Literature review: does the distribution of condoms to male prison inmates affect (decrease) the spread of sexually transmitted diseases like HIV/AIDS?

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2008
Dedication

First and foremost I would like to thank God for everything he has done for me because without Him I would not be where I am today. To my husband, Julius A. Hill, you mean so much to me more than words can express. I love you because you have been there from the beginning of this process from the interview to now, and I would not have it any other way. My boys, Sebastian and Ar’rees Hill, you boys are the love of my life. You endured 27 months with me in another state and never complained about it, at least not to me, thank you. My mother, Marva L. Johnson, you are my rock and my strength. You give the best advice and have been there for me through everything from the day I was born. I love you so much. To the rest of my family thank you for your support and I love you all.
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Introduction

In mid 2007 there were 2,299,116 prisoners held in either state, federal prisons, or local jails, according to the United States Department of Justice, Bureau of Justice Statistics. This staggering number is up, a 1.8% increase from year-end 2006 (US Dept. of Justice, 2008). A very small percentage of these individuals in jails and prisons are serving a life sentence or are on death row. However, as more and more people are imprisoned, they could be leaving the justice system with a “life sentence of being HIV/AIDS infected.” The reason for this is because HIV/AIDS is increasingly being spread amongst the prison population throughout the United States (Braithwaite & Stephens, 2005; Peller 2006; Mahon, 1996; Bryan, Robbins, Ruiz, & O'Neill, 2006).

According to Arroila (2006), “little empirical research explores intra-prison HIV transmission with scientifically rigorous methods.” This is due to several reasons including the fact that incarcerated individuals are considered a special population by the Research Institutional Review Board. Reportedly, inmates are deserving of additional research protections; however, in general prisoners are a distrusting population and less willing to be a subject of a study. Also correctional administrators do not see research as a priority possibly in fear that something unflattering about them may surface in study findings (Arriola, 2006).

Several other factors including poor surveillance systems, brief incarceration periods, and a lack of medical care in prisons also contribute to higher prevalence rates of HIV/AIDS infections. More importantly, a crucial reason why an accurate prevalence rate among the inmate population is unknown is because of the stigma surrounding
HIV/AIDS and other STD’s and infectious diseases (Dolinsky, 2007) and secondary to varying testing policies (Grinstead, Zack, & Faigeles, 1999; Kantor, 2006). Inmates may feel if they speak openly about HIV/AIDS and its prevention then they may be admitting to engaging in homosexual behavior (consensual or not) and possible drug use which may be looked at negatively amongst their peers. Also there is stigma associated with a positive HIV/AIDS test result and this could make inmates fearful of being tested (Braithwaite & Arriola, 2003). So, prevalence rates may actually be higher than reported due to one or more likely combination of these factors.

Given this background this scholarly project is a literature review that identifies relevant data from studies about the spread of HIV/AIDS amongst the incarcerated population and the concept of “harm reduction” which in this case includes condom distribution programs. Topics to be covered in this literature review in fulfillment of this scholarly project, will include: (1) Introduction; (2) Significance; (3) Methods; (4) The face of the prisoner; (5) HIV/AIDS background including etiology, signs/symptoms, complications; (6) HIV/AIDS impact and burden on the diagnosed; (7) Facilities and studies done on condom distribution programs amongst incarcerated populations; (8) Conclusion; and (9) Abstract.
Significance

HIV/AIDS is being contracted in the prison system, even though prevalence rates are unknown (Braithwaite & Stephens 2005). According to a study conducted between 1992 and 2005 in a Georgia state prison system, during July 1988 and February 2005, 88 male inmates were known to have had a negative HIV test result upon entering the facility, some of which having more than one negative result, and a confirmed positive HIV test result sometime during the incarceration period (Taussig et al., 2006). The inmate population could benefit from the same type of care available in the community (Braithwaite & Arriola 2003), regarding HIV/AIDS prevention and transmission, and that is condom use.

Condoms are readily available for those who can afford them at gas stations, and many stores including drug and grocery stores. Also, condoms are available at local public health departments throughout the United States because they realize that the virus that causes HIV/AIDS is a public health concern. This preventative practice is appropriate and very useful for those in the community, but does not help the population, such as those incarcerated, especially males that are locked away from these resources.

Only correctional facilities in two states and five cities have condom distribution programs. Mississippi, Vermont, Los Angeles, New York, Philadelphia, San Francisco and Washington D.C. are the only locations currently that have condom distribution programs. Mississippi Correctional Facility condom distribution program began in 1992 and is a limited type of condom distribution program (Peller, 2006). Condoms are only
distributed to married inmates to be used during conjugal visits. These visits can last up to one hour in length and the inmates are given two condoms that can be used at that time. HIV/AIDS spread is not the primary concern here but “birth control” is the driving force behind Mississippi’s condom distribution program (Peller, 2006).

In Los Angeles, a community based organization provides county jail inmates with condoms at their request. One condom can be given per week to an inmate in a special unit called the K-11 unit, which houses inmates who identify themselves as gay, bisexual or transgender. HIV/AIDS testing is not mandatory but education is provided for those who request it. Estimates of about 100 condoms are given out each week through this organization throughout Los Angeles county jails (Peller, 2006).

Riker’s Island, a New York City Facility, provides up to three condoms to each prison inmate through their medical clinics. Like in most correctional facilities sex between inmates is prohibited and having more than three condoms per person is considered contraband. HIV testing is voluntary and all inmates upon arrival to the facility receive a medical examination (Peller, 2006).

Philadelphia provides condoms to their inmates in a two-fold process. Condoms are available to inmates through commissary for a fee and also provided for free on medication carts and through social worker’s offices. Condom distribution began here in the late 1980’s and an annual amount of around 15-20,000 condoms are distributed throughout various facilities in Philadelphia (Peller, 2006).

The condom distribution program in San Francisco began in 1987. Condoms are distributed amongst inmates at their request from a health educator once the required HIV/AIDS prevention program is complete. Provided through an organization within the
San Francisco Department of Public Health, the Forensic AIDS Project supplies inmates with education and counseling and once complete they may request condoms. In 2006 there was a bill that passed State legislation regarding expanding the condom distribution programs to all facilities throughout California but it was vetoed by Governor Schwarzenegger (Peller, 2006; McLemore, 2008). Washington D.C. jail provides condoms to their inmates through health workers along with education and counseling. The program is different in that inmates can become peer educators through training and participate in support groups. Two different organizations provide the condoms to the D.C. facility, Family and Medical Counseling Services, Inc. and Miracle Hands (Peller, 2006). HIV/AIDS testing is voluntary, as in most correctional facilities.

In Vermont several State prisons provide HIV/AIDS education, counseling, rapid testing, substance abuse and other STD education. Vermont CARES and Imani make it possible for inmates to get the resources they need to become educated about HIV/AIDS and various other illnesses like substance abuse and other diseases (Peller, 2006). Condoms are given through the health centers once inmates propose a request for them.

These are just a small number of facilities that allow condom distribution compared to the total number of facilities throughout the U.S. that house inmates. If these were the same types of resources, or lack of resources offered in the community, than the virus HIV/AIDS would be running rampant throughout the United States.

The prison population has great difficulty accessing condoms to use as protection against HIV/AIDS and other STD’s. May and Williams (2002) wrote, “less
than 1% of the jails and prisons in the United States allow inmates access to condoms, and none allows access to needles.” One percent is such a small number considering the number of American men in the prison system engaging in risky sexual behaviors that could benefit from this type of intervention (McLemore, 2008). Given the legal mandates on prisons to provide inmates with the same quality and standard of health care available in the community (Braithwaite & Arriola, 2003), than why is as little as 1% of the entire prison population in the U.S. given condoms? In the U.S. there are several reasons why condoms haven't gained full acceptance and aren't widely distributed inside prisons and jails: (1) promotion of illegal behavior; (2) use of condoms as transport devices for drugs within the prison system; and (3) cost and/or access to condoms. In this paper each of these barriers to condom distribution within U.S. prisons will be addressed.

First, many correctional officials and policy makers feel that if condoms are distributed in prison, this will promote sexual behavior that is illegal in most prisons (Lipton, 1997; Hammett, 2006). Despite sexual activity being illegal in all prison and jail institutions, prisoners are still engaging in this type of behavior (May & Williams, 2002; Arriola, 2006; Mahon, 1996; Hammett, 2006; Moseley & Tewksbury, 2006). Since this is the case then these prisoners should have the opportunity to take advantage of ways to protect themselves from receiving the HIV/AIDS virus and/or STD's (Hammett, 2006). Transmission related to sexual activity in jails and prisons occur, and sexual activity occurs extremely often in a variety of ways. Different forms of sexual activity that take place in prisons and jails are rape or coercion, consensual sex, sexual actions or favors as a form of prostitution, sexual partnering and sexual promiscuity all increasing the risk
of spread of diseases (Spaulding, Lubelczyk, & Flanigan, 2001; McLemore, 2008). The attitude that condom distribution would promote illegal behavior can hinder legal action needed to implement programs such as distribution of condoms to all inmates in prisons if that will decrease HIV/AIDS transmission there.

Secondly, condoms as contraband used to transport drugs and other illegal items within prison walls has also been a concern for many correctional staff (Lipton, 1997). This is another reason why support for condom distribution within the prison and jail systems is very limited. According to May and Williams (2002) a study done on the acceptance of the condom distribution program in the District of Colombia concluded that the program was not disruptive and even worthy of being reproduced in other facilities. They stated that, “No major security infractions involving condoms have been reported in the jail since the inception of the program.” Also Leh (1999) found that contrary to what critics may think, there have been very little, if any, problems with condoms being used as weapons or to smuggle contraband into or within an institution. McLemore (2008) agrees with Leh (1999), May and Williams (2002) also concluding that no major security problems arose in facilities where condoms are distributed. Findings from May and Williams (2002), Leh (1999), and McLemore (2008) support the fact that condoms are really not being used or haven’t been recognized as being used as contraband to transports drugs within the facilities and thus should not be a barrier to inmates receiving access to them.

Thirdly, cost and access to condoms within the prison system is another big problem with wide distribution throughout the United States. According to Braithwaite and Arriola (2003), even when there is concern about inmate healthcare, prevention
services are usually at the bottom of the list of priorities. “With budget constraints and the existence of competing programs, it is clear how correctional officials may not consider HIV prevention programs to be important enough for funding, although public health officials remain adamant in support of such programs,” (Braithwaite & Arriola, 2003). This lack of monetary resources hinders implementing HIV/AIDS prevention programs even though there is awareness that these programs are needed (Braithwaite & Arriola, 2003; Arriola, 2006). The reason for this is because it is expensive to distribute condoms to such a large population of incarcerated individuals. The World Health Organization (WHO) buys condoms for about five cents apiece (Pinkerton, Abramson, & Holtgrave, 1999). If the prison systems are working with WHO or the Center for Disease Control (CDC), they can probably also benefit from this low price for condoms. Also as stated above regarding the facilities already distributing condoms in their facility, most of these programs are funded by HIV/AIDS organizations that provide free condoms or pass the cost onto the inmates.

The dollar amount can become very high when it comes to purchasing and distributing condoms to male prison inmates. But when compared to the cost of living with the HIV/AIDS infection, which can be up to around $275,000/case for the entire life of the patient as stated by Pinkerton and Holtgrave (cited by Pinkerton et al., 1999), the cost of a condom is minimal. According to Eng and Butler (as cited in Pinkerton et al., 1999), annual health care related costs for STDs is about 7.5 billion dollars and when HIV is added this figure increases to 12.5 billion dollars. These costs affect society by increasing health care costs, taxes, and insurance premiums. Even though condoms
cost money, they can also reduce the burden on the economic resources of society by preventing HIV and other STDs.

The reason for the concerns about HIV spread amongst prisoners is because at year-end 2006, the US Dept. of Justice, Bureau of Justice Statistics reported that 19,842 male and 2,138 female inmates were HIV infected or had confirmed AIDS (Maruschak, 2008). This community is one that is greatly impacted by this disease (Arriola, 2006). The overall rate of confirmed HIV/AIDS among the prison population (0.46%) was more than 2.5 times higher than in the United States general population (0.17%) (Maruschak, 2008). In 2006, 155 state inmates died from AIDS-related causes, of which 74% were Black-non Hispanic (Maruschak, 2008). It is estimated that 25% of those living with HIV pass through correctional facilities each year stated by Spaulding et al., (2002). The number of male prison inmates (state and federal) infected with HIV or AIDS in 2006 was 19,842 (2,138 females) compared to 20,444 in 2005, so the number has decreased from the previous year and has actually shown a steady decrease since 1999 (Maruschak, 2008), but this is still a lot of men who can benefit from protection.

This literature review specifically talks about the impact that can be made if men are given the right to use condoms when engaging in sexual activity. The reason this literature review focuses on men only is because there are significantly more men in prison than women; since more men are imprisoned, this gender is more likely to contract HIV/AIDS in prison and jails when compared to female inmates. Currently there are also more HIV/AIDS infected men in prison (actual number, not percentage)
than HIV/AIDS infected women so targeting this population will have a greater impact in reducing the spread of STD’s like HIV/AIDS.

The numbers of HIV/AIDS infected male inmates are decreasing for several different reasons, mostly due to faulty reporting. One reason for the decrease is because New York, which has one of the highest HIV/AIDS inmate populations (4,000 HIV/AIDS infected individuals in 2006), obtained their data through estimates (Maruschak, 2008). “Due to this estimation method, New York has reported very large decreases in the number of HIV positive inmates from year to year,” (Maruschak, 2006). Since their reporting data is estimated this could possibly skew the data and lower the true figures. Also California’s 2004 HIV/AIDS data amongst prison inmates was estimated by applying the same percentage of infected HIV/AIDS inmates in 2002 to the 2004 inmate population (Maruschak, 2006). Again this does not represent the true AIDS population amongst California inmates but a mere estimation from the 2002 data. The HIV/AIDS data from Maine, Kentucky, Alaska, and Oregon correctional facilities have been excluded from years 2002-2004 due to incomplete reporting (Maruschak, 2006). Such estimations of the number of individuals infected with HIV/AIDS in facilities across the United States can down play the actual values and show a decrease when there is actually no change or maybe even an increase.

Even though the data has shown a decline in HIV/AIDS cases in prisons, inmates as well as staff can still benefit from education and safe sex practices. Prison systems can increase an inmates risk for infectious diseases like HIV/AIDS (Lipton, 1997; Dolan, Kite, Black, Aceijas, & Stimson, 2007). Some reasons for this are due to close contact, close living quarters, poor sanitation, and risky sexual practices as compared to the
non-prison community. For this reason HIV/AIDS prevention is absolutely necessary in this population and should be taken very seriously. Acquiring AIDS whether in prison or not is a very devastating diagnosis. There are many new retroviral drugs, and other medications used to treat HIV/AIDS that can make patients lives far better but there is still no cure, often leading to a lifetime of treatment, cost, increasing opportunity to infect others, and subsequently death from the virus. Most of the inmates are released into the community returning to their normal and/or dysfunctional sexual activity (Hammett, 1999; Zack et al., 2001). It would be devastating to society and possible infection of unknowing partners if HIV/AIDS transmission could have been prevented while inmates were incarcerated.

The Federal Bureau of Prisons requires HIV testing upon inmate release and refusal could result in an extension of the inmate’s sentence stated by Hammett (cited in Leh, 1999). By doing this the federal system can mandate HIV testing and possibly give a diagnosis, initial treatment, education and follow-up contact information to those inmates who might not otherwise have sought medical attention for this problem. It is only required within the federally run correctional institutions, not state, county or other facilities, which should follow suit and possibly save lives and decrease spread of the disease. Action needs to be taken, to help implement programs enforcing prevention, to aid in the reduction of HIV spread amongst the prison community before they are released into society (Braithwaite & Stephens 2005; Glaser & Greifinger, 1993). HIV diagnosis and treatment has a negative impact on the individual who has the disease, family members, friends, work, plus many other aspects of the person’s entire life. Everyone, including inmates should be able to protect themselves against the spread of
the deadly disease HIV/AIDS and distributing condoms inside prison walls can aid in this.
Methods

For this literature review, Medline, Google scholar, CINAHL, MD Consult, journals, and text resources are several database sources that were used with search terms being: sexual behavior, inmates, prisoners, HIV/AIDS, HIV virus, correctional facilities, prisons, jails, cost, cost effectiveness, protections, and condoms. Exclusion criteria for the articles chosen included those written in a foreign language, articles older than 25 yrs old, non-criminal justice, non-condom use, and articles on adolescents, women and criminal justice theory. Also, articles and text resources dealing with juveniles and other forms of incarceration like mental health facilities, except prison and jail systems were excluded.

Items to be covered in fulfillment of this scholarly project; a literature review paper when completed will include: (1) Introduction; (2) Significance; (3) Methods; (4) HIV/AIDS background including etiology, signs/symptoms, complications; (5) The face of the prisoner; (6) HIV/AIDS impact and burden on the diagnosed; (7) Facilities and studies done on condom distribution programs; (8) Conclusion; and (9) Abstract.
What is HIV?

HIV is a cytopathic retrovirus that kills infected cells. There are two major subtypes of HIV, HIV-1 and HIV-2. HIV-1 is the most common type found worldwide and is the type that causes AIDS. Exposure time between contact with the virus and onset of symptoms takes approximately 2-4 weeks and resembles the influenza virus very much. The virus can be transmitted through semen, vaginal secretions, blood, blood products, breast milk, and across the placenta in utero (Cline, 2004).

These routes of transmission for the HIV virus give a possible solution of one way to protect against this debilitating virus, like condom use for instance. Fever, sore throat, fatigue, rash, headache, and lymphadenopathy are the most common symptoms reported by HIV infected individuals. Other symptoms that were reported during the acute infection but occurred less often include: myalgias, diarrhea, and weight loss.

Seroconversion takes about 3-8 weeks after exposure, in which HIV antibodies are found in the bloodstream and this is followed by a lengthy dormant period where a person may not have any signs of the virus on physical examination except generalized lymphadenopathy. If a person infected with HIV receives no treatment they can develop AIDS in 8-10 years if they are an adult and about 2 years in a child under 5 years of age. The medical definition of AIDS is to have a CD4 count of less than 200 cells/mm³ or to have one or more of an opportunistic disease (Cline, 2004).

Once the CD4 count drops below 200 cells/mm³ the survival rate drops dramatically due to the rise in opportunistic infections. HIV/AIDS can begin to affect several body systems including the lungs, brain and spinal cord, the gut, skin and eyes.
Pulmonary complications can include mostly cough secondary to different types of pneumonias by non opportunistic bugs. Other pulmonary symptoms include hemoptysis, chest pain and shortness of breath. Neurologic symptoms include seizures, headaches, confusion or altered mental status, fever and focal neurologic deficits. Gastrointestinal symptoms include abdominal pain, diarrhea, and bleeding, oral thrush, pain upon swallowing, enlarged liver and proctitis. Cutaneous complications include Kaposi sarcoma, herpes zoster, herpes simplex virus, bullous impetigo and chronic ulcerations of the skin. Manifestations in the eye include CMV retinitis and herpes zoster infecting the eye. Currently there is no cure for HIV/AIDS (Cline, 2004).
Face of a Prisoner

There are more males in prison and jails compared to females, 215,355 female inmates compared to 2,153,423 male inmates at mid-year 2007 (Sabol & Couture, 2008; Sabol & Minton, 2008). Since more men are imprisoned, this gender is more likely to contract HIV/AIDS in prison and jails when compared to female inmates.

Also according to the U.S. Department of Justice, Bureau of Justice Statistics (2007) at mid-year 2007 there were 4,618 black male sentenced prison inmates per 100,000 black males in the United States, 1,747 Hispanic male inmates per 100,000 Hispanic males and 773 white male inmates per 100,000 white males. This is almost the exact opposite of the general population where whites make up the majority of the total population. According to the 2000 census 211.5 million people reported being of white race, this includes men and women (Grieco, 2001), and in 2002 only 36.0 million people reported being of African American or Black race (McKinnon, 2003) and 37.4 million people reporting Hispanic race (Ramirez & Cruz, 2003). Even though these figures include both men and women just by the shear number it is clear that white males dominate the population outside prison walls.

These numbers show that a disproportionate number of African American and Hispanics are incarcerated (Spaulding et. al., 2002; Hammett, 2006) and are pulled out of the community and away from their homes and families. African Americans especially but also Hispanics represent the “face of the prisoner.” This increase throughout the country is largely due to the government’s “War on Drugs” campaign and also mandatory sentencing laws for drug related offenses (Braithwaite & Arriola 2003;

Most inmates encountered are of one of these two races and are at a higher risk of being exposed to HIV/AIDS while incarcerated (West, 2001). According to Kantor (2006) African Americans bear the burden of HIV infection in prison more than any other race.

According to Krebs and Simmons (2002) a study conducted on the demographics of inmates in an undisclosed correctional facility that was known to have contracted HIV in prison, were more likely to be Black. This study did pose some limitations and had difficulties researching this population of individuals because of confidentiality and other legal and ethical issues, but overall this study did identify with a significance level of 0.001, that a person contracting HIV in this particular facility is most likely an African American male.

Numerous researchers support the disproportionate amount of African American and Latina men and women infected with HIV/AIDS in U.S. prisons compared to other races (Arriola, 2006; West, 2001; Swartz, Lurigio & Weiner, 2004; Desai, Latta, Spaulding, Rich & Flanigan, 2002). Since inmate health care is supposed to be very similar, if not identical to that received in the community, an incarceration period is a perfect time to potentially equilibrate access to prevention and protection services compared to most communities where African Americans and Hispanics live (Braithwaite & Arriola 2003; Arriola 2006; Fullilove, 2008; Lipton, 1997). According to Swartz et al., (2004), “The criminal justice system presents unique opportunities for preventive interventions that aim to curb the rates of HIV infection.” This is a theory
also supported by Bryan et al., (2006) that incarceration is an opportunity that should be taken to implement and test these types of programs.
Burden of HIV/AIDS infection

HIV/AIDS is a very tumultuous disease with extensive morbidity and mortality associated with it. Most of these complications require many medications and also extensive follow-up and maybe even inpatient hospital admission. For example if an HIV/AIDS patient contracts systemic mycobacterium avium the treatment regimen consists of clarithromycin twice a day, ethambutol and rifabutin once a day, continuation of antiretroviral drugs (usually more than one medication) and possibly steroids for several weeks (Cline, 2004). This one complication alone is very expensive and complex and requires so much compliance that taking care of oneself with HIV/AIDS can be a huge burden.

The cost of the medications (antiretrovirals) used to treat HIV/AIDS can become extremely expensive especially in the absence of insurance, and this isn’t figuring in cost for other manifestations that may occur during the course of the disease. Intergovernmental AIDS Reports of 1993 (as cited in Leh, 1999) relates that the District of Colombia Correctional System estimates a yearly cost of $23,300 just to keep an inmate locked up; for an inmate with full-blown AIDS, the costs soars to $60,000. This is a huge difference in cost for treatment versus prevention. From a cost-benefit perspective, it is much less expensive to prevent HIV/AIDS than to treat HIV/AIDS and its possible co-morbidities.

The signs and symptoms associated with HIV/AIDS can make quality of life very poor especially if patients do not have access to the antiretroviral drugs or other medications used in treating HIV/AIDS. Even with treatment, quality of life can still be
affected tremendously by the disease, co-morbidities related to the disease, or even medications used to treat the disease, because of their possible side or adverse effects. The ultimate complication is death because at this time there is no cure for HIV/AIDS. If there is anyway at all possible to prevent this life threatening, horrible disease, than every action should be taken within reason, to protect against it.

It has been shown that condoms provide a barrier during sexual intercourse that can minimize contact of the bodily fluids that can have HIV/AIDS viral particles in them like semen and vaginal secretions. According to UNAIDS, when condoms are used properly they represent a proven, effective solution in preventing transmission of the HIV virus along with various other STDs (UNAIDS, 2000). Condoms are a very reasonable, possible solution to try and attack this problem and reduce the spread of HIV/AIDS (Scott-Sheldon, Glasford, Marsh, & Lust, 2006; Flannigan, 2007; Feldblum, Welsh, & Steiner, 2003) according to many groups including the CDC and WHO.

Condoms are already available to the general population at low costs or free of charge at any local public health department. Condoms are not available to the prison population as a whole and are only allowed in a very small number of U.S. correctional facilities (Spaulding et. al., 2001). In certain situations condoms are distributed to inmates, which comprise only 1% of the entire prison population (May & Williams, 2002). Knowing the types of infections and complications that can be caused by HIV/AIDS and also having the knowledge and the resources to prevent it and not taking action in this population seems very inhumane and unethical. Leh (1999) states that it is a social injustice that inmates are not able to reduce their risk of contracting HIV/AIDS like the general population can especially when the risk of HIV/AIDS in prisons is higher.
Prison inmates are still human beings regardless of their prior actions and should be treated as such with comparable health care to what is offered in the community.
Facilities and Studies on condom distribution in US and International prisons systems

There has been an effort to try and reduce the spread of HIV/AIDS within correctional facilities, but this has proven ineffective. According to Polonsky, in 1992 there were five facilities that segregated known HIV positive inmates from HIV negative inmates within the facility (as cited in Leh, 1999). Arriola (2006) and Lipton (1997) also speak of inmate segregation amongst HIV/AIDS infected individuals and non-HIV/AIDS infected individuals; this is a current policy still enforced in Mississippi State Corrections (Peller, 2006). There are several problems with this method of isolation. First, since almost all correctional facilities HIV/AIDS testing is voluntary, inmates in the general population could still be infected with the disease. This gives inmates the false security that the people in segregation are the only inmates in the prison population infected with HIV/AIDS and this may not be entirely true. Secondly, isolating or segregating HIV/AIDS infected inmates can further encourage the stigma and undesirable treatment (assaults, discrimination, etc.) from fellow inmates. This behavior can lead to other inmates who may need testing to learn their HIV/AIDS status to avoid discovering their status because of the possibility that they may be treated in some kind of harmful fashion (Hammett, Harmon, & Rhodes, 2002). Thirdly, this type of isolation eliminates confidentiality which is important to all people regarding their health and health care, and is a right of any patient. This is important because prisoners are already wary about their rights to confidentiality. Again disregarding confidentiality can lead to possible HIV positive inmates to not ascertain their status because fear of
repercussions by staff or unwanted treatment by inmates (Leh, 1999; Arriola 2006; Hammet et. al., 2002).

Currently HIV prevention efforts aim at education, counseling and the provision of information to their inmates (West, 2001), which is clearly not enough to effectively reduce the spread of HIV inside prison walls (Leh, 1999). Even if information and education regarding HIV/AIDS is adequate, inmates are still denied the very mechanism that is known to reduce the spread of this disease (Krebs & Simmons, 2002). It makes no sense to give these people the information that tells them that a protective barrier like a condom can prevent the spread of infectious diseases like HIV/AIDS, but then refuse there distribution. Education and counseling is an important aspect of prevention but a more collective strategy, one that includes condom distribution would seem much more effective. These more useful and productive strategies need to be implemented to successfully reduce the spread of HIV/AIDS in prisons and in the community once prisoners are released (Glaser & Greifinger, 1993). This is a public health concern affecting all of society and should be seen as such and not just a concern for the criminal justice system (Krebs & Simmons, 2002).

Braithwaite, Hammett, and Arriola  (2002) state that interventions not only help the potentially infected inmate, but also their families, partners and the general public health. Most people in the community either do not know or do not care about prison healthcare because it is not their concern, but truly it is. If these prisoners are released into the community HIV/AIDS infected than they are another vector for the disease spread.
There has been very little research, if any at all, discussing statistics on whether condom distribution programs in the United States are effective in preventing disease. For this reason this paper ventures into international public health and a study done on a condom distribution program outside the U.S. The focus is not to rely on this study for answers on the effectiveness of condom distribution but to prompt others to do research here in the U.S. so that more facilities will take heed and implement similar programs.

One significant study on a condom distribution program in New South Wales, Australia will be noted in this paper (Yap et al., 2006). Responding to a law case in 1993, in 1996 a pilot condom distribution program was implemented in three New South Wales prisons and was expanded at the end of the six months to include all facilities throughout the entire state of New South Wales (Yap et al., 2006). The program allows for condom vending machines to dispense at no cost: one condom, lubricant, information on condom use, and a disposal plastic bag; inmates can also receive condoms through prison clinics (Yap et. al., 2006).

In the Yap and colleagues (2006) study a survey looking at several reasons against condom distribution programs was distributed to a randomly selected sample of the prison population. The inmates were given information regarding the study and if they decided to participate had to sign a written consent and was paid $10 for their participation (Yap et. al., 2006). These barriers to the condom distribution programs are very similar to those seen in the U.S. Condoms encouraging sexual behavior, condoms increasing sexual assaults and condoms being used as contraband or as weapons were all analyzed in this study. A face-to-face interview with a nurse interviewer was the method of data collection (Yap et. al., 2006). Chi-square analysis was used to test for
significance and information was also obtained from correction report databases related to unauthorized possession and misuse of condoms (Yap et. al., 2006).

The results of the survey showed that there was no increase but a decrease in males engaging in either consensual or non-consensual sexual activity since the implementation of the program with a significance of $p<0.001$ for both (Yap et. al., 2006). Even though this was noted and reported through the survey by the prisoners there is a possibility that this statement is not entirely true due to the fact of inmates not wanting to admit to homosexual (consensual) or illegal (non-consensual) behavior. There was also a reported decrease on the awareness of sexual assault by other inmates committed since the program was established, $p<0.001$. This result is more reliable in that the inmates are not divulging information about themselves but about others and so they do not have to worry about being reprimanded. The study also showed that, admitted by the inmates themselves, the condom kits were sometimes used for other purposes besides sexual activity which would constitute them as contraband (Yap et. al., 2006). These uses include storing tobacco and other drugs, using the lubricant for hair and shaving gel or the flavored lubricant as milk flavoring, masturbatory usage, “water bombs” as well as various other uses (Yap et. al., 2006). Even though this was observed and admitted to by inmates the data states that, “condom misdemeanors were rare and that incidents involving the unauthorized possession or misuse of condoms in 1996 and 2001 amounted to 0.0/100 inmates and 0.1/100 inmates respectively” (Yap et. al., 2006).

According to Yap et. al. (2006) it is not believed that the presence of the condom kits increased the use of drugs at all and that inmates would find anyway to store or
hide contraband even if the condom kits were not available. There were several limitations to this study one of which is discussed above. Another limitation discussed by the authors themselves states that of the 30,000 condoms and dentoals dams distributed monthly, they were unable to ascertain the proportion that were used for various other purposes (Yap et al., 2006). They realize that this data was obtained through self report and there may have been a better way to retrieve the same data but the results still show follow-up on programs like these are essential to assess outcomes of policy initiatives (Yap et al., 2006). They believed that attitudes towards condom distribution programs were negative and if not for studies like this one to prove otherwise further action would not be taken. Their study concluded in New South Wales, “condoms did not cause rape and mayhem” (Yap et al., 2006).

Like many other papers this one states the belief that HIV interventions like condom distribution programs are needed and would truly benefit the prison inmate in protecting their health status (Mahon, 1996; Hammett, 1999; Hammett, 2006). Unfortunately there are few studies supporting these reasonable statements and that is where research is lacking on this subject (Pont, Strutz, Kahl, & Salzner, 1994). There is a need for more research particularly on distribution programs in the U.S.

Although research directly showing the effectiveness of HIV/AIDS programs in U.S. prisons and jails are lacking in the literature, May and Williams (2002) did a survey on condom distribution program acceptability in a Washington D.C. facility. In 1993, the then mayor of Washington D.C., Sharon Pratt Kelly, made a proposal to supply condoms to inmates in the Washington D.C. jail and it became law. These condoms are actually free of charge to the facility provided by the public health and AIDS service
organizations. Around 200 condoms are distributed on a monthly basis and no record is made about the request, to preserve confidentiality.

The survey regarding the distribution program was given to inmates as well as staff at the correctional facility and asked several questions resulting in an overall theme, if they believe there is a need for condom distribution programs inside prison walls (May & Williams, 2002). May and Williams’ (2002) survey was given to anonymous inmates who had attended health education classes regarding HIV/AIDS and various other topics. The inmates participating in the survey was very representative of the jail demographics (meaning they were an appropriate sample of the population being studied). The same instructor that taught the class conducted the survey and read each question aloud to accommodate for any handicaps.

The outcome of May and Williams’ (2002) survey was that in general both officers and inmates agree that there is a need for distribution programs. Fifty-five percent of inmates and 64% of staff support the availability of condoms. Fifty-eight percent of inmates did not believe having condoms available led to an increase in the amount of sexual activity taking place in jail. Another important finding regarding the distribution program was that “no major security infractions” involving condoms had been reported, which helps to debunk one of the barriers to these types of programs. Overall inmates and staff felt that condoms were a low risk and effective method in preventing the transmission of HIV and other STD’s, plus they were essentially free to inmates and did not take away from the prison budget. Even though research needs to be done on condom distribution effectiveness and data analysis to a significance level
of at least $p<0.05$; this is a start and a good foundation to base the need and acceptance of distribution programs throughout this country.
Conclusion

Information regarding prison health care, the need for condom distribution inside prison facilities, and general HIV/AIDS knowledge has been available for decades. It is very sad that more lawmakers, researchers, correctional staff, and even prison health care workers are not paying attention to the big problem of HIV/AIDS spread amongst incarcerated individuals. The lack of studies done on facilities that have condom distribution programs makes it difficult for those in power to see the effectiveness of prevention programs and how this can ultimately impact the community. According to Leh (1999), studies need to be done to determine the extent of HIV seroconversions inside prison and jail facilities and HIV prevalence monitored. Leh (1999) also stated that, accurate methods of data collection need to be implemented in these studies to eliminate error and ensure reliability.

Leh (1999) believes that nurses working in correctional systems as well as those in public health have a unique opportunity to provide services to inmates and ultimately protect the community (Gaiter & Doll, 1996). This is true but also applies to all health clinicians especially Physician Assistants. The role of the physician assistant is to diagnose, treat, educate and be a patient advocate when it comes to their health care. Physician Assistants usually have more time, compared to doctors, to sit with patients and discuss aspects of their health which is a prime opportunity to discuss inmates HIV concerns, educate on HIV/AIDS, and distribute condoms to individuals who request the need for them. All patients including inmates deserve the opportunity to protect their health by being educated and made aware of what HIV/AIDS is, their possible risk of
contracting the disease by being incarcerated and how they can prevent this from happening.

Prevention programs need to include education which is an important aspect of making a patient cognizant and better able to make choices about their health regarding HIV/AIDS, also testing and management of infected HIV/AIDS individuals can help decrease the spread of the virus while incarcerated and once released. Testing needs to be accessible, acceptable, confidential, and accompanied by counseling according to Leh (1999). Making condoms available on request or in places where inmates can access them without going through a health professional should also be a strong part of prevention interventions (Pont et. al., 1994). Either option should be a choice that the prisoner has to ensure comfort and allow maximum effort by the staff to reduce HIV spread. And lastly but most importantly, studies and surveillance on these types of programs should be done regularly to ensure the quality and success or possible failure of prevention programs (Spaulding et. al., 2001) and how changes can be made, if necessary, to guarantee effective HIV/AIDS prevention policies within correctional facilities because clearly there is a need for them (Spaulding et. al., 2002).

The reason for this literature review is to make the reader, especially fellow PA’s, aware that there is a problem of HIV/AIDS spread in the incarcerated community. According to Arriola (2006), continuing to trivialize intra-prison transmission can be dangerous for many reasons. Hopefully this paper will spike interest and encourage others to do research on facilities that already have condom distribution programs. With this research and data, changes can be made within correctional facilities like implementing HIV/AIDS prevention programs. Influential people like Congress, prison
wardens, healthcare professionals, researchers, lawmakers and other stakeholders, especially family members and significant others are the people who can make these changes happen once it is realized this is a serious problem that is not going away unless something is done about it. There may not be an answer to the question posed in this literature review. The community as a whole including inmates may never know if condoms truly decrease the spread of the HIV/AIDS virus in prisons and jails throughout the U.S. But who has the right to withhold this simple device to human beings just because they have committed a crime is something to ponder.
References


Abstract

Objective: Will distributing condoms to inmates decrease the spread of HIV in prisons? My goal is to get this information in mainstream media so that there is awareness of the problem of HIV/AIDS spread and possibly a reasonable solution.

Methods: For this literature review, Medline, Google scholar, CINAHL, MD Consult, other journals, and text resources are several database sources that were referenced.

Conclusion: As a Physician Assistant there is a lot to offer to inmates regarding their sexual health. Education given to those who are willing to learn about sexually acquired diseases, prevention of them, and what they can do to be an active part in that prevention. The administration of condom prophylactics is also a possible avenue that can be pursued by a PA. It is unknown if condom distribution inside prison walls decreases the spread of HIV/AIDS, therefore there needs to be trial programs and proper research conducted to see if this is a rational solution.