



Preventing HIV in Prisons and Jails

A N H I V I S I O N P U B L I C F O R U M



“Winston Churchill once observed that ‘a civilization is judged by how it treats its prisoners.’ By this measure, we are failing enormously....The increasing rate of HIV in prisons is truly a crisis.”

—Mark Cloutier

“Preventing HIV in Prisons and Jails,” a public forum presented October 11, 2007, by the San Francisco AIDS Foundation and the Center for Health Justice, brought together experts in the fields of HIV medicine, public health, and prisoners’ rights and as well as community members affected by HIV and incarceration. Produced in partnership with Centerforce, the Forensic AIDS Project, the Safe Communities Reentry Council, and WORLD, and hosted by the Delancey Street Foundation, the collaborative program marked the second event in the Foundation’s new HIVision forum series.

As Mark Cloutier, the Foundation’s Executive Director, noted in his opening remarks, the forum was designed to initiate a community-based conversation about current research, policy, and practice regarding HIV prevention in prisons and jails. The panel assembled to discuss these issues featured **Joseph Bick, MD**, Chief Medical Officer and Director of HIV Treatment Services at the California Medical Facility (part of the California Department of Corrections and Rehabilitation); **Robert Fullilove, EdD**, Associate Dean for Community and Minority Affairs and Professor of Clinical Sociomedical Sciences at the Mailman School of Public Health at Columbia University; **Olga Grinstead, PhD, MPH**, Adjunct Professor at the UCSF Center for AIDS Prevention Studies and Director of the NIH-sponsored Collaborative HIV Prevention Research in Minority Communities program; and **Ron Snyder**, Special Projects Director for the Center for Health Justice and an openly HIV-positive, formerly incarcerated person. **Dana Van Gorder**, Executive Director of Project Inform and former Director of State and Local Affairs at the San Francisco AIDS Foundation, provided a summary of pending legislation related to HIV and incarceration. The panel was moderated by **Mary Sylla, JD, MPH**, Director of Public Policy and Advocacy at the Center for Health Justice.

“Prisoner health is public health. There’s no getting around it.”

—Olga Grinstead

Prison populations bring together those at highest risk of HIV infection: people of color, individuals with a history of substance abuse, and people living in poverty. Sexual activity occurs in prisons and jails more frequently than many local and state governments care to admit, yet condom-access programs exist in only two state prison systems (Mississippi and Vermont) and five county jail systems (Los Angeles, New York, Philadelphia, San Francisco, and Washington, D.C.). The concentration of high-risk individuals, the denial of access to sexual barrier devices, and the exponential increase in incarceration rates since the beginning of the U.S. HIV/AIDS epidemic have created a health crisis: documented HIV prevalence among prisoners is eight to ten times higher than in the general population, and an estimated 25% of HIV-positive people in the U.S. have been incarcerated at some time.

Efforts to curb the spread of HIV among prisoners and in the communities hit hardest by incarceration have centered on a handful of HIV prevention interventions, including testing, condom distribution, and prevention education in prisons, and transitional planning and substance-abuse treatment programs for ex-prisoners. Following is a summary of the panelists’ responses to questions on these issues and their broader suggestions for improving HIV prevention in prisons and jails—and in our communities.

If you were incarcerated today, would you take an HIV test?

“No, I would not. When I was incarcerated, I made the mistake of actually disclosing that I was HIV-positive....Due to my HIV status, I was ‘an unacceptable risk to the community,’ and I had to do my whole term on the inside.”

—Ron Snyder

Ron Snyder’s personal disclosure stimulated a lively discussion of the pros and cons of voluntary HIV testing in prisons and jails. Like Snyder, Joseph Bick noted that prisoners identified as HIV-positive may lose access to work programs and educational opportunities that would otherwise make them eligible for reduced sentences;

openly HIV-positive prisoners may also face more severe penalties for sexual activity or fighting (both of which may involve the exchange of infectious bodily fluids, such as semen or blood). “Based on what I’ve seen in many jails and prisons around the country,” said Bick, “if I came in and thought that I was going to get out in a year, and I was feeling okay, I would probably take my chances.”

Robert Fullilove and Olga Grinstead agreed that prisoners need to be educated about the potential risks and benefits of testing in order to make informed decisions about their health. In addition to the risks outlined by Snyder and Bick, stigma, discrimination, and even segregated housing may await prisoners diagnosed as HIV-positive. At the same time, however, an HIV diagnosis allows those in need of antiretroviral therapy to begin treatment; testing positive may therefore save a prisoner’s life. Without information about both the risks and benefits, many prisoners may forego testing and become ill or infect others. As Bick explained, “we have to be able to do a better job of demonstrating what it is that we can bring to someone who voluntarily decides to test and perhaps be identified as HIV-infected.”

The panelists also strongly agreed that, while it is important for people to know their HIV status, policy makers should not mandate testing of prisoners. Bick commented that, for some people who support mandatory testing of prisoners, “it’s a misguided attempt to protect vulnerable people from infection, maybe people who don’t have power to negotiate sex.” In recent years, a number of mandatory prison testing bills have been introduced in an effort to curb the spread of HIV among African-American women in communities deeply affected by incarceration. “This has led to one of the most difficult conversations between black men and black women,” said Fullilove. “The goal is no longer, ‘What do we do to prevent HIV? What do we do to prevent it for ourselves and our children?’ It’s ‘Who’s to blame?’” The panelists concurred that mandatory testing bills stigmatize HIV testing and foster discrimination. As Grinstead observed, mandating HIV testing for prisoners is not an easy policy fix: “In this case, it’s much more complicated.”

What evidence do we have that HIV transmission occurs in prisons and jails? Does it support access to sexual barrier products in these settings?

“Long before this epidemic, it was clear that prisoners have sex with each other. I think the next logical step is to say, ‘okay, if it happens, we’re going to protect the people who are engaging in it and limit the likelihood that they’re going to be exposed to a wide variety of sexually transmitted diseases.’”

—Robert Fullilove

In general, Bick explained, most HIV-positive prisoners entered the correctional system already infected. However, he commented, “in my clinic, I see people who were re-

peatedly HIV-negative [in tests] and are sexually active while they’re incarcerated, and they become infected. ...Absolutely, there is transmission within jails and prisons.”

Despite laws criminalizing sex between prisoners, prison officials can be complicit in the activity: Snyder recounted that he openly shared a bunk with a cellmate for six months with no objection from correctional officers. Sex between prisoners and prison staff also occurs. Referring to a 2006 report on HIV transmission in Georgia’s state prisons, Fullilove pointed out that “a significant number of folks said that they’d had sex with a member of the prison staff”—emphasizing that the health of prisoners is closely linked with community health.

The panelists agreed that access to sexual barrier devices—including condoms and dental dams—is essential to protecting prisoners and their communities from HIV, but they acknowledged concerns about distributing such products in prison systems. For example, some community members, including policy makers, have voiced fears that distributing condoms will encourage prisoners to have (illegal) sex, or that condoms will be used as weapons or to smuggle contraband. However, in the seven state and city systems that currently offer condoms, the panelists noted, no data support these claims. In addition, as both Grinstead and Fullilove observed, many prison systems around the world provide sexual barrier devices (and even sterile syringes) to prisoners as a harm-reduction strategy, and data from these systems indicate reduced prevalence of sexually transmitted infections, low incidence of prisoners using barrier devices as weapons, and no increase in sexual activity.

Bick offered another perspective, observing that some correctional officers regard doling out condoms as tantamount to “providing people tools to break the law.” The panelists agreed that, in order to change the penal code and legalize access to sexual barrier products, health care providers, prison health advocates, and researchers must collaborate and present an evidence-based case to their legislators. “I believe we could develop a group of peace officers and health care professionals and community-based folks who could get together and bring a proposal to the [California] governor, satisfying the various needs of all constituents,” said Bick. The panelists emphasized that, through collaboration among all stakeholders (and, as Grinstead commented, “everyone is a stakeholder here in making the community safer”), acceptable and effective solutions can be developed.

What kind of HIV education occurs in prisons and jails?

“Education isn’t very sexy. There’s not enough money spent on it....There’s so much more that we could be doing in the area of education.”

—Joseph Bick

HIV prevention education could be vastly improved, and the panelists agreed that incarceration represents an op-

portunity to teach particularly at-risk individuals how HIV is spread and how to protect themselves and others. In prison populations, Bick noted, “it’s downtime for some of these folks. They’ve got the food provided. They’ve got shelter....I think there is a lot that you can do with education in that period of time.” Grinstead pointed out that HIV education is the first step in implementing other prevention tools; for example, prisoners who do have access to condoms need to learn how to use them correctly, or the intervention is ineffective.

Prisoners themselves often make the best educators, according to both Grinstead and Snyder. Having experienced incarceration first-hand, they may be considered more credible than prison system staff or outside educators; “people will listen to peers in a way that they won’t listen to people that haven’t had that experience,” Grinstead remarked. Peer education has the added benefit of low cost, she noted: “it’s an intervention you can do on a shoestring.” Not only can prisoners provide harm-reduction information, they can also inform peers about how to engage the prison’s sociomedical mechanisms for better medical treatment—“how to actually make the system work for you while you’re on the inside,” explained Snyder.

HIV education is vital to prisoners’ health, the panelists agreed. So why do few education programs operate in the U.S.? “We have lots of good ideas,” Dr. Fullilove observed. “Our inability to actually put them into [situations] where they can be effectively rolled out is the problem.”

How does community reentry influence HIV risk? How can we adapt HIV prevention interventions to target this transitional period?

“Whether you care about prisoners or not, you really should care that they’re healthy, because most of them are going to go home.”

—Joseph Bick

According to the panelists, many prisoners who reenter their communities do not know they have HIV or—due to the lack of HIV prevention programs in prisons and jails—are unaware of ways to avoid transmitting the virus to others. Delayed notification of HIV test results is another barrier to care and prevention, as prisoners may not receive their results before being transferred or released. “The normal thinking for us inmates at Chino was, ‘if you’re not told you’re positive, you must be negative,’” Snyder recalled. “So we’re sending the people back to the community with the message that ‘okay, you’re negative.’”

Snyder explained that parole officers are alerted to the HIV status of their new parolees; however, unless parolees contact their parole officers immediately after release, they may not learn they are HIV-positive until after they

have engaged in high-risk behaviors. “You have 48 hours to report to your probation officer once you get out, and that is not the first place you go—especially if you’re married and you’ve been inside for a while,” Snyder said.

The panelists agreed that prisoners who are aware of their HIV-positive status typically receive substandard care while serving time in correctional facilities—but for many, as Snyder pointed out, it is the only medical care they’ve ever had, and exiting the prison system eliminates their treatment options. In California, HIV-infected ex-prisoners can access the Transitional Case Management Program (TCMP), designed to connect parolees with medical care, substance abuse treatment, housing resources, and employment assistance. However, Bick noted, TCMP is “a phenomenal program for those that are ‘lucky’ enough to have HIV, who are served by a county where there’s actually a [TCMP] worker.” As Snyder observed, TCMP currently has funding to assist only six of the roughly 70 HIV-positive prisoners released monthly in Los Angeles County.

The panel went on to illuminate the health care disparities found in communities most heavily affected by incarceration. Health care systems in poor communities and communities composed largely of people of color are “broken,” as Fullilove put it. Unless they are fortunate enough to participate in TCMP or a similar program, HIV-positive parolees reentering this broken health care system may have limited or no access to basic medical care and antiretroviral therapy, thereby risking the development of drug resistance, opportunistic infections, and progression to AIDS. “We’re talking about a system that has completely failed them and is about to basically fall apart under its own weight,” said Fullilove.

Treatment for alcoholism and drug addiction is either lacking or cost-prohibitive in many communities, and because substance users are targeted for incarceration rather than treatment, a significant number of prisoners suffer from alcohol and/or drug dependence. When these prisoners are released, Bick observed, they often return to communities and situations that contributed to their incarceration in the first place, leading to high rates of recidivism and further risk of acquiring or transmitting HIV in prison.

Mental illness also contributes to recidivism, and is therefore another factor in HIV incidence. According to Fullilove, an estimated 30% of admissions to the psychiatry departments of emergency rooms in Bronx County, New York, are “people who have been incarcerated and who are struggling with the same issues on the outside that they weren’t able to get resolved on the inside.” Bick noted that, given the lack of mental health treatment options in many poor communities, incarceration may be the only way to get mentally ill individuals into care: “You arrest them, and then they have a better than average chance that they’ll actually see...a mental health professional.”

Although cycling in and out of incarceration puts prisoners and communities at risk, the panelists agreed that the reentry period can and should be the target of HIV prevention efforts. “How do people reintegrate into their families?” asked Grinstead. “How can we support families who are on the outside waiting for people to come home?” These questions and others speak to the urgent need for community involvement in HIV prevention interventions for prisoners and others affected by incarceration. Grinstead revisited the peer-education model, which, she remarked, can be expanded beyond prison walls to result in “inmates educating inmates, visitors educating visitors, families educating families, and so on.”

What is the current state of pending legislation related to HIV prevention in prisons and jails?

“We’re coming to the issue of HIV in prisons later than we should have. Among the key lobbying organizations in Sacramento with whom we work, there is a certain amount of frustration—and guilt, even—that we have not dealt with this issue in a more forthright manner than we are trying to now.”

—Dana Van Gorder

The panel unanimously agreed that HIV prevention in prisons is possible. Numerous prevention interventions, including testing, access to sexual barrier devices, and HIV education, are successful. But how can we put them into place? Addressing this question from a policy perspective, Van Gorder provided an update on relevant pending legislation.

The health and well-being of prison populations has not been elected officials’ highest priority, said Dana Van Gorder. In recent months, however, prisoner HIV testing and condom access legislation have been under consideration at both state and federal levels. A significant nationwide conversation about mandatory HIV testing for prisoners has begun in the past few years. Assemblyman Mervyn Dymally (D-Los Angeles) included an opt-out provision in his most recent testing bill (AB 66), and saw the bill perform well in most committees, although it is currently stalled in the Senate Appropriations Committee due to financial concerns. “I am confident that a mandatory testing bill will never be successful in California,” said Van Gorder.

Sandré Swanson’s (D-Oakland) bill to allow prisoners access to sexual barrier devices (AB 1334), was on Governor Schwarzenegger’s desk at the time of the HIVision forum; he vetoed it just days later. The bill would have allowed nonprofit or health care organizations to work with correctional facilities to distribute condoms and dental dams to prisoners, and also specified that possession of sexual barrier devices by prisoners could not be considered a crime. As Van Gorder predicted, the Governor issued a veto statement calling for one correctional facility to launch a pilot program to assess the feasibility of condom distribution in prisons.

At the federal level, Congress has considered the Stop AIDS in Prison Act of 2007 (H.R. 1943), introduced by Representative Maxine Waters (D-Los Angeles). As Van Gorder explained, H.R. 1943 would require that all federal prisoners be offered opt-out HIV testing; the bill also stipulates that the correctional system must provide antiretroviral medications and ensure the confidentiality of prisoners’ HIV test results. The bill passed the House and is awaiting a sponsor in the Senate.

Van Gorder observed that the goals of improved HIV prevention for prisoners will most likely be reached through incremental legislative steps, but added that no goals will be achieved without the involvement of stakeholders in prisoners’ rights and public health. Van Gorder encouraged panelists and audience members to keep abreast of state and federal legislation by joining advocacy groups such as the San Francisco AIDS Foundation’s own HIV Advocacy Network. “We need telephone calls and letters written,” he said, “and the more people we have,...the more effective we are.”

What should we do next to improve HIV prevention in prisons and jails?

“We’re not going to be able to treat ourselves out of this. We have to find alternatives to incarceration [and] ways to keep people from coming back.”

—Joseph Bick

The forum concluded with panelists’ responses to audience questions, including one audience member who asked pointedly, “What do we do next?”

Bick framed his response in terms of recidivism: without better transitional planning for parolees and improved drug and alcohol treatment programs, recidivism will continue to burden the community, tax the correctional system’s capacity to provide medical care, and endanger the health of prisoners and communities alike. Bick acknowledged that incarceration is necessary for some criminals, but emphasized that alternatives to incarceration are sorely needed for others, such as treatment programs for people imprisoned because of illegal substance use. “There are some who need to be locked up,” Bick remarked, “but we should be focusing our resources on them and finding ways for the other ones to succeed.”

Emphasizing the need for collaboration among state and federal policy makers, Fullilove described his commitment to working with the Centers for Disease Control and Prevention (CDC) to secure funding for HIV prevention programs in prisons. Advocates like Fullilove are encouraging outgoing, high-ranking CDC officials—freed from political pressure as they prepare to leave office—to release further funding for such programs. As Fullilove observed, “there needs to be a coordinated federal effort to work with state systems of incarceration to do something about HIV prevention.”

Echoing the panel’s emphasis on collaboration among stakeholders, Grinstead stressed that policy makers and community members must work together to identify and roll out effective HIV prevention interventions for prisoners, educate prisoners about HIV, and reduce HIV-related stigma in prisons and jails—and elsewhere. “Each one of us can walk out of here with a commitment about challenging those stigma issues,” she said.

Ron Snyder concluded the discussion by highlighting his own work as an advocate for HIV-positive prisoners. By telling his story and working with law enforcement agencies, Snyder has helped to desegregate housing for HIV-positive prisoners in California and hopes to help keep people from returning to the prison system. “My personal goal is to eliminate recidivism,” Snyder said, smiling. “Then I will be able to retire. But until then, I will keep pushing.”

Conclusion

As the panelists repeatedly emphasized, prisoner health and public health are inseparable. U.S. policy makers are beginning to recognize that the spread of HIV in correctional settings affects people within and outside of the prison population, including prisoners’ parents, siblings, partners, and neighbors—in short, every member of our community.

The Foundation’s HIVision forum sparked a much-needed conversation among community members, HIV experts, and advocates. Through collaboration with researchers, policy makers, prison officials, advocates, and those most affected by HIV and incarceration, we at the San Francisco AIDS Foundation hope a better, healthier future can be created for people within and outside of the prison system