Chapter 10

HIV Prevention: Behavioral Interventions in Correctional Settings

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To date, preventive care and prevention services have not been included in our conceptualization or operationalization of prisoners’ “right to health care.” Given the potential public health impact of focusing on prevention for prisoners, however, the time has come to examine this issue. Although not specifically a right under the Constitution, correctional systems should be obligated to offer comprehensive HIV prevention services to those in custody. The justification for this obligation, at a minimum, has to do with some of the basic tenants of public health disease control: target your prevention dollars on illnesses with high morbidity and mortality rates among populations with the highest rates and whom you can access.

With the prevalence of HIV at least five times higher among the incarcerated compared to those who are not incarcerated, providing effective prevention programs would have a powerful impact on incidence rates in this population. Furthermore, in one well-referenced study, in 1997, 25% of all HIV-positive people in the United States reportedly serve some time in a correctional facility (Hammett et al., 2002) and 90% of prisoners, representing an estimated 7.5 million prisoners annually, return to the free community at some point (Bureau of Justice Statistics Correctional Surveys, 1996). As approximately 51.8% of those individuals are reincarcerated within 3 years (Bureau of Justice Statistics Correctional Surveys, 1996), it is clear that providing effective disease prevention programs to those who are incarcerated would not only help protect them, but would also likely have a synergistic impact on HIV rates in our communities. If departments of corrections were to adopt evidence-based prevention measures, prisoners would simultaneously be returning from incarceration less likely to be infected with HIV and armed with the knowledge and skills to play an important role in reversing the current epidemic trends. This role includes protecting themselves and their loved ones by reducing their own risk behaviors and protecting their communities by educating others and changing norms.

Background

Since its discovery in the early 1980s, more than 25 million people have died worldwide of HIV/AIDS, including more than 500,000 in the United States (World Health Organization, 2005; Centers for Disease Control and Prevention,
Geographically, this disease has levied its toll most heavily in sub-Saharan Africa. However, in almost every corner of the world, HIV has infiltrated the poorest communities and/or those with the least political power to the greatest degree.

In the United States, HIV/AIDS initially emerged most extensively in the largely white, gay/MSM (men who have sex with other men and do not identify as gay or bisexual) communities of New York City, Los Angeles, and San Francisco. Overall, MSM account for 54% of the cumulative AIDS diagnoses since the start of the epidemic and are estimated to be currently acquiring 45% of incident cases (Centers for Disease Control and Prevention, 2004, 2006c). However, HIV has long since penetrated non-white, gay/MSM communities and is now characterized more by the race and ethnicity of those it has infected than by any single behavior. Although African Americans represent 13% of the U.S. population, they accounted for 51% of newly diagnosed cases of HIV in 2001–2004, resulting in rates 8.5 times higher than for whites. Also at disproportionate risk, Hispanics are infected with HIV at rates 3.3 times higher than for whites (Centers for Disease Control and Prevention, 2006a). The estimated rate of HIV and AIDS among African-American women in 2005 was nearly 24 times and 4 times, respectively, that of white and Hispanic women (Centers for Disease Control and Prevention, 2006d).

The most current information suggests that African-American men who are diagnosed with AIDS are more likely to have been infected by male–male sex than by other behaviors (accounting for 46% of cases compared to 25% and 23%, respectively, for IV drug use and heterosexual sex)(Centers for Disease Control and Prevention, 2006b). Like their male counterparts, African-American women most often contract HIV from their male sexual partners (with heterosexual contact representing 72% of diagnosed AIDS cases among black women in 2003) (Centers for Disease Control and Prevention, 2006b).

In recent years, there has been a great deal of speculation in the scientific as well as lay press suggesting that women are disproportionately burdened with HIV and AIDS as a result of their partnerships with currently and formerly incarcerated men (Johnson, 2006). In addition to any contribution that recently released men may make to the HIV epidemics in their communities, there is also the indirect effect of sentencing laws and other policies which disproportionately incarcerate those engaging in behaviors that are associated with both crime and HIV risk (injection drug use and sex work). With so many men in these communities incarcerated, the result of these policies is likely a decreased “pool” of eligible partners thus creating a smaller sexual and drug network and, consequently, a greater opportunity for disease transmission in these communities.

In-Prison Risk

Although less frequent than risk behaviors in the community, in-prison risk behaviors (including sex, use of intravenous drugs, and tattooing) may place the prison population at greater risk for contracting HIV. Compounding the risk inherent in any act that may expose a person to the blood and/or semen/vaginal fluid of another is the fact that in prison, the person to whom