Ignorance in the time of AIDS

AIDS behind bars

By Daniel de Vise

THE U.S. PRISON SYSTEM IS PLAYING HOST TO an alarming rate of new AIDS cases, but prison officials are ill-equipped to handle the epidemic, AIDS-rights workers say.

Last year, for the first time ever, the rate of new AIDS cases in prison surpassed the general U.S. rate. A new report of AIDS in prison commissioned by the National Institute of Justice (NIJ) found a 72 percent leap in total AIDS cases from 1988 to 1989, with 5,411 cases now on record. In the general population, the corresponding increase was only 50 percent, with 110,333 known cases.

Experts trace the flood of new AIDS cases to intravenous (IV) drug use among prisoners, and AIDS workers fear that prison hospitals and staffs will be unequipped to handle the flood of new cases.

"Medical care in prison, in general, reads like a litany of horror stories," says Judy Greenspan, AIDS information coordinator for the American Civil Liberties Union's (ACLU) National Prison Project in Washington. "Compound it with HIV infection and you have something worse."

AIDS is a relatively new concern to the prison system. Few prisons had any AIDS policy before 1985, and the first AIDS-related lawsuits concerning prisoners were settled in 1986.

But according to Theodore Hammett, co-author of the NIJ report, AIDS itself is not new to U.S. prisons. Because of HIV's latency period, prisoners who develop AIDS today may have picked up the virus 10 or more years ago, he says.

"What we're seeing is what happened a long time ago," Hammett says. It's always been true that the proportion of prison inmates with AIDS has been higher than the proportion in the general population."

Poor treatment: The rise in reported AIDS cases has sparked irrational and often harsh treatment of HIV-infected inmates by prison officials, according to Greenspan. Rather than nurture the sick prisoners during their painful battle with AIDS, wardens often treat them to a display of superstitious ritual and overzealous caution reminiscent of the plague, she says. Guards assigned to escort HIV-infected prisoners usually wear protective masks, surgical gloves, plastic boots or full hygiene suits, fearing that mere physical contact with an infected prisoner will transmit the virus. They often shackle or physically restrain prisoners, fearing an attempt to bite, spit at or scratch the officer and thereby spread the HIV infection.

"There is some risk involved" in the routine handling of HIV-infected prisoners, Hammett says, "but it's quite a low risk."

Nonetheless, prison officials contend that the precautions are sensible and necessary. They say that calm and reason are the rule at prisons and panic and superstition the exceptions.

"Sanity prevails," says Kevin McDonald, disease coordinator for the U.S. Bureau of Prisons. "Our policies and practices are dictated not by emotional factors but by epidemiological information. We've managed to stay this course."

Numerous courts have agreed, upholding potentially humiliating policies undertaken by guards and other prison officials. A Maryland judge permitted the words "AIDS Cell" to be marked on a cell containing a prisoner with AIDS. A Minnesota judge allowed guards to shackle prisoners with AIDS and wear surgical gloves while escorting them. The judge referred to AIDS as a "peculiar circumstance," an admission that spotlights the lack of a unified policy on handling AIDS and privacy disputes in prisons.

Forced ignorance: Often underlying prison policy is the belief that drug use and sex do not occur in prison, a blind spot that persists despite strong evidence to the contrary. A survey of Michigan prisoners found that 60 to 70 percent said they engaged in sexual relations during incarceration. Official prison documents, meanwhile, suggested that fewer than one percent of inmates had engaged in sex.

Michigan and several other states have denied prisoners condoms and other safe-sex devices—even as they approved AIDS-related education and counseling—because they claimed such actions run contrary to their policies.

Rather than confront sex and drug use among inmates, prison officials have opted for isolating prisoners.

In various states, prison officials have isolated not only prisoners with full-blown AIDS, but also groups of HIV-infected prisoners and even persons suspected of carrying the virus. In most cases, the courts have upheld these systems as constitutional, ruling that stopping the spread of the virus outweighs constitutional rights of prisoners dictated in the equal protection clause of the 14th Amendment.

Legal defenders of persons with AIDS (PWAs) approve of isolating HIV carriers in certain circumstances, noting the potential for AIDS to spread in an unsupervised, integrated prison. Some HIV-infected prisoners sexually assault other inmates, thereby exposing them to HIV infection. These "predators," as Hammett calls them, may be the primary source of spreading AIDS in prisons, and he says they should be isolated from other prisoners.

"But the vast majority of prisoners with HIV are not predators at all, and they should not be punished for having the virus," Hammett says. "They're being punished already."

An issue of privacy: Some prisons have adopted mandatory HIV tests as a catch-all defense against HIV predators and as a mechanism to spot carriers who do not know they are infected. Some prisons rely on the AIDS test as their only defense against the spread of the disease. Fifteen state prison systems and all federal prisons currently require AIDS tests.

Mandatory AIDS tests have come under fire because they are perceived as a threat to privacy rights. In Alabama, a court upheld a mandatory testing policy, ruling that stopping the spread of AIDS outweighed the right to privacy. Advocates for PWAs, though, insist that a voluntary testing program is just as good as a mandatory test and less intrusive. Furthermore, mandatory testing serves little purpose if it is not complemented with education and counseling programs, according to the ACLU's Greenspan.

"There's nothing worse than discovering you're HIV positive and not being able to do anything about it," says Greenspan. Many prisons, she notes, fail to provide early treatment and therapy for HIV-infected prisoners. Without such treatment, prisoners can become distraught, especially when they have no recourse but to sit and wait for full-blown AIDS to set in.

At the other extreme, some prisons choose to shut PWAs into prison hospitals, holding them there even after their symptoms have receded. Such was the case in Massachusetts until the prisoners were integrated into the general prison population this year.

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"The way it was working, as soon as someone was diagnosed with AIDS, they were moved out of the general population," says Robert Greenwald, an attorney with the Boston AIDS Action Committee. "Once they were sent to the hospital, there was no way out. They stayed after the point of time when they had recovered. Many individuals, as they got sicker, tried to hide their condition. They knew it was a one-way ticket."

But with integration into the general prison population, PWAs may be forgotten and left untreated. Or else they may undergo shoddy treatment at the hands of an unqualified medical staff.

"I don't approve of [integration] to the degree that they cannot guarantee the safety of PWAs and training the staff to provide adequate health care," says Greenwald.

Nearly all AIDS-in-prison experts agree that AIDS-related education is the key to stopping the spread of HIV. They also ask that prisoners have free access to condoms and latex barriers.

But AIDS education advocates have found little support in the prisons or the courts. New York and Connecticut courts have enforced AIDS education programs and a few other states have developed programs on their own, but they are often incomplete, outdated and poorly administered, critics say.

"The best way to stop AIDS in the prisons is through education, and that is exactly what the prison system is falling down on," says the ACLU's Greenspan. "They're showing outdated videos; they're handing out pamphlets that are way over the heads of prisoners or not written in language that the prisoner can understand."

Greenspan's National Prison Project has published a pamphlet for prisoners and prison staffs, entitled "AIDS and Prison: The Facts," that dispels common misconceptions about AIDS. The project hopes to change policy toward AIDS from the bottom up: starting with prisoners and guards, who must fight the day-to-day battle to halt the spread of AIDS.

"Corrections officers and prisoners say that because prison is so different from the free world, AIDS transmission inside prison must be different from what it is like on the outside," the pamphlet says. "This is not true. It will not fly across the room and infect you on its own."

The pamphlet continues: "We want to help each prisoner and officer fight the real enemy—which is AIDS, and not the phantom enemy—the fear of AIDS." □

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Indian health disservice

By E.J. Levy

IT'S NO SECRET THAT AIDS IS AN UNCOMFORTABLE subject within the Indian Health Service (IHS)—the public health agency responsible for Native American health.

Off the record, sources in and close to the agency confirm that people within the IHS haven't even learned to say the "A-word." Misconceptions that AIDS is "a white man's disease" and that few Indians are gay or intravenous drug users and therefore at risk have compounded people's reticence to confront the issue head-on.

With only 194 AIDS cases among Indians recorded by the Centers for Disease Control (CDC) as of June 1990, many believe AIDS is simply not a problem for Indians. However, with the incidence of sexually-transmitted disease among Indians running two to four times higher than that of the general population, Native Americans are, in fact, at great risk for rapid transmission of HIV and—considering their generally depressed health—potentially for an AIDS epidemic.

"Given the low socio-economic and health status of Native Americans and the high incidence of substance abuse, it's safe to assume that we already have a population with compromised immune systems," says Ron Rowell, executive director of the National Native American AIDS Prevention Center (NNAAPC) in Oakland, Calif.

While documentation of intravenous drug use among Native Americans is scarce, a preliminary study conducted in one rural Indian community found that as much as 14 percent of the community's 2,500 people were reportedly regular IV users—an "alarmingly" high incidence, concludes the study, which signals the "potential for rapid HIV transmission." A sample survey of Indians in alcohol treatment programs in Seattle taken early last year found 25 percent reported chronic or occasional IV drug use.

Unwritten truths: Similarly, there has been no comprehensive study done of sexual behavior among Indian peoples, although regular lesbian Sun Dances in the Southwest and the "Basket and Bow" gatherings of lesbian and gay Indians in the Midwest during the last several years attest to the existence of a vital Native gay and lesbian community.

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At present, the majority of Native AIDS cases are thought to occur among urban Indians—those who have left their reservations for cities like Los Angeles, San Francisco, Minneapolis, Gallup and Tucson. As a result, health workers contend that AIDS does not pose a threat to Indians living in isolated rural communities like the pueblos of New Mexico.

In fact, there is no way of knowing which Indian communities are most affected by AIDS, since epidemiological reports specify only the state in which each case occurs in order to protect the privacy of Indians who, given the small number of AIDS cases, might otherwise be identified.

Available evidence indicates, however, that rural Indians are not isolated from risk. Sexual interaction is common at the annual Pow Wow and on the rodeo circuits—two cornerstones of Indian social life. In addition, a recent article by Rowell in *Drugs and Society* cites two studies that document a high level of interaction between urban and the so-called "isolated" rural Indians. Conducted in Minnesota and three Northwestern states, the studies reveal that as many as 51 percent of Indians on the reservation have had sexual contact with people off the reservation.

More recently, a 1990 CDC/IHS study of HIV seroprevalence among Alaskan Native and American Indian prenatal patients found .15 percent, or 1.5 in every 1,000 patients in their third trimester, to be HIV positive—a rate similar to that of the overall U.S.

A 1988 CDC study revealed Indians to have rates of HIV infection greater than or equal to other racial groups in a variety of test settings. Indians had higher rates of infection than either blacks (by 11 percent) or whites (by 43 percent), according to data gathered from California statewide anonymous testing sites. Preliminary data taken from a survey of non-AIDS patients in a portion of the CDC's Sentinel Hospital System indicated that Indians were three times as likely to be HIV seropositive as others.

Erroneous zones: The discrepancy between high levels of HIV infection and low numbers of reported AIDS cases suggests to researchers that the AIDS count among Indians may be erroneous. George Conway, a CDC medical epidemiologist who designed seroprevalence surveys, speculates that the undercount may be partially due to the misregistration of Native Americans as Hispanics by hospital and clinic personnel. In some cases, however, Indians may be reluctant to describe themselves as Native American for fear of being referred back to a reservation for health care.

Whatever the source of the error, it is likely that the actual AIDS count is significantly higher than currently recognized. Many estimate that at least six new cases of AIDS occur among Indians each month—and the NNAAPC's Rowell cites a figure twice that high. "No matter what we do," adds E.Y. Hooper, AIDS coordinator for the IHS, "we know there's a harvest out there that's going to accrue to us. The numbers are only going to increase with time."

Despite the potential for an epidemic, until recently the IHS had neither a policy nor funding for AIDS prevention. While IHS Director Everett Rhoades announced a seven-point AIDS agenda following the 1987 Minority AIDS Conference in Atlanta, the IHS did not require its health facilities to have trained counselors available for HIV testing and counseling until 1988. And it wasn't until fiscal 1989 that the IHS appropriated $258,000—about 25 cents per person—for AIDS education and prevention.

Hooper contends that limited financial and human resources are responsible for his agency's "belated" response. "There is so much that is affecting the morbidity and mortality of Indians that it's hard to get resources together to combat AIDS," he says. "In certain parts of the country, they don't have the resources to do adequate prenatal care for women or to treat acute types of illnesses. Doctors there are saying, 'We acknowledge the risk of AIDS, but we don't have time to deal with [it].'"

In order to provide funding for AIDS-related programs, the IHS must divert human and financial resources intended for other purposes, adds Hooper. Lacking monies to hire additional full-time employees, developing the programs falls to already overtaxed health providers. Hooper, for example, maintains his position as director of continuing education while acting as AIDS coordinator. When the IHS received a special $350,000 grant from the CDC to train health workers in HIV testing and counseling in 1988, the agency had to "rob $3 million to $4 million from other services" to implement the program, says Hooper.

But limited resources only partially explain the IHS' reluctance to tackle AIDS. Not until fiscal year 1990—three years after Rhoades announced his agenda and nearly a decade into the epidemic—did the agency request AIDS funding, a delay attributed in part to ignorance. Rhoades told a congressional subcommittee in 1988 that until an

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