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A Guide to AIDS Research and Counseling

HIV in the Georgia State Prison System

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The prevalence of HIV among state prison inmates in the United States is more than four times higher than prevalence in the general U.S. population.[1,2] However, the full extent of HIV transmission within prisons is unknown, in part because HIV testing strategies vary across state prison systems.[1] The Georgia Department of Corrections has mandated HIV screening of all inmates upon entry since 1988 and offers HIV testing during incarceration upon inmate request, if medically indicated, following exposure to bodily fluids, or in response to a court order. The Department of Corrections also routinely offered voluntary HIV testing to inmates during annual physical examinations from July 2003 through June 2005.

In mid-2003, a male Georgia Department of Corrections inmate who tested HIV-negative on entry into prison several years earlier was diagnosed with AIDS and died shortly thereafter. In early 2004, a second male inmate who had tested HIV-negative on entry was diagnosed with AIDS and died. Following these deaths, Department of Corrections medical staff reviewed routinely collected HIV testing data from 1988 through 2005 and identified an additional 86 male inmates who, having tested HIV-negative on entry, subsequently tested HIV-positive during the same incarceration. (Analysis of HIV testing histories is ongoing to determine if any inmates who seroconverted might have acquired HIV infection prior to incarceration.)

The Georgia Prison Investigation

From 2004 through 2006—in response to an invitation from the Georgia Department of Corrections and the Georgia Department of Human Resources—the U.S. Centers for Disease Control and Prevention (CDC), along with these Georgia agencies, conducted a case-control study to determine inmate factors associated with HIV seroconversion in Georgia state prisons. Investigators approached inmates who seroconverted ("case-inmates") and uninfected male inmates ("control-inmates") to ask if they would participate in a structured audio computer-assisted self-interview (ACASI), during which respondents recorded their responses to a survey using a computer touch screen.[3] Most inmates agreed to participate.

Investigators found that male-male sex during incarceration, tattooing during incarceration, a body mass index less than or equal to 25.4 kilograms per square meter on entry into prison, and Black race were associated with HIV seroconversion.[3] There were high rates of self-report of prohibited behaviors during incarceration. Among the 68 case-inmates, 71 percent reported sexual activity, 59 percent reported tattooing, and 10 percent reported injection drug use. Among the 68 control-inmates, 16 percent reported sexual activity, 41 percent reported tattooing and 1 percent reported injection drug use.[3]

The Georgia Department of Corrections agreed that investigators could provide an assurance to participants that reporting of prohibited behaviors such as sex, drug use, and tattooing in prison would not result in punitive action. Further, all data were reported in aggregate and no potential identifiers were available to corrections staff. Computer-assisted self-interview may be especially important in this setting because it enhances privacy. Inmates used touch screens without difficulty, and this method may account for the high proportion of inmates who reported prohibited behaviors when compared to results of previous correctional studies.

Findings from the case-control study suggest that inmates' risks for HIV infection during incarceration may differ from their risks before incarceration. When asked about

Editorial: No Escape

Robert Marks, Editor

Last year, I heard a radio interview with Patrick Sullivan, one of the authors in this issue of *FOCUS.* He told an interviewer that a Georgia state prison study had found that, despite public perceptions otherwise, much of the sexual activity in prisons was consensual. His words stuck in my mind. I was struck by the realization that the sequestered nature of prisons not only separates inmates from society but also hides the truth about prison culture in a series of stereotypes and assumptions.

For those of us working with HIV, the truth of prisons is important, because prison conditions can spread HIV. But as Sullivan and lead author Krishna Jafa point out, it is difficult to quantify the extent of prison epidemics because state prison systems have not been effective in tracking HIV rates. That's two questions—the nature of prison sexual behavior and the prevalence of HIV in prisons (and the incidence of HIV within prisons)—that the Georgia investigation brings under scrutiny.

The punishment that incarceration exacts derives not only from denial of freedom, but also from the privation and misery of prison conditions. Just as little of the reality of prison emerges outside the prison walls, little of society seems to get in—including adequate health care and HIV prevention. As politicians prioritize security over all other prison-related goals, it should come as no surprise that it has taken court intervention to ensure that prison health care meets minimal standards.

A prison is not simply an edifice. It is a psychological experience and a state of mind that extends beyond prison itself to the place where society and prison meet: the process of re-entry. As Kim Blankenship and Amy Smoyer observe in this issue, the limitations placed on probationers, parolees, and releasees make it impossible for inmates ever to escape the effects of prison. When releasees return to their communities, their treatment while incarcerated affects how they reintegrate both emotionally and physically. Further, post-incarceration strictures on employment and housing seem to seek to extend punishment beyond the jury's sentence and to make reintegration difficult.

Ironically, the effects of these confused policies undermine the chief societal goal of incarceration: to create a safer world. Instead, these policies create conditions within prisons—limited HIV prevention and health care—that foster HIV transmission. They create unnecessary hardship for releasees trying to reestablish their lives and instability within the communities to which releasees return—effects that also foster HIV transmission. We must find alternatives.

risks for HIV in the six months immediately before their current incarceration, large percentages of both case-inmates and control-inmates reported specific risk behaviors only after entering prison: 35 of 45 (78 percent) case-inmates and 4 of 9 (44 percent) control-inmates who reported male-male sex in prison did not report male-male sex prior to incarceration; 20 of 40 (50 percent) case-inmates and 19 of 28 (68 percent) control-inmates who reported tattooing in prison did not report tattooing prior to incarceration; and 4 of 7 (57 percent) case-inmates and the single control-inmate (100 percent) who reported injection drug use in prison did not report injection drug use prior to incarceration.[3] While the investigation did not assess lifetime risk, that is, participation in these behaviors prior to the six months before incarceration, the investigation can infer that some inmates who did not report male-male sex, tattooing, or injection drug use before incarceration likely initiated these risk activities only after entering prison.

Anecdotes and Data

A recent newspaper headline proclaimed, "Answer to AIDS Mystery Found Behind Bars," and drew the conclusion that Black people in the United States are disproportionately affected by HIV because they become infected in prison.[4] Compelling personal stories highlighted in the mainstream media may have left the impression that prisons are a breeding ground for the HIV epidemic—especially in Black communities—and that inmates who have male-male sex in prison are an important bridge between the HIV epidemic in prisons and the community at large.

Indeed, many Black women have only one degree of separation from the risks men assume in prison. A recent investigation of Black women in North Carolina found that 88 percent of HIV-positive women and 68 percent of HIV-negative women had a male partner with a history of incarceration.[5] Data from the Georgia investigation, however, suggest that 90 percent of all known HIV-infected inmates became infected prior to the current incarceration.[3] The contrast of this fact and the perception that prison is the primary source of HIV infection in the Black community suggest that both substantiation and context are essential to avoid creating and perpetuating myths about HIV transmission and stigmatizing particular groups.

Likewise, dissemination of initial findings from the Georgia investigation was

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2. McQuillan GM, Kottiri BJ, Kruszon-Moran D. The prevalence of HIV in the United States household population: The national health and nutrition examination surveys, 1988 to 2002. Presentation from the 12th Conference on Retroviruses and Opportunistic Infections, Boston, Mass., February 2005.

3. Centers for Disease Control and Prevention. HIV transmission among male inmates in a state prison system—Georgia, 1992–2005. Morbidity and Mortality Weekly Report. *2006; 55(15): 421–426.*

followed by widespread media coverage, best summarized by the headline "Few Men Found to Get HIV in Prison."[6] While it is true that most known HIV-positive Georgia prison inmates became infected prior to the current incarceration, it is also true that the investigation was not designed to determine how commonly HIV infection occurred. Some inmates who were infected with HIV in prison may not have been tested; therefore, the 88 cases of HIV infection identified in Georgia state prisons likely represent the minimum number of infections that occurred. Ongoing analyses will help establish the proportion of the 88 seroconversions that represents intra-prison HIV transmission.

Findings from the Georgia prison investigation suggest consensual sex is more common than rape: 73 percent of inmates who reported sex in prison characterized it as consensual.

Georgia is not alone in being unable to determine seroconversion incidence in the prison system. Data on HIV transmission within other U.S. state prison systems are also sparse, because few prison systems offer routine HIV testing to inmates.[1,7] Identification of new cases of HIV infection during incarceration may also be hampered by fear: inmates may be reluctant to request a test when such a request might be viewed as an admission of prohibited or stigmatizing behavior. Inmates may also be justifiably concerned that if they test HIV-positive, others will learn of their status and that they may be formally or informally segregated from their peers.

Routinely offering HIV testing is a promising strategy for diagnosing HIV infections that may have been acquired during incarceration.[8] While HIV testing data for the two-year period when voluntary annual testing was offered to Georgia Department of Corrections inmates are still being analyzed, data from 29 prisons for May 2005 show that more than 90 percent of inmates offered a test in that month agreed to be tested. Further, of the total of 88 seroconverters identified in the Georgia Department of Corrections prisons, 41 (47 percent) were diagnosed during the investigation's two-year period compared to 47 (53 percent) diagnosed during the preceding 16.5 years.[3]

Consent is a Continuum

The media often highlight reports of prison rape and sexual slavery. Findings from the investigation, however, suggest consensual sex may be more common than rape in Georgia prisons.[3] In the case-control study, 73 percent of inmates who reported sex in prison characterized it as consensual, 22 percent characterized it as "exchange sex" (they traded sex for goods or services), and 12 percent characterized it as rape.[3] There was considerable overlap in reasons for consensual and exchange sex; for example, some inmates reported consensual sex, but said that the reason they had consensual sex was for money, drugs, food, personal protection, or cigarettes. This flexible conceptualization of the meaning of consent was also reflected in qualitative interviews with inmates and suggests that conventional definitions of consent have limited meaning in the complex prison environment. Rather, sex among prison inmates might be characterized as a continuum that includes truly consensual, non-exchange sex; sex in exchange for tangible or intangible benefits; and physically coerced sex, including rape.

Among inmates who reported sexual activity in prison in the Georgia investigation, 44 percent reported sex with male prison staff and 36 percent reported sex with female prison staff.[3] Sixty-two percent of inmates who reported sex with prison staff characterized such sex as consensual. This characterization has been borne out at the national level: two-thirds of all substantiated incidents of staff sexual "misconduct" against inmates have been determined by correctional authorities to be of a "romantic" nature (even though the Prison Rape Elimination Act defines sexual contact between correctional staff and inmates to be nonconsensual and illegal).[9]

Further, during qualitative interviews, prison staff requested education about HIV, hepatitis, and other sexually transmitted diseases. These findings highlight, from an epidemiological perspective, that prisons are not a "closed system" for the spread of HIV.

Risks and Realities

In the investigation, tattooing was associated with HIV seroconversion during incarceration and 18 percent of seroconverters reported tattooing as their only risk behavior for acquiring a sexually transmitted or blood-borne infection during incarceration.[3] There is currently no documented case of HIV infection in which tattooing was shown to be the route of HIV transmission. Outside prison, however, commercial tattoo establishments

4. Morin R. Answer to AIDS mystery found behind bars. Washington Post. *9 March 2006.*

5. Centers for Disease Control and Prevention. HIV transmission among black women—North Carolina, 2004. Morbidity and Mortality Weekly Report. *2005; 55(04): 89–94.*

6. Brown D. Few men found to get HIV in prison. Washington Post. *21 April 2006.*

7. Hammett TM. HIV/AIDS and other infectious diseases among correctional inmates: Transmission, burden, and appropriate response. American Journal of Public Health. *2006; 96(6): 974–978.*

routinely use sterile equipment. Prisons have a relatively high prevalence of HIV infection, and tattooing is done with non-sterile and improvised equipment. Follow-up interviews with the Georgia inmates who reported tattooing as their only risk for HIV infection will be an important way to ascertain whether these inmates have additional risks, and the results may warrant further study of the association between tattooing and HIV transmission.

The prohibition of behaviors, such as sex and injection drug use as well as tattooing, creates a difficulty for prison officials and lawmakers who are considering the implementation of practical risk reduction interventions in prisons. In the United States, there have been few evaluations of the acceptability and effectiveness of prison HIV prevention interventions such as condom distribution. Several U.S. correctional jurisdictions, and prisons in Canada, Europe, and Australia, provide condoms to some inmates with no reports of negative consequences. While no U.S. prisons provide bleach to inmates, Canadian, European, and Australian prisons do, and several European countries successfully run prison needle exchange programs. Following the Georgia investigation, the CDC has recommended that U.S. correctional jurisdictions evaluate the feasibility of implementing condom distribution programs.[3]

Despite the fact that most HIV-infected inmates are ultimately released from prison, little is known about how HIV risk behavior, awareness of risk, and disclosure of HIV status to partners changes after release. The Georgia investigation did find that 85 percent of inmates who reported having sex in prison also reported they would be very likely to use a condom with their sex partners after release. However, only 66 percent of these inmates agreed that inmates who have unprotected sex while in prison should use a condom with sex partners after release, and only 63 percent said they would be willing to tell their sex partners outside prison about their unprotected sexual behavior in prison.

Conclusion

The high prevalence of HIV in U.S. prisons combined with insufficient prevention efforts and continued risk behavior may create the conditions for a "perfect storm." As is clear from the Georgia investigation, U.S. prisons face a variety of needs, including: quantifying the extent of HIV transmission in prison, improving understandings of HIV transmission risks in prison, evaluating existing prison-based HIV prevention programs, and increasing the availability of prevention programs, including routine voluntary HIV testing, HIV education, and practical risk reduction interventions.

It is unclear, however, if all of the Georgia findings can be generalized to other prison settings. While the behaviors documented in the Georgia investigation have been reported in facilities throughout the country, there are important differences between the Georgia prison population and inmates in some other states. Approximately 60 percent of Georgia inmates are Black—and being Black was a marker for increased risk of infection in the Georgia investigation—so it will be important to conduct similar investigations in prison settings with greater racial and ethnic diversity.

The debate about the role that prisons play in the HIV epidemic is ongoing. Nonetheless, it is clear that prisons are a point of congregation for men who face substantial risks for HIV infection before, during, and, likely, after incarceration. At this center of HIV-related jeopardy, prisons provide an important opportunity to deliver comprehensive HIV education, testing, and prevention counseling, and to link inmates with HIV to appropriate care and treatment in prison and upon release. These efforts, plus ongoing research, will reduce risks of HIV transmission among inmates and the larger non-incarcerated community to which most of them will return.

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9. Beck AJ, Harrison PM. Sexual Violence Reported by Correctional Authorities, 2005: Bureau of Justice Statistics Special Report. *Washington, D.C.: U.S. Department of Justice, July 2006.*

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Prison, Re-Entry, and HIV Prevention

Kim M. Blankenship, PhD and Amy B. Smoyer, MSW, MPA

Prisons and jails are part of a broader criminal justice system that removes large numbers of citizens from, and then returns them to, their communities. The result is a massive migration that produces or exacerbates instability and vulnerability in the lives of inmates, their families, their social and sexual networks, and their communities. This is true even if these other people have never themselves been under the jurisdiction of this system. For this large group of people, the criminal justice system represents a critical aspect of the social context that enhances the likelihood of their exposure to HIV.

The prison system removes many people from their communities—and then returns them. This massive migration destabilizes communities and creates vulnerability for former inmates and their families.

In addition, because of the disproportionate numbers of African-Americans in the criminal justice system, this movement of inmates between prison and the community may contribute to the disproportionately high rates of HIV infection among Black people. Making up only 13 percent of the U.S. population, Black people accounted for 42 percent of all AIDS cases reported in the country through 2005 and 49 percent of all new HIV cases reported in that same year.[1] Further, while rates of HIV have declined over the past decade, they have declined more slowly for Black people than for White people.

Elevated rates among Black people cannot be fully explained by differences in unprotected sex or injection drug use and needle-sharing practices. For example, a recent study found that young Black adults report higher rates of condom use than their White counterparts.[2] Similarly African American heroin users are less likely than other racial and ethnic groups to have injected,[3] and rates of needle sharing are lower among African American women than non-Hispanic White women.[4]

Reducing HIV-related race disparities requires moving beyond individual-focused explanations of risk and targeted interventions, instead implementing structural interventions to address social structures of risk.[5] The criminal justice system represents one such social structure and one with a high concentration of Black people: 39 percent of local jail inmates[6] and 40 percent of those under state or federal jurisdiction.[7] The problem, however, extends beyond incarceration itself to, for example, the difficulties of community re-entry and the high rates of recidivism among former inmates. Little is known about the ways these well-documented patterns contribute to HIV-related risk, although researchers have hypothesized a number of mechanisms through which this may occur. Among these are: undermining families and social networks; and creating or increasing socioeconomic vulnerability.[8]

Disruption, Instability, and HIV Risk

Ongoing Yale University research, funded by the National Institute of Drug Abuse (NIDA), expands upon these hypotheses. Known as Project SHARPP (Structures, Health and Risk among Parolees and Probationers), the study involves three semi-structured qualitative interviews conducted at six-month intervals over one year with 48 probationers and parolees recently released from prison or jail. The average age of respondents is 37. Sixty percent are Black, 27 percent are Latino/Latina and the remaining are White. Women com-

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prise 27 percent of the sample, men 71 percent. There is one transgender person. Preliminary findings document the HIV-related implications of movement from jail to community and, for many, back to jail again.

Respondents describe how their families are torn apart. All women in the sample have lost custody of at least one of their children, either temporarily or permanently, because of their involvement with the criminal justice system. Grief and a sense of desperation can exacerbate, if not create, mental health problems and drive former users back to drug use. Couples, seeking to remain together, may be unable to do so because of federal policies that prohibit people with criminal histories from living in public housing. This leaves the couple with two unattractive choices: either prioritize the goal of reuniting, which means that the partner with no criminal record (usually a woman) must relinquish the relative security of public housing; or prioritize the goal of preserving public housing for the eligible partner, which means that the partner with the criminal history (often the man) may end up living with someone else, who is sometimes also a sexual partner.

Indeed, concurrent sexual relationships are pervasive, and men and women both describe relationships that begin when a partner is in prison and continue once the partner returns. Male respondents in Project SHARPP also describe fathering children born to more than one woman within months of each other. Male respondents describe another dynamic: their incarceration forces their partners, who cannot afford to live alone, to seek other living arrangements, which often introduces these women to new male sexual partners. Limited housing options also lead some female respondents to live in situations where they are at risk of violence. Remaining drug free, a common condition of release, and reducing drug-related HIV risk is difficult for respondents who are required to live in halfway or sober houses that are, ironically, most often located in neighborhoods where drugs are easily accessible. Many other respondents describe how limited housing options upon release force them into homes where drugs are being used or sold.

The Failure of Probation and Parole

These consequences of criminal justice involvement—family and network instability, drug use, mental health problems, economic vulnerability, and violence—are all, in turn, associated with HIV transmission-related behaviors. SHARPP respondents who have been able to overcome these consequences have tended to do so by relying on support networks and savvy manipulation of safety net and social service programs. This becomes increasingly difficult the more times an individual circulates through the criminal justice system. What respondents almost universally describe as failing them are the probation and parole systems.

Whether a probation or parole officer is sympathetic, indifferent, or harsh, respondents agree that the probation and parole systems offer little help with re-entry, though this is what is needed most. As one respondent noted: "If I could change something about parole, I would say . . .: You got the guys coming out of jail. Help them. Help them get a frigging job. . . . Help them get a place together. . . . Know what I'm saying?"

Conclusion

In response to the massive migration of individuals between communities and the criminal justice system, particularly within communities of color, the HIV prevention agenda must evolve. It must extend beyond HIV-specific programs to encompass a range of initiatives to keep people out of jail and to improve the chances of successful community re-entry for those who are incarcerated.

Such initiatives include a reexamination of drug enforcement policies, which put nonviolent offenders behind bars, as well as policies that restrict access to housing and employment among former inmates. Intensive case management programs linking released inmates to services, housing, and jobs can help, to the extent that the services, housing, and jobs are available. Collaborations with local employers through which inmates are guaranteed decent jobs after completing appropriate training have considerable potential. Programs to ensure housing, even to active users, are also promising.

Even simpler alternatives such as providing bus passes, identification cards, and phone cards can facilitate access to re-entry services. By increasing stability of the lives of former inmates, these approaches can contribute to reducing HIV- and health-related racial disparities.

Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rob.marks@ucsf.edu or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

Recent Reports

Releasees and Risk to Female Partners

As Krishna Jafa and Patrick Sullivan note in this issue, women who are sexual partners of men who are, or have been, in prison are separated by only "one degree" from the HIV-related behaviors of these men while they are incarcerated. Also in this issue, Kim Blankenship and Amy Smoyer discuss life after release for releasees and their families. Two studies examine the HIV- and sexually transmitted disease (STD)-related behaviors of releasees. The following summaries were excerpted from the cited articles and their abstracts:

Grinstead O, Faigeles B, Comfort M, et al. HIV, STD and hepatitis risk to primary female partners of men being released from prison. *Women and Health*. 2005; 41(2): 63–80. (University of California; Brown University; and U.S. Centers for Disease Control and Prevention.)

In a study of 105 incarcerated men, concurrent risk of HIV and STD transmission to their primary female partners was higher prior to incarceration rather than after release. For the purpose of the study, concurrent risk was defined as a man who had unprotected vaginal or anal sex with their primary female partner and one or more of the following: unprotected intercourse with another female, unprotected intercourse with a male partner, or needle sharing for injection drug use.

Researchers interviewed 105 male participants ages 18 to 49 from state prisons in California, Mississippi, Rhode Island, and Wisconsin. All men were scheduled for release within 30 to 60 days. Interviews covered sexual and drug-related risk behaviors and were conducted before release from prison, and one and three months after release. (Qualitative data were also gathered at other intervals but not included here.)

While many women with HIV are incarcerated, only a small number in the U.S. South were diagnosed within prisons.

In the prerelease interview, 81 percent of participants reported sex with a primary female partner. Of these 85 men, 78 (92 percent) reported having unprotected sex with their primary female partner. Thirty-six (46 percent) of the 78 men had unprotected sex with concurrent risk prior to incarceration. Of these, 32 had unprotected vaginal or anal intercourse with a female partner, two shared needles, one had unprotected anal sex with another man, and one both shared needles and had unprotected vaginal or anal sex with a woman.

One month after release, 63 of 94 participants (67 percent) reported having a primary female partner, and 55 (87 percent) engaged in unprotected intercourse with her. However, only 10 men (18 percent) reported unprotected intercourse with another female partner. There was no reported risk due to injection drug use or intercourse with a male partner.

Finally, three months after release, 61 of 86 participants (71 percent) reported having primary female partners. Eighty-two percent had unprotected sex with their primary female partners, and 24 percent of those engaged in risky behavior. Of these 12 men, 2 percent shared needles, 2 percent both shared needles and had unprotected sex with a female partner, and 10 percent only had unprotected sex with another female partner.

At all time intervals, the greatest concurrent risk was correlated with the following factors: being White, having risky female partners or a history of injection drug use, and having a higher number of lifetime partners. Risky female partners were defined as sexual partners whom the men believed had traded sex for drugs or money, injected drugs, used crack cocaine, were HIV-positive, or had an STD.

Stephenson B, Wohl D, McKaig R, et al. Sexual behaviors of HIV-seropositive men and women following release from prison. *International Journal of STD and AIDS*. 2006; 17(2): 103–108. (University of North Carolina; U.S. National Institute of Allergy and Infectious Diseases; and Catawba Care Coalition, Rock Hill, South Carolina.)

After release from prison, all participants in a North Carolina study of HIV-positive inmates reported increased condom use, particularly with non-regular partners.

Researchers recruited participants from the two main prison HIV clinics in the North Carolina state prison system between May 2001 and February 2003. Participants were HIV-positive inmates scheduled for release within three months of prerelease survey completion. Of 156 eligible participants, 86 completed the prerelease survey, but only 64 (74 percent of the 86) were retained for the entire study. Seventy-four percent of study participants were Black; 83 percent were heterosexuals; and 76 percent were diagnosed with HIV prior to incarceration.

Investigators conducted prerelease interviews face-to-face, and conducted post-release interviews by telephone. Both surveys examined a range of HIV-related behaviors and relationships and incarceration history.

Sexual behaviors changed little before and after incarceration. However, condom use differed prior to incarceration and post-release. Seventy-nine percent of all releasees

reported increased condom use compared to condom use before their last incarceration. However, only those with non-regular partners reported using condoms every time they engaged in sex. Thirty-three percent reported engaging in unprotected sex with their HIV-negative partners.

Sixty-six percent of all participants said they believed in fully disclosing their status to their partners, and 69 percent were concerned about transmitting HIV sexually. Only 28 percent reported being drunk or high during sex after release.

HIV Testing in a Massachusetts Prison

Liddicoat R, Zheng H, Internicola J, et al. Implementing a routine, voluntary HIV testing program in a Massachusetts County prison. *Journal of Urban Health.* 2006; 83(6): 1127–1131. (Veterans Administration, Los Angeles.)

Jafa and Sullivan call for routine, voluntary testing in prisons. The Veterans Administration study below examined the acceptability of voluntary HIV testing in a Massachusetts prison. The following summary was excerpted from the cited article and its abstract:

An investigation of the acceptance of routine HIV testing by newly admitted inmates in a Massachusetts county prison found that this service was utilized far more often than on-request HIV testing had been.

Between November 2004 and April 2005, 1,004 new inmates received group HIV prevention counseling and were offered private HIV testing, performed on blood drawn for mandatory syphilis testing. Of these, 734 (73 percent) accepted. Twenty-seven percent declined testing. Of those that declined, 48 percent tested the previous year and 29 percent believed themselves to be low risk. Of the 734 that tested, 2 (0.3 percent) tested HIV-positive. The results were compared to a 12-month control period in 2003.

During the control period, 1,723 inmates were informed at prison orientation that HIV testing was available upon inmate or physician request. Only 18 percent of inmates or their physicians requested HIV testing during the control period. The high rate of acceptance demonstrated that routine HIV counseling and testing is acceptable to inmates.

Southern Women, Prisons, and HIV Risk

Hammett T, Drachman-Jones A. HIV/AIDS, sexually transmitted diseases, and incarceration among women: National and southern perspectives. *American Sexually Transmitted Diseases Association.* 2006; 33(7): 17–22. (Abt Associates, Cambridge, Massachusetts.)

Both of the articles in this issue examine women's HIV risk as it relates to their partnerships with incarcerated and formerly incarcerated men. To supplement this, an Abt Associates article explores the HIV and STD risks of incarcerated women in the southern United States. The following summary was excerpted from the cited article and its abstract:

While many women with HIV—especially poor, Black women in rural areas—are incarcerated, only a small number of women with HIV in the southern United States were diagnosed within correctional facilities, according to a review of national and state statistics.

Researchers obtained data on correctional populations, incarceration rates, number of prison admissions, and HIV prevalence among inmates from the U.S. Bureau of Justice Statistics, the U.S. Centers for Disease Control and Prevention, and state health departments. While incarceration rates for women are higher in the South than any other U.S. region, overall HIV rates are also higher in the South than in other regions.

Only small percentages (0.6 percent to 7.0 percent, depending on the state) of newly reported AIDS cases in women in the South were diagnosed in correctional facilities. These numbers stand in contrast to four comparisons between the southern United States and other U.S. regions: the South has the highest burden of HIV (26 percent); the South bears the second highest HIV burden among female releasees (15 percent); the prevalence of syphilis, gonorrhea, and chlamydia in women entering the prison system are highest in the South; and STD and HIV rates in the South are higher among women than among men. Regional incarceration rates did not differ significantly based on a single factor of gender or race and ethnicity.

Next Issue

The extent to which it is a crime for a person with HIV to have sex depends on where that person lives, how courts interpret laws, and whether prosecutors enforce laws. In the May issue of *FOCUS*, **Zita Lazzarini, JD, MPH,** Director of the Division of Medical Humanities, Health Law, and Ethics at the University of Connecticut School of Medicine, and **Ross Friedberg, JD/MPH Cand.** at the University of Connecticut, review U.S. state law and enforcement as it applies to the criminalization of HIV.

Also in the May issue, **Tiffany Chenneville, PhD**, Assistant Professor of Psychology at the University of South Florida, articulates guidelines to help providers appropriately apply the duties to protect and to warn to HIV-positive clients who engage in unprotected sex.

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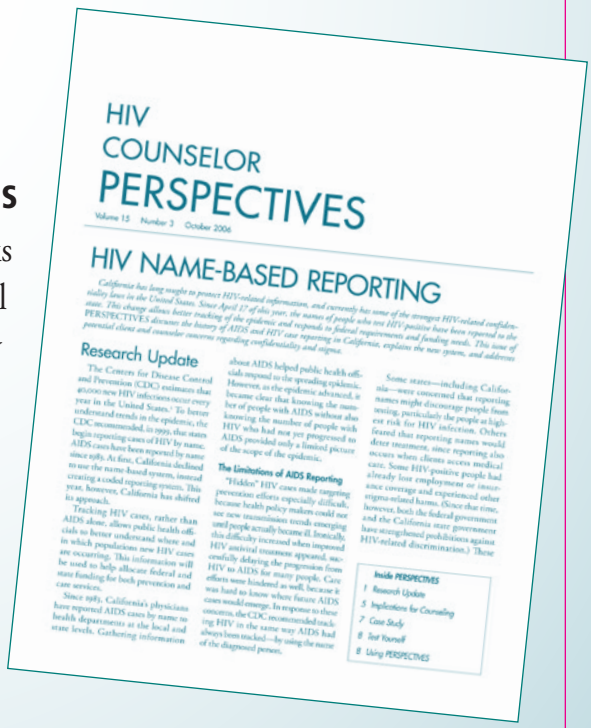
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