>Luxemburg</td>
<td>Turnbull et al 1991</td>
</tr>
<tr>
<td>13.00%</td>
<td>France</td>
<td>Porras 1986</td>
</tr>
<tr>
<td>Between 5.00% and 20.00% of all inmates</td>
<td>Between 5.00% and 20.00% of all inmates</td>
<td></td>
</tr>
<tr>
<td>16.80% of 30 392 prisoners screened</td>
<td></td>
<td>Heilpern and Egger 1989</td>
</tr>
<tr>
<td>66.80% of all inmates</td>
<td></td>
<td>Spain</td>
</tr>
</tbody>
</table>

From 1985 to October 1990 more than 25 000 admissions to Australian prisons were tested and in November 1990 there was a total of 39 known HIV-positive prisoners, a cumulative number of 206 since 1985 (Egger & Heilpern 1990). In England and Wales some 150 000 persons are admitted to prison each year, giving a daily average inmate population of between 45 000 and 50 000. By March 1991 the cumulative number of known HIV-positive prisoners since 1985 was 338 (Turnbull et al 1991:4). However, as the number of tests conducted is unknown, it is impossible to calculate a rate for HIV prevalence in either Australian or English and Welsh prisons.

The HIV/Aids problem in most Scandinavian prisons seems to be insignificant in relation to other countries (Kranz in Bishop 1991:80). Up to
the present 2,500 prisoners in Finland have been tested, and of this number four have been found to have HIV antibodies.

Comparative statistics indicate that 0.173 per cent (1 in 532 people) of the South African prison population is HIV infected, compared with the 0.81 per cent (1 in 40 people) with HIV seropositive status in the South African general population (Greyling 1992).

Another method of gaining some preliminary indication of the potential scale of the problem in prisons is to turn to what is known about the 'high risk' characteristics:

- **Drug injectors (IV drug users) in the prison system**: Dolan et al (1991:177–186) found in a recent follow-up study of IV drug users in London and the South West of England that approximately one in six spent time in prison over the course of one year.

- **Reported findings of drug-injecting equipment in prison**: There has been a dramatic increase in the number of confiscated needles and syringes used by IV drug users in English and Welsh prisons, as indicated in table 4.

Table 4 Confiscated injecting equipment in English and Welsh prisons: 1985–1989

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of needles</th>
<th>Number of syringes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>1986</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>1987</td>
<td>49</td>
<td>92</td>
</tr>
<tr>
<td>1988</td>
<td>77</td>
<td>114</td>
</tr>
<tr>
<td>1989</td>
<td>91</td>
<td>167</td>
</tr>
</tbody>
</table>


- **Injecting and syringe sharing in prison**: Several studies in the UK have found that up to 25 per cent of IV drug users report that they managed to inject drugs whilst in prison and that most were willing to share syringes.

Table 5 IV drug users sharing syringes in prison

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>Shared syringes</th>
<th>Research reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>387</td>
<td>7%</td>
<td>Stimson 1988</td>
</tr>
<tr>
<td>1988</td>
<td>220</td>
<td>17%</td>
<td>Stimson 1988</td>
</tr>
<tr>
<td>1989</td>
<td>286</td>
<td>20%</td>
<td>Donoghoe 1990</td>
</tr>
<tr>
<td>1990</td>
<td>113</td>
<td>17%</td>
<td>Dolan 1991</td>
</tr>
</tbody>
</table>

- **Homosexual activity in prison**: Although homosexual activity is a reality in prison, very little is known about homosexual people in prison. The only type of data available is the number of people sentenced for homosexual offences. In 1989, 404 men received custodial sentences in the UK for offences involving homosexuality. Such information in itself would not be a good guide to sexual activities in prison because homosexual behaviour among inmates may not be confined to those who are homosexual outside. One report (Prison Reform Trust 1988:3), based on observations of prison staff and ex-prisoners in England and Wales, estimates that 20 to 30 per cent of prisoners on long-term sentences may be involved in sexual activities of this kind at some time.

- **Tattooing**: Evidence exists that tattooing takes place in prison with unsterile needles and other equipment. One study found that 7 per cent of 98 injectors reported sharing tattooing equipment during a previous prison term (Dolan et al 1991:177–186).

Although caution must be exercised in extrapolating from international data, there is evidence from some countries indicating that

- an important proportion of prisoners are HIV positive; and that
- behaviour patterns with a high risk of HIV transmission do occur within prison.

These indications are probably only a prelude to what can be expected in prisons by the end of this decade. Pagliaro (Pagliaro & Pagliaro 1992:203) bases this supposition on the following:

- an assumption that no significant progress will be made in relation to finding a preventative vaccine or effective treatment for the cure of AIDS before the turn of the century.

- the alarming incidence of reported HIV-seropositive inmate rates in North America and certain Western European countries;

- over 100,000 AIDS-related deaths were reported in the US from 1981 through 1990, with about one-third of these deaths occurring during 1990 alone. During the next two years, it is estimated that approximately 200,000 North Americans will die of AIDS. This data is particularly significant in relation to understanding the potential seriousness of the increased prevalence of HIV infection and AIDS among inmates over this decade, if effective prevention and intervention strategies are not developed and implemented.
Strategies for prevention and control

The Aids epidemic has undoubtedly made an already complicated prison environment even more challenging for correctional administrators as they attempt to develop and implement policies which will prevent transmission of the virus within the prison population. Several correctional facilities have begun to implement a number of strategies including:

- mandatory screening or HIV testing of inmates;
- segregation of infected prisoners;
- confidentiality/access to the results of positive HIV tests; and
- condom distribution and provision of sterile injection equipment.

Only the main issues involved in each of the mentioned policy options are addressed in the following paragraphs.

Mandatory HIV testing/screening

Mass screening for HIV antibodies, both upon entry and release, is an ideal situation and has been instituted in only a few American states. There appears to be significant confusion about the nature and meaning of HIV antibody testing. Although terms such as ‘Aids testing’ are often used, the fact is that there is no blood test for Aids. Testing for HIV seropositive status is accomplished by an indirect measure that actually tests serum for antibodies which develop in response to HIV infection. This test is not completely satisfactory because the human immune system generally requires one to three months after exposure to HIV to develop a sufficient quantity of antibodies to be detected by the test. There is, therefore, a period of time (window period) during which people are capable of transmitting the HIV virus to others, even though their test results may be negative (Horsburgh et al 1990:209–210).

Despite the possibility of producing false negatives by means of the current testing procedures, proponents of compulsory mass screening argue that

- mass testing is the only way to identify seropositive inmates and to gather information regarding the dynamics of transmission;
- antibody screening in a correctional setting provides an opportunity of improving medical monitoring and care of infected persons and of targeting education and prevention programmes;
- infected individuals can be placed under special supervision to prevent spread of the virus;
- mandatory testing is a necessary step to safeguard or indemnify correctional institutions from being held liable in cases of transmission of the virus in prison; and
- mass screening could enable correctional officials to plan more effectively and to provide a more accurate projection of future developments regarding the incidence of the disease in prison.

Critics of mass mandatory screening respond with the following arguments:

- Education and prevention efforts (as encouragement to refrain from ‘high-risk’ behaviour) must be directed toward all inmates and not just those identified as seropositive.
- Segregation of infected individuals from the inmate population is problematic.
- It is impossible to identify all infectious inmates on entrance (problem of false negatives). New admissions would need to be tested once and then retested at least three months later in order to be able to assert with any significant degree of confidence whether or not they were HIV seropositive.
- Mass mandatory testing will label the seropositive inmates as outcasts within the institution and subject them to harassment and discrimination and perhaps even violence in prison.
- There is also the question of how prisoners will respond to the knowledge that they are seropositive. (LaMarre (1988: 100) discusses the devastating physical and psychological effects of an Aids diagnosis on a prisoner.)

Other essential questions in this debate are the following:

- Can mass screening prevent transmission of HIV?
- Will mass screening improve medical monitoring and care?
- What are the legal implications of mass testing?
- How costly are mandatory mass screening programmes?
- Is mass screening the best way to assess the extent of Aids in an inmate population?
- Should correctional institutions be taking steps which are not at present taken within society at large?

Segregation of HIV-infected inmates

Medical quarantine of HIV seropositive inmates has been put into effect in several prison systems, primarily for three reasons:

- Medically, Aids patients have impaired immune systems and should be hospitalised to protect
them from infectious conditions which do not usually threaten healthy persons.

- It helps to protect the infected individuals from fellow prisoner violence.
- Quarantine is used as a general policy to prevent the transmission of HIV within the institution ('blanket segregation' policy).

The latter rationale raises a great deal of controversy and posits the following reasons in favour of segregating infected inmates:

- Segregation makes it easier to protect infected inmates on the one hand, and to prevent transmission on the other.
- The above motivation is closely tied to concerns regarding the potential liability of the system for any HIV infection that may occur within its facilities.
- The grouping of infected inmates (usually in the medical section or one wing of the institution) allows for a central location of services for prisoners with similar medical and counselling needs.

There is significant disagreement regarding segregation policies, except for valid medical reasons or in cases involving protective custody. Critics contend the following:

- Institutional segregation undermines the basic public health message that HIV is not transmitted except through intimate contact.
- Infected prisoners are often placed in substandard living quarters and are denied the opportunity of participating in certain work assignments and correctional programmes (sometimes losing the opportunity of earning 'good time' credit or remission of sentence, or of being eligible for work release programmes).
- In addition to concerns regarding human rights (the rights of the infected inmate versus potential risks and benefits to other persons), segregation also raises the question of feasibility in relation to the physical space, correctional manpower and financial resources involved in such decisions. Segregation can become very expensive and may require the development of what is in fact a second institution or correctional system. The duplication of existing correctional programmes and services could become an administrative nightmare.
- Although correctional administrators may have a legal as well as an ethical responsibility to pursue policies that minimise the possibility of HIV transmission, it is questionable whether or not a 'blanket policy' of segregation is the best way to accomplish this objective.

Other debatable questions regarding the issue of segregation of HIV infected inmates are as follows:

- Is diversity of treatment among inmate groups per se a violation of equal protection?
- Does the danger of the spread of the disease, and the potential for assaultive behaviour against HIV-positive inmates, pose an imminent threat of disruption?
- Are conditions of confinement in segregation punitive by nature?
- Is participation in the mainstream services and programmes of an institution a privilege or a right?
- Who should be segregated (i.e., any inmate testing HIV seropositive, any inmate with AIDS, only those infected who are 'irresponsible' in their behaviour and thus pose a high risk of transmission of HIV to others)?

Confidentiality/access to the results of positive HIV tests

One of the most sensitive issues regarding AIDS in correctional institutions is the question of who receives information concerning the medical status of the seropositive inmate. The bone of contention is whether or not the case should be disclosed to correctional personnel other than the attending physician and selected medical staff.

Decisions regarding notification are often governed by legal and policy standards, such as requirements for written authorisation to release test results or other medical records. Where the law or policy allows any discretion, decisions regarding disclosure versus confidentiality raise the question of which should take precedence:

- the prisoner's right (?) to have medical information kept confidential; or
- the correctional system's perceived legal and moral responsibility to protect its staff, fellow prisoners and society from HIV transmission.

There are valid claims on both sides.

The case for disclosure is based on the following rationale:

- Notification is necessary to enable line officers to take precautionary measures when interacting with seropositive inmates ('right to know' argument).
- Correctional management needs to know test results in order to make informed classification and other decisions regarding, for example segregation.
- Disclosure may be designed to reduce or eliminate the correctional system's legal liability in the case of transmission of the virus.
- Notification to public health departments and
formal correctional institutions involved may also be considered important to facilitate contact tracing.

Opponents to disclosure note that:

- the circumstances under which the virus is or is not transmitted suggest that the inmate's right (?) to confidentiality should take precedence over the employee's right to know;
- prisoners known to have AIDS may be victimised in terms of threats and possible violent intimidation;
- knowledge of antibody status could also cause discrimination in employment, housing and insurance coverage after discharge from prison; and
- a false sense of security could be created if correctional officials are under the impression that they know who all the infected inmates are. It may lead to a situation in which correctional officials fail to take adequate precautions.

Whatever policy is followed, institutions must ensure that the antibody status of inmates does not become known in the general prison population. Actual diagnostic results should be made available only on a 'need to know' basis (Guerrero & Koenigsfest 1986:130).

The range of options regarding who receives information include the following:

- very restrictive provision: only the subject may receive the results and written consent from the infected inmate is required for each separate disclosure;
- attending physician and correctional medical staff;
- correctional authorities and officers (selected disclosure);
- other criminal justice agencies, for example the parole and community corrections authorities on release;
- public health departments;
- spouses/sexual partners; and
- contact tracing.

Condom distribution and the provision of sterile injection equipment

Several correctional institutions in the USA (Vermont, Mississippi and New York City – Hornblum 1988:88) make condoms and sterile needles and syringes available to inmates, emphasising that this is not to condone prohibited behaviour, but only to recognise that it occurs and to provide for reasonable risk reduction. The issue has serious moral, medical, philosophical, religious and administrative implications.

The case for the dissemination of mechanisms designed for safe sex and IV drug activity is based on the following considerations:

- Many educational and needle/syringe exchange programmes have been implemented in high-risk community settings as a means of avoiding exposure to and spread of the virus (Fournis 1991:1).
- A human life is the most important consideration and we should do whatever we can to foster it (Hornblum 1990:21).
- Homosexuality and the use of IV drugs are realities in prison and administrators must not continue to ignore this serious behaviour currently considered to be the highest risk behaviour associated with the transmission of HIV infection. Proactive measures to impede the spread of the deadly virus are, on the contrary, of the utmost importance.

Opponents to the distribution of mechanisms note the following:

- the distribution strategy could create the impression that homosexuality and drug use are condoned by establishing a ‘Catch 22’ policy whereby condoms and clean needles and syringes are supplied, whilst sex and IV drug use are prohibited.
- there is concern that condoms might be used to hide contraband and that bleach (disinfectant for needles and syringes) can easily be used as a weapon (Hammet 1988:92).
- apart from the question of whether condoms actually offer significant protection against HIV infection during anal intercourse, the concern also exists that seropositive inmates would not refrain from sharing or exchanging needles and that they would be inclined to engage in unbridled sexual activity (Clements 1989:21).

Conclusion

Concerns regarding the incidence of AIDS in correctional institutions have been posed and several strategies to address the prevention and control of the problem have been described very briefly.

Policy-makers are forced to wrestle with many of the same issues which confront society at large.

Two factors, namely the concentration of high-risk people in correctional institutions; and the unique nature of the prison community may force
prison authorities to deviate from accepted strategies in the community.

The strategies which have been discussed are far from definite solutions to the problem of AIDS in prisons and it is recommended (Pagliaro & Pagliaro 1992:209) that the following needs be addressed and the related strategies developed and implemented:

- the need for unbiased and factually correct information concerning HIV infection and AIDS for both prisoners and personnel;
- the need for scientifically and ethically sound policies to prevent and control AIDS effectively in prison;
- the need for proper counselling of both inmates and personnel in order to deal with both the fear of becoming infected and the issue of coping with AIDS in the event of a positive diagnosis;
- the need for scientifically and ethically sound strategies to meet effectively the health care and living/working requirements of infected inmates and correctional staff.

Bibliography


