Access to condoms in U.S. prisons

Despite overwhelming evidence that condom use prevents the transmission of HIV, U.S. prison officials continue to limit the availability of condoms to incarcerated persons. Concern for transmission of HIV in prison and in the community upon prisoners' release has increased the interest of some policymakers in the issue. In this article, Megan McLemore addresses security concerns as well as human rights arguments in support of efforts to adopt a public health approach to harm reduction in U.S. prisons.[1]

The management of infectious disease in prisons is a human rights imperative as well as a matter of public health. Given the high level of HIV infections among those who enter prison, making condoms readily accessible to inmates is an effective and inexpensive measure that corrections officials should take to limit the spread of infection.

Recent studies indicate no adverse security consequences in correctional systems where condoms are available. These findings, and a growing imperative to reduce transmission in the community when offenders are released, have prompted efforts in several states and the U.S. Congress to permit condom use in prison. These efforts should be endorsed by corrections professionals and policymakers.

Since 2006, legislators from states with the largest prison populations, such as Texas, California, Illinois, New York and Florida, have introduced bills permitting non-profit or medical personnel to provide condoms to inmates. At the federal level, Representative Barbara Lee has introduced the *Justice Act of 2006* (HR 6083), a comprehensive attempt to address HIV/AIDS in prison which includes a provision permitting condom distribution to reduce transmission.

None of these bills has become law, but their introduction reflects the willingness of lawmakers to revisit a controversial issue in the interest of public health. In Texas, for example, Representative Garnet Coleman explained to the Corrections Committee considering his bill that it was intended to protect not only the health of inmates but the health of members of the African-American community, where HIV transmission rates are alarmingly on the rise. In California, Governor Arnold Schwarzenegger vetoed a bill permitting widespread condom distribution but authorized a pilot program in one prison to evaluate the feasibility of such a program.

Infectious disease in prisons

More than 2.2 million persons are currently incarcerated in U.S. prisons. Incarcerated individuals bear a disproportionate burden of infectious diseases, including the hepatitis B virus (HBV), the hepatitis C virus (HCV), and HIV/AIDS. Although inmates comprise only 0.8 percent of the U.S. population, it is estimated that 12–15 percent of Americans with chronic HBV infection, 39 percent of those with chronic HCV infection, and 20–26 percent of those with HIV infection pass through a correctional facility each year.[2]

The HIV prevalence in state and federal prisons is two and a half times higher than in the general population.[3] The prevalence of HCV among prisoners approaches 40 percent.[4] Co-infection is also a concern: A significant number of HIV-positive inmates are also infected with HCV.

Although the majority of inmates infected with HBV, HCV and HIV acquired the infection outside of prison, the transmission of infectious disease in prison is increasingly well documented.[5] Targeted interventions to reduce the risk of HIV transmission in prison, such as the provision of condoms, methadone maintenance treatment, and supplying bleach to clean needles and syringes, have proven highly effective in preventing HIV transmission in prisons, just as they have been when implemented outside.

These harm reduction approaches have been endorsed by the World Health Organization (WHO), UNAIDS and the UN Office of Drugs and Crime as an integral part of HIV prevention strategies, including in prison.[6] Government failure to ensure access to harm reduction services puts inmates at unnecessarily increased risk of infection.

Regardless of institutional regulations, sexual activity, both consensual and coerced, is common in prisons. Sex among inmates has been documented extensively not only in academic studies and by human rights organizations, including Human

Rights Watch, but by correctional systems themselves in the form of individual grievances and disciplinary actions against inmates engaging in prohibited behaviour.[7]

The Prison Rape Elimination Act (2003)[8] found that an estimated 13 percent of U.S. prisoners had been sexually assaulted in prison, and called for research into its prevalence and patterns. A national Prison Rape Elimination Commission has held a series of hearings examining sexual violence in local, state and federal correctional facilities; the U.S. Bureau of Justice Statistics has begun a nationwide survey of sexual violence in detention; and national standards are being developed to address the problem.

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Correctional policy and condom distribution

Despite overwhelming evidence that condom use prevents the transmission of HIV, U.S. prison officials continue to limit the availability of condoms to incarcerated persons. Fewer than one percent of correctional facilities provide condoms to inmates, though those that do include some of the nation's largest urban prisons.

These policies stand in stark contrast to the public health approach taken by prison officials in Canada, Western Europe, Australia, Ukraine, Romania and Brazil, where condoms have been available to inmates for years. Moreover, several large, urban prisons in federal jurisdiction, as well as one state, have provided condoms to inmates, either through medical staff or more general distribution. Where institutional policy provides for condom distribution, no correctional system has yet to find any grounds to reverse or repeal that policy.

Leading correctional health experts endorse condom distribution in prisons. The National Commission on Correctional Health Care (NCCHC), the nation's primary standard-setting and accreditation body in the field of corrections, has endorsed the implementation of harm reduction strategies, including condom distribution. The Commission states, "While NCCHC clearly does not condone illegal activity by inmates, the public health strategy to reduce the risk of contagion is our primary concern." [9] Further, the American Public Health Association Standards for Health Services in Correctional Institutions (3rd Edition, 2003) recommends that condoms be available for inmates.

Condom distribution programs: U.S. prisons

Some corrections officials have expressed concern that condom distribution would negatively affect institutional security. This concern has proved unfounded in studies from Canada and Australia.[10] As discussed below, a recent evaluation of a U.S. condom distribution program provides further evidence that security is not compromised by this vital harm reduction measure.

One study examined the condom distribution program in effect since 1993 at the Central Detention Facility in Washington, D.C. (CDF). The study found that the CDF housed approximately 1400 adult males, 100 adult females and 40 juveniles, and processed an average of 2800 inmates per month. It was staffed by 551 correctional officers.

Condoms were provided free of charge through public health and AIDS service organizations. Inmates had access to the condoms during health education classes, voluntary HIV pre-test or post-test counselling, or upon request to members of the health care staff. Approximately 200 condoms were distributed each month according to inventory audits.

Both inmates and staff were interviewed about their opinion of the condom distribution program. The findings indicate that 55 percent of inmates and 64 percent of correctional officers supported the availability of condoms at the CDF facility. Objections related primarily to moral and religious concerns about homosexual activity.

Thirteen percent of correctional officers said that they were aware of institutional problems associated with condom distribution, though none provided descriptions of those problems. No major security infractions related to condoms had been reported since commencement of the program. There was no evidence that sexual activity had increased, based upon staff interviews as well as a review of disciplinary reports for the relevant period. The researchers stated:

> Permitting inmates access to condoms remains controversial among most correctional professionals. Even so, no jail or prison in the United States

allowing condoms has reversed their policies, and none has reported major security problems. In the Washington, D.C. jail, the program has proceeded since 1993 without serious incident. Inmate and correctional officer surveys found condom access to be generally accepted by both.[11]

Several large urban prisons, including the Los Angeles and San Francisco County prisons, make condoms available to inmates. San Francisco Sheriff Michael Hennessey was a strong supporter of California's legislation permitting condom distribution in prison, which was passed in 2005 and again in 2007, but was vetoed in both instances by the Governor.

In an editorial opinion letter published April 19, 2005 in the *San Francisco Chronicle*, Sheriff Hennessey stated that correctional officials should "do everything we can to prevent sexual activity in custody, but we shouldn't turn a blind eye to the reality that it occurs." Further, he noted that the risk of contraband smuggling was much greater from routine contact between inmates and outside visitors than from the availability of condoms inside the facility. Significantly, following his recent veto of the bill, Governor Schwarzenegger agreed to permit a pilot program for condom distribution, the first of its kind in the California state prison system.

Legal standards and guidelines

International legal standards

In its treatment of prisoners, the U.S. must comply with its international human rights obligations. The U.S. is a party to the International Covenant on Civil and Political Rights (ICCPR), which guarantees to all persons the right to life, and to be free from cruel, inhuman or degrading treatment; and, if deprived of their liberty, to be treated with humanity and with respect for the inherent dignity of the human person.

The U.S. is also a party to the Convention Against Torture (CAT), which protects all persons from torture and ill treatment; and is a signatory of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which guarantees the right to the highest attainable standard of health.[12]

States have a "positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty."

The obligations to protect the rights to life and health, and to protect against torture and other ill treatment create positive duties on the government to ensure access to adequate medical services and to take appropriate measures necessary to prevent and control disease.[13]

International human rights law clearly affirms that prisoners retain fundamental rights and freedoms guaranteed under human rights law, subject to the restrictions that are unavoidable in a closed environment. The conditions of confinement should not aggravate the suffering inherent in imprisonment, because loss of liberty alone is the punishment.

States have positive obligations to take measures to ensure that conditions of confinement comply with international human rights norms and standards. The Human Rights Committee, an expert UN body that monitors state compliance with the ICCPR and provides authoritative interpretations of its provisions, has explained that states have a "positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty."

The ICESCR recognizes in Article 12 "the right of everyone to the highest attainable standard of health." The ICESCR requires that states take all the steps necessary for "the prevention, treatment and control of epidemic … diseases" which include the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS.

Realization of the highest attainable standard of health requires not only access to a system of health care; according to the UN Committee on Economic, Social and Cultural Rights, it also requires states to take affirmative steps to promote health and to refrain from conduct that limits people's abilities to safeguard their health. Laws and policies that are "likely to result in … unnecessary morbidity and preventable mortality" constitute specific breaches of the obligation to respect the right to health.

Key international instruments establish the general consensus that prisoners are entitled to a standard of health care equivalent to that available in the general community,

without discrimination based on their legal status.

In some cases, state obligations to protect prisoners' fundamental rights, in particular the right to be free from ill-treatment or torture, the right to health, and ultimately the right to life, may require states to ensure a higher standard of care than is available to people outside of prison who are not wholly dependent upon the state for protection of these rights.[14] In prison, where most material conditions of incarceration are directly attributable to the state, and inmates have been deprived of their liberty and means of self-protection, the requirement to protect individuals from risk of torture or other ill-treatment can give rise to a positive duty of care, which has been interpreted to include effective methods of screening, prevention and treatment of life-threatening diseases.

Guidance from the WHO, UNAIDS and United Nations Office on Drugs and Crime (UNODC) elaborate measures to protect prisoners' fundamental rights to HIV/AIDS prevention, care and treatment.[15] The principle of equivalence is specifically set forth in the *Basic Principles for the Treatment of Prisoners,* adopted by the United Nations General Assembly in 1990: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[16]

The WHO guidance also state that prisoners are entitled to prevention programs equivalent to those available in their community, and specifically addresses the issue of condom distribution in a prison environment:

> Preventative measures for HIV/AIDS in prison should be complementary to and compatible with those in the community. Preventative measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injection drug users and unprotected sexual intercourse…. Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention.[17]

U.S. legal standards

The Eighth Amendment to the U.S. Constitution protects prisoners from "cruel and unusual punishment" and requires corrections officials to provide a "safe and humane environment." In the U.S., prisoners have a right to health care beyond that of the general population. As Justice Marshall explained in the *Estelle* decision:

> These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or lingering death," the evils of most immediate concern to the drafters of the Amendment.
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> In less serious cases, denial of medical care may result in pain and suffering, which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation, codifying the common law view that "it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself."[18]

The *Estelle* case, however, applies a difficult standard to Eighth Amendment claims, requiring inmates to demonstrate that officials were "deliberately indifferent to serious medical needs." This standard involves both an objective (serious medical need) and subjective (deliberately indifferent) component. Courts have consistently held that prisoners diagnosed with HIV/AIDS have demonstrated a "serious medical need."[19]

The subjective component has been interpreted as met when a prison official "knows of and disregards an excessive risk to inmate health or safety."[20]

In *Farmer,* a transgendered prisoner sued federal prison officials for compensation for a brutal beating and sexual assault that, the complaint alleged, could have been prevented by prison officials. The Supreme Court remanded the case for further hearing, but the opinion contains a detailed discussion of the scope of the duty of prison officials to protect prisoners from harm when the risk of harm is known or acknowledged.

There are no reported U.S. cases addressing the constitutionality of a prison system's failure to provide condoms to inmates but, arguably, the refusal to implement condom distribution programs in prisons meets the "deliberate indifference" standard, particularly when the rates of infection among inmates, their high-risk behaviour, and the incidence of transmission of disease is increasingly well documented.

Conclusion

Despite increasing documentation of high rates of infectious disease, the occurrence of high-risk behaviours, and transmission of disease among inmates, the distribution of condoms in U.S. prisons continues to be limit-

ed. Opposition to these programs on the basis of security concerns is not supported by the evidence provided in reports from prisons in jurisdictions that have established, evaluated and chosen to retain their condom distribution policies. U.S. policymakers should endorse current efforts to adopt a public health approach to this issue, thereby ensuring compliance with the recommendations of national correctional health experts as well as with international legal standards and guidelines.

– Megan McLemore

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[1] Except in quoted text, this article uses the term "prison" to designate all correctional facilities, including jails.

[2] C. Weinbaum et al, "Hepatitis B, hepatitis C, and HIV in correctional populations: a review of epidemiology and prevention," *AIDS* 19(3) (2005): 41.

[3] U.S. Bureau of Justice Statistics, *HIV in Prisons 2005*, September 2007. Available via www.usdoj.gov.

[4] A. Spaulding et al, "A framework for management of hepatitis C in prisons," *Annals of Internal Medicine* 144 (10) (2006): 763; S. Allen et al, "Hepatitis C among offenders — correctional challenge and public health opportunity," *Federal Probation* 67(22) (2003): 22.

[5] See, e.g., "HIV Transmission among male inmates in a state prison system — Georgia 1992-2005", *CDC Morbidity and Mortality Weekly Report (MMWR)*, 55(MM15) (2006): 421. For a review of HBV, HCV and HIV transmission studies for both international and U.S. prisons, see R. Jurgens, "HIV/AIDS and HCV in prisons: a select annotated bibliography," *International Journal of Prisoner Health* 2(2) (2006): 131. For a review of the U.S. literature in this area, see T. Hammett, "HIV/AIDS and other infectious diseases among correctional inmates: transmission, burden and an appropriate response," *American Journal of Public Health* 96(6) (2006): 974.

[6] See, e.g., WHO/UNAIDS/UNODC, *Effectiveness of Interventions to Manage HIV in Prisons – Prevention of Sexual Transmission*, 2007.

[7] See, e.g., C.P. Krebs et al, "Intraprison transmission: an assessment of whether it occurs, how it occurs, and who Is at risk," *AIDS Education and Prevention* 14(Supp. B) (2002): 53; A. Spaulding et al, "Can unsafe sex behind bars be barred?" *American Journal of Public Health* 91(8) (2001): 1176; N. Mahon, "New York inmates' HIV risk behaviors: the implications for prevention policy and programs," *American Journal of Public Health* 86 (1996): 1211; and Human Rights Watch, *No Escape: Male Rape in US Prisons*, 2001.

[8] *Prison Rape Elimination Act, 2003*, Public Law 108-79, 108th Congress.

[9] NCCHC Position Statement, *Journal of Correctional Health Care* 11(4) (2005).

[10] Correctional Services of Canada, *Evaluation of HIV/AIDS Harm Reduction Measures in the Correctional Service of Canada*, 1999; L. Yap et al., "Do condoms cause rape and mayhem? The long-term effects of condoms in New South Wales prisons," *Sexually Transmitted Infections (STI) Online* (December 19, 2006), at www.stibmj.com.

[11] J. May and E. Williams, "Acceptability of condom availability in a US jail," *AIDS Education and Prevention* 14(Supp. B) (2002): 85.

[12] In signing the ICESCR, but not yet ratifying it, the U.S. has not agreed to be legally bound by the Convention, but should not take regressive steps in relation to the obligations therein and is obliged to refrain from acts which would defeat the object and purpose of the treaty (Article 18 of the *Vienna Convention on the Law of Treaties 1969*).

[13] These leading international human rights instruments may be found online at the website of the United Nations High Commissioner for Human Rights, www.unhchr.ch/html/intlinst.hm.

[14] *See,* R. Lines, "From equivalence of standards to equivalence of objectives: the entitlement of prisoners to standards of health higher than those outside prisons," *International Journal of Prisoner Health* 2 (2006): 269.

[15] WHO, *Guidelines on HIV Infection and AIDS in Prisons,* 1999; UNAIDS, *International Guidelines on HIV/AIDS and Human Rights,* 2006; UNODC, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for Effective National Response,* 2006.

[16] Basic Principles for the Treatment of Prisoners, U.N. General Assembly Resolution 45/111 (1990), para. 9.

[17] WHO, para. 20.

[18] *Estelle v. Gamble*, 429 U.S. 97 (1976).

[19] *See Smith v. Carpenter*, 316 F.3d 178 (2d Cir. 2003); and *Montgomery v. Pinchak*, 294 F.3d 492 (3d Cir. 2002).

[20] *Farmer v. Brennan*, 511 U.S. 825, 114 S.Ct. 1970 (1994).