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Female Prisoners in the US: HIV/AIDS and Opportunistic Co-Infectious Diseases

Mario J. Azevedo^α, James S. Madiralla^σ, Shonda Lawrence^ρ & Kira L. Johnson^ω

I. INTRODCUTION

Abstract - Objective : This study is an overview of the most current state of the US prison system relative to incarcerated women, focusing specifically on the risks of HIV and opportunistic diseases that affect women's health and lacking concerted interest in understanding and addressing women's specific needs by policy-makers and managers of our prison facilities.

Methodology : Conducted by an interdisciplinary team of socio-behavioral scientists in epidemiology, social work, policy, and education, the study relies on the most updated research data provided by federal and state government agencies, hospital registries, biomedical, public health, and socio-behavioral databases, relevant and peer-reviewed research studies published in journals and other accepted information sources, using a comparative national and global approach to the subject of female prisoners and the impact of infectious diseases.

Conclusions : This study confirms, strengthens, and validates many previous less definitive studies on the issue of women's health, lack of adequate care, and lax safety measures in our prison facilities. It provides new figures and expanded reasons for the phenomenal rise in the US prison population, the unprecedented rates of HIV/AIDS (almost two to one compared to men) and other infectious diseases in women prisoners, stemming from male-dominated prison management practices, the disproportionately unacceptable cases and risk factors that contribute to the daily rape, physical assault, and bullying of women in prisons perpetrated by both inmates and prison officials, especially in certain regions of the country, and the under-rating of women's biological, psychological, and socio-mental needs. This study warns of vicious and destructive increasing spillover rates of the diseased inmates from our community into our prisons and the constant revolving door of infected individuals who return to the general population. The inequities associated with the war on drugs, tolerance of unsafe practices in the prison facilities, such as intravenous drug use, a culture of violence, and exchange of goods for sexual favors that feed into our prison system, constitute a heightened health and safety risks of its female population, which ought not to be a part of our prison system.

Limitations and Recommendations : As others have done so, the authors strongly recommend a review of our prison system and conclude that now is the time for our federal and state legislatures to take the specific needs of women more seriously. The researchers simultaneously point to the need for the enactment and strict enforcement of policies that are designed to better protect women's safety in jail. Finally, while the authors urge school officials and policy-

makers to minimize the unacceptable rates of incarceration of juveniles that have not committed serious offenses, they ask the academic community and service providers to ensure that future studies of women prisoners be preferably conducted by interdisciplinary teams involving both men and women researchers, community representatives, and current and former inmates.

Keywords : HIV/AIDS, prisons/jails, rape and physical assault, "zero tolerance" laws, "War on Drugs," "law and order."

a) Study Objective

The following article is a state-of-the-art analysis of the condition of women in jails and prisons in the United States in relation to the risk of exposure to HIV/AIDS and other co-infections while serving their sentences. Basing the analysis on available data published by the Bureau of Justice Statistics, state archival information, and the work of scholars and activists, such as Human Rights Watch, the authors focus their attention on the profile of women who end up in our jails and prisons, the environment where they come from, the types of offenses that land them in confinement facilities, the health hazards, the violence, and the constantly bullying sub-culture to which they are subjected daily, and the mechanisms they use to cope with the prison health conditions. In the process, the authors also look at the impact women's health conditions have on their communities once they are released from confinement. The four authors argue that imprisoned women are by and large victims of a system that punishes the weakest and the poorest of our society through laws that are exponentially harsher than they deserve to be and that jails, state and federal prisons, although improving, are cluster epicenters of contagion from the most deadly diseases man has ever known, often associated with violence, rape, and little consideration for the specific biological, social, and psychological needs of women. Often, these conditions are fed by a lack of clear and enforceable national policies in regard to incarcerated women incarcerated.

Currently, each state and locality or county has its own prison laws or statutes, some resembling practices of centuries past, at times bordering on the inhumane, which allow one jurisdiction to impose harsher sentences for a similar offense or crime, in such places as the South, where resilient institutional racism, discrimination, and gender prejudices cannot be easily shaken. The article ends with a series of recommendations based on the study findings, the

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existing prison guidelines, and internationally-accepted principles aimed at protecting the human rights of all prisoners, with special attention to women and female adolescents who find themselves confined and languishing in correctional facilities. Finally, the authors include, as well, suggestions about the direction future research might take to improve the plight of women in our primarily man-designed jails and prisons.

b) *Historical Overview of Retributive Versus Utilitarian Justice in America*

The issue of punishment or non-punishment for offenses perceived as harming the individual or society has been with us for many centuries. As Pollock (2005) notes, punishment is defined generally as a specific way of inflicting pain in the offender. Is such action wrong or a legitimate means for society to rid itself of “criminals” or offenders, be it in reference to horrendous crimes or petty infractions of the law, for which people in the US are sent to a life behind bars? Some thinkers see inflicting pain as a punishment that is not “inherently wrong” because the offender deserves it; justice based on this thinking has been commonly known as “retributive” justice, which supposedly balances the wrong and the right through punishment, as long as it is administered as an impersonal and a fair act against an individual who broke the social code or rule, expressed in the traditional concept of a “social contract.” In this context, the criminal or offender deserves punishment or, in the words of Pollock, quoting past philosophers, “has the right to be punished” (2005: 4).

On the other side of the spectrum lies the utilitarian theory and approach to the prison system, which sees punishment as unjustifiable unless it is conceived for and results in a “greater good” using means that are often described as “deterrence, incapacitation [physical or psychological inability to repeat the crime], or rehabilitation” [state of re-adjustment to society, making the offender a productive individual] (see Weaver and Nicholson, 2012: 9-16). Under utilitarian philosophy, punishment is always evil, except if it benefits both the offender and the community, or the “many in society.” From this perspective, adds Pollock, “if punishment did not deter or incapacitate or facilitate rehabilitation,” then “the many” (all society) would not benefit, and punishment would not be good” (2005: 6). Expressed differently, “cruel” incarceration is unjustified if it is not intended to make the individual a better human being rather than a monster, as some of our prison systems have been accused of doing today.

The early American experiment and debate over prisons or penitentiaries made it difficult for politicians and thinkers to reconcile the two philosophies, but, as the years and centuries elapsed, the retributive element seems to have triumphed. In fact, as Faulkner notes, it has always been hard to “reconcile demands for more

rigorous enforcement of the law, longer sentences, more people in prison and less regard for offenders’ rights with providing more help for offenders’ rehabilitation, more and earlier intervention, a greater emphasis on reconciliation and restoration and fewer people in prison” (Faulkner, 2012: 3). Calvinistic dogmatic teaching undoubtedly influenced the concept of retributive justice in America, as it viewed the poor and the unemployed, many of whom ended in jail or prison, as unblessed by God because they did not adhere to a work ethic preached by the first Calvinists in Europe and the US. Recent occurrences, however, as the debate over the use of marijuana as a criminal act, decriminalized now in states such as Oregon and Washington has demonstrated, have revived the old controversy over the worth of harsh methods for society to rid itself of those who break the laws or our cherished traditions. Indeed, the more the American penal system tries to eliminate crime by sheer force and prison fortresses, the more we see crime and our prison population on the rise, especially after the 1930s, while the few prisoners released have, in general, found it hard to adapt to society, as the following discussion will show. Many of the so-called “released offenders” re-engage in criminal conduct and are forced to return to the same unforgiving and threatening correctional facilities.

The nature of the U.S. prisons with their intended and unintended social and individual consequences, especially for female inmates, are imbedded in an almost 500-year history. Therefore, understanding prison history in the US helps one grasp the intended role of the prison system in its frustrating and unending effort to clamp down on the criminal element or the unacceptable social behavior of its citizens. History also helps one to understand the current controversy over how society should run its prisons to ensure punishment is a deterrent and a rehabilitating process, which, at the same time, facilitates a smooth social re-adjustment of its incarcerated populations once they have served their sentences. As a backdrop to the following historical section, it was important for the authors to draw attention to the distinction between a “penitentiary” and a “jail,” and between a state and a federal prison. In official settings, jails are defined as “locally operated, or managed, institutions that detain individuals who typically are serving short sentences, of one year or less,” for a certain “crime” (Dwyer et al., 2011: 1). Jails are reserved for people called in for arraignment and trial, those who are on parole after being convicted of an offense, or parole violators, or awaiting sentencing by a judge. A jail is, therefore, a temporary institutional facility and “is short in its application of the laws against ‘crime,’” which may be a misdemeanor or a felony.

As a result, a jail does not provide long-term care, such as prevention and treatment of HIV/AIDS, TB,

Hepatitis C, and other infectious diseases to its inmates, nor does it have the rehabilitative resources for its inmates, particularly women. Prisons, on the contrary, are long-term correctional facilities, which may be run or managed by the state or the federal government.

It is on these institutions that most of this article focuses, even though, when numbers of incarcerated populations are referred to, jails are also included. Penitentiary, a word derived from the Latin and a Catholic Church tradition going as far back as the Middle Ages, when prisons or "workhouses" were also run by the clergy, religious institutions, and the monks, meant a facility where the criminal or offender was kept in to repent from his sins, fulfilling a specific task designed to induce remorse or penance, before being allowed back into the community to resume his normal life. Currently, the term is still in use, especially in reference to specific federal prisons, the British at times calling the penitentiary a *gaol* (cage) in their popular vernacular. As a result, it may be said without hesitation that the church has played a major role in shaping our prison system (Whitehead, 2012: 23). The Romans were the first to use prisons as a system of governance, a tradition that was carried on to the middle Ages, the Enlightenment, and the modern era. However, in the US, the controversy over the running of the correctional facilities and their intended mission became a major issue during the 18th century, mainly as a result of the teachings of the Quakers or the Society of Friends, who were quite influential in Pennsylvania in general, and Philadelphia in particular, as well as in the northeastern colonies and, later, in the United States itself. The colonies attempted first to replicate the correctional system adopted in England as early as 1557, where the prisons were known as "workhouses," designed to house "strumpets, vagrants, rogues...manacled, flogged, and forced to carry out hard labor" (Editors, *Monthly Review*, 2001: 1).

c) *US Prisons and their Growth*

Historically, prisons, as loci of punishment for a crime or offense committed, started in the US between 1789 and 1848, sometimes known as the "Age of Revolution," spreading thereafter to Western Europe, particularly in industrial Britain and revolutionary France. Europe, indeed, became the first continent to admire and subsequently adopt the American prison system. In the American colonies, Pennsylvania, spurred by individuals such as Benjamin Rush, surgeon and a signer of the Declaration of Independence, through his "An Inquiry into the Effects of Public Punishments upon Criminals and Upon Society" (1787), systematized the first houses of repentance. Influenced by Quaker teachings, Philadelphians believed that a criminal could find what the preachers of the era called "introspection" and be rehabilitated through exposure to the Bible, prayer, solitary confinement, and labor. The first correctional facility of this type, which the *Monthly*

Review calls the era's First Experiment, emerged at the Philadelphia Walnut Street Jail in 1787, replicated thereafter at Auburn and the Sing Sing Penitentiaries.

These emerging prisons were conceived and organized into "solitary systems," at times called "congregate systems," where the correctional facilities and their inmates were isolated and secluded from the community. Inmates lived separately, day and night, in single cells, except at meal times, but had to remain in total silence, under the watch of the guards, while working during most of the day. The original intent was to punish the inmate per se through the conditions of the facility itself which was architecturally designed to inspire awe from the vindictive activities occurring inside its walls. The US system drew such attention from Western Europe that it prompted the French Foreign Ministry to dispatch young Alexis de Tocqueville and Gustave Beaumont to visit America and report primarily on its prison system, even though de Tocqueville expanded his curiosity to examine and write on American society, emphasizing its independent spirit and its embrace of democratic principles.

Tocqueville and Gustave praised the American prison system, but also saw its inhumane side, criticized by many as leading to mental insanity, suicide, and inmates' inability to re-adapt to society following their prison term. In Europe, the purpose of a prison had been primarily to rehabilitate the inmate, using, except for capital offenses like murder, such perverted methods as torture, mutilation, forced labor, corporal punishment, and personal embarrassment. The "second experiment," initiated in America around 1925, saw the physical and psychological prison facility as the epitome and epicenter of punishment, strengthened by the intent to "incapacitate" the criminal, eventually resulting in "a massive" and sanctioned incarceration program. Prisons were no longer designed for the prevention of crime alone but became almost solely reserved for the lower classes, the poor, and for ethnic and racial minorities.

d) *From the 1930s to the Present*

During the Great Depression (1929), the number of inmates in the US grew at an unprecedented pace, at the rate of 137 per 100,000 persons, a trend that declined during World War II (1939-1945), apparently as a result of the boom in employment both from military enlistment and civilian job opportunities at home. However, during the 1970s and thereafter, as a result of an economic slowdown that allegedly led to heightened poverty and "crime" among the lower classes, the prison system entered its own second boom period. Thus, by 1990, the inmate population peaked to 458/100,000, and, including offenders on probation, rose to 6,000,000, five to eight times higher than in Europe. In 2001, the number of inmates in state and federal prisons stood at 2,000,000, most of it concentrated in the South, where the remnants of the

Jim Crow tradition, the laws and the new initiatives of the Nixon and Reagan Administrations, expressed in such coded language as “War on Crime” and the “War on Drugs,” took root. However, the unprecedented building of mega, fortified prisons by the federal and state governments began during the 1930s, following the creation of the Bureau of Prisons through Public Law N. 71-218, 46 Stat. 325 (1930) within the Department of Justice. The Bureau of Prisons, which became responsible for the “management and regulation of all federal penitentiaries and correctional institutions,” turned the US into a formidable machine in the prosecution of criminals and offenders. In 1930, large and massive facilities were in operation, housing 13,000 inmates. Ten years later, the number of federal facilities spiked from 11 to 24, housing an estimated incarcerated population of 24,360 offenders. Between 1940 and 1980, some 44 correctional facilities were home to 24,252 inmates (Bureau of Prisons, 2001). As of 1998, there were 94 federal prisons, 1,378 state prisons, and 2,994 local jails. Four of the 94 federal prisons were for women only, and four designed to house men and women inmates, while 9 were administrative correctional facilities. Nationwide, the number of women-only state facilities stood at 65, while 56 were co-educational (ACA, 1998).

The most impressive act of inmate housing and correctional extravaganza was the federal government's erection of Alcatraz “fortress” in San Francisco Bay in 1934 designed to house the worst criminals in the nation. Prisoners worked here, but the conditions in the so-called “D Block,” the prison solitary wing or the prison's “solitary confinement hallway,” was frightening. The cell, called “the hole,” was a room consisting of “bare concrete with a hole in the floor,” with no light, where the inmate was kept naked and fed bread and water “shoved to him through a small hole on the door.” Even though the cell was designed for short periods of solitary confinement, some of the inmates remained in for years. However, in the history of the prison system, the year 1983 has gone down as infamous. That year, two correctional officers were murdered on different occasions at the Marion, Illinois, Prison, which forced its “permanent lockdown,” 23 hours a day, with no “communal yard time,” no work, no educational programs, and no inmates' joint cafeteria meals, with sentenced criminals being kept behind the almost militarized and fortified bars. During the 1940s, many build a huge and growing complex of durable *totalitarian* institutions. This massive use of imprisonment has made American society highly dependent on prisons both economically and politically as well as socially.

These conditions were reinforced by the coded language of “Law and Order” and “War on Crime” of the Nixon and the Reagan Administrations, as noted, and the Sentencing Reform Act of 1984, which prescribed states, including Mississippi, Virginia, Indiana, Ohio,

Oregon, and Wisconsin, following the example of the federal government, began a massive build-up program of “Supermax or control unit prisons,” new “free-standing, isolated units,” numbering altogether 40, which, by 2005, were designed to accommodate 25,000 inmates. As a result of the massive prison building initiative, by 2008, the prison population had grown to 1,600,000, making America the only country in the Western world where one out of 100 citizens was incarcerated in federal and state prisons, while some 723,000 people accused of crimes languished in “local jails.”

e) *Incarceration and Gender and Racial Inequalities in US Prisons*

Racially and by gender, in 2006, one in 36 people in confinement facilities was Hispanic, one in 15 adults was African American, and one out of 19 black men, between the ages of 20 and 34 years, was in prison. Women were not spared either. That year, the number of female inmates grew to one out of 355 women, ages 35-39 years, and one out of 100 black women was in prison, the states spending then about 7 percent of their annual budget to sustain the prison system (Liptak, 2008: 14). The noted prison boom of the 1970s and 1980s, which witnessed the doubling of the capacity of the correctional facilities in the South, forced some states to spend, by 1996, as much as \$234-\$454 per capita on inmates, diverting the scarce resources from education and welfare towards feeding and punishing incarcerated “misfits.” Consequently, an overwhelming number of prisons were filled to capacity. Overcrowding in correctional facilities prompted a judge in Alabama to complain that, in 2001 alone, some 2,000 innocent people were being sandwiched behind bars in the state's small county jails. Another judge characterized one jail that housed a large number of black inmates in the same state of Alabama as a “slave ship” (*New York Times*, 2001). By 2012, the number of inmates per capita in the nation had risen since the 1930s by more than 500 times, 5 to 8 times more than Western Europe, and 17 times more than Japan. This almost exponential growth of correctional facilities and the number of people put behind bars, severely tainted by the treatment of prisoners, especially in the South, puzzled many observers and incarceration experts, given that America had always proclaimed itself to the world as the bastion of freedom and democracy. Writes Christianson (2005):

This history [of incarceration] helps to explain the paradox of a country that prides itself on being the citadel of individual liberty, yet imprisons more of its citizens per capita than any other nation in the world. It also provides a warning about the future, for even as the US epitomizes and sanctifies democracy, it continues to build a huge and growing complex of durable *totalitarian* institutions. This massive use of imprisonment has

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These conditions were reinforced by the coded language of “Law and Order” and “War on Crime” of the Nixon and the Reagan Administrations, as noted, and the Sentencing Reform Act of 1984, which prescribed specific sentencing, abolition of parole for many offenses, and reduced good time for inmates no matter how well they might behave in prison. These initiatives were followed by mandatory minimum sentencing laws in 1986, 1988, and 1990, epitomized by the “three strikes you are out” enacted in California. The Editors of the *Monthly Review* wrote in 2001 (1):

Yet, although this is a social crisis of the highest magnitude, it barely causes a ripple in the news media, with their emphasis on issues that concern the elite or the middle class, or in academia, where this sort of research is scarcely encouraged. Nor is this massive incarceration program an issue in the money driven political system, where politicians vie to win the honor of appearing to be “tough” on crime by building even more prisons and lengthening sentences for nonviolent offenses.

There is also an almost sinister reason why the prison population is dominated by racial and ethnic minorities and disadvantaged socio-economic females: The Zero Tolerance Law (Gun-Free School Act--GFSA) passed by Congress in 1994 against children who bring guns to elementary and secondary schools that receive federal assistance. Although it is valid to ask why and who makes the conditions possible for a child to carry a gun to a school environment or anywhere, zealous state and county schools have added their own list of offenses to the unintended provisions of the law, which have included fighting, truance or absenteeism, disobedience, fighting in school, drug and alcohol possession or use, swearing, disrupting a class, and over a dozen other forms of behavior, some resulting in automatic suspension and others in expulsion from school. At a Senate Hearing held on December 10, 2012, Mr. Monty Neill, Executive Director of the National Center for Fair and Open Testing, revealed that the majority of children affected by the law were African American, especially male, male, and students with disability, who once given to the justice system, eventually end up in jail, confirming what has been called the *School-to-Prison Pipeline*. Mr. Neill also testified that: Approximately 8.8 percent of public school children have been identified as having disabilities and are represented in jail at a rate of nearly four times... and that “one in nine black males between the ages of 20 and 34 is behind bars compared to one in 30 for men in that age in general” (See US Senate Committee Hearing on the Judiciary, December 10, 2012). Some states and counties are worse than others in interpreting and applying the expanded provisions of the law. In Lauderdale County, Mississippi, for example, this law

seems to have been so abused and applied so much more harshly to African American children and students with disabilities that, in August, 2012, the Justice Department threatened to sue the State of Mississippi, the City of Meridian, and Lauderdale County if negotiations did not result in a an agreed settlement within 60 days that would end school-to-prison pipeline practices (Martinez, *CNN Report*, August 10, 2012).

The US Department of Justice charged that the State of Mississippi was violating the constitutional rights of juveniles. This was corroborated by a 10 year-study by the PERICO Institute and by the Children’s Defense’ won research that found that nationwide black students accounted for 72 percent of all incidents in the classroom and 71 percent of all dispositions. In the State of Mississippi, the five dispositions were thus ranked: Out of school suspensions, 249,243 or 41 percent; in-school suspensions, 170,918 or 28 percent; corporal punishment, 8,309 or 10 percent; warnings/administrative discipline, 34, 846 or 6 percent; and alternate school, 13,098 or 2 percent (PERICO Institute and Children’s Defense Fund, 2009-2011).

Concerned about the implementation and consequences of the *Zero Tolerance* policy, the Children’s Defense Fund has determined that one of its top priorities would be to help dismantle the “Cradle to Prison Pipeline,” which shows, for example, that, in the lifetime of a black boy and a white boy born in 2001, the black boy had one-in-three chances of going to prison, more than five times the odds of the white boy being incarcerated. Other studies and the vast experience gained since 1994 have also made it clear that the *Cradle to Prison Pipeline* was, in fact:

A trajectory that leads to marginalized lives, imprisonment and often premature death, and is fueled by racial disparities, pervasive educational poverty, inadequate health and mental health care, gaps in early childhood development, disparate educational opportunities, chronic abuse and neglect, and overburdened and ineffective juvenile justice systems. Failures [adds the Children’s Defense Fund] of our child serving systems, especially when coupled with race and poverty, increase the likelihood of children entering the pipeline to prison” (Children’s Defense Fund, 2013: 3).

The best way to grasp and understand the magnitude of the incarceration of men and women in the US and its impact on the health of inmates, women in particular, is to compare its rates with those of the rest of the world’s population and prison systems. This comparison is particularly revealing when one considers that America is one of the most developed, if not the most developed, country in the world, and one that claims also to be “God fearing” and the most caring nation in the world, as one hears often from itinerant Tele-Evangelists and people that live in the so-called Bible belt of the Deep South. Globally, at any given moment, a minimum of 5 percent of the world’s

population lives behind bars, while this number continues to rise, particularly as both “illegal” substance use and trafficking spread over the globe. Worldwide, imprisonment per 100,000 persons has thus oscillated: 30 in India, 75 in Norway, 119 in China, 628 in Russia, and 750 in the US (Wilper, Andrew et al., 2009). Experts estimate that in 2005 more than 500,000 people were either awaiting trial in jails or imprisoned, the annual rate being about 1.5 million people imprisoned globally. In the US, specifically, the growth of the prison population has been particularly overwhelming. Statistics show, for example, that at the end of December 2004, the number of US citizens (and non-citizens) incarcerated under our criminal justice system stood at 7 million, while more than 2.2 million remained behind bars (about 1,225,680 in state prisons, 129,196 in federal prisons, with the remaining thousands in local jails) (Wilper et al., 2009), constituting the highest number in one country alone globally. The gender composition of inmates worldwide is also an issue of concern. Presently, 5 percent of the world’s inmates are women, particularly in areas where literacy is lowest. Still worldwide, in 2005, to cite one example, 500,000 women and girls were behind bars. The UN estimated then that this number would grow three times faster than any other time in human history (UN Office of Drugs and Crime, 2012).

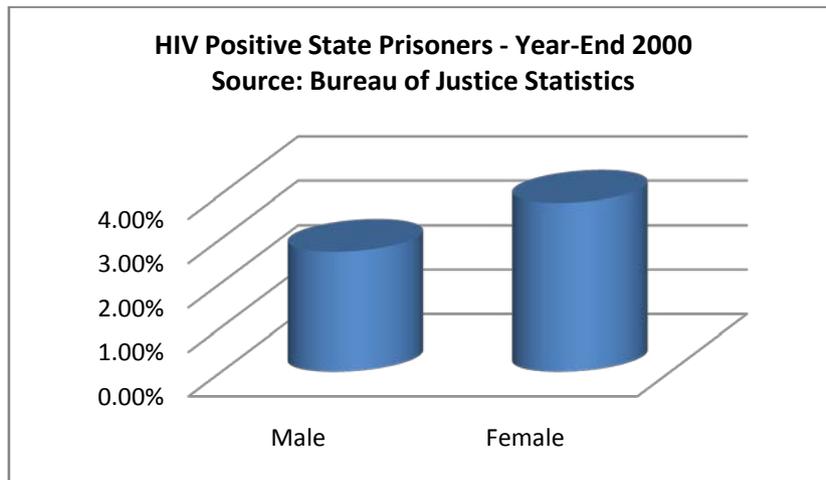
Worldwide, notes the United Nations further, some 30,000,000 people languish in prisons and jails, while the US houses 2,000,000 or 22 percent of the world’s population, at the rate of 714/100,000 annually.

Besides the US, South Africa has the largest number of men and women in prison, some 157,402, at the rate of 335/100,000 persons. However, in Sub-Saharan Africa, in 2007, the number of men and women in jails and prisons stood at 600,000, while in Africa, as a whole, female prisoners constituted only 14,000 of the prison population. Five years ago, in other areas of the world, the number of prisoners ranged from 6,000 to 183,000 (UN, 2007: 12).

f) *Incarceration of Women in US Correctional Facilities*

Until the 1870s, women had not been systematically separated from men in the prison system. It is clear historically, dating back to the time of horse-mounted cowboy justice and hanging trials in the Wild West, that jails and prisons in America were not designed to house women, because rarely were they committed to harsh solitary confinement. Thus, even in our era, jails and prisons have been built primarily to accommodate male criminals, the reason why, today, 40 percent of the correctional facilities are still managed by male officers, wards, or guards. This is likely the reason why the history of prisons and jails is virtually silent on women prisoners and, when mentioned, little is said about the risks they are exposed to when being behind bars (e.g., violence, rape, and inhumane treatment). Indeed, the rate of female incarceration in the US is growing faster relative to its male counterpart, as shown in the figure below.

Figure 1 : Comparison Between Male and Female HIV-Positive State Prisoners



Source: Institute of Correction. "Gender Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders"(2003:2).

The proportion of women among people living with HIV/AIDS in the US United States is generally higher among younger people than among older people. Among reported cases of HIV among 13-19 year olds in 2001, 57% were among females. This is the highest

proportion of female HIV cases among any age group (CDC. "HIV/AIDS Surveillance Report" 13, No. 2, 2001: 17).

In 2011, some 200,000 women lived as criminals in US prisons, a rate three times higher than

the previous years, for an estimated growth of 800 percent compared to a rate of 416 percent for men's imprisonment over the previous two decades. From 1990 to 1998, the number of female inmates had increased by 92 percent, with 40 percent being incarcerated on a drug-related offense (Baldwin, et al., 2000). In this respect, the State of Oklahoma has had the infamous honor of incarcerating the largest number of women in the nation, 134/100,000 persons, while Massachusetts houses the smallest number of female inmates: 13/100,000, most of whom charged with illegal possession of drugs or drug use (Stern et al., 2011: 1). Thus, between 1986 and 1991, a span of five years, the number of women in prison in America rose by 75 percent to 139,000. In 1998, the number of men had jumped by 60 percent, while that of women had risen to 92 percent, as noted, in federal and state prisons, the year when most of women's sentences had spiked by 80 percent since 1990 (Beck & Munola, 1999).

Sadly, as recently as 2007, in the US, two-thirds of the imprisoned women have been women of color. During the first part of the 21st century, black women in the United States were twice as likely as Latina women and eight times more likely than white women to be in prison" (Kleinman, 2007: 1). Over the centuries, most incarcerated women have also tended to come from poor backgrounds, lacking marketable job skills, and from certain racial and ethnic groups," namely, African American and Hispanic, population "subgroups" that are already at an increased risk of incarceration" and, therefore, exposed to a variety of problems in an already hostile environment when they enter prison. It should also be noted that, currently, 25 percent of black women are considered to be poor by the US census, and it is known that jail and prison incarcerations are often associated with low socio-economic status. Thus, Kleinman adds to the discussion by noting that poverty and the oppression of women "play a huge role" in the high HIV infection rates found among incarcerated populations (2007: 2).

From 1993 to 2008, the arrest of women for drug/alcohol use in the country increased by 19 percent compared to 10 percent for men. In 2007, this number climbed to 93,000 in federal and state prisons, representing 6.6 percent of the total incarcerated population in the country. The size of the prison population reflected a growth of 5 times over the previous 20 years (Groot, 2007), distributed as 7.5 percent for women and 5.7 for men, a difference of 1.8 percent, which represented a significant tilt towards an increase in the number of women sent to languish behind the prison bars. During the same period, the rate of women offenders committed to state and federal correctional facilities was 5.2 percent of the prison population--up from 4.7 percent in 1986 (Stern, 2011). The highest incarceration rate for women occurred in the Bible belt, where it reached the 790/100,000 person-

mark. Currently, within the South, incarceration rates have remained about the same for rural and urban counties (1,194 and 1,160 people, respectively). In this context, it is instructing to remember what Stephenson and Leone (2005) note in their study in relation HIV infections, namely, that: "Although prisons in the northeast [have had] the highest rate of HIV infection, 4.6 percent, southern prisons have had the highest number of HIV cases by geographical region," and the situation has not changed since then.

A study conducted in 2001, found that women of color, particularly those between the ages of 14 and 24, constituted 42 percent of the inmate population. That year, in Minnesota, for example, 25 percent of women incarcerated on sexual charges were black. Studies further reveal that most incarcerated women are over 30 years of age; tend to be high school graduates or "holders of a GED"; are, as noted, from racial or ethnic minorities; mostly unmarried; are mothers of children under 18 years of age; and grew up in households with just one parent, most having experienced physical or sexual abuse in childhood. The other characteristic observed of women in prison is that 17 percent of those serving in state prisons tend to be repeat offenders, on probation or incarcerated, including 20 percent who were once housed in Juvenile facilities (Snell, 1991). Also, most of these women were under the influence of drugs when they were arrested, of whom 36 percent were habitual users of cocaine or crack prior to committing the offense that landed them in prison. In 1991, about 10 percent of the women were arrested and convicted of fraud, although this represented a 17 percent drop from 1986.

II. HIV/AIDS INFECTIONS AND WOMEN IN US PRISONS

a) *Theoretical Framework*

As we proceed to discuss the issue of women's health in our prison system, it is instructive to point out that historically, women have been systemically excluded from prison design and policy development and implementation (Reyes, 2001). As a result, little consideration has been given to the healthcare needs of incarcerated women (United Nations Office on Drugs and Crime, 2007). The absence of rigorous prison policy/mandates that address health care provisions for women exhibits a lack of concern for their well-being and state of health while incarcerated (Reyes, 2001). In addressing the issue of women and HIV in the prison setting, it is therefore imperative to look at the systems and feminist theories frameworks. In general, examining these frameworks provides some insight as to the historical oppression of women. However, more importantly and specifically, the theories help one to understand how the prison system, an institution designed for men, has not concerned itself with

providing for the needs of women and how this lack of concern promotes increases in the number of HIV cases among women in prison.

Over the years, the number of women involved in the criminal justice system and the rate of incarceration of women has increased (Snell & Morton, 1991). During the period of 1977 and 2007, the women's prison population grew by 832% (West & Sabol, 2007). Although these numbers are staggering, few corrections/criminal justice policies focus specifically on women. Fewer focus on incarcerated women and health related issues during incarceration. Although incarcerated women are 80 times more likely to be HIV positive than non-incarcerated women (Correctional Association of New York, 2012), few policies address the issue of incarcerated women and HIV. The most recent piece of legislation in the nation, signed by Governor Patterson of New York in 2009, mandates the New York Department of Health to monitor HIV and Hepatitis C in prisons and jails (Correctional Association of New York, 2009). However, even this legislation does not provide for treatment or specific considerations for women.

Social control theorists posit that, when individuals are threatened with punishment, they become socialized and learn to control behaviors that warrant direct or implied punishment (Hirschi, 2002). Much of the mass incarceration of women during the 1980s and 1990s can be attributed to the "War on Drugs" legislation (United Nations Office on Drugs and Crime, 2007). The legislation was formulated to punish drug users in the hope that individuals would become socialized and learn self control and not indulge in drug use, thereby, putting the drug cartel and distributors out of business. These white house policies and mandates could be seen in some form or another throughout the institutions of justice at state, local and federal agencies and governments. Community, court, policing, and prison systems readily implemented these criminal justice laws and policies without considering the massive numbers of women that would be caught in this wide net legislation.

The systems theory examines interrelated relationships between institutions/organizations, the impact those relationships have on individuals, and how each component contributes to the well being of the individual while promoting holistic change (Turner, 2011). Since most prison systems are male dominated in prison population, staff, and administration (Mazza, 2012), most prison policies are not inclusive of the needs of women (Covington, 1998). Unfortunately, women now make up a large number of those involved with the criminal justice system. However, the prison "system" has failed them in terms of providing adequate health care and education to combat sexually transmitted diseases such as HIV, although the increase in the numbers of incarcerated women can partly be

attributed to criminal justice/corrections legislation and the lack of preparedness to receive women in this system.

The feminist theory aims to understand the totality of gender inequality by examining social roles of women, their experiences, and politics, by critiquing social relations through analyzing and the promotion of women's rights, interests, and issues (Turner, 2011). Prison systems in the United States have mirrored the traditional social and moral norms of society that posit that, if an individual commits a crime, he or she is, therefore, forever a criminal (Marcus-Mendoza, 2004). Incarcerated women are then viewed as individuals who have failed society and considered inept (Marcus-Mendoza, 2004). Prison programs have replicated this stereotype and designed programs that address the stereotypes instead of the underlying causes that led to being imprisoned (Marcus-Mendoza, 2004).

The aforementioned theories come together to highlight the lack of preparedness of prisons to house women in institutions developed and designed for men and outline why it is important to look at systems and how they affect individuals. The underlying assumption of each of the preceding theories is that relationships with systems/institutions influence behavior and outcomes for individuals. These relationships can be positive or negative depending upon whether the treatment of women is considered. However, the theories do not address the issue of how systems intersect to create a system of oppression for women involved in the criminal justice system. Intersectionality is a feminist sociological theory that supports the use of multidimensional conceptualizations (Crenshaw, 1991) when attempting to understand "the relationships among multiple dimensions and modalities of social relationships and subject formations" (McCall 2005).

Intersectionality theorists posit that individual identifying markers, such as race and gender, do not operate alone as targets of oppression but intersect to contribute to systematic oppression (Crenshaw, 1991). In the case of incarcerated women, for example, identifying markers of being a woman, drug user, HIV+ and African American simultaneously intersect on multiple levels. Each of these markers intersects with the criminal justice/corrections system, legislation, community, and themselves to contribute to inequality/oppression within the prison system. The theory lends itself to the explanation of how and why prisons and policy-makers fail to provide adequate health care for women and why this lack of concern promotes increases in the number of HIV cases among women in prison. The authors expect that the reader of the following sections of this work have these theoretical perspectives in mind if the wish to better understand why, overall, women are in such precarious conditions in prisons whose primary concern and focus of care are men.

b) Women and HIV Infections in Prison

Regarding the disease factor, as a mirror of the general population, women tend to bear the brunt of the HIV/AIDS burden, confirming what Nelson Mandela, former President of South Africa, once said, that, globally, the HIV epidemic was taking the “face of a woman” (Groot, 2005). It is no secret today that HIV/AIDS prevalence in US prisons is high, even though studies’ statistics vary considerably. A UN study notes that women are at least twice as likely as men to contract HIV through sexual contact, of which the likelihood is increased by pre-existing sexually transmitted infections (STIs). This is also true of incarcerated men. In US prisons, the rate of HIV infection seems to be 1.7 percent among men and 2.4 percent among women. In New York, the prevalence is more alarming as it is estimated at 14.2 percent among women prisoners and 6.7 percent among male inmates. For 2003, one statistic reveals the rate of the female prison population as having been 5-10 percent, with an accompanying rate of 2.8 percent in HIV cases, compared to 1.9 percent for men.

It is generally accepted that, from a sociological, psychological, and environmental perspective, women are at a higher risk of being infected with HIV and other opportunistic sexually transmitted infections and diseases than their inmate counterparts. However, biological factors make women, especially those in prison, more vulnerable to the devastating effects of HIV. Other statistics show that, in 2007, state and federal prisons combined housed some 21,987 HIV-positive offenders, the worse states being Florida, New York, and Texas. Struckman-Johnson and Struckman-Johnson’s study in *The Journal of Prison* (2000: 379) found that:

Twenty percent of the inmates had experienced at least one episode of pressured or forced sexual contact since incarcerated in their state, and 16 percent reported that an incident had occurred in their current facility. At least 7 percent of the sample had been raped in their current facility. Seven percent of the sample had experienced sexual coercion, and at least 4 percent had been raped during the most recent 26 to 30 months. Factors that appeared to increase sexual coercion rates were large population size, racial conflict, barracks housing, inadequate security, and having a high percentage of inmates incarcerated for crime against persons.

In the following section, we discuss the risks to which women are biologically more predisposed to HIV than men, summarizing what is known, as presented in Herman Reyes’ work. First of all, Reyes stresses the point that, in general, sexually transmitted infections, “quite often in female prisoners, and often undetected,” are major contributors to the spread of HIV, “as they enhance transmission as well as diminish general

resistance to the patient” (Reyes, 2010: 193). It is important to note that the symptoms of HIV infection in women are generally gynecological. Thus, problems with cervical dysplasia (pre-cancerous changes in cervix or uterus cells) are generally associated with “infection with the human papilloma virus (HPV) and enhanced by HIV, resulting in complications during pregnancy and child birth.” As known, HIV appears in infected males’ semen, in the semen fluid and mononuclear cells, whereas, in women, the virus is found in the cervico-vaginal secretions. Noted by experts is the greater volume of semen compared to the cervico-vaginal secretions, which means that the virus associated “with AIDS is found in greater concentration in men, and ...the Langer-Hans cells of the cervix may provide a portal of entry for HIV.” Studies also stress that men transmit HIV infections easier than women do, due to “increased genital shedding of HIV-1 in them,” even though, in Uganda, a study of the transmission pathway showed that “plasma HIV RNA levels and genital ulcer disease, *but not gender*, were the main determinants of HIV transmission” (Groot, 2005: 2). Finally, the 2007 figures released by the Bureau of Justice Statistics put the number of HIV-positive inmates at 21,987 and an overall rate of confirmed AIDS cases in federal and state prisons at 0.41 percent, more than double the rate of cases in the general population, estimated at 0.17 at the time.

In the case of minorities, the HIV situation has always been grimmer. Thus, even though African Americans and Hispanics represent 61 percent of all AIDS cases in the US, put together, African American and Hispanic women represent less than one-fourth of the US female population, but, since 1986, they have represented three-fourths of the total number of AIDS cases for women in America. As a result, AIDS has become the leading cause of death for African American women ages 25-44 years, most of whom having contracted the disease through heterosexual contact. Telling was a recent finding by the CDC that concluded that characteristics associated with prisoners’ HIV sero-conversion were “male-male sex in prison, tattooing in prison, age older than 26 at entry, more than 5 years served of the current prison sentence, *the black race*, and a body mass index less than 25.4kg/m² square on entry into prison” (CDC Report: 3). Additionally, some HIV experts believe that the overall rate of HIV among women in America is 0.2 percent, but that among incarcerated women, the rate stands at 15 times higher, corresponding to almost one in 10 incarcerated females, a 3.0 percent rate in 2002, compared to 2 percent among male inmates. This is in contrast to the figures from previous years (e.g., 1996), when the number seems to have been 3.5 percent among female and 2.3 percent for male inmates. Studies further claim that one in 10 prisoners who have HIV is a woman, and a woman in prison is three times more likely to contract HIV while

there. Kleinman's study suggests that as many as 20 percent of females in prison are HIV-positive, while only 9 percent of the men are so. The 2012 report of the Bureau of Justice Statistics reveals that 3.6 percent of all female inmates in the US are HIV-positive compared to a 2 percent sero-prevalence among incarcerated males. For illustrative purposes, in Nevada, estimates are that 30.6 percent of women prisoners are HIV-infected, while, in Connecticut, the rate among incarcerated women is 15 percent.

Some reports claim that New York prisons and jails show an HIV rate of 20 percent among female prisoners contrasted to 7 percent among their male counterparts. In southern and northeastern state prisons, the rate of HIV infection may be as high as 8 percent among inmates, while, Washington, D.C., shows a rate of 6.0 percent, and Massachusetts 4.0 percent. In fact, for 2003, figures on AIDS prevalence in prisons were estimated to have been higher than in the general population, namely, 0.51 percent and 0.15 percent, respectively. During the late 1990s, HIV rates among inmates released from prisons in the South were estimated at 26 percent, with 15 percent found among released former female inmates (Hammett, 2006: S17). In New York, authorities claimed then that two-thirds of their state prison population was HIV-positive. Notwithstanding these frightening and differing numbers, on one hand, the US is not the worse place on earth with high HIV rates among female prisoners. South Africa, on the other hand, is believed to house as many as 41.4 percent HIV-positive female inmates, a mirror of the three times higher general population rate of 17.8 percent. In Canada, as a whole, as recently as 2009, 4.1 percent of the incarcerated women were HIV-positive, contrasted to 1.7 percent in the male prison population.

III. RAPE, INTRAVENOUS DRUG USE (IDU), TATTOING, AND HIV STIGMA

Stigma is an issue that all inmates, especially women, fear. The persistent stigma stemming from such an infectious disease as HIV/AIDS, disproportionately plagues women in prison because they know that, while in "captivity," they remain outcasts among both their male and female inmates, and that, once released from prison, society will continue to ostracize or avoid them if their health conditions are known. On this, the United Nations (1995-2012) notes that "upon release, the stigma of imprisonment weighs more heavily on women than on men." In some countries [continues the UN], "women are discriminated against and are unable to return to their communities once released from jail," even if they are not infected with HIV/AIDS or with another sexually transmitted disease (UNAIDS, 1995-2012: 2). In fact, argues Zaitzow (1999: 78), "stigma and privacy concerns [are] prominent prison context barriers to [the delivery of] HIV prevention services during incarceration." Separating, isolating, or quarantining

infected prisoners is something all inmates fear. In the general population, often wealthy people are able to hide their condition through effective medication and, when they die from it, the reasons given are not always revealed. In the States, people often characterized the causes or associated factors of death euphemistically as pulmonary or respiratory complications. In Africa, for example, deaths associated with HIV/AIDS are often described as resulting from "a long illness." Within the African American community, sometimes family members may say that their relative died from sickle cell complications, such as anemia, rather than from HIV/AIDS (*New York Times*, 2004). A case highlighting the lingering stigma from HIV/AIDS allegedly occurred to an Indian woman charged in court of "fraud, cheating, criminal conspiracy" under the Indian Penal Code and Passport Act, which mandates the imprisonment of anyone involved in providing false passports and visas, of which the accused was charged in New Delhi, Haryana, and Punjab. The woman claimed in court that the wardens "beat her up badly, and got the AIDS patient to *scratch her with her nails*" (*Times of India*, 2012).

Even though HIV/AIDS is contracted mostly through sexual contact or the sharing of needles and contamination through particular body fluids, ignorance causes many people to completely avoid the infected, just as all prisons tended to isolate lepers in Biblical times and people with tuberculosis during the 19th century. In March 2010, the ACLU filed a complaint against Alabama, Mississippi, and South Carolina, because they segregated prisoners based on their HIV/AIDS-positivity. The ACLU (April 2010) argued that the practice was inhumane, cruel, and degrading, as it unnecessarily stigmatized individuals and violated international law. As a result, the Commission of the Mississippi Department of Corrections stopped its prisoner segregation policy. South Carolina and Alabama did not reverse their policy. One would think, however, that stigma from a disease would be much less widespread in the United States, where knowledge of the mode of transmission of HIV is expected. What contributes to the level of the HIV/AIDS stigma is that most information obtained from the tests performed in the doctor's office or at hospitals is supposed to remain confidential. In most states, however, HIV-infected inmates do not work or attend educational or vocational programs, and are usually kept "in maximum security facilities irrespective of their crime at a tremendous cost to taxpayers" (Edwards, 2010).

a) *Rape and Assault of Women in US Prisons*

Few Americans realize that, in the United States, even in such a confinement as the prison cell, rape is a common occurrence. According to *Culture of Prison Sexual Violence* (Lockwood, 2008), 5 percent of women say they are aware of rape occurring in the institution in which they were housed (Fleisher and

Krienert, 2006: 15). The Bureau of Justice Statistics reports that annually 216,000 inmates are sexually abused by other inmates and prison guards" (Guerino, 2008: 11) and that the rate of rape of female inmates is 10 times higher than in the general population. This speaks volumes about the vulnerability of female prisoners to rape and sexual assault perpetrated by their fellow inmates and the prison personnel. The rate of inmate-on-inmate sexual victimization is estimated to be at least 3 times higher for female (13.7 percent) than for male prisoners (4.2 percent) (Beck and Johnson, 2008: 5). Female prisoners report not only that that staff-inmate mutual sexual relationships are common (Fleisher and Krienert, 2006: 17) but also that the relationships are similar to a barter system in which contraband or other goods are exchanged for sex. The Review Panel on Prison Rape cites the Fluvanna Correctional Center for Women as an example of what happens inside America's prisons. Of the 1,200 women in the facility, 11.4 percent said they were sexually abused by another inmate and 6 percent revealed that they had been sexually abused by staff (Kaiser & Stannow, 2012). Studies stress that such behavior is often tolerated by the prison staff, which results in female inmates not trusting the prison personnel, creating an environment that is threatening, scary, and psychologically damaging. "If we cannot trust staff to obey the rules [say the women], why should we?" (Fleisher, 2006: 17). Given the confined environment of the prison setting, the raping incidents between inmates occur often in the corner of cells, stairwells, showers, laundry rooms, and bathrooms. Staff-on-inmate rape may take place in a closet, an office, or in any locked room (Beck et al., 2008). Stories of guards watching women disrobe or use the bathroom are very common (Rosen, 2012). In instances where women and male inmates do not live in separate facilities, or where cells are adjacent to men's, women are much more vulnerable to rape and violence from both male inmates and prison guards. During the early 2000s, estimates were that 16 percent of male prisoners were "pressured or forced into sexual contact." By 2003, statistics indicated that some one million inmates "had been sexually assaulted" during the previous 20 years (<http://www.org/prisons-hiv-aids.htm>). While some studies also show that inmate-inmate rape occurs regularly in jails and prisons, others indicate that, even in federal prisons, the number of rapes among inmates oscillates between 9 percent and 20 percent.

Lockwood's work identifies the characteristics of sexual behavior in the prison sex culture. The book reveals that the targets tend to be white inmates, who are younger and unfamiliar with prison life, and that the aggressors are usually black. On aggressive behavior and its tactics, Lockwood writes that black women tend to be more aggressive in the prison system and that white women show aggression mainly for safety reasons

(Fleisher and Krienert, 2006: 52). Research also indicates that many incarcerated women are desensitized to sexual coercion. First, some may have already been sexually assaulted prior to prison and often do not know they are being forced into a sexual relationship. Second, others participate in such behavior because they seek protection or use the relationship in an exchange for economic favors. In prison lingo, these women are known as "box whores." At this point, the coercion fades into a consensual relationship. Kaiser and his colleague add that 78.7 percent of the rapes committed by staff are often characterized as "consensual." However, it must be noted, as the two authors do, that "all sexual contacts between inmates and staff are legally nonconsensual" (2012), because there is a disproportionate imbalance of power between the inmate and the corrections officer. Over half of the women said to be willingly to have sex with staff do so to ensure that they are protected from other inmates or seek drugs/alcohol and economic favors.

Unfortunately, there are consequences to reporting rape. Many women do not report or retaliate and learn to accept the violation and may end up becoming a part of the homosexual lifestyle in the prison (Fleisher and Krienert, 2006: 178). Yet, even when a woman accepts this lifestyle, she may still be abused because she remains a victim (Fleisher & Krienert, 2006: 178). When she dares to report the rape, a woman runs the risk of being further abused by the system. As Fleisher and Krienert point out, often "Correctional officers blame victims for their victimization and officers stigmatize inmates by their failure to believe victims" (Fleisher & Krienert, 2006: 178). Indeed, if a victim does not fit into the prison officers' definition of a victim, the officer listening to the complaint does not believe that he/she was raped. Obviously, the rape of women by men always happens within a context of physical or psychological violence, which puts them at a great disadvantage. Sadly, prison experts also report that "available data indicate that rape is a disciplinary tactic and a control mechanism by prison authorities who not only ignore or do not prevent rape, but encourage it as a punishment tool" (UNAIDS, 2007: 8). Currently, there is a case under review by the Justice Department of the only women prison in Alabama, *Julia Tutwiler*. The case was brought up by the civil rights group *Equal Justice*.

Equal Justice alleges that, with knowledge by the authorities, "male corrections officers have repeatedly abused and even raped their female inmates" regularly, in exchange for "banned goods," while other guards remain on the lookout to protect their fellow ward(s). These factors place women at higher risk regarding intimacy because, as is often the case with prostitution, the paying male partner may refuse protected sex, particularly if he pays extra" for her services. Of course, we cannot overlook the prison life sub-culture, which is replete of bullies who physically

and mentally torment their fellow inmates. Bullying is often presented in the form of physical abuse, like placing a mop on a prisoner's head and setting fire to it; making practical jokes on someone; intimidating or threatening, for example, by pouring gasoline over a prisoner's feet and "threatening to set fire to them"; sexually abusing an inmate, for example, by "masturbating another prisoner" in plain view; verbally abusing another inmate; and gossiping, spreading rumors, and ostracizing a mate (Ireland, 2002: 130).

Given that some men are already infected prior to entering prison or jail, the likelihood of transmitting HIV and other sexually transmitted diseases and infections to others is high. In 2005, Maryland and New York, for instance, housed women prisoners with an HIV rate of 10 percent partly because of a prior history of drug injection use. Such women had "sexual partners of IDUs, [had] supported themselves through sex work, and, more often than not, [had] been forced to have (unprotected) sex or [to] trade sex for housing and food" (Groot, 2005). These factors place women at higher risk regarding intimacy. Studies have also shown that female prisoners who were previously prostitutes, participated in intravenous drug use or had contact with someone who was HIV positive are keenly at risk for the AIDS virus (Kantor, 2006). Female inmates, have a higher rate of HIV virus than male inmates (2006).

Texas prisons, in particular, are notorious for sexual assaults on inmates, having been classified by the Bureau of Justice as among the 10 US prisons where between 9 percent and 16 percent of all inmates have reported incidents of rape by fellow prisoners and prison personnel (*Equal Justice*, 2012). A former prison guard, Scott L. Anderson, who lives in Port Townsend, Washington, and has conducted research on rape and sexual assault incidences in jails and prisons, estimates that 30,000 such instances occur in American prisons every year: 196,000 on male prison inmates, 123,000 on men in county jails, 40,000 on boys "either in adult prisons or juvenile facilities or lock ups," and 5,000 on women. Globally, this tool of submission is more pronounced in some countries than others. Of Africa, for example, UNAIDS says: "Rape and other forms of sexual violence among male and female prisoners are rife in African prisons, between prisoners of the same or different sex, and between staff and prisoners" (2007: 16).

b) Risk of Disease Transmission: Practices of Tattooing, Piercing and Syringe/Needle Use

Tattooing is an old practice that goes back to ancient times and must be distinguished from masquerading, whereby one paints his body or part of his body, such as the face, for group or ethnic identity, usually done on special occasions, as during the initiation of the young men and women among many African societies or in warring practices in Asia. However, tattooing resembles scarification in that it is

physically intrusive and, once done, it may be almost impossible to remove the marks or incisions it leaves. In American society, especially among the young, tattooing is quite common and serves several purposes: group identity, as is the case among certain motorcycle "gangs"; attempts at looking different or a sign of rebellion against tradition; and a way of portraying meanness, machismo, unusual physical strength, or striking muscular appearance. The problem with tattooing, if not done with the proper instruments and if carried out without concern for cleanliness and one's health, may be harmful to the body. The crude "operation" is known to be a conduit of sexual infections and diseases, including HIV/AIDS, even though the rate is still being debated. The CDC study in a Georgia State Prison concluded that "Findings from the investigation demonstrated that risk behaviors such as male-male sex and tattooing are associated with HIV among inmates" (MMWR, 2006).

Unfortunately, tattooing has been allowed in virtually every prison in the US, without insistence on the part of the authorities that the practice be stopped unless certain safety precautions are taken to prevent physical injury and disease transmission. Studies conducted in prison have shown that this growing practice, which can also be a result of boredom from living behind bars, has caused or been associated with transmission of disease (MMM, 2006). As such, therefore, it endangers the health of the incarcerated population and becomes a health hazard once the inmate is released to the public. Piercing, popular among young women and certain segments of our society, can also be a health hazard, if not properly handled. Quite often, makeshift unclean instruments are used in the process, especially in a prison setting, where sharp instruments, such as needles, scissors, and syringes are not allowed. As a result, desperate inmates improvise tools from a variety of materials available on the prison premises or in the cell, using "multiple punctures" with such "recycled, sharpened and altered implements" as knives, staples, guitar strings, sewing needles, paper clips, empty plastic writing casings from pens, or plastic ink tubes from ballpoint pens (Kantor, 2006). A popular process, known as the "pluck method," involves "inserting ink with a single shared needle, which is not sterilized," proven to be a transmitter of the AIDS virus from one tattooed candidate to another, even though the rate of transmission has not been established by HIV studies.

As commonly known, most of the syringes used in prison tend to be used and re-used without sterilization, and may also carry and transmit deadly viruses to the injected individual(s). Bleach or disinfectant substances used in prisons outside the US, as is the case in some 20 European nations, including Austria and Canada, are often not available or provided in our federal or state prisons, even though these have

been proven to reduce the use of illicit drugs through unsterilized implements. Just like careless tattooing, the use of non-sterilized syringes in prisons and our communities increases the rate of transmission of infectious diseases, such as HIV/AIDS, especially in confined quarters as the prison environment, with women inmates being at a greater risk of vulnerability to potentially deadly practice because of their already compromised health condition in jail. Given that, in most cases, women in our prisons have been incarcerated as a result of the use of illicit drugs, sometimes intravenously injected, in their communities, the prison setting heightens the chances that they will continue their habit with their new mates. This is confirmed by many research studies, including several conducted by the UN, that confirm that more women than men with drug addiction are in prison (UNAIDS, 1995-2012). Other studies indicate that “women arrested for drug-related offenses or for prostitution are at high risk for already being infected with HIV when they enter the prison system.” Thus, the use of unclean syringes to satisfy the craving for being “high” seems to be riskier for female inmates. Incidentally, clean syringes are provided to inmates in many European countries but not in US prisons.

The intravenous use of drugs, especially in prison, presents at least two greater risks: Sharing unclean needles, which makes infection transmission more likely and impairs one’s judgment when a decision has to be made as to whether or not to engage in risky health behavior, especially among younger and middle-age women prisoners. In fact, those familiar with the lives of women in our prisons believe that needle sharing constitutes the greatest risk for women prisoners to contract the virus associated with AIDS. Says one Prisoners’ AIDS Commission member:

[Wanting] the drug is compounded by ‘secrecy’ and this often means that sterilizing goes out of the window. Women are depressed; they have little self-respect and feel worthless. They often come from “crisis” situations and intense pressure, especially for younger women, means respectability is lost, as are the educational messages. Only a handful bother to go through the two times water, two times bleach, two times water method and usually the same fit (needle) is used throughout; so God knows! (Walsh, 2011: 270).

The relevant question is why these unhealthy practices are allowed in prisons. Common sense would indicate that, if allowed, the responsible authorities ought to provide the proper “gear” and implements to protect the health of the inmates and the public to which these careless individuals will be eventually released. This seems more urgent particularly now that the numbers of former inmates has increased, as the absolute number of incarcerated offenders continues to rise. On releases from prison, in 1998, for example, some 11.5 million former offenders, violent and non-

violent, were released from our correctional facilities and “dumped” in communities across the nation.

Many prison care advocates note that the prison environment would be much healthier if clean needles and other injection drug use equipment, such as bleach, condoms, dental dams, and lubricants, were available. Additionally, if information on safer tattooing and piercing practices were provided, and if the mental status of some prisoners, were taken into account in the process of caring for the inmates, especially the most vulnerable population, namely, women, the conditions in jail would improve. Unfortunately, the rate of infection from unclean implements in prison is not entirely clear. We only know for certain that drug use is common in prison. During the time period between 1994 and 1996, 61 percent of US inmates injected drugs into their veins compared to 27 percent of the total cases outside the prison environment (Kantor, 2006). It might be illustrative to include the following information regarding the use of needles in prison:

...Needle sharing goes on regardless of the reality of AIDS. The prisoners’ peer educators seem to suggest education can only be effective if issues of self-esteem, boredom, and peer pressure and drug addiction are also addressed. They suggest, too, that the type of prison—maximum or medium security--may have a bearing on the effectiveness of HIV/AIDS education (2011: 271).

Currently known is the fact that both drug use and HIV infection are more prevalent among women in prison than among imprisoned men (UAIDS, 2012). Known also is that drug use itself, with or without sterilized needles, is a practice that many women begin engaging while in confinement, under pressure from peers, male drug users (UNAIDS, 1995-2012), and out of boredom. A Canadian study found that alcohol consumption and drugs during incarceration is significantly higher among men than women. However, it is also suggested that “length of incarceration, security level, pre-incarceration drug use, and prior regular drug use are risk factors associated with substance use during incarceration” for both men and women (Plourde et al., 2012: 506).

c) *Sexual Activity and Reproductive Health in Prison*

Even though most US prisons control and prohibit sexual activity on the facilities premises, it is allowed in some jurisdictions, e.g., between an inmate and his/her special visitor, such as a wife, a husband, or a boyfriend. Some US prison facilities even allow marriage ceremonies in prison. Pregnancies and child births in prison also occur frequently. Cases of pregnancy, as a result of sexual encounters or rape in prison, are also common: 4 percent in state correctional facilities, 3 percent in federal prisons, and 5 percent in jails. Unfortunately, most prisons do not provide pre- and post-natal care to expecting mothers, nutritional diet to pregnant inmates or breastfeeding mothers, or AZT

and other modern therapies, to prevent mother-to-child vertical HIV transmission. We should mention here that vertical HIV transmission can be easily detected in the new born through simple tests and thus trace the infection to the mothers. The new rapid HIV test is done "either through a blood specimen obtained by finger stick or venipuncture or an oral fluid specimen obtained by a swab," with results being available in 20 minutes." These, however, need to be "confirmed with a Western blot essay" (Beckwith et al., 2012: S184). Unfortunately, many young women imprisoned for drug and sexual offenses never reveal that they inherited the habits or the infections from their mothers, afraid of exposing their closest relatives to the public. As noted in a United Kingdom House of Lords' report, "by putting out there that they acquired [HIV] from their mothers [or fathers], infected young women would also be exposing the fact that their mothers were injecting drugs or were engaged in sex work" (Sopha Forum Round Table, 2011: 2).

Related to family upbringing, studies from Framingham correctional facilities have found that women with a history of childhood sexual abuse are 4.5 times more likely to have participated in three risky behaviors (sex work, drug use, and non-condom use) and 2.8 times more likely to be HIV infected than women who did not report such personal history (HEPP, 1996: 2). Overall, it appears that 59 percent of women in a maximum security facility were sexually molested at home or elsewhere during childhood. Another study confirmed the association between early childhood sexual and physical abuse, drug use, and sex work (prostitution), with risky behavior in prison and the prevalence of HIV infection among inmates. Kleinman writes:

According to self-report data, as many as one-third to two-thirds of incarcerated women report prior sexual abuse and, as many as five, report a history of childhood sexual abuse. More than 80 percent of incarcerated women have experienced significant and prolonged exposure to physical abuse by family members or inmates (2007: 1-2).

One study suggests that the rate of physical sexual abuse against women ranges from 43 percent to 57 percent in state and federal prisoners some time while serving their sentences (National Commission on Correctional Health Care, 2005)

Returning to the issue of reproductive health, apparently, there are still prisons in the US where pregnant women are handcuffed in bed while in labor, or where prison guards use leg iron implements to prevent them from escaping or as punishment when they are en route to a baby delivery facility. Some states, such as California, New York, Connecticut, Illinois, and the District of Columbia, have passed statutes prohibiting the practice, which seems to be a violation of the 8th Amendment. Between 1998 and 1999, the number of children born from incarcerated mothers was estimated

at 1,400, with 150 women having entered the prison system pregnant. Among all incarcerated women, in 1998, 70 percent of those in jail, 65 percent in state prisons, and 59 percent in federal prisons had a least one child born outside or inside the correctional facility. Also, in some jurisdictions, prisons allow mothers to keep their babies on prison grounds, if the latter are not given for adoption. Incidentally, women in prison still have the right to abortion, as this is the law of the land. Yet, it appears that prison authorities, depending on location, often make it difficult for women to exercise this right.

IV. HIV/AIDS AND OPPORTUNISTIC SEXUALLY TRANSMITTED INFECTIONS

a) *Gonorrhea, Chlamydia, Syphilis, Trichomoniasis, Tuberculosis and Hepatitis C Virus*

Sexually transmitted infections (STIs) and sexually transmitted diseases (STDs) in general are also a major health risk in our jail and prison systems. Studies conducted in 2003, revealed that, at that time, the inmate infections rates were: gonorrhea 1.8 percent; Chlamydia 6.3 percent; and syphilis 7.5 percent. Untreated gonorrhea and Chlamydia "can lead to pelvic inflammatory disease, ectopic pregnancy, infertility, or chronic pelvic pain in women" and are "associated with increased risk for contracting HIV" (CDC, MMWR, September 1999). A study conducted by the National Commission on Correctional Health Care found that, in Rhode Island, 49 percent of the women who had contracted infectious syphilis "had been incarcerated at some point between 1992 and 1998" (National Commission on Correctional Health Care, 2005). Globally, the rates are higher, as expected, among developing and some "developed" countries. Thus, in Brazil, for example, 13.9 percent of the inmates have the AIDS virus; 16.2 percent have hepatitis C; and 22.8 percent suffer from syphilis. In 2005, in Moscow, 50 percent of the juvenile detainees had at least one form of STI, as did almost two-thirds of women "at the temporary detection centre, and three quarters of homeless women," with those at the center "showing an HIV infection rate of 4 percent, compared to 1.8 percent of the homeless men" (UNAIDS, 1995-2012: 2).

Numerous studies show higher rates of syphilis, Hepatitis C and other STIs (Cu Uvin & De Groot, 2005). We noted that the rate of HIV infection among women who are in prison is 15 times higher than that of the general population. Several other studies have indicated that STIs in women increase the risk of HIV infections from sex by two to five times than among those who do are not sexually engaged. Genital herpes, cancrroids or syphilis (primary chancre stage), Chlamydia, trichomoniasis, and gonorrhea increase the risk of HIV infection, because "any genital ulceration or other disruptions of the normal mucosal defense mechanisms

make it easier for HIV to enter the bloodstream.” Trichomoniasis (or “trick”) is a sexually transmitted infection caused by a protozoan parasite. This micro-organism infects at least 3.7 million people in the US annually, particularly women, who do not know they are infected. Some of its symptoms include pain during urination, discomfort during intercourse in both men and women, and vaginal itching and irritation in women. It has been confirmed that women with STIs “also have an associated diminished immune response, making infection with HIV more likely” (Reyes, 2010: 4). Furthermore, scientists know that lowered immunity from STIs, “combined with the presence of genital ulcers, creates additional likelihood of HIV infection, if exposure takes place.”

The incidence of tuberculosis (TB) has been increasing at an alarming rate worldwide, affecting 7-8 million people at present. TB contagion is a common occurrence in prison settings, including the US, where medical advances are capable of eliminating or reducing its spread to a minimum. Known as the most common opportunistic disease in its relation to HIV/AIDS, due to its ability to further weaken the immune system, TB has also been associated with drug use, common in US prisons, where one-third of the women inmates are serving sentences for drug offenses compared to only one-fifth of the male inmates. Obviously, the reasons why men and women are incarcerated vary, but, between the two, “injecting drug users and sex offenders are overrepresented,” circumstances that favor the spread of related illnesses, such as TB, among both men and women. However, given the prevalence of “multiple-risk factors” among the prison populations, including, generally, lower inmates’ socio-economic status, overcrowding, poor ventilation, poor light, and poor hygiene settings, all of which enhance the spread of TB, women are more vulnerable to its contagion than men. The rapid spread of TB in prisons is also attributed to delay or absence of testing, lack of isolation of infectious individuals “during diagnosis,” absence of adequate “supervision or of medication and treatment, lack of follow-up,” non-compliance, frequent transfers from prison to prison stemming from repeated offenses, overcrowding and the resulting turn over, and inadequate screening or testing of both the facilities’ personnel or staff and inmates (Kantor, 2006). Studies conducted on HIV and TB co-infections among released prisoners between 1993 and 2003 revealed a prevalence of 3.8 percent among former inmates, comparatively three to four times higher than it is within the general population.

Hepatitis C Virus infection (HCV) is also becoming a major problem in our prisons, some studies suggesting a rate of 40 percent among inmates, even higher than the HIV infections, and is common among injection drug users (Hammett et al, 1999). In 1999, New York, at times called the “epicenter of HIV infections” in

its prisons, housed women inmates whose rate of hepatitis C was 20 percent, the same state prison system showing higher rates of such chronic ailments as asthma, diabetes, and heart disease than the general population. In California, the rate of HCV infection among incoming inmates was 41 percent in 1999, and its prevalence was found to be higher among women than men (Ruiz and Mikanda, 1994). Female inmates hit by HIV/AIDS, TB, Hepatitis C, and other diseases, often including chronic ailments like diabetes and heart problems, should be a concern for all involved and ensure, to the extent possible, that, when released, they adjust to community life, particularly in cases where no relative comes forth to claim them. Transmitted through contaminated blood, Hepatitis C is a viral disease that causes liver inflammation and damage. The disease can remain asymptomatic for years. A nationwide study on women’s HIV and Hepatitis C prevention needs in prison by the Prisoners’ HIV/AIDS Support Action Network (PASAN) in Canada, a country that, in general, tends to provide better health care than the US, revealed that:

...Current programs and services were plagued by inconsistent implementation and accessibility. This was found within individual institutions and across the national systems as a whole. The study also identified that confidentiality was a major concern of inmates seeking harm reduction of HIV-related services. New and innovative approaches to meet the HIV and Hepatitis prevention needs of women across Canada are crucial (Mc William et al., 2005: 1).

b) *Women Mental Illness and Prison Life*

It is estimated that some 450 million people worldwide experience mental or behavioral disorders, “especially prevalent in prison populations” (Brinded, 2001: 35). Prison health experts are convinced that, among incarcerated women, the rate of mental illness is high, some calling it “a common co-morbidity for the HIV infected,” obviously complicating the issue of handling HIV/AIDS. In 2004, for example, 37 percent of female inmates in the US were diagnosed as mentally ill or showed mental illness symptoms, compared to 55 percent among incarcerated men or those receiving professional treatment the year prior to their incarceration. Prevalence of serious mental illness in prisons appears to be high also, “ranging from 7 to 16 percent, or... four times higher for men and eight times higher for women than rates found in the general population” (Abram, K.L., & Teplin, L.A. 1991). One study also found that, among the mentally ill inmates who were never treated, only 25 percent of federal, 29.6 percent of state, and 38.5 percent of local prisoners were under psychiatric medication when they were arrested (Wilper, 2009: 1). The rates on mental illness in prison seem to be worse in New York, where, at the beginning of 2007, over 42 percent of the female inmate population had “serious mental illness, compared to

only 12 percent among the male prisoners” (Stern, 2011). This situation is expected, given that the US has had a long history of neglect of the mentally ill, often relegating their care and treatment to relatives or private organizations such as the church.

c) *Homosexual and Lesbian Sexual Activity in US Prisons*

It is also common knowledge that tearing and bleeding, as might occur during “rough intercourse,” particularly with younger males or during rape, dry sex (i.e., sex without natural or artificial lubrication), anal intercourse without lubrication, and sexual activity without a condom are high risk activities. Anal intercourse, for example, common among homosexual partners, is particularly risky, “as the anal mucosa is fragile and can easily tear and bleed” (Reyes, 2010: 198). Studies have also shown that HIV heterosexual transmission is “more likely man-woman than woman-man,” the rate being as high as eight times likely from man-woman than vice-versa;” and “taking vaginal intercourse into account, anal sex enhances the risk of transmission for both man and woman.” Clearly, the higher the number of men infected, as in a prison setting, the riskier it is for female sex partners. It is also common knowledge that, in prison (as well as outside prison), women are sometimes forced to engage in intercourse with an HIV-infected man during menstruation or when bleeding from other causes. Under such conditions, sexual contact presents a higher risk to the female involved. It is also important to note that certain HIV “sub-types,” (e. g, HIV-2 in parts of Africa and HIV-1 in the West) do have a bearing on the degree of risk for women. Finally, younger women are at a higher risk of contracting HIV because their genital tract is not fully developed, especially the “immature cervical epithelium,” and the “scant vaginal secretions in adolescent women,” which present as an enhanced port of entry for the virus to the genital area. Under normal conditions, the genital tract functions as a strong barrier to the most devastating destroyer of the human immune system, HIV.

It is natural, then, that, in prison, as well as outside prison, the question arises as to whether woman-woman sex might be safer. Unfortunately, lesbian sexual activity, especially now that the laws discriminating against lesbians, homosexuals, and trans-vestals, are being eliminated and marriages allowed by a growing number of states--reducing the need for one to relegate his or her sexual orientation to the closet--requires further and more in-depth studies chronicling the frequency and the rate of HIV/AIDS and opportunistic infections. Some experts believe that oral sex seems to constitute “low risk,” even though the evidence is debatable. However, sex toys or dildos are a risk, as they may be contaminated by vaginal secretions and may also cause “trauma to the genital tract.” The same can be said of such latex barriers as dental

dams,” or the “newer user-specific items encouraged in woman-woman sex.” The so-called dental dams, popular among lesbian partners, are defined as “latex sheets that are used by dentists to cover the mouth while working on one tooth,” believed to prevent contact with HIV concentrated fluid during oral sex. Reyes ends his remarks by stressing that “what makes the risk for HIV transmission difficult to assess is that woman-to-woman sex individuals often inject drugs, engage in commercial sex, and often have sex with bisexual and heterosexual men as well” (2010: 200). Unfortunately, dams have not been available in correctional facilities, and many women who use them, consider them uncomfortable and “an obstacle to sexual pleasure” (Walsh, 2011), just as many men feel about a condom.

Homosexuality is a common occurrence in US prisons where men forcibly congregate and where women as inmates are fewer (see Eigenberg, 2000). A 1982 study concluded that 30 percent of males in federal prisons engaged in homosexual activity while serving their sentences. In 1984, figures in Tennessee prisons suggested that 17 percent of the inmates engaged in homosexuality, and that, in most cases, the victims and perpetrators come from economically low backgrounds. Additionally, one study found that one-fourth of the HIV-positive individuals in the US have been inmates once and that, when released, present a major risk to the general population. In New York, where the frequency of sexual activities is known, inmates avail themselves of “makeshift devices” for safer sex, including latex gloves, when condoms are not available. Mississippi, Vermont, and some major metropolitan centers such as New York City, Philadelphia, San Francisco, and the District of Columbia, distribute condoms to their inmates. It is also interesting that, so far, evidence suggests that virtually no HIV infections have been found among prison staff from their inmate contact. Methadone, unlike in the US, is made available to prisoners in most Western such as Canada and Austria, and in some Eastern European countries. In 2009, some 2,195 [HIV infected women] and 19,808 infected men were in prison, representing 7 percent of inmates nationally. The relative large number of women behind bars prompted researchers to posit that “...high incarceration rates increase risk behaviors associated with HIV by skewing the ratio of women to men, worsening economic conditions and increasing the social capital of men who are not imprisoned” (*New York Times*, 2004).

In confinement settings, such as jails and prisons, the following HIV infection symptoms, which most often differ between men and women, may provide further awareness of the state of the virus in the human body and perhaps help protect the health of vulnerable female inmates. These include, but are not limited, to: The rate of Kaposi’s Sarcoma (KS), more frequent in homosexual and bisexual men, much less seen in

heterosexual men, and said to manifest in less than 2 percent of infected women; “invasive” cervical cancer often associated with HIV; fever, muscular and joint pain, diarrhea, vomiting, and swollen glands in women (according to doctors, swollen lymph glands, if found elsewhere in the inguinal region, “is the only physical finding that may be more common in women with HIV than men”) (Reyes, 2010: 201). However, it is important to emphasize that as many as 40 percent of HIV infected women do not present these clinical symptoms at the onset of the infection. Other symptoms in women may include, beside swollen lymph nodes: Bacterial pneumonia, acute retroviral syndrome, and oral thrush (oropharyngeal *candidiasis*). Finally, for prison inmates, “bacterial infections, particularly respiratory ones with *Streptococcus pneumoniae* and *hemophilus influenzae*, occur more frequently in intravenous drug users with HIV” (in both men and women), gynecological disorders, particularly pelvic inflammatory disease (PID), infections resulting in abnormal pap smear (called cervical dysplasia, as noted above), and chronic yeast infections.

d) Other HIV Prison Risks

Furthermore, due to the association of violence and rape in prison, women (and men) may face instances of biting, splattered blood, and partners’ or rapists’ body fluids, lacerations, bleeding in two or more participants, and more frequently when there are two or more inmates in a single cell, as is the case in many of the overcrowded prison facilities in the US. Naturally, such conditions may contribute to the spread of HIV infection. Experts also say that women face far more risks from natural and man-caused calamities, seem to take monogamy more seriously than men, who may engage in extramarital relationships with impunity, feel disproportionately the impact of wars and refugee conditions, as well as the devastating effect of rape and other types of violence, and divorce. In most cases, however, sexual activity in prisons is considered a crime, and is usually non-consensual, at least at the beginning. Yet, this does not deter inmates. Such conditions, have led many women into a state of despair and behavior that is sexually risky, and drug use and abuse, all of which have landed some in jail or prison in the first place, and, in many cases, into prostitution or sex work. All these factors increase a woman’s risk of incarceration and getting careless about her health while in prison. It is clear that the prison environment tends to reinforce women’s previous behaviors, which might make them easy preys of their aggressive male and female inmate sexual predators

e) HIV/AIDS-Related Deaths in US Prisons

Given the contradictory statistics and incomplete research on AIDS-related deaths, discussion of the issue is brief in this study. Even though some data

on causes of prison deaths are available, in most cases are only estimates, which have to be revised by the Bureau of Justice Statistics frequently. Also, quite often, data are not segregated by gender and, at times, the federal government might provide state prisons’ death numbers and rates per 100,000 persons, but not report deaths in its prisons. Overall, it appears that, in 2007, 130 state and federal prisoners died from AIDS while confined to correctional facilities. Gender-based rates in federal statistics have not, as well, been as consistently reported. For example, the report put out by the Bureau of Statistics in September 2012 notes that, in 2010, “the estimated rate of HIV/AIDS among state and federal prisoners dropped to 146/10,000 [sic] inmates from 194/10,000 cases in 2001, representing a drop rate of 3 percent each year. The report then inconsistently adds: “Whereas *male death rates* from HIV/AIDS declined from 19,337 at the end of 2009 to 19,027 at the end of 2010, the number of *females with AIDS* decreased from 1,853 to 1,756. This is “fuzzy” math, given that the comparison should focus on absolute numbers and deaths, and comparative death rates between *male and female prisoners*, as the first statistic data noted here suggested. The first HIV/AIDS- related death was announced in New York in 1981. Since the 1980s to 2012, official statistics have shown that 619,000 Americans have died from AIDS complications, with one million people currently living with AIDS. One-third among them are unaware of their condition. Also, currently, the incidence or rate of new AIDS cases stands at 40,000, with African Americans and Hispanics experiencing six times and three times that rate, respectively, compared to whites.

V. DISCUSSION

a) Criminal Activity among Female Offenders

Statistics on women offenders who have been imprisoned give us a clear idea of how men and women differ in the commission of “crime,” as summarized by Kimberly Cellica. This known researcher informs her readers that, among women who are charged with drug/alcohol use infractions, only 1 percent are chronic adult criminal recidivists, compared to 6 percent among the men. Overall, only 10 percent of women are charged with negligent manslaughter, 12 percent of larceny, 12 percent of Larson, 31 percent of fraud, 14 percent of drug possession, 11 percent of drug trafficking, and only 1 percent of sexual assault. In other words, most female inmates have been incarcerated for crimes related to “drug use, property, or public order.” Indeed, of the 14 percent violent crimes committed by women in our society, 75 percent are “simple assault” cases, and 28 percent are committed by female minors. It is also known that, in most cases, or in 75 percent of the infractions, women victimize other women (rather than men) whom, in 62 percent of the cases, they knew.

Statistics also show (Cellica, 2013) that homicides committed by women against an intimate partner or relative (60 percent of the cases) have been on the decline since 1993. Revealing is also the fact that “women who kill are much less likely than men to have a criminal history, they are more likely to have killed as a result of domestic violence,” and often play only an ancillary role to men even on drug crimes. In Cellica’s findings, women “occupy the lowest levels of the economic drug ladder” by serving as the “look outs, steerers, or sellers” (Cellica, 2013: 5). Given their minor role in drug crime, Cellica notes, women are more prone to be caught by law enforcement because they are more visible on the streets and their arrest is much easier than that of the actual perpetrators of drug trafficking, i.e., the men. Noteworthy also about women offenders is that, unlike men, the limited role they play in these types of crime “precludes them from obtaining information on higher-ups” which might “help them to plea bargain.” In fact, a August 10, 2012 CNN Report noted that “While women’s own drug use is often assumed to be a major co-factor for both HIV and incarceration..., most women offenders are arrested because they couldn’t or wouldn’t snitch on boyfriends, husbands, or casual acquaintances” (Martinez, *CNN Report*, August 10, 2012). It is under these difficult conditions for women that male drug users refuse protection during sexual activity and prevail over their female partners who might insist on safe sex, reflecting what often goes on in the general public and the prison environment. For women, cultural norms and practices have a strong bearing on men’s imposition of their will and use of physical force to obtain what they want. These include: gender inequalities in most societies, to the detriment of women; lack of employment and lower educational levels for women generally; and higher levels of poverty among women, even in the US. Indeed, most women offenders have not had steady employment, and 30 percent are said to rely on public assistance. Reports are that over 50 percent of women inmates and some 75 of women in jail have been unemployed and, in fact, some women state that “they committed their offense to finance purchases” (Baldwin, 2000: 2). Studies and experience have suggested that women who were not involved in rehabilitation programs “were 10 times more likely to be sent back to prison within a year.” One-third of those who were not in any program returned to prison in six months (*Free Alcoholism Newsletter*, 2011: 1).

b) *The Minorities Issue and Specific Women’s Needs*

The debate over the optimal set up and proper management of prisons and their populations are unending and have attracted the attention of the best minds and the most ardent defenders of human rights over the past centuries. This work, could not, therefore, purport to provide solutions to the issues plaguing our jails and prison facilities. However, like others before, it has exposed what is lacking in the system regarding the

conditions under which some of the most vulnerable members of our society, children, and young adolescents, female citizens, and the mentally-ill live when incarcerated. Studies and experience have made it crystal clear that the so-called “war on drugs” has been overplayed, committing to prison confinement an untold number of law-abiding citizens who are prosecuted daily for the possession and use of ridiculously small, insignificant numbers of “illicit” drugs. Unfortunately, the prosecutions have fallen unevenly on minorities, especially African Americans and Latinos, women, and the poor.

The unmitigated rush to incarcerate targeted society’s sub-groups, hoping to solve crime and maintain pristine the social environment from which it grows, while protecting white collar crime, for example, has resulted in blatant social injustice, unfairness, and overcrowding in our correctional facilities, a bonanza complex that feeds private corporations and state operations, assisted by the failure of an educational system that, in many ways, has turned, at least in some states and poor counties and cities, into prison pipelines. Our prisons have become the breeding ground for sexually transmitted infectious diseases and violence, and cesspool clusters of horrendous consequences from the rape of women, sexual assault, deprivation of one’s privacy and confidentiality, and female prisoner’s physical and psychological insecurity coming from both the inmates and the very individuals chosen to protect them, the prison authorities and the wardens, especially in such states as Florida, New York, South Carolina, Texas, Alabama, Arkansas, Mississippi, and Oklahoma, all done under the banner of ridding society of the “wretched of the earth.”

The issue of a clear separation of facilities for women and men, especially when dealing with hard core criminals, such as rapists, incorrigible intravenous drug users, violent drug dealers, and murderers, is no brainer: A humane and realistically implementable separation of inmates to protect women and female adolescents ought to be one of the top priorities of prison policy and the daily concern of prison authorities. To protect the health and safety of the female prisoners, testing for HIV seems to be a reasonable step, as recommended by the Centers for Disease Control and Prevention, particularly among entering inmates. Experts argue about the merit of prisons’ “voluntary” versus “mandatory” testing-screening or none for HIV/AIDS, TB, Hepatitis C, and many sexually transmitted infections, of which some can result in deadly diseases for a number of prison inmates. National statistics seem to indicate that, of the reporting 51 facilities, 16 state prisons screened all inmates, five only at the request of the inmate, 27 screened for HIV, and three had a random screening policy (Hammett et al., 1999). A study published in the *American Journal of Public Health* (2012) recommends that “Correctional facilities should

provide detainees with routine opt-out HIV testing, unless the prevalence of previously undiagnosed HIV infection has been documented to be less than 0.1 percent" (Van Handel et al., 2012: S201). The cardinal principle ought to be the protection of the most vulnerable in the "human jungle" society has created, with a view towards preserving the welfare of the community and society-at-large through effective rehabilitative programs for those accused of insignificant acts classified as "crimes."

HIV testing in jail or prison protects the general public when inmates are released. To illustrate this point, we might mention that New York released 630,000 inmates in 2005, with at least 50 percent of them not tested for HIV while in prison or prior to "unleashing" them to the general public. Finally, testing is particularly useful to minorities, black women, in particular, as long as these are not specifically targeted and singled out and thus stigmatized, given that studies show that, in the US, "64 percent of new HIV infections occur in black women, who are also disproportionately represented in correctional facilities due to overwhelmingly institutionalized racism" (Kleinman, 2007: 1). What contributes to resistance from female inmates against screening and testing is the often intrusive nature of the process and the fact that the prison system seems to be unable to explain clearly the purpose and the manner in which tests are performed. Alarming reports indicate that guards harass, degrade, grope and sexually abuse female inmates during body searches (Rosen, 2012). When, for example, the prison personnel carries out the type of search sometimes called "digital body cavity search," which allows the guard to land his fingers in "a prisoner's nose, mouth, anus, or vagina," with such disregard for individual privacy, can only be characterized as intrusive. Critical searches should be held on a case-by-case basis and reserved for specific individuals suspected, for example, of concealing weapons, and not as a random act of intimidation and breach of sanctioned authority (Stern, 2011). In fact, on the issue of testing, studies have shown that women prisoners are less opposed to it when they understand the reasons. In North Carolina, for example, 680 or 84 percent of 805 female inmates consulted did not mind revealing their medical history to researchers, and 71 percent accepted being tested. Regrettably, until 2004, only 19 states had mandatory testing of HIV for their inmates (Stern, 2001).

Conducted in 1991, this same study noted that "HIV testing was associated with accepting money or drugs for sex and conviction for a drug but not with drug injection, drug injecting sex partners, and a history of sexually transmitted disease" (Colten-Oldenburg et al., 1991: 28). Significantly, the North Carolina prison researchers added that testing was becoming more acceptable even among female prisoners "potentially at risk for HIV, especially women inmates who exchanged

sex for money or drugs." Understandably, testing should always be accompanied by counseling, open discussion of the modes of transmission of infectious diseases, sexuality, condom use, safe forms of sexual activity, and other important information related to health, female reproductive health, follow-up compliance, and treatment through such protocol as AZT. AZT has been found to be effective in studies conducted in Africa and elsewhere, where treatment of STIs decreased HIV transmission by 4 percent.

VI. RECOMMENDATIONS ON FEMALE PRISONERS' CARE AND DIRECTION OF FUTURE RESEARCH

a) *Health Care Services for Women and Human Rights*

The latest figures on the rate of HIV/AIDS in the US among prisoners are said to have declined considerably since 1999, even though prison populations are "disproportionately represented in the HIV epidemic." Overall [says the Bureau of Justice Statistics], 2.2 percent of state inmates and 0.8 percent of federal prisoners are known to be HIV-positive, and, by the end of 2000, 5,528 of them were diagnosed with AIDS (Maruschack, 2002). However, studies have also found that women who are at highest risk of HIV infection are "unaware of their risk, have little or no access to HIV prevention, and are afraid, for fear of violence, to ask their partners to use condoms."

The advancement of women's rights, health, and safety in jails and prisons, which are clearly being violated by some in our prison system, requires implementation of steps and policies that have been upheld by the international community. Women's needs in jail and prison must be a consistent concern for the authorities. In fact, these should be "categorized" and separated from men's needs, as several experts have advocated. For centuries now, prisons have essentially catered for the needs of male prisoners. It is high time that prison facilities provide women with the health services that are equivalent to those available in the community, and actively involve them, including the mentally-ill, in "HIV prevention, treatment, care, and support programs..." that will positively affect their lives. Obviously, in correctional facilities, female inmates must have greater access, e.g., to showers, clean toilets, sanitary napkins, as well as to doctors, especially during the most critical months of their biological cycle, and be allowed to spend quality time with their babies.

It is also important to demand, on the one hand, that women continue to receive adequate health care, even though they may have tested negative for HIV and other sexually- and non-sexually transmitted diseases, such as AIDS, tuberculosis, hepatitis C, and be provided "non-judgmental education around risk and prevention methods." On the other hand, prison staff need to be thoroughly familiar with the social, psychological and

physical hazards facing women in jail and prison--what the United Nations calls "increased professional capacity-building opportunities on HIV in prisons," through counselors, social workers, doctors, nurses, staff, and pharmacists--and be mindful of the principles of respect and fair treatment of all inmates, particularly women. Naturally, some cultural competence training should be required of prison wards so that they can provide "a more ethical response to the cultural differences of offenders and reduce conflict between personnel and offenders" (Myers, 2000: 184). The Association Nurses' AIDS Care laments that "A by-product of the recent 'confinement era' within the criminal justice is the influx of ill and generally unhealthy female offenders into this nation's correctional institutions," a situation that can only be remedied through gender-appropriate programs and facilities that meet women's health needs (Zaitzoo, 1999: 78).

It is also incumbent upon our prison authorities to help women follow-up on their medical and prescriptions appointments and coordinate schedules with such care providers as pharmacists, physicians, social workers, counselors, and psychiatrists. Additionally, and more importantly, our society and those charged with the responsibility of running our prison system must never cease to tap into better evidence-based alternatives to incarceration or imprisonment, and ensure that inmates who commit violent acts such as assault and rape against women, are appropriately punished, while enacting "gender-sensitive legislation, penal policies and prison rules," as recommended by international community. Finally, the penal system should never cease to "monitor and evaluate HIV risks for women in prison and responses."

b) *Community Re-Adjustment Rehabilitative Skills*

It stands to reason that, even though release from prison should be a happy moment, finding a home and a proper location to live, a safe environment enhanced by medical facilities, and work opportunities, ought to be a responsibility shared between the former inmate and the prison authorities or other appropriate agencies prior to and following release, as specified by policies and practices. We know that the average sentence time for all offenses is three years for women and five for men and, for violent offenses and illicit drug use, is four and seven years for women and men, respectively (Greenfield and Snell, 1999). It makes sense, therefore, that prisons provide opportunities for inmates to acquire skills that will help them find gainful employment once they are released. In fact, what Cellica characterizes "invisible punishment" for released inmates, that is, the disenfranchisement, limited access to employment, loss of parental rights to foster care, if involved in drug trafficking, unavailability of state and federal assistance for college, and loss of public assistance they face, must as well be a concern of our

prison system. Scholars have clearly demonstrated that "having a job directly influences whether an ex-offender commits further crimes. Other studies show that, former prisoners who land a job, "are between 30-50 percent less likely to re-offend" (Murray, 2012). Unfortunately, most of the hardships noted here are the result of the "one strike" rule, which keeps the inmate's prison record until she/he does not recidivate. One study conducted on substance abuse offenders concluded that:

One-third had lost parental rights to a child, these mothers were young, but had more children, were less likely to have ever worked or been married, initiated regular drug use at a younger age, and were more likely to have been in foster care or adopted themselves and to have engaged in sex work. Higher self-efficacy, decision making ability, social conformity, and childhood problems were associated with less risky parental attitudes, whereas depression, lower education, and *non-White ethnicity* were associated with greater risk" (Grella and Greenwell, 2006: 89).

The New York Times (6 August 2006) reported the adventures and opinions of two HIV-infected former inmates as they described the first weeks following release from jail. One confessed that "the first weekend after release is consumed with sex—with prostitutes, old flings, fresh one-night stands or a combination of thereof" [sic]. Another, who had been infected through heterosexual sex and had served a four-year sentence, provided this information about the women he knew:

A lot of women, they are looking for a man to give them a sense of strength, a sense of authority... Men come out of prison; they are all big, great muscles, looking good. And the women, they're all up on them. It's not like people don't know they are putting themselves at risk. They just don't care.

If this is true of men and women just released from prison, what happens to women who leave jail or prison and have no one to welcome them? Interviewing women ex-prisoners on such issues might provide an insight into prison life.

c) *Special Needs of Women Populations in Southern Prisons*

Researchers have pointed out that, since more women with HIV/AIDS and STDs are incarcerated in rural southern prisons, a special and concerted effort should be made in this region to "deploy programs for prevention, diagnosis, and treatment of infectious diseases and other health problems" because "such interventions, as well as interventions focused on the rural communities themselves, would benefit not only males and released prisoners, but also the larger public health" (Hammett, 2006: S17). In addition, women's support groups in the prison facility, such as the well known Texas' *Love Me Tender*, can also play a crucial role in building self-confidence among women inmates, provide emotional support, and suggest safe activities

while in prison and upon release. In Walsh's view, these activities can also serve to inform "gao/ superintendents about HIV-positive prisoners' needs" (Walsh, 2011: 271). Support group programs should focus on issues important to women, as suggested by Cellica, including: HIV and the immune system; stigma and blame; transmission of HIV and STIs; risky behavior and risk reduction; contraception; self-esteem; nutrition; women's issues; medications; HIV testing and partner notification; opportunistic infections; living with HIV/AIDS; video viewing and discussion; and anything else that will empower women to take control of their lives and negotiate sexual behavior that protects both partners. Additionally, if well handled, the prison facility could be the place where destitute and unhealthy poor inmates and future freed prisoners have an opportunity to receive needed health care and counseling (Reyes, 2010: 193). Important are the studies that have shown, in fact, that "...incarceration itself has no adverse impact in clinical outcome when inmates are given adequate clinical care and provided an opportunity to access it" (Stephenson and Lore, 2005). Southerner prison authorities need to take the findings of recent studies seriously and realize that using prisons or jails as a deterrent to intravenous drug users, for example, does not work, unless specific and effective alternative programs are provided (Freedman et al., 2011: 344).

d) Future Research

On future research, it is obvious that, given the various statistical contradictions floating around in the literature on HIV and female prisoners, more in-depth and better organized interdisciplinary studies are needed. These ought to be conducted by scholars and practitioners in public health, social work, psychology, and sociology, to enhance the myriads of assessments of the lives of women prisoners on such issues as HIV/AIDS and opportunistic infections and diseases. Former inmates' rates of success in re-adjusting to life in the community also deserve special attention from researchers, as we know that, unable to cope with the new realities, many revert to the same offenses that landed them in a confinement facility, and more so if they are infected, sick, and abandoned by relatives and friends.

Continued careful studies of innovative prison policies in various US states would go a long way toward our understanding and reduction of the violence perpetrated against women in prisons and the personal coping mechanisms they use to survive in such a hostile environment. Indeed, as Welch et al. note, "Scholarship over the past three decades has generated considerable insight into the roles of the media [e.g., *The New York Times*], politicians, and law enforcement officials in constructing images of criminal justice; still, that body of research has rarely ventured into the realm of corrections" (Welch et al., 2000: 245). She suggests that current research in this area, which began during

the early 1900s (Hensley et al., 2000), has been biased toward the official view of our prison system and has not focused on the conditions prevailing in the prisons themselves. Only now, for example, is the issue of sex in prisons being brought to light. Mental health is certainly an area that needs considerable research. Why is it, for example, that "Us-born Caribbean black fathers [have] alarmingly high rates of most disorders, including depression, anxiety, and substance disorders?" (Doyle et al., 2012: S222).

Important also are study projects that deal with second-time offenders who are forced to return to a life in prison, comparing their previous and new survival techniques, attitudes, and approaches to risky behavior, their views on testing for infections and diseases, and their attitudes toward sexual violence and the rape of women. Last but not least, since we live in a shrinking world, given the rapid technological advances, instant and fast travel modes, and the rising overcrowding conditions that breed the conditions for both chronic and infectious diseases vividly reflected in our prison systems, ecological or global comparative studies of HIV/AIDS among female inmates would help drive across the urgency for nations to work together and enact national and international policies that address the health and human needs of the largest segment of the human population, women. On this issue, in 1992, the United Nations (WHO) announced that the US was one of the four of 19 states in the West that did not have a national policy on HIV management in its prisons at the time. Unfortunately, till today, America still does not have a comprehensive national policy on its prison system.

We could not end this work without noting the nefarious consequences of the Zero Tolerance Law [Gun-Free School Act (GFSA)] passed by Congress in 1994, mentioned in the first section of this work. Can the American public, federal and state legislatures, and our justice system wonder why our prisons are the way they are in terms of the racial, ethnic, gender, and age composition of their prison populations, and the precarious safety and human conditions prisoners face, especially women inmates, fairly or unfairly, behind bars? Considering the best practice-based alternatives to children's incarceration being suggested and adopted across the country, no valid reason seems to justify why racially- and ethnically-skewed approaches continue to poison our educational system.

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