

# HIV/AIDS in US Prisons and Gaols: Epidemiology, Policy, and Programs

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**A**quired Immune Deficiency Syndrome (AIDS) remains one of the most difficult and complex public health problems in the United States and worldwide. Over 150 000 cases have been reported in the United States since AIDS was first identified in 1981. Over 75 000 of these have been reported to the US Centers for Disease Control in the past two years.

AIDS also continues to be a major policy and management issue for correctional administrators in the United States. Correctional institutions are a focus of public concern about this disease. This is due to perceptions that prisons and gaols hold high concentrations of individuals at risk for Human Immunodeficiency Virus (HIV) as a result of prior intravenous (IV) drug abuse and that within institutions inmates frequently engage in behaviours associated with transmission of HIV - particularly homosexual activity and needle sharing. Almost 7000 cases of AIDS have been reported among US correctional inmates since 1981.

While the crisis atmosphere surrounding AIDS in prisons and gaols seems to have dissipated somewhat in the US, the disease remains a serious issue for correctional administrators. Most correctional systems have adopted policies regarding HIV/AIDS. Certain principles, such as the importance of inmate and staff education on AIDS, are still indisputable. However, concern among correctional systems has shifted significantly from short-term 'crisis' matters such as fear of casual transmission to 'long-haul' issues such as housing, programming, and medical care for prisoners with HIV disease. Resolving these issues is often complicated by political, legal, and cost considerations

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In response to the continuing needs of correctional administrators for up-to-date information as they address these difficult and complex policy issues, the National Institute of Justice (NIJ), a research branch of the US Department of Justice, has sponsored five annual reports on *AIDS in Correctional Facilities: Issues and Options*. These reports summarise the latest medical information on AIDS, present statistics on the prevalence of HIV infection and AIDS in correctional facilities, and enumerate the key policy issues and options facing correctional administrators as they formulate policy responses. This paper summarises the major findings and conclusions of the 1990 update of the report.<sup>2</sup>

### **HIV Infection and AIDS in the Correctional Population**

The 1990 NIJ study included the Federal Bureau of Prisons, all fifty State correctional systems, and twenty-seven large city and county gaol systems in the United States. Responses revealed a cumulative total of 6985 confirmed inmate AIDS cases between initial reporting of the disease in 1981 through October 1990. Of these, 4519 cases have been confirmed among inmates in forty-five State and federal correctional systems. In addition, twenty-five large city and county gaol systems reported a cumulative total of 2466 cases of AIDS among inmates. Due to incomplete, inconsistent and under-reporting, these should be considered minimum estimates. No job-related cases of HIV-infection or AIDS, have been documented among US correctional staff, although one such case is alleged to have occurred in Australia.

Cumulative total inmate AIDS cases in the United States have increased by over 800 per cent since the first NIJ study in 1985 and 29 per cent since the fifth survey in 1989. As shown in Table 1, between 1988 and 1989, for the first time since the NIJ surveys were initiated, the percentage increase in total US correctional cases (72 per cent) exceeded the increase in cases in the population at large (50 per cent). This jump in correctional cases may reflect, in part, improved reporting and record-keeping in several correctional systems. In any case, the relationship was reversed between 1989-90, when cases in the total population increased by 38 per cent compared to a 29 per cent increase in correctional cases.

These figures represent cumulative total cases from when the responding jurisdictions began keeping records. As for current cases, as of October 1990, there were 1312 among State and federal inmates in thirty-nine systems and 560 among city and county inmates in eighteen large systems.

Data from the 1990 NIJ survey on demographics and exposure categories of AIDS cases are incomplete. However, studies performed by individual correctional systems suggest that demographic and risk factor patterns among prisoners with HIV infection and AIDS have remained stable. Inmate cases are primarily male, blacks and Hispanics are overrepresented relative to the outside population, and, in some cases, to the correctional population as well. IV drug use is the predominant exposure category.

The distribution of cumulative total AIDS cases throughout US correctional systems is still quite skewed (Table 2). No State or federal systems reported their first inmate cases in 1990. There remain five States which report never having had an inmate AIDS case. Forty-five per cent of all responding systems still have had ten or fewer cases. At the other extreme, sixteen State and federal systems and seven responding city and county systems have had more than fifty cases. Eight State and federal systems (16 per cent) and three of the city and county systems (11 per cent) accounted for more than three-quarters of the cumulative total AIDS cases in such systems.

Table 3 shows that the regional distribution of cumulative total AIDS cases remains uneven, both in State and in city/county systems. Among State systems, the share of the

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<sup>2</sup> The full report, 1990 Update: AIDS in Correctional Facilities, to be published in the spring of 1991, will be available from the NIJ AIDS Clearinghouse, Box 6000, Rockville, MD 20850, telephone 301-251-5500. The Clearinghouse can make available copies of numerous other NIJ publications on HIV/AIDS and law enforcement, criminal justice, and correctional systems.

Middle Atlantic States (especially New York and New Jersey) was 55 per cent. The overall regional breakdown of cases in State systems remained quite stable between 1988 and 1989. The regional distribution of city/county gaol cases also remained quite stable since 1989. The share of the Middle Atlantic region rose from 44 to 54 per cent and that of the Pacific region declined slightly.

AIDS incidence rates are predictably higher in the correctional setting than in the population at large because of the higher concentration among inmate populations of individuals with histories of high-risk behaviour, particularly IV drug use. The incidence rate of AIDS for the entire US population was seventeen cases per 100 000 population in 1990; the aggregate incidence rate for State/federal correctional systems was 181 cases per 100 000 inmates. However, there was an extremely wide range of incidence rates across correctional systems. In State and federal systems, incidence rates ranged from zero to 1047, with fourteen systems under twenty-five and only twelve with rates over 100. This wide range reflects the uneven distribution of cases across systems.

The aggregate AIDS incidence rate in responding city/county gaol systems was 560 cases per 100 000. Here, too, there was a wide range of rates across systems, from zero to 4027 cases, with ten systems below ten and twelve systems over 100. The figures for city/county gaol systems are problematic, however, due to extremely high turnover in these populations.

HIV seroprevalence rates among inmates in most correctional systems are still probably 1 per cent or lower, according to available data from mass screening programs and blind epidemiologic studies, shown in Tables 4-5. It should be noted, however, that most high-prevalence States have not undertaken mass mandatory HIV antibody screening of prisoners, but some of these jurisdictions have undertaken epidemiologic studies. Higher seroprevalence rates, mostly between 2 and 4 per cent, are found in correctional systems covering jurisdictions with larger numbers of AIDS cases in the outside population. A blind epidemiologic study among incoming New York State prisoners in late 1987 and early 1988 found an HIV seroprevalence rate of 17 per cent. A similar study a year later found an even higher rate among female prison entrants in New York State.

Although substantial debate continues, little hard data exists on the extent of transmission of HIV within correctional institutions. Data from several jurisdictions (Maryland and Nevada, in particular) suggest infrequent transmission. Logic and common sense indicate, however, that even in the best-managed correctional facilities, at least some transmission of HIV is occurring among inmates. Systematic studies of in-prison transmission are under way in the Illinois State correctional systems. Results will be available in the spring of 1991.

### **Correctional Policy Issues and Options**

The major policy areas involved in the correctional response to HIV are education and training; HIV antibody testing and notification; medical care, psychosocial services, housing and correctional management issues; and legal issues. Trends and issues in these areas are summarised in the following sections.

#### *Education and training*

While the original crisis atmosphere around AIDS in prisons and gaols seems to be dissipating, a number of studies of individual correctional systems reveal continued and substantial concern. Education and training programs still represent the cornerstone of efforts to prevent transmission of HIV infection in prisons and gaols, as well as in the population at large. In fact, the actual and potential role of education affects decisions on virtually all of the other AIDS issues and policy options in correctional facilities. For example, the effectiveness of educational programs may play a major role in determining both inmate and staff attitudes on whether inmates with AIDS or asymptomatic HIV infection should be segregated.

Most correctional administrators feel strongly that AIDS education and training are not options but absolute requirements. Virtually all responding jurisdictions currently offer or are developing some live AIDS training or educational materials for staff and inmates (Figures 6-8). There remains some unevenness in the provision of AIDS education. Seventy-one per cent of prison and gaol systems provide live AIDS education to staff at all of their institutions. Over three-quarters of prison systems but just over half of gaol systems provide live training to inmates at all institutions. There is a serious shortage in programs and materials for Spanish-speaking prisoners and those with special needs, such as the hearing- or visually-impaired.

Ninety per cent of responding correctional systems have at least some mandatory AIDS training for staff, while two-thirds of the prison and gaol systems have at least some mandatory education for inmates. The percentages are higher for State/federal than for city/county systems. The discrepancy regarding inmate education is probably a result of logistical problems posed by high inmate turnover in city/county gaol systems. Ironically, because the high turnover may present the risk of transmission both within and outside institutions, some form of mandatory education for every gaol inmate, possibly as part of orientation or medical screening, is particularly important.

HIV/AIDS education has two basic objectives: to foster behaviour change, reducing HIV transmission, and to allay concerns regarding casual transmission of the virus. Inducing changes in firmly entrenched social, sexual and addictive behaviours pose serious challenges for AIDS educators and policymakers. Research is beginning to show clearly that simply providing information is insufficient. Behaviour change requires ongoing empowerment, support and reinforcement. However, the effort is worthwhile, since AIDS education has been effective in significantly changing behaviour among IV drug users and gay men in the community.

Ideally, HIV education and training should occur before widespread concern takes hold and is repeated periodically so that timely, updated information can be presented and new staff and inmates quickly reached. Programs should be mandatory for both inmates and staff. Inmates and staff should be involved in the development of educational programs and in the delivery of training to peers. The use of peer trainers along with knowledgeable and approachable professionals will help to build credibility, a critical element in the success of AIDS training. Peer education and support programs may be particularly useful in fostering and maintaining risk reduction among inmates. However, as shown in Table 6, less than one-fourth of State/federal systems and only 15 per cent of responding city/county systems have instituted such programs.

HIV education should be geared to the specific concerns of the audience, focusing on specific risks and precautionary measures for inmates and staff. It should be appropriate to the educational levels, racial/ethnic composition, and special needs of the population, and avoid extremes of alarmism and complacency. Finally, all training and education should be documented so that its provision can be proven in the event of future lawsuits.

As knowledge about HIV education increases, educational strategies become more sophisticated. Some correctional systems are moving to develop and implement more comprehensive educational strategies which may involve counselling, HIV antibody testing, ongoing support groups, drug treatment opportunities and other components. Several examples exist of consortia of community organisations that are successfully working with correctional administrations to bring such programs to inmates. Drug treatment programs are a particularly important component of a comprehensive correctional response to AIDS.

### *HIV testing and counselling*

Advances in treatment regimens for HIV infection have resulted in an increasing emphasis on early identification and intervention. Therefore, in the world outside correctional institutions, testing is now viewed more and more as an integral part of medical treatment. The situation is not quite the same in correctional facilities, where testing is still considered by some to be an infection control tool. But many correctional systems are now offering voluntary or on-

request testing. This trend is at least in part responsive to the movement toward early therapeutic intervention.

The major applications of HIV antibody testing in correctional inmate populations are mass screening, 'risk-group' screening, testing in response to potential transmission incidents, voluntary testing, testing on request, testing in support of blinded epidemiological studies, and testing in the presence of clinical indications or symptoms. Testing of staff may also occur in limited instances - such as in response to possible transmission incidents. Mass screening (the mandatory testing of all inmates, all new inmates, or all releasees in the absence of clinical indications) continues to be a controversial testing application.

The trend toward mandatory mass screening evidenced in correctional facilities between 1986 and 1987 has abated somewhat, although some systems still strongly avow such policies. As of October 1990, seventeen State systems and the Federal Bureau of Prisons but no city/county or Canadian systems had mass screening policies (Figure 9). This represents a net increase of three systems since 1988. The majority of jurisdictions currently conducting mass screening are small States with few correctional AIDS cases.

Several State systems which have discontinued policies of mandatory mass screening have done so for a number of reasons, including funding shortages and the realisation that mass screening was creating more problems than it was intended to solve.

Because of the recent findings regarding medical intervention for asymptomatic HIV-infected inmates, the importance of offering voluntary/on-request testing has increased. However, only about two-thirds of prison and responding gaol systems make testing available to inmates on request. Table 10 shows that less than half (41 per cent) of State/federal systems and just under two-thirds (63 per cent) of responding city/county gaol systems have testing policies based on a voluntary/on-request model.

There is evidence that voluntary testing of inmates serves the needs of both inmates and correctional systems. Results of some carefully controlled studies show that voluntary testing can capture a significant percentage of IV drug users and seropositive inmates.

Appropriate and sensitive pre- and post-test counselling are also critical. Survey results show that all prison and gaol systems report making at least some counselling available to inmates. It is particularly important that counselling sessions be used as important occasions for education. In addition, post-test counselling should be provided on an individual basis for those who have both positive and negative results.

Policymaking regarding the confidentiality and disclosure/notification of an inmate's HIV status remains a controversial and difficult issue for correctional systems. Many States have laws protecting the confidentiality or anonymity of individuals tested for HIV antibody. While almost all prison and gaol systems notify the inmate and attending physician or health-care worker of an inmate's test results, only a small fraction of systems have official policies of notifying correctional officers (Table 11). However, it is apparent from lawsuits filed by inmates that news of a particular inmate's positive test results or seropositive status travels rapidly through an institution. Breaches of confidentiality are alleged to occur frequently.

Continued staff education on the low-risk nature of most staff-inmate contacts and training on following universal precautions is necessary to ease staff concerns about transmission which prompt demands for widespread disclosure of inmates' HIV status. Such disclosures may, in fact, lull correctional officers into a false sense of security, leading them to believe that all infected prisoners have been identified. False negatives do occur on the antibody tests, and because of the sometimes long 'window' period between infection and appearance of antibodies, no testing program can guarantee the identification of all HIV-infected prisoners. Since disclosure has potentially serious consequences, it is essential that correctional systems adapt and enforce clear policies on the issue.

### *Medical care, psychosocial services, housing and correctional management issues*

In responding to HIV/AIDS, correctional administrators must address both medical and psychosocial considerations and complex management factors, such as housing and precautionary measures.

Medical care Costs of medical care have escalated dramatically in recent years and represent a major budget item for correctional systems. In many correctional systems, the increasing numbers of prisoners with HIV infection and AIDS have rendered medical care costs an even more severe financial strain than was already the case. In these constrained circumstances, correctional systems are, and will continue to be, under pressure to contain medical care costs. However, cost containment should not come at the expense of reducing standards of care for HIV-infected prisoners.

As discussed earlier, there have been significant recent advances in medical treatment of HIV-infected persons. These include findings regarding the effectiveness of AZT in delaying disease progression in asymptomatic HIV-infected patients and of aerosolised pentamidine in preventing and treating *pneumocystis carinii* pneumonia. These and other therapeutic advances have prompted optimism that in many patients HIV infection may be manageable as a chronic disease and that life expectancy for AIDS patients may increase. Virtually all prison and gaol systems report providing AZT to inmates. However, not all correctional systems are providing AZT to all HIV-infected inmates with CD4 counts below 500 (the US government standard) even after the release of data in 1989 showing the drug's effectiveness in asymptomatics. Because AZT is an expensive drug, it may represent a serious budgetary strain for many jurisdictions.

Many of the improvements in treatment depend upon early identification and ongoing monitoring of HIV-infected persons. For this reason, it is important that all correctional systems offer HIV antibody counselling and testing to all inmates on request.

Psychosocial services It is increasingly well established that there is a close link between psychological and physiological health in HIV-infected persons. Therefore it is critical that they be provided with a range of supportive services. Correctional and public health officials, as well as AIDS advocacy groups, have established programs of supportive services for HIV-infected prisoners in several jurisdictions. Inmates in a few systems have initiated innovative peer support services.

Inmates with HIV infection and AIDS who are about to be released into the community also require important services. First, they need intensive counselling on their responsibility to notify their sexual partners of their medical status and to avoid any behavior that may transmit infections to others. Second, pre-release planning should include notifying and referring inmates to all government benefit programs for which they may be eligible - such as Medicaid and Supplemental Security Income. Of course, pre-releasees should also be referred to appropriate sources of hospice care, hospitalisation, outpatient care, counselling, and other support services in the community.

Housing and programming policies It appears that the trend in presumptive housing policy in many systems is away from blanket segregation of HIV-infected prisoners toward 'mainstreaming' - that is, maintaining all categories of HIV-infected prisoners in the general population. Many other systems are following a policy of case-by-case determination of housing, basing decisions on the specific medical or security needs of individual infected inmates.

Table 12 summarises housing policies according to mutually exclusive combinations and shows how these policy combinations have changed since 1985. Only nine State/federal systems still segregate/separate all AIDS patients. However, more than three-quarters of prison systems now make housing decisions for HIV-infected prisoners based on presumptive mainstreaming or case-by-case determination. Indeed, in recent years, presumptive general population housing seems to have overtaken case-by-case policies. City/county jail systems are also moving away from blanket segregation policies and reviewing the option of implementing case-by-case determination policies.

The trends in housing policy for HIV-infected inmates reflect a combination of factors, varying from system to system. Both presumptive general population housing and case-by-

case decisionmaking policies are more in accordance with offender classification schemes, which may be overridden when systems decide to base housing decisions solely on HIV status. Other factors include a less fearful and more compassionate attitude on the part of inmates and staff towards individuals with HIV disease, increased costs of hospitalising inmates, and class action lawsuits filed by segregated inmates. Segregated prisoners generally have only severely restricted, if any, access to institutional programming and recreational activities. However, most HIV-infected persons, and even many with AIDS diagnoses, are able to lead perfectly normal lives for long periods. It can be very damaging psychologically to be isolated from one's peers. Less restrictive housing also follows the realisation among correctional systems that, due to the increasing numbers of inmates with AIDS or HIV infection, segregation/separation may be impractical and unfeasible, as well as unjustly discriminatory.

### *Precautionary and preventive measures*

Correctional systems continue to face the challenge of protecting their staff and inmates from HIV infection without raising suspicions or exacerbating fears through extreme precautionary measures. To address the issue, correctional agencies have instituted a wide range of precautionary measures to control the spread of AIDS within institutions. While most systems have instituted infection control measures to help staff and inmates protect themselves, only a handful have taken the much more controversial step of making condoms available to inmates in institutions.

Virtually all correctional systems have established some infection control policies in response to the HIV epidemic. In 1989, the US Centers for Disease Control released guidelines for the prevention of HIV transmission to health care and public safety workers, including correctional officers. These guidelines encourage institutions to tailor their infection control procedures to their unique needs, within the framework of 'universal precautions' - i.e., treating all persons as if they are infected. Precautionary measures should always be commensurate with the risk involved. Obviously, correctional personnel cannot predict with certainty when they will encounter blood or body fluids in the course of their duties. Many situations involve the potential for such contact. Staff members must exercise their professional judgment in using gloves, airways, infectious waste receptacles or other protections.

Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that HIV infection is transmitted by unusual or casual contact. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also foster suspicion of the correctional system for, in effect, saying one thing about the transmission of HIV but doing something else. Hence, correctional systems should be extremely cautious in adopting precautionary measures beyond those recommended by the Centers for Disease Control.

The issue of condom availability in correctional institutions continues to evoke argument. Only five US correctional systems - those in the States of Vermont and Mississippi and in the cities of New York, Philadelphia, and San Francisco - make condoms available to inmates while in the institutions. In these systems, condoms are dispensed either through medical staff (with counselling) or at institutional canteens.

Most correctional officials continue to believe that making condoms available, in effect, condones conduct that is prohibited by correctional regulations and, perhaps, by State law as well. By contrast, the few systems that make condoms available have essentially acknowledged that sexual activity occurs in correctional facilities despite its prohibition and determined that the importance of increasing the possibility of preventing HIV transmission outweighs any appearance of 'condoning' proscribed activity. These systems emphasise that they are not condoning the conduct, but rather taking what they believe to be a reasonable step to help inmates protect themselves against a deadly disease.

### *Legal issues*

In late 1985, when the first edition of the NIJ study was prepared, most legal issues regarding AIDS in correctional facilities remained theoretical; few actual cases had been filed. Since then, however, numerous cases have been filed by inmates, and many have reached disposition. Most cases have been filed in United States District Courts, although some have been filed in State and county courts as well.

AIDS-related issues continue to produce substantial litigation involving correctional inmates and staff. Several major cases are moving toward decision or settlement. Recent developments this year include the first successful challenges to correctional systems' policies on segregation, medical care and AIDS education. However, there remains a good deal of uncertainty on the legal status of other important correctional policies related to HIV infection and AIDS.

The main types of cases brought by inmates have involved challenges to mandatory HIV antibody testing and to segregation and conditions of confinement for persons with HIV infection or AIDS. Lawsuits also include allegations of inadequate medical care for persons with AIDS, breaches of confidentiality, and inadequate AIDS education.

Three major AIDS-related lawsuits have recently been concluded. In *Walker v. Sumner*, a Nevada case, a State prison system's mass mandatory HIV screening policy for inmates was overturned by a court for the first time. The US Ninth Circuit Court of Appeals ruled that the Nevada system had provided no evidence that its policy served a legitimate penological interest (the precedential standard). On the contrary, the court held, the testing policy violated prisoners' constitutional rights under the Fourth, Eighth, and Fourteenth Amendments.

On the other hand, a US District Court judge upheld a policy of mandatory testing and segregation in *Harris v. Thigpen*, a case brought by Alabama inmates. The plaintiffs also alleged that the medical care provided to prisoners with HIV infection and AIDS was inadequate. In January 1990, the case was decided in favour of the correctional department. The court held that the State's policies represented reasonable measures taken in pursuit of a legitimate penological interest and that the right of uninfected prisoners to be protected from potential exposure to HIV-infected prisoners outweighed the claims of the latter group to be free from discrimination on the basis of their HIV status. The case is still on appeal.

A California case, *Gates v. Deukmejian*, challenged the State's policy of segregating all HIV-infected prisoners in a locked unit at a correctional medical facility. A settlement has been negotiated and approved by the judge, under which a one-year pilot project has been established for 20-30 HIV-infected inmates to live in a separate but not closed unit of the institution and participate with general population inmates in all programs and activities.

Prisoners and staff have initiated both civil and criminal actions arising from incidents, such as biting, in which transmission of HIV could allegedly occur. As yet, however, there have been no cases in which a plaintiff asserted that he or she became infected with HIV as a result of the incident. Several cases seeking expanded testing, disclosure of results, and restrictions on HIV seropositive prisoners are pending.

Many correctional systems are justifiably concerned about their potential liability should HIV infections occur among inmates while incarcerated and among staff while on the job. Such cases would face serious proof problems given the difficulty in linking infection with a particular episode. However, the most important actions correctional systems can take to minimise potential liability and maximise safety in their institutions are to intensify efforts to prevent sexual victimisation of inmates and provide all inmates and staff with clear and complete education and training on how to avoid becoming infected with HIV.

### **Conclusion**

AIDS continues to pose complex and difficult problems for correctional systems. The only certainty is that these problems will not go away. With accumulating experience and

information, many correctional systems seem to be developing fair and reasonable policy responses to AIDS. But this is an evolutionary process. Correctional administrators and policymakers need up-to-date information on policy options and programmatic experience to continue the refinement and improvement of their HIV/AIDS policies.

## Appendix - Tables

Table 1

### Cumulative Total AIDS Cases among Correctional Inmates and the Population at Large, United States, 1985-90

	Correctional Cases <sup>a</sup>		Cases in Population at Large <sup>e</sup>	
November 1985	766		14 519	
October 1986	1 232		26 002	
% Increase 1985-86		61%		79%
October 1987	1 964		41 770	
% Increase 1986-87		59%		61%
October 1988b	3 136		73 621	
% Increase 1987-88		60%		76%
October 1989c	5 411		110 333	
% Increase 1988-89		72%		50%
October 1990d	6 985		152 231	
% Increase 1989-90		29%		38%

<sup>a</sup> The figures in this and other tables represent inmate AIDS cases in the federal prison system, all 50 state prison systems, and a sample of 28-37 city and county gaol systems (depending on the year of the NIJ Survey).

<sup>b</sup> Figures for 1988 include 28 city/county gaol systems.

<sup>c</sup> Figures for 1989 include 32 city/county gaol systems.

<sup>d</sup> Figures for 1990 include 27 city/county gaol systems.

<sup>e</sup> Adult/adolescent cases only. Paediatric cases excluded.

Sources: CDC, *AIDS Weekly Surveillance Reports* - US, November 4, 1985, October 6, 1986, October 5, 1987, October 3, 1988; CDC, *HIV/AIDS Surveillance Report*, November 1990; NIJ Questionnaire Responses.

Table 2

**Distribution of Cumulative Total Inmate AIDS Cases, United States,  
November 1985 and October 1990<sup>a</sup>**

State/Federal Prison Systems									
Range of Total AIDS Cases	November 1985 (N=51)				October 1990 (N=51)				
	Number of Systems	%	Number of AIDS Cases	%	Number of Systems	%	Number of AIDS Cases	%	
0	26	51	0	0	5	10	0	0	
1-3	15	29	24	5	5	10	10	0.2	
4-10	5	10	30	7	6	12	39	1	
11-25	2	4	42	9	16	31	241	5	
26-50	1	2	33	7	3	6	96	2	
51-100	1	2	95	21	8	16	547	12	
>100	1	2	231	51	8	16	3 586	79	
<b>Total</b>	<b>51</b>	<b>100</b>	<b>455</b>	<b>100</b>	<b>51</b>	<b>101<sup>b</sup></b>	<b>4 519</b>	<b>99<sup>b</sup></b>	

  

City/County Gaol Systems									
Range of Total AIDS Cases	November 1985 (N=33)				October 1990 (N=27)				
	Number of Systems	%	Number of AIDS Cases	%	Number of Systems	%	Number of AIDS Cases	%	
0	13	39	0	0	2	7	0	0	
1-3	10	30	16	5	4	15	9	0.4	
4-10	7	21	43	14	3	11	17	1	
11-25	1	3	12	4	4	15	63	3	
26-50	1	3	40	13	7	26	195	8	
51-100	0	0	0	0	4	15	299	12	
>100	1	3	200	64	3	11	1 883	76	
<b>Total</b>	<b>33</b>	<b>99<sup>b</sup></b>	<b>311</b>	<b>100</b>	<b>27</b>	<b>100</b>	<b>2 466</b>	<b>100</b>	

a The figures in this table represent the minimum number of correctional AIDS cases to date, since the NIJ survey does not include every United States county gaol system.

b Due to rounding.

Source: NIJ Questionnaire Responses.

Table 3

**Regional Distribution of Cumulative Total Inmate AIDS Cases, United States  
(Federal Prison System Excluded)<sup>a</sup>**

Region	State Prison Systems				City/County Gaol Systems			
	November 1985 (N=50)		October 1990 (N=50)		November 1985 (N=28)		October 1990 (N=27)	
	Total AIDS Cases	%	Total AIDS Cases	%	Total AIDS Cases	%	Total AIDS Cases	%
New England <sup>b</sup>	16	4	284	7	0	0	8	0.3
Mid-Atlantic <sup>c</sup>	327	75	2 315	55	222	71	1 329	54
E.N. Central <sup>d</sup>	6	1	258	6	8	3	31	1
W.N. Central <sup>e</sup>	0	0	35	1	1	0.3	15	1
S. Atlantic <sup>f</sup>	49	11	675	16	24	8	178	7
E.S. Central <sup>g</sup>	1	0.2	61	1	0	0	2	0.1
W.S. Central <sup>h</sup>	12	3	244	6	3	1	60	2
Mountain <sup>i</sup>	2	0.5	79	2	1	0.3	26	1
Pacific <sup>j</sup>	20	5	242	6	52	17	817	33
Total	433	100	4 193	100	311	101 <sup>k</sup>	2 466	99 <sup>k</sup>

a The regional divisions used in this table are standard geographic divisions and are not based on numbers of AIDS cases. The figures in this table represent the minimum number of correctional AIDS cases to date, since the NIJ survey does not include every United States gaol system. Recent tightening of case identification and recording may partially explain the large increase since last year, in correctional AIDS cases in certain regions.

b Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

c New York, New Jersey, Pennsylvania

d Ohio, Indiana, Illinois, Michigan, Wisconsin

e Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

f Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

g Kentucky, Tennessee, Alabama, Mississippi

h Arkansas, Louisiana, Oklahoma, Texas

i Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

j Washington, Oregon, California, Alaska, Hawaii

k Due to rounding

Source: NIJ Questionnaire Responses.

Table 4

**Available Seroprevalence Data From Mandatory Mass Screening of Inmates,  
United States**

	Correctional System	Dates	Number Tested		Number Seropositive		% Seropositive
All Incoming Inmates	Alabama	10/89-10/90	7 306	M&F	88	M&F	1.2 M&F
	Colorado	10/89-10/90	3 093	M	20	M	0.6 M
			358	F	1	F	0.3 F
	Georgia	7/89-5/90	20 435	M&F	561	M&F	2.7 M&F
	Idaho	8/87-10/90	3 000	M	10	M	0.3 M
			50	F	0	F	0.0 F
	Iowa	11/87-10/90	13 434	M&F	26	M&F	0.2 M&F
	Missouri	1985-10/90	24 284	M&F	127	M&F	0.5 M&F
	Nebraska	3/87-10/90	6 426	M&F	21	M&F	0.3 M&F
	New Hampshire	1/87-9/89	1 760	M	9	M	0.5 M
			92	F	6	F	6.5 F
	Oklahoma	6/87-11/90	19 120	M	51	M	0.3 M
			2 347	F	3	F	0.1 F
Utah	7/89-11/90	4 000	M	33	M	0.8 M	
		231	F	6	F	2.6 F	
Wyoming	1/90-10/90	181	M	1	M	0.5 M	
		46	F	0	F	0.0 F	

Table 4 continued

**Available Seroprevalence Data From Mandatory Mass Screening of Inmates,  
United States**

	Correctional System	Dates	Number Tested		Number Seropositive	% Seropositive
All Current Inmates	Mississippi	7/89- 10/89	7 743 M		78 M	1.0 M
			310 F		7 F	2.3 F
	Oklahoma	6/87 7 811 403	M 34		M 0.4	M
			F 0		F 0.0	F
Utah	8/89- 10/89	2 579 M		19 M	0.7 M	
		136 F		5 F	3.7 F	
Wyoming	1984- 10/90	74 M		0 M	0.0 M	
		0 F		0 F		
All Inmates at Release	Alabama	1987- 1989	25 321 M&F		2 M	0.008 M&F
	Missouri	1985- 10/90	16 435 M&F		33 M&F	0.2 M&F
	Wyoming	7/90-	34 M		0 M	0.0 M
			0 F		0 F	
	Federal Bureau of Prisons <sup>a</sup>	1989	14 643 M&F		224 M&F	1.5 M&F
All Incoming & All Releasees	Nevada	1/89- 9/89 384	3 775 M		34 M	0.9 M
			F 8		F 2.1	F
All Incoming & All Current	North Dakota	1987- 11/89	460 M		3 M	0.6 M
			40 F		0 F	0.0 F

<sup>a</sup> Federal Bureau of Prisons, unpublished data.

Source (unless otherwise noted): NIJ Questionnaire Responses.

Table 5

**Seroprevalence Data from HIV Antibody Testing of Inmates in Blinded  
Epidemiological Studies<sup>a</sup>**

Correctional System	Dates	Number Tested	Number Seropositive	% Seropositive
Arkansas	7/90	698 M	6 M	0.9 M
		23 F	0 F	0.0 F
California <sup>b</sup>	4/88-5/88 (All Incoming)	5 372 M	137 M	2.5 M
		807 F	25 F	3.1 F
Florida	1988 (Consecutive Intakes)	1 000 M&F	69 M&F	6.9 M&F
Hawaii	1/88-10/90	2 327 M	22 M	0.9 M
		142 F	0 F	0.0 F
Illinois <sup>c</sup>	4/89-6/89 (All Incoming)	501 M	20 M	4.0 M
Michigan	11/89-9/90	2 221 M&F	24 M&F	1.1 M&F
New York (State)	12/87-1/88d (All Incoming at Downstate Correctional Facility, Fishkill)	494 M	84 M	17.0 M
		500 F	94 F	18.8 F
North Carolina	11/89-4/90	7 942 M	238 M	3.0 M
		784 F	36 F	4.6 F
Oregon	9/90-10/90	437 M	4 M	0.9 M
		76 F	0 F	0.0 F
South Carolina <sup>e</sup>	4/88-6/88 (All Incoming at 1 Reception Centre)	457 M	8 M	1.7 M
		3 F	0 F	0.0 F
Tennessee	7/88-8/90	4 461 M	52 M	1.2 M
		448 F	1 F	0.2 F
Texas	9/89-10/89	1 226 M&F	30 M&F	2.4 M&F
Virginia <sup>f</sup>	6/89-8/89	1 287 M	30 M	2.3 M
Washington	8/87-1/88	796 M	5 M	0.6 M

Table 5 continued

**Seroprevalence Data from HIV Antibody Testing of Inmates in Blinded  
Epidemiologic Studies<sup>a</sup>**

Correctional System	Dates	Number Tested	Number Seropositive	% Seropositive
Wisconsin <sup>g</sup>	1/88-8/88 (All Incoming)	1 621 M	9 M	0.6 M
Maricopa County, Arizona	6/89-11/89	813 M	28 M	3.4 M
Los Angeles County, California	10/90	400 M 100 F	11 M 1 F	2.7 M 1.0 F
Santa Clara County, California	10/86-10/89	348 F	6 F	1.7 F
Fulton County, Georgia	7/88-12/88	160 M 40 F	11 M 3 F	6.9 M 7.5 F
New York City, New York	9/89	1 690 M 546 F	272 M 140 F	16.1 M 25.6 F
Quebec, Canada	12/87-10/90	520 M 248 F	44 M 19 F	8.5 M 7.7 F

- a These studies are anonymous (not identity-linked) and conducted to determine seroprevalence rates in a population. Several systems did not specify the inmate category (for example, all incoming) tested in their study.
- b J.A. Singleton et al., *HIV Seroprevalence Among Prisoners Entering the California Correctional System*, California Department of Health Services, January 1989.
- c Illinois Department of Corrections and Abt Associates Inc., unpublished data.
- d B.I Truman et al., HIV Seroprevalence and Risk Factors Among Prison Inmates Entering New York State Prisons, Presented at 4th International AIDS Conference, Stockholm, June 1988.
- e M.C. Monroe et al., *Studies of HIV Seroprevalence and AIDS Knowledge Attitudes and Risk Behaviors in Inmates in the South Carolina Department of Corrections, 1988*, December 1988.
- f Commonwealth of Virginia, Department of Corrections, *HIV Seropositivity Study*, October 1989.
- g Wisconsin AIDS/HIV Program, Wisconsin Department of Health and Social Services, HIV Seroprevalence and the Acceptance of Voluntary HIV Testing Among Newly Incarcerated Male Prison Inmates in Wisconsin, May 1989.

Source (unless otherwise noted): NIJ Questionnaire Responses.

Table 6

**Live AIDS Education for Inmates, October 1989 and October 1990<sup>a</sup>,  
United States**

Live Education	U.S. State/Federal Prison Systems				U.S. City/County Gaol Systems				Canadian Systems			
	October '89 (N=51)		October '90 (N=51)		October '89 (N=31)		October '90 (N=27)		October '89 (N=11)		October '90 (N=12)	
	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Provided <sup>b</sup>	46	90	49	96	21	68	20	74	9	82	11	92
In All Institutions	34	67	41	80	15	48	15	56	7	64	7	58
Mandatory	23	45	26	51	1	3	3	11	3	27	2	17
Sometimes Voluntary and Sometimes Mandatory	20	39	18	35	4	13	5	19	1	9	2	17
Peer Education Programs	7	14	11	22	0	0	4	15	0	0	0	0

a Live education involves the participation of a trained leader in some substantial part of a session.

b Includes programs in operation and under development.

Source: NIJ Questionnaire Responses.

Table 7

**Live AIDS Education for Correctional Staff, October 1989 and October 1990<sup>a</sup>,  
United States**

Live Education	U.S. State/Federal Prison Systems				U.S. City/County Gaol Systems				Canadian Systems			
	October '89 (N=51)		October '90 (N=51)		October '89 (N=31)		October '90 (N=27)		October '89 (N=11)		October '90 (N=12)	
	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Provided <sup>b</sup>	48	94	50	98	24	77	26	96	10	91	11	92
In All Institutions	32	63	42	82	19	61	24	89	8	73	10	83
Mandatory	26	51	30	59	11	35	15	56	5	45	2	17
Sometimes Voluntary and Sometimes Mandatory	19	37	17	33	10	32	8	30	2	18	5	42

a Live education involves the participation of a trained leader in some substantial part of a session.

b Includes programs in operation and under development.

c Figures include systems that specified centralised training staff.

Source: NIJ Questionnaire Responses.

Table 8

**AIDS Education in Correctional Facilities, October 1990, United States**

Procedures	For Inmates						For Staff					
	U.S. State/ Federal Prison Systems (N=51)		U.S. City/ County Gaol Systems (N=27)		Canadian Systems (N=12)		U.S. State/ Federal Prison Systems (N=51)		U.S. City/ County Gaol Systems (N=27)		Canadian Systems (N=12)	
	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Distribute Written Materials	50	98	25	93	11	92	51	100	26	96	11	92
Use Audio-Visual Materials	48	94	20	74	10	83	50	98	26	96	10	83
Topics Covered in Education Program Safe Sex Practices	44	86	23	85	10	83	45	88	22	81	10	83
Cleaning Techniques for Drug Injection Equipment	31	61	18	67	6	50	28	55	17	63	6	50
Spanish Language Education Available	14	27	14	52	-	-	6	12	8	30	-	-
Distribute Spanish Written Materials	31	61	21	78	-	-	23	45	13	48	-	-
Education for Individuals with Special Needs (e.g. hearing, or visually impaired)	12	24	11	41	1	8	-	-	-	-	-	-

Source: NIJ Questionnaire Responses.

Table 9

**Correctional Systems Conducting Mandatory Mass Screening of Inmates,  
October 1990<sup>a</sup>, United States**

U.S. State/Federal Prison Systems (N=51)	U.S. City/County Gaol Systems (N=27)	Canadian Systems (N=12)
Federal Bureau of Prisons	None	None
Alabama		
Arkansas		
Colorado		
Georgia		
Idaho		
Iowa		
Michigan		
Mississippi		
Missouri		
Nebraska		
Nevada		
New Hampshire		
North Dakota		
Oklahoma		
Rhode Island		
Utah		
Wyoming		

- a Defined as mandatory HIV antibody testing, generally identity-linked, of all new inmates, all releasees, and/or all current inmates, regardless of whether they do or do not show clinical indications of HIV infection. In terms of correctional policy, this type of testing differs in purpose and method from blinded epidemiological studies. These studies are anonymous (not identity-linked) screenings intended to assess seroprevalence rates in a particular population.

Source: NIJ Questionnaire Responses.

Table 10

**HIV Antibody Testing of Inmates, Mutually Exclusive Categorisation, October 1989 and October 1990<sup>a</sup>, United States**

	U.S. State/Federal Prison Systems October 1990 (N=51)		U.S. City/County Gaol Systems October 1990 (N=27)		Canadian Systems October 1990 (N=12)	
	Number of Systems	%	Number of Systems	%	Number of Systems	%
Mandatory Mass Screening (all incoming inmates, current inmates and/or inmates at release)	18	35	0	0	0	0
Voluntary/Inmate Request Testing	21	41	17	63	9	75
Testing if Clinical indications <sup>b</sup>	12	24	9	33	3	25
Other	0	0	1	4	0	0
<b>TOTAL</b>	<b>51</b>	<b>100<sup>c</sup></b>	<b>27</b>	<b>100</b>	<b>12</b>	<b>100</b>

<sup>a</sup> Includes actual and planned policies. This is a hierarchical categorisation. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that screen identifiable inmates with histories of high-risk behaviours, but do no mass screening, are placed in the 'screening of high-risk groups' category regardless of whether they also do testing for diagnosis, incident involvement, or epidemiologic studies; and so on.

<sup>b</sup> In this table, clinical indications includes lowered CD4(T4) counts, opportunistic infections, and TB positivity or active TB.

Source: NIJ Questionnaire Responses.

Table 11

**Policies regarding Disclosure/Notification of Inmates' HIV Antibody Test Results,  
October 1990<sup>a</sup>, United States**

Parties to be Notified during incarceration and/or at release according to policy <sup>a</sup>	U.S. State/Federal Prison Systems (N=51)		U.S. City/County Gaol Systems (N=27)		Canadian System (N=12)	
	Number of Systems	%	Number of Systems	%	Number of Systems	%
Inmate	51	100	27	100	12	100
Attending Physician or Health-Care Worker	51	100	25	93	11	92
Other Medical Staff (Community or Correctional)	30	59	13	48	5	42
Correctional Management - Central Office	29	57	8	30	5	42
Correctional Management - Institution	33	65	10	37	3	25
Correctional Officers (Security)	7	14	6	22	2	17
Public Health Department	44	86	19	70	5	42
Spouse/Sexual Partner(s)	8	16	1	4	2	17
Victims of Inmate (in community and/or in prison/gaol)	8	16	4	15	0	0
Parole Agency	17	33	2	7	2	17
Residential Placement <sup>b</sup>	4	8	3	11	1	8
Work Placement <sup>b</sup>	3	6	2	7	1	8
Other <sup>c</sup>	2	4	2	7	1	8

<sup>a</sup> Figures include both systems which specified the conditions under which disclosure/notification to certain parties could be made (e.g. only with inmate consent and/or on a 'need-to-know' basis) and systems which did not specify these conditions.

<sup>b</sup> Most systems view notification of residential or work placement as falling in the domain of parole agencies/divisions.

<sup>c</sup> This category includes public agencies, courts, and other parties unspecified by responding systems.

Source: NIJ Questionnaire Responses.

Table 12

**Combinations of Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection, November 1985 and October 1990<sup>a</sup>**

Housing Policy Combination	U.S. State/ Federal Prison Systems				U.S City/ County Prison Systems				Canadian Systems			
	November'85 (N=51)		October'90 (N=51)		November'85 (N=33)		October'90 (N=27)		October'87 <sup>b</sup> (N=12)		October'90 (N=12)	
	Number of Systems	Number of % Systems	Number of % Systems	Number of % Systems	Number of % Systems	Number of % Systems	Number of % Systems	Number of % Systems	Number of % Systems	Number of % Systems		
Separate/Segregate AIDS Cases; ARC Cases and Asymptomatics Maintained in General Population	3	6	5	10	3	9	0	0	0	0	0	0
Separate/Segregate AIDS and ARC Cases; Asymptomatics Maintained in General Population	10	20	0	0	3	9	0	0	0	0	0	0
Separate/Segregate All Three Categories	8	16	4	8	13	39	2	7	3	25	0	0
No Separation/Segregation of Any Category	2	4	16	31	0	0	7	26	0	0	2	17
Combinations Involving Case-by-Case Determination (for at least one category)	16	31	24	47	10	30	17	63	9	75	9	75
Other Policy Combinations, No Policy, or Policy Unknown	12	24	2	4	4	12	1	4	0	0	1	8
<b>TOTAL</b>	<b>51</b>	<b>101<sup>c</sup></b>	<b>51</b>	<b>100</b>	<b>33</b>	<b>99<sup>c</sup></b>	<b>27</b>	<b>100</b>	<b>12</b>	<b>100</b>	<b>12</b>	<b>100</b>

<sup>a</sup> In this categorisation, 'separate/segregate' means that the basic policy is to hospitalise or administratively segregate, regardless of whether clinically ill inmates are returned to general population when the symptoms subside. This categorisation is mutually exclusive.

<sup>b</sup> October 1987 was the first year Canadian systems were included in the NIJ survey.

<sup>c</sup> Due to rounding.

Source: NIJ Questionnaire Responses.