AIDS In Prisons Essay, Research Paper

AIDS. Ryan White. Magic Johnson. Prisoners. Which of the three doesn’t fit in?In an era where we rally behind the good guy to prevail against the bad guy, prisoners have a difficult time finding their niche in the “good guy” category. The mere mentioning of the word “AIDS” strikes fear and panic into most Americans. AIDS is a killer, and one that law enforcement, doctors, or even the common man cannot stop. When someone such as Ryan White or Magic Johnson contracts the AIDS virus, they are quickly termed “victims,” and people from all walks of life line up to support them. However, a prisoner with AIDS lies in a lowly cell with no support from the public. Instead, he or she is blamed for acquiring what will ultimately be their killer.

The HIV/AIDS epidemic has struck prisons, jails, and other places of detention with particular severity. Penal institutions around the world have grossly disproportionate rates of HIV infection and of confirmed AIDS cases. In the United States in 1994, for example, there were 5.2 cases of AIDS per 1,000 prisoners, nearly six times the incidence found in the general adult population. French prisoners are estimated to be HIV-positive at a rate roughly ten times that of other adults. Prisoners in Brazil and Argentina, among other countries, have even higher levels of HIV-infection. Not only do people entering prison tend to have a relatively high incidence of HIV, prisons provide perfect breeding ground for transmission of the virus. High-risk behaviors, such as injecting-drug use and unprotected sex, including coerced sex, are common in prisons around the world. Health care is usually substandard and sometimes nonexistent. Rather than providing prisoners with prevention tools — notably, condoms, for safe sex, and liquid bleach, for sterilizing needles and syringes — prison administrators frequently bar the entry of these items. Even HIV/AIDS education, which could help prisoners understand the invulnerability to the virus, is rarely found in the world’s penal institutions.

The situation [of HIV/AIDS in prisons] is an urgent one. It involves the rights to health, security of person, equality before the law and freedom from inhuman and degrading treatment. It must be urgently addressed for the sake of the health, rights, and dignity of prisoners; for the sake of the health and safety of the prison staff; and for the sake of the communities from which they come and to which they return. In New York State prisons, correctional officials conservatively estimate that 8,300 prisoners are living with HIV. In the New York City jails, 22% of female inmates and 13% of male inmates are estimated to be HIV-positive, totaling approximately 2,500 inmates at any given time. Nationally, the rate of confirmed AIDS cases in federal and state prisons is more than 7 times higher than in the general U.S. population or almost 23,000 prisoners. Over one-third of all prisoner deaths are from AIDS-related causes. The vast majority of prisoners living with AIDS/HIV survive their prison terms. By and large, they return to poor, inner-city communities of color, which have been the hardest hit by the AIDS epidemic.

Four million people in the United States live under the jurisdiction of the criminal justice system, and approximately 1 million are currently in jail or prison. The United States imprisons its population at the highest known rate in the world. These figures, which increase daily, indicate the country’s devotion to a formidable social policy of imprisonment. Eighteen states have doubled or tripled their prison populations during the past decade, primarily because the central tactic of the United States’ “war on drugs” has been incarceration. The millions of intermittently incarcerated people in America, many of whom are illicit drug users, are among the most difficult people to reach with critical health information. The incidence of AIDS is 14 times higher in state and federal prisons than in the general U.S. population. Prisoners are at exceptional risk for infection with HIV, in part because of the connection between injection drug use and imprisonment. Women prisoners who have practiced prostitution, which is frequently associated with injection drug use and contact with HIV-infected sex partners, are at additional risk for HIV infection. There is no precise count of HIV cases in prisons and jails; brief incarceration, limited access to health care, and inadequate health services prevent identification and diagnosis of inmates with HIV infection.

Tuberculosis (TB) has long been an infection of particular concern in correctional institutions because of its higher incidence there than in the community at large and the ease and frequency of airborne transmission of tuberculosis bacilli in the crowded conditions within prisons. In the presence of HIV infection, latent TB more frequently becomes active and more infection is more easily acquired. Moreover, the inconsistent treatment that often characterizes prisoners’ medical care can permit the development of multidrug-resistant (MDR) strains of mTB, a medical nightmare reported in the New York and California state prisons. Routine TB testing of inmates at intake is performed variably in U.S. prisons. Tuberculin skin testing, despite its many imperfections, is the procedure of choice. False-negatives due to HIV immune suppression are common among the populations at greatest risk. Prison administrators and personnel rarely have information about the ventilation systems in their institutions. Investigation usually reveals airflow pathways that circulate air extensively within prison facilities rather than directly to building exteriors. Even designated medical isolation areas must be carefully and frequently scrutinized, as unexpected negative pressures often keep air from exiting vents as intended. In addition to intake screening for TB, subsequent routine follow-up and surveillance programs are essential for inmates and prison staff.

Numerous activities known to occur among prisoners pose a risk for HIV infection, but until recently no new infection was shown to have occurred after incarceration. Sexual activity between male inmates is not uncommon in prisons and jails, but reliable figures quantifying this activity are not available. Homosexual activity by many inmates is limited to the time they are incarcerated and predominantly occurs between consenting men. The frequency of homosexual rape in jails and prisons is extremely difficult to estimate. Interpersonal dynamics discourage the victim from reporting rape; he must consider the probability of further suffering and worse injury from his attacker as well as from his attacker’s associates, who always wield more power in the prisoner hierarchy than authorities. Incidents of interpersonal violence (including rape and fights involving lacerations, bites, and bleeding in two or more participants) present varying risks for HIV transmission. Fights usually occur among inmates only, although they may involve correctional staff. These risk activities in prisons and jails do not involve consenting participants, and condoms or educational programs are not likely to prevent HIV transmission in these situations. In fact, morbidity and mortality in prisons occur regularly as the result of traumatic injuries, independent of HIV transmission. Prison authorities prevent violence among prisoners with adequate staffing, supervision, programming, and housing. Although imprisoned intravenous drug users do not use drugs with the frequency that they can outside, they do share injection equipment more and sterilize it less because of scarce resources. A handmade syringe may be fashioned from (among other things) the glass found inside a light bulb. Other potential vectors of infection include shared razors: A common policy prior to practice of HIV precautions was the distribution of a single razor to groups of inmates. Because blades are potential weapons, inmates were told that if the common blade were not returned after its use, all prisoners’ visits would be canceled. Thus, the guard did not need to observe every shaver and the blade would not be “lost.” Prisoners may also share toothbrushes, another potential source of HIV infection, in facilities where they are not issued, where inmates are unable to purchase their own, or where infection control precautions are not understood. Tattooing is widely practiced in prisons and is usually performed without fresh or sterile instruments. It involves multiple skin punctures with recycled, sharpened, and altered implements such as staples and paper clips. Prison wisdom holds that tattooing that causes blood to flow results in the best quality image and is least likely to become infected. Procedures for cleaning these “needles” and syringes in prison vary. Water and matches are generally available. Peroxide, alcohol, or bleach may be available to inmates who work in health-care areas or on cleaning assignments. No prison is known to have a policy of making sterile equipment available to inmates.

Although prisoners have been affected by HIV disproportionately in the United States, they have not received commensurate attention. Every jurisdiction is responsible for providing health care to its prisoners. There are no required or generally accepted standards of care, although several organizations have developed voluntary standards for correctional facilities. None of these standards, however, include any guidelines for medical management of HIV. Medical personnel, public-health advisers, correctional administrators, legislators, courts, and the electorate have developed policies for management of HIV in prisons. Prisons and jails, designed to confine and punish people, many of whom are generally poor and without influential outside advocates, have not voluntarily provided the extraordinary levels of health services patients with HIV require. Prisons have often escaped outside attention to serious failures of care. HIV management practices in correctional institutions vary widely.

HIV in prisons raises a number of issues that do not exist for the general community; one of these is mandatory testing for the HIV antibody. In fact, most public policy debates on HIV in prisons have focused not on care and prevention but on whether to mandate testing. Many jurisdictions require mandatory testing of prisoners and use test results primarily for correctional management purposes. Studies suggest that mandatory testing is less productive and probably less effective in educating prisoners and changing their behavior than voluntary testing and broad education programs. Prison officials use HIV-antibody test results to make decisions about housing and segregation, work assignments, and visiting privileges, among others. It is common practice to bar inmates with HIV (or AIDS) from kitchen work and to serve them food only on paper plates. In some jurisdictions, results of HIV tests go directly to correctional staffs. Many practices and policies in prison contradict the public health facts: HIV is not transmitted through food, HIV is not acquired through casual contact, and the only truly safe assumption is that everyone may be HIV infected and should be handled cautiously and equally.

Confidentiality of medical information in the prison setting is virtually impossible to maintain. Where quarantines exist, confidentiality cannot. In the close and closed system of jails and prisons, confidentiality is commonly breached. Persons other than medical staff may handle medical records, and staff members may not be meticulous about protecting privacy. Once such information is released in a prison, it travels rapidly. It is hard to find a person in the prison setting who does not believe that he or she has a particular “need to know” who in the institution is infected with HIV. It has been argued that prisoners have a greater need for privacy than those outside because they live in a closed community where violence is common. Prisoners cannot give true, free informed consent. In every area of life inmates bargain for privileges, better conditions, and, ultimately, release. Where HIV testing is not mandatory, prisoners require more information than others to make informed decisions about taking the test or participating in HIV-related studies. To give informed consent, prisoners must understand the institutional consequences of a positive HIV-antibody test result, such as segregation and loss of access to activity programs, visitation, and jobs. This information has indeed discouraged many prisoners from being tested.

Prisoners have a constitutional right to health care that people “on the outside” do not have. Under the Eighth Amendment, inmates are entitled to a “safe and humane environment.” In an important U.S. Supreme Court decision, this right was further defined as prohibiting “deliberate indifference to serious medical need.” A small number of terminally ill patients with advanced AIDS at a few U.S. correctional institutions have been granted compassionate release from prison before the expiration of their sentences. They have been released to families or hospices with access to community health services.

Prisons historically have approached prevention of HIV transmission in two very different and often contradictory ways: either quarantine and segregation, or education. In the general community, experience and respect for fundamental human rights have discouraged quarantine, but the controlled nature of the prison environment and the fears held by prison staff and the public regarding prisoners have made quarantine an attractive option to some administrators, staff, and prisoners. The other approach to prevention in prisons, as in the community, is education. Prisoners represent a crucial and huge target population for HIV education programs; prisons concentrate persons at risk who are not easily reached in the community by such efforts. As many as 50 percent of American prisoners are functionally illiterate, and many are not native English speakers; to be effective, educational programs must be modified to communicate with them. The generally available literature on HIV infection and AIDS cannot be understood by most inmates or does not address many of their particular needs. Although the primary goal of HIV education in prisons is prevention, other critical objectives include promoting an understanding that engenders rational and humane treatment of affected inmates. Accurate and adequate information for staff and inmates can reduce fears and ultimately affect institutional policies in ways that can profoundly alter prisoners’ lives.

Control and prevention of HIV infection must be viewed in the context of the need to improve significantly overall hygiene and health facilities in prisons. In many countries there may be substantial numbers of prison inmates who have a history of high-risk behaviors, such as injection drug use [and] prostitution. In addition, situational homosexual behavior may occur as a consequence of heterosexual deprivation, characteristic of prison conditions. Prison authorities therefore have a special responsibility to inform all prisoners of the risk of HIV infection from such behaviors. Prisons provide an opportunity to inform and educate large numbers of persons who may have engaged, or may be likely to engage, in HIV high-risk behaviors. Many of these persons are unlikely to have received such education in the general community. Prison administrations should recognize their responsibility to minimize HIV transmission in prison (and consequently in the general community when prisoners are released). Prisoners should be treated in a manner similar to other members of the community, with the same right of access to: educational programs designed to minimize spread of the disease, including up-to-date information on AIDS and preventive measures; testing for HIV infection (serological testing) on prisoner request, with confidentiality of results, timely pre- and post-test counseling, and support from appropriately trained persons acceptable to the prisoner; medical, nursing, inpatient and outpatient services of the same quality as those for AIDS patients in the community at large; information on treatment programs and the freedom to refuse such treatment. In addition, prisoners with AIDS should be considered for compassionate early release to die in dignity and freedom; Prisoners should not be subjected to discriminatory practices relating to HIV infection or AIDS such as involuntary testing, segregation or isolation, except when required for the prisoner’s own well-being. All prison staff should receive up-to-date information and education on AIDS prevention and control in prisons, as part of broader training in occupational health and hygiene. Information on AIDS should include recognition of possible AIDS-associated conditions and guidance on the most humane management of HIV-infected prisoners. Homosexual acts; intravenous drug abuse and violence may exist in prisons in some countries to varying degrees. Prison authorities have the responsibility to ensure the safety of prisoners and staff, and to ensure that the risk of HIV spread within prison is minimized. In this regard, prison authorities are urged to implement appropriate staff and inmate education and drug-user rehabilitation programs. Careful consideration should be given to making condoms available in the interest of disease prevention. It is also recognized that, within some lower-security correctional facilities, the practicability of making sterile needles available is worthy of further study. Decisions regarding testing and/or screening should be considered in the context of informed consent, the ability to maintain confidentiality and the provision of positive assistance to affected persons. These are human beings. It’s time they were treated like it?