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HIV and Corrections

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Module 6: Key Populations
Lesson 5: HIV and Corrections

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Overview of United States Correctional System

Background

The United States correctional system consists of local and tribal jails, state prisons, federal prisons, military and immigration facilities, and community correctional facilities, which include probation and parole programs.[1]

- **Jails**: Typically, jails house persons charged with a crime who are awaiting trial or transfer, as well as persons convicted who have sentences of less than 1 or 2 years. Persons leaving jail are often supervised on probation for a defined period of time.
- **Prisons**: In contrast to jails, prisons house persons convicted of a felony serving longer sentences. Whether the offense committed involves federal law or state law determines placement in a federal or state prison.
- **Parole**: The term parole refers to conditional release from prison prior to completing a sentence with the responsibility of completing the remainder of the sentence in the community. Upon leaving prison, many people continue to be monitored by the correctional system while on parole.

At any point in time, about twice as many persons are incarcerated in prisons than in jails in the United States, but over the course of a year the number of individuals incarcerated in the jail system far exceeds those incarcerated in prisons (Figure 1); this difference over a year results from the low turnover rates in prisons (longer stays and infrequent releases) versus high turnover rates in jails (shorter stays and frequent releases).[2]

Global Prison Statistics

In 2021, the United States had a higher total prison population in than any other country in the world (Figure 2).[3,4]

United States Prison Statistics

The total adult population in the correctional system in the United States, including local jails, state prisons, and federal prisons, increased significantly during the 1980s and 1990s (largely as a result of the crackdown on illegal drug use), peaked in 2008, and then leveled off for about a decade, and has decreased in recent years (Figure 3).[4,5,6,7] According to the Bureau of Justice Statistics, at the end of 2021, the United States had an estimated 1,767,200 adults incarcerated in correctional facilities, of which 91% were male.[4] From 2007 through 2021, incarceration rates were consistently higher among Black and Hispanic individuals than

among White individuals.[4,7]

Epidemiology and Prevention of HIV in Correctional Setting

Prevalence of HIV in Prisons

In the United States, during the years 1991-2021, the annual number of persons with HIV in state or federal prisons ranged from a high of 25,976 in 1998 to a low of 11,810 in 2021 (Figure 4).[8,9,10,11] Since the state prison population is much larger than the federal prison population, it is not surprising the number of persons with HIV in state prisons (10,600) far outnumbers the number in federal prisons (1,216).[8] Epidemiologic surveys indicate the prevalence of HIV in 2021 was approximately 1.1% among persons in correctional facilities, which is markedly higher than the 0.3 to 0.4% HIV prevalence in the general United States population.[2,8,12] In 2021, the prevalence of HIV among persons incarcerated in state prisons varied significantly by geographic region, with Mississippi, New York, Louisiana, and Florida having the highest prevalence (2.0% or greater).[8]

Injection Drug Use and HIV in Prisons

The higher prevalence of HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV) within correctional facilities can partially be explained by the high percentage of persons incarcerated with a history of injection drug use. Although injection drug use may directly result in the transmission of HIV, it is also associated with sexual activity that can increase the risk of HIV acquisition.[13] Although the number of persons who have ever injected drugs is not routinely assessed in prison populations, a 2017 Bureau of Justice Special Report, which was based on data collected during 2007-2009, noted that 58% of persons in state prisons and 63% of persons sentenced in jail meet the criteria for a substance use disorder.[14] Although 15-22% of individuals in jail and prison report regular use of heroin/opiates prior to entering a correctional facility, many correctional facilities currently do not offer medication for opiate use disorder (MOUD) and some continue to use illicit drugs while incarcerated.[15,16,17] Available data suggest that for persons with HIV and a history of opioid dependence, receipt of opiate agonist therapy within an HIV clinic upon release from prison improves HIV treatment outcomes in the community.[18,19]

Differences in HIV Prevalence by Sex in Prisons

In the United States, the absolute number of men with HIV in state or federal prisons is consistently far greater than the number of women with HIV, which is not surprising given the prison population is predominantly male. In contrast, when analyzing the prevalence rate of persons with HIV in state or federal prisons, the percentage of persons incarcerated who have HIV is similar among males and females. For example, in 2021, among persons incarcerated with HIV, 95% were male, but the percentage of women with HIV (0.9%) was similar to that of men (1.2%).[9]

Racial Differences in HIV Prevalence in Prisons

In recent years, the Department of Justice has not provided HIV prevalence data in correctional facilities based on race.[9,11] The Department of Justice does report on AIDS-related deaths in prison based on race, and the death rates are higher among Black individuals than in White or Hispanic individuals.[11]

Intra-Prison HIV Transmission

Although consensual sex, rape, tattooing, and injection drug use occur within the correctional setting, available data suggest that most persons with HIV who are incarcerated acquired HIV prior to entering prison or, for those with multiple incarcerations, between periods of incarceration.[13,20,21] A large meta-analysis estimated the incidence of transmission of viral infections within prisons and found rates of 0.08 per 100 person-years with HIV.[13] In a study conducted among incarcerated male individuals in a Georgia state prison system, intra-prison transmission of HIV was associated with male-male sex in prison, receipt of tattoos while in prison, age older than 26 years, having served at least 5 years of the current sentence, Black race,

and low body mass index upon entry to prison.[20]

Prevention of Intra-Prison Transmission of HIV, HCV, and HBV

Many have called for a comprehensive strategy to help stop HIV transmission within the correctional system through interventions such as voluntary counseling and testing, disease prevention education, treatment of HIV as prevention, HIV preexposure prophylaxis (PrEP), and treatment for substance use disorders.[22] Other strategies include access to condoms, regulated tattoo parlors in prison, and facility-based needle exchange programs. All of these infection control strategies would also provide an opportunity to address the prevention of infection with hepatitis C virus (HCV), which is important given that as many as 41% of persons who are incarcerated have chronic HCV.[16] The same meta-analysis noted above in the Georgia state prison system also reported an intra-prison HCV transmission rate of 0.75 per 100 person-years, which was significantly higher than the intra-prison HIV rate.[13] The transmission of HBV within prisons could be reduced by administering hepatitis B vaccine to all persons who do not have immunity to hepatitis B.[13,16,23] The CDC recommends hepatitis B vaccination for all persons who are incarcerated and do not have immunity to or active infection with HBV.[23]

HIV Testing in the Correctional Setting

HIV Testing Practices in Correctional Facilities

In the United States, upon entry into jail or prison, it is estimated that approximately 22% of persons with HIV are unaware they have HIV.[24] Although the Centers for Disease Control and Prevention (CDC) recommended in 2006 that correctional facilities perform routine opt-out HIV testing, the HIV testing practices and policies in correctional settings continue to vary from state to state.[9,25,26] Data on state prison HIV intake testing practices for 2021 showed that 16 states performed mandatory HIV testing (tested everyone regardless of the need for consent), and 23 states provided opt-out HIV testing (offered the HIV test and the test was performed unless declined); these practices have changed some from earlier years (Figure 5).[8,9] An opt-in HIV testing approach is when the person requests the test, or the test is offered and performed only if the person consents to the test. The use of an opt-out HIV testing approach increases the number of persons tested for HIV when compared with the use of an opt-in HIV testing approach.[27,28] Jails, prisons, and community corrections are important settings in which to test individuals for HIV, especially given that many persons involved with the criminal justice system may be hard to reach with routine community-based testing and incarcerated populations have a higher HIV prevalence than the general population.[29,30,31]

Studies of HIV Testing in Correctional Facilities

Studies have shown that HIV testing within the structured environment of corrections is effective and feasible; the cost-effectiveness of testing incarcerated populations varies with the prevalence of undiagnosed HIV among individuals in any given testing area, but, overall, is on par with the cost of testing in the non-correctional setting.[29,32,33,34,35] One HIV testing project that included more than 33,000 persons who were incarcerated in four states (Florida, New York, Wisconsin, and Louisiana) identified 269 (0.8%) with previously undiagnosed HIV, and 40% of them were among persons whose only reported risk was heterosexual contact; this study underscores why HIV testing based only on reported risk factors will fail to identify a significant proportion of persons with HIV during incarceration.[35] A more recent CDC HIV corrections testing project conducted from 2009-2013 found that 0.3-0.4% of persons tested in a broad range of correctional facilities were newly diagnosed with HIV (Figure 6).[36] The CDC has released a comprehensive document to guide the implementation of opt-out HIV testing in the correctional setting.[37]

HIV Medical Care in Correctional Settings

Access to Medical Care

The landmark Supreme Court *Estelle v. Gamble* decision in 1976, which established that all individuals have the right to adequate health care, provides the constitutional mandate for HIV care and access to treatment within the correctional setting.[38,39]

Linkage to HIV Medical Care and Referral to Partner Services

Receiving a new diagnosis of HIV while in jail or prison can be difficult; thus, appropriate counseling and linkage to care during incarceration are essential components of any correctional testing program, just as in non-correctional settings.[40] The 2009 CDC document on HIV Testing Implementation Guidance for Correctional Settings provides specific recommendations on the management of persons newly diagnosed in a correctional facility, including recommendations that address immediate clinical management issues and linkage to appropriate medical care during incarceration.[37] The immediate clinical management issues that should be addressed include HIV prevention counseling, referral for mental health treatment if needed, initial evaluation and staging of HIV, and referral for HIV treatment (Table 1).[37] The linkage to appropriate medical care during incarceration can be challenging since HIV specialists may not be available to provide medical services on-site at the correctional facility. Persons newly diagnosed HIV within a correctional facility with may require outside expert medical consultation.[36]

Antiretroviral Therapy in the Correctional Setting

Initiation and Continuation of Antiretroviral Therapy

Considering the high prevalence of HIV in correctional settings, it is imperative that strategies and systems are in place to maximize initiation and uninterrupted administration of antiretroviral therapy within jails and prisons. Indeed, for some individuals, the structured environment of incarceration may lead to better antiretroviral medication adherence than when in a community setting, regardless of how the medications are dispensed.[15,41] Several studies evaluating the impact of directly observed antiretroviral therapy in prisons have found that directly observed antiretroviral therapy does not necessarily lead to better medication adherence than self-administration. Directly observed antiretroviral therapy is less convenient, decreases patient control, and may inadvertently jeopardize confidentiality.[15,42] In addition, directly observed antiretroviral therapy in the correctional setting does not empower individuals to develop the habit of eventually taking antiretroviral medications on their own, which they will need to do in a community setting. There is a wide range of practices for the administration of antiretroviral therapy in correctional facilities, including the use of the “keep on person” approach, whereby the individual is responsible for taking their own medication and for obtaining medication refills.[43]

Barriers to Antiretroviral Therapy Success in Correctional Settings

Many of the barriers to successful antiretroviral therapy within prisons are similar to those outside the correctional system. These include untreated mental conditions, medication side effects, lack of trust in the medical provider or in the benefit of taking antiretroviral medications, and social isolation.[44,45] In the Connecticut prison system, psychiatric disorders were common in the cohort of incarcerated individuals with HIV, and 45.6% were taking either antidepressants or antipsychotic medications.[15] Women with HIV who are incarcerated have an even higher prevalence of psychiatric disorders than their male counterparts.[46] In the prison setting, unique barriers to antiretroviral adherence exist, such as frequent transfers between facilities or assignments within the facility that can interfere with continuity of care.[45] Some prison-specific barriers include unauthorized medication confiscation, medication theft, medication stock-outs, and the inability to access medications during lockdowns.[40] Individuals with HIV may have concerns about confidentiality and/or a lack of trust in the prison health care system; these concerns may compromise adherence and deter individuals from acknowledging their HIV status and accessing HIV care.[40,45]

Access to Antiretroviral Therapy in Correctional Settings

Based on the constitutional mandate for HIV care, antiretroviral therapy must be available to all incarcerated individuals who are incarcerated and have HIV.[38,39] The ability of correctional facilities to successfully provide antiretroviral treatment for persons with HIV is variable.[31] One analysis, based on total antiretroviral sales in correctional facilities, found a substantial unmet need for HIV treatment in state and federal facilities, highlighting a major treatment gap.[47] Financial barriers also prevent the timely initiation or continuation of antiretroviral therapy in correctional settings. Antiretroviral medications are expensive, and insurance no longer covers these medications in the correctional facility; annual budgets in small- to moderate-sized jails are often too small to support payment for antiretroviral medications for even a limited number of persons with HIV.[47] Jails and temporary detention settings pose the most challenges in terms of accessing antiretroviral therapy. Persons with HIV who are detained for fewer than 7 days have the highest risk of treatment interruption; this is likely due to the chaotic nature of the jail setting, with rapid turnover, unpredictable lengths of stay, and lack of communication with regular care providers.[48] Also, with short stays, there may be inadequate time to collect a medical history, inquire about and verify current and previous medication regimens, or obtain the necessary antiretroviral medications before an individual is released.

HIV Care Cascade and Outcomes in the Correctional Setting

The HIV care cascade model has been applied to the correctional system in order to improve performance at every stage along the HIV care continuum, from HIV diagnosis to linkage and retention in care to antiretroviral therapy and virologic suppression (Figure 7).[24] Fewer than 30% of persons with HIV in the United States who enter the correctional system do so with an undetectable HIV RNA level.[15,24] For some persons with HIV, the correctional setting may be their first engagement in HIV care, and during incarceration, substantial gains may be made along all steps in the HIV care cascade, including increasing the percentages of persons taking antiretroviral therapy and achieving virologic suppression. In a retrospective review involving 882 persons with HIV in the Connecticut Department of Corrections system, virologic suppression (less than 400 copies/mL) improved from 29.8% at entry to 70.0% by release.[15] For many persons with HIV, the greater ability to achieve viral suppression in prison is likely influenced by access to HIV care and mental health services, a structured daily routine, and decreased use of alcohol and illicit drugs.[15] Unfortunately, large declines in the HIV care cascade are seen after release from incarceration, often to levels even lower than before incarceration.[24,49]

AIDS-Related Deaths Among Persons in State and Federal Prisons

As a result of improvements in antiretroviral therapies over time, the number of AIDS-related deaths in corrections has plummeted since the mid-1990s, similar to the trend in the general population.[11] Since 2010, fewer than 75 AIDS-related deaths per year have occurred among persons with HIV who were incarcerated in state prisons (Figure 8).[9,11] In addition, since 2010, fewer than 10 AIDS-related deaths per year have occurred among persons with HIV who were incarcerated in federal prisons.[11]

Maintaining Confidentiality in the Correctional Setting

Privacy and Confidentiality in Correctional Settings

Maintaining confidentiality in jails and prisons can be challenging since the health information of people who are detained or incarcerated is not always considered a protected entity. In the typical noninstitutional medical setting, confidentiality in the context of health care is a protected entity under the Health Insurance Portability and Accountability Act (HIPAA). In the correctional context, the relationship between the person's privacy and institutional "right-to-know" remains contested, since correctional institutions are not always considered covered entities under HIPAA. Within a correctional facility, the health and safety considerations for a patient may take priority over the right to confidentiality, but some have interpreted this to mean that all officers should know the HIV status of individuals who are incarcerated.[50] In this setting, however, the use of universal precautions should negate the need for correctional staff outside of health services to know the HIV status of any individual patient. The privacy of the individual should be protected to the greatest extent possible, which typically means that medical interviews with the patients should be conducted out of earshot of correctional officers, and the disclosure of protected health information should be limited to situations that directly impact the health and safety of other persons in the facility and/or correctional staff.

Disclosure of HIV Status

Because individuals with HIV in the correctional system often perceive that accessing HIV care may increase their risk of being subjected to violence, maintaining adequate privacy measures within the correctional system is of paramount importance.[40] In a small exploratory study of 42 individuals with HIV who were recently released from correctional centers in Illinois, only about one-half said they reported their HIV status at jail or prison entry, and some study participants only disclosed their HIV status to the correctional officers when their health deteriorated.[40] Fear of interpersonal violence and lack of safety and privacy were cited as key reasons for HIV nondisclosure.

Cohorting of Persons with HIV who Are Incarcerated

Because of limited access to HIV specialists, some prison systems have attempted to cohort persons with HIV in one or two facilities that have the easiest access to the specialists they need. Unfortunately, this practice limits persons with HIV from transferring to facilities that may have unique work or school programs and may result in persons with HIV being imprisoned far from visitors, thereby limiting or preventing visitations. In addition, this process likely identifies them as a person with HIV to everyone else in the facility. Further, efforts to cohort incarcerated persons with HIV have also led to adverse health outcomes due to the close proximity of multiple persons with immune suppression. In one instance, a single case of tuberculosis rapidly spread among persons with HIV in one facility, and ultimately 31 individuals developed tuberculosis.[51] In the past, some correctional administrators and officials thought placing all persons with HIV together in special units—and, in some cases, identifying them by an armband or special clothing—would reduce HIV transmission to both staff and other persons in the facility. This has never been shown to be true, and facilities in the United States now do not use the HIV cohorting practice.[52]

Chronic Medical Conditions Among Persons with HIV who are Incarcerated

Complexity of Care

Prevalence studies of incarcerated populations in the United States have found higher rates of multiple chronic medical conditions, including hypertension, cardiovascular disease, asthma, arthritis, and malignancies, when compared with the general population in the United States, even when adjusted for sociodemographic factors and alcohol consumption.[53,55] Persons with HIV who are in a correctional setting have high rates of HCV coinfection, more mental health disorders, and are significantly less educated than the general population of adults.

- **HCV**: Various studies have determined the HCV seroprevalence rate among the general incarcerated population in the United States ranges from 15% to 40%, depending on the region of the country, with viremia estimated in 2021 to be 8.7% of the entire state prison population.[16,56,57] Rates of HCV are considerably higher among those with HIV.[28,56] In a study of individuals entering the Maryland Department of Corrections, HCV infection was five times more common among persons with HIV compared with persons without HIV (65% of persons with HIV had HCV confection).[58] The high rates of injection drug use in these study populations underlie this dual epidemic.
- **Mental Health Conditions:** People with HIV have higher rates of mental health conditions compared with the general population and incarcerated populations also show a high prevalence of mental health disorders.[59,60] The Justice Department estimates that 50% of individuals in correctional facilities have a mental health disorder, and this percentage is likely to be even more prevalent among persons with HIV.[61] The need to link incarcerated persons exiting the corrections setting to needed mental health services in the community is the basis of the Special Projects of National Significance (SPNS) initiative called Enhancing Linkages to Primary Care and Services in Jail Settings (EnhanceLink), which works to connect individuals with community counseling and support services.[62]
- **Lack of Education**: The lack of education is a pervasive and often overlooked issue among incarcerated populations. It is estimated that 3 out of 5 persons in a correctional setting have difficulty reading and writing, and 85% of juveniles who are incarcerated have difficulty reading. Lack of education has been linked to higher rates of crime and poverty; the lack of basic education also complicates the delivery of quality medical care since persons with low literacy may be less able to follow medical advice or even read their prescription labels.[63] Many patients do not disclose their inability to read to their medical provider unless asked directly.

Use of Telemedicine for HIV Care in Correctional Settings

Persons with HIV who are in correctional settings often present complex management challenges to prison medical staff who lack HIV expertise. As noted earlier, other non-HIV-related chronic medical conditions may also complicate care. Treatment by experts in HIV medicine is strongly correlated with better medical outcomes, so one solution to the knowledge gap has been to introduce HIV subspecialty care to the prison setting through telemedicine.[64,65] Developing new models of prison healthcare, such as telemedicine, that can effectively deliver best-practice medicine to persons with HIV who are in a correctional setting is crucial to ensuring the constitutionally protected right of individuals to receive adequate health care while incarcerated.

Transition from the Correctional Setting to the Community

Importance of Transition Planning

The transition from a correctional facility to the community is a critical event for persons with HIV who are incarcerated. The CDC report on HIV Testing Implementation Guidance for Correctional Settings includes recommendations on linkage to appropriate medical care upon release from custody (Table 2).[37] Adequate discharge planning and linkage to community medical care upon release often fall short of practices recommended by the CDC, and only 30% of individuals are retained in HIV medical care after 6 months in the community.[24,28] Release from prison has been associated with increases in HIV RNA levels and decreased CD4 counts, which reflect some of the challenges with engaging in medical care and adhering to antiretroviral therapy while trying to reintegrate into society.[45,66] Programs that enhance linkage and entry into HIV care are crucial.[24,67] Multiple potential interventions can improve linkage to care, including HIV education during incarceration, careful discharge planning, securing stable housing, availability of transportation, employment opportunities, and care for substance use and mental health disorders.[24,68] Individuals taking antiretroviral therapy at the time of discharge should receive an adequate supply of antiretroviral medication as a bridge from jail or prison release to an appointment with a community provider. Community clinics and correctional systems need to work together to find ways to adequately meet the needs of this population upon reentry into the community.

HIV Transmission Risk After Release

After release from prison or jail into the general community, persons with HIV may engage in sex activities that may increase their risk of transmitting HIV to others, particularly with their pre-incarceration sex partners.[69,70] Several studies have shown that women, especially women in the South, have an increased risk of acquiring HIV when they have sex with a male partner with HIV who is released from prison.[71,72] Therefore, in this setting, it is important to utilize a range of HIV prevention strategies that include keeping released individuals engaged in medical care, assisting them in taking antiretroviral therapy, consistently achieving suppressed HIV RNA levels, identifying and treating sexually transmitted infections (since sexually transmitted infections can increase the risk of HIV transmission to partners), and facilitating the use of HIV PrEP for community serodifferent partners.[68,69] In addition, some investigators have also demonstrated that incarceration disrupts primary intimate relationships, suggesting the use of prison-based programs to help couples maintain their relationships during incarceration may reduce the number of sexual contacts after release.[73] Although some people leaving prison who test negative for HIV may also benefit from HIV PrEP to prevent HIV acquisition after release into the community, few jails and prisons offer HIV PrEP prior to or upon release. Preliminary studies have found that among individuals leaving a correctional facility, knowledge of HIV PrEP and perception of HIV risk is low, but willingness to use HIV PrEP is high.[74,75]

Community Corrections

Community corrections refers to adults on probation or parole.[76] At the end of 2021, among the total correctional population of 5,444,900 in the United States, approximately 3.7 million were in community corrections (Figure 9).[4] The demographics of community corrections closely mirror that of jail and prison settings, with disproportionate representation of poor, disadvantaged, and racial and ethnic minority populations.[76] Inadequate data exist regarding HIV prevalence in community corrections, and HIV testing rates are low in this setting.[77] Nevertheless, the community corrections population represents an important target for HIV screening and prevention services. For persons with HIV, the community corrections officer or parole officer can often play a key role in keeping an individual engaged in care. These officers are an underutilized resource, perhaps because of the public's misunderstanding of their role. The officers can help provide guidance, support, and program opportunities to persons in the community correctional system while helping them remain accountable for their imposed conditions as they transition back into the community. At times, obtaining a release of information from a patient to discuss their care with the community corrections officer or parole officer is an important step in coordinating medical care.

Summary Points

- As of year-end 2021, the United States had approximately 1.8 million persons housed in correctional facilities, which exceeded that of all other countries.
- Among persons in correctional facilities in the United States, approximately 90% are male and incarceration rates are consistently higher in Black and Hispanic individuals than among White individuals.
- In the United States, the HIV prevalence among incarcerated individuals is 1.1%, which is more than three times higher than among the general population.
- Among all adults with HIV in prisons in the United States, approximately 95% are men, and 5% are women, but the HIV prevalence rate among men (1.2%) and women (0.9%).
- In state prisons, HIV testing practices during prison intake vary, and most states utilize mandatory or opt-out testing policies.
- Incarceration offers a structured environment to initiate and continue antiretroviral therapy.
- Barriers to successful antiretroviral therapy within the correctional setting include high rates of substance use and mental health disorders, lack of continuity of medical care, distrust of prison-based medical care, and concerns about confidentiality and safety.
- The transition from a correctional facility to the community is a critical event for persons with HIV. After release, drop-offs occur at every step of the HIV care cascade.
- Since individuals often engage in activities that may increase their risk for HIV acquisition following release from the correctional setting, secondary prevention is a critical component of transitional care planning.
- High rates of HIV risk activity coupled with low rates of HIV testing make the community corrections population an important priority for HIV screening and prevention services.

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Figures

Figure 1 Persons Incarcerated in Prisons or Jails Over Time

On any given day in the United States, there are significantly more individuals incarcerated in prisons than in jails, but many more persons move through jails over time than in prisons. The higher total annual volume in a jail is due to much higher admission and release rates than in prisons, where persons typically have long sentences.

Illustration: David H. Spach, MD

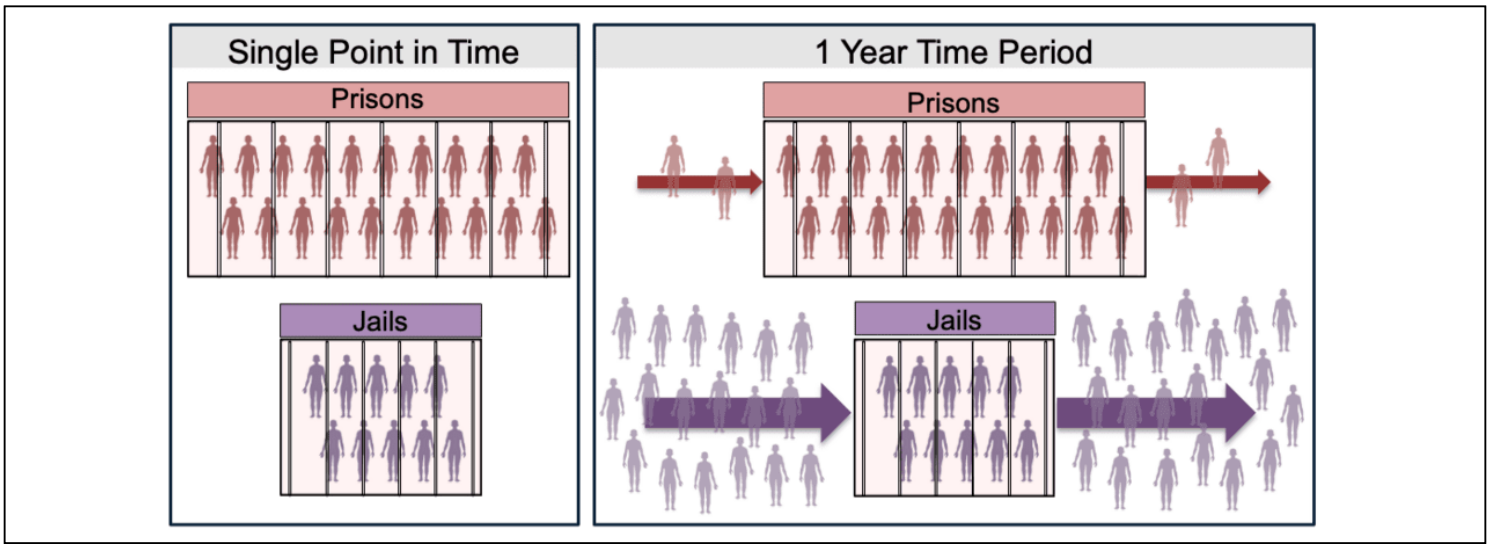

Figure 2 Global Prison Population Totals, by Country, 2021

Source: World Prison Brief: Highest to Lowest—Prison Population Total. World Prison Brief, Institute for Criminal Policy Research. 2021.

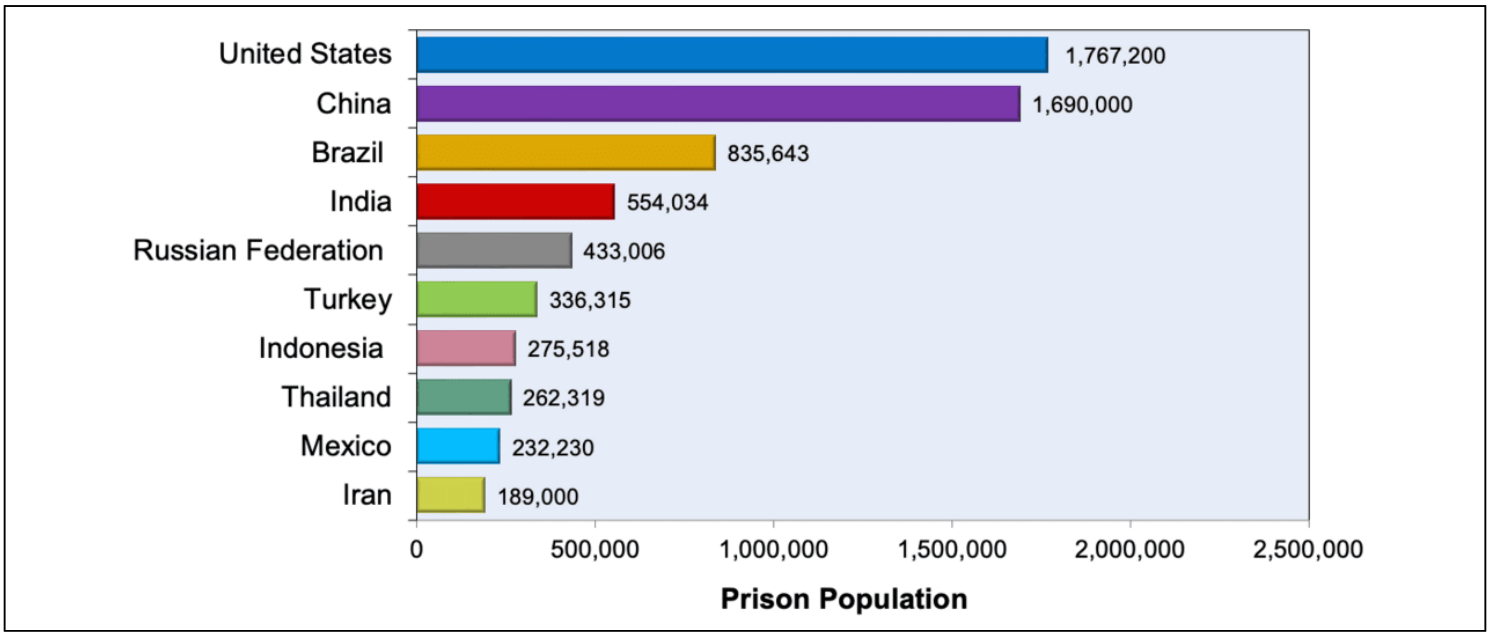

Figure 3 Estimated Number of Incarcerated Adults, United States, 1980 through 2021

The numbers for each year represent a sample taken at one point in time. Persons who are incarcerated represent persons in prison (federal prison or state) and in local jails.

Source: Carson EA, Klucklow R. Correctional Populations in the United States, 2021 – Statistical Tables. Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice. February, 2023.

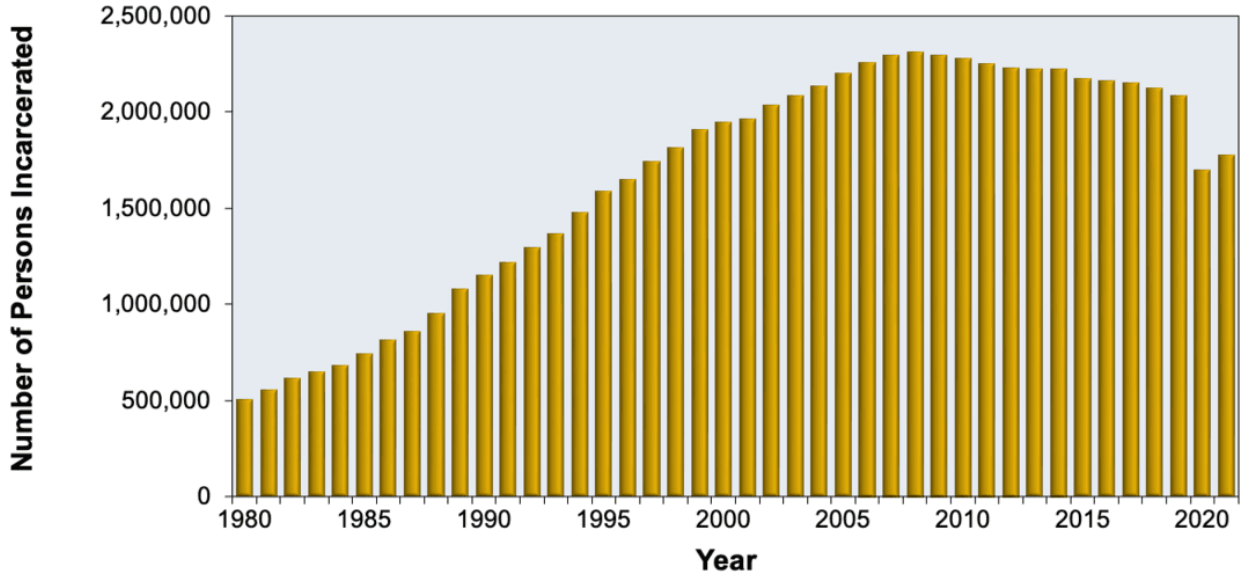

Figure 4 Persons with HIV (and HIV Rate) per 100,000 in State and Federal Prisons Combined, 1991–2021

The numbers for each year represent a sample taken at one point in time and represent persons with diagnosed HIV.

Source: Maruschak LM. Statistical Tables. Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice.

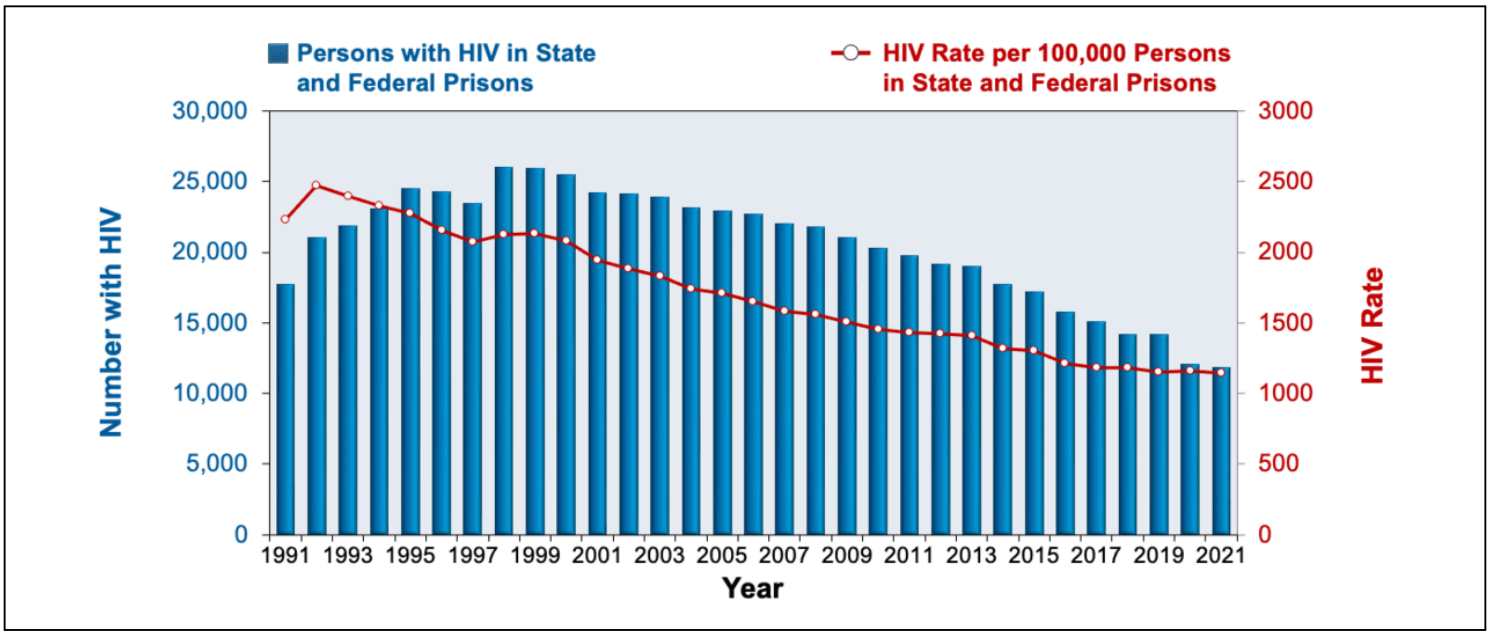

Figure 5 HIV Testing Practices During the Prison Intake Process, 2011, 2015, and 2021

Source: Maruschak LM, Bronson J. HIV in Prisons, 2015—Statistical Tables. Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice. August 24, 2017.Maruschak LM, Bronson J. HIV in Prisons, 2021—Statistical Tables. Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice. March 2023.

HIV Testing Practices During Prison Intake Process, 2011, 2015, 2021

Intake HIV Practice	Year		
	2011	2015	2021
Mandatory	14	15	16
Opt-Out	13	17	23
Opt-In	10	8	7
Upon Assessment	2	3	3
Did Not Report	3	2	1

Figure 6 CDC-Funded HIV Testing in Correctional Facilities and Percentage HIV Positive, United States, 2009-2013

These data are from correctional facilities in 59 CDC-funded health department jurisdictions.

Source: Seth P, Figueroa A, Wang G, Reid L, Belcher L. HIV Testing, HIV Positivity, and Linkage and Referral Services in Correctional Facilities in the United States, 2009-2013. Sex Transm Dis. 2015;42:643-9.

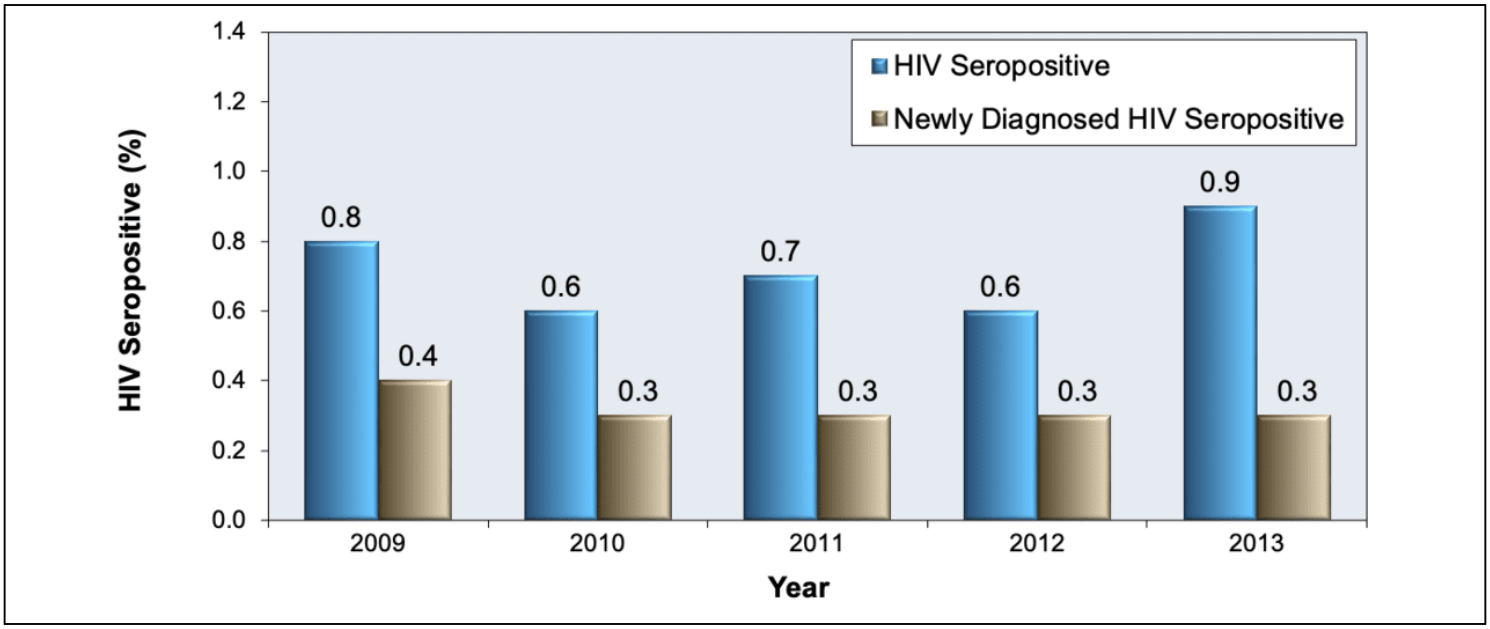

Figure 7 The HIV Care Cascade Before, During, and After Incarceration

This graphic represents systematic review and data synthesis compiled up to January 13, 2015. For this analysis, undetectable HIV RNA was defined as HIV RNA level of less than 500 copies/mL.

Source: Iroh PA, Mayo H, Nijhawan AE. The HIV Care Cascade Before, During, and After Incarceration: A Systematic Review and Data Synthesis. Am J Public Health. 2015;105:e5-16.

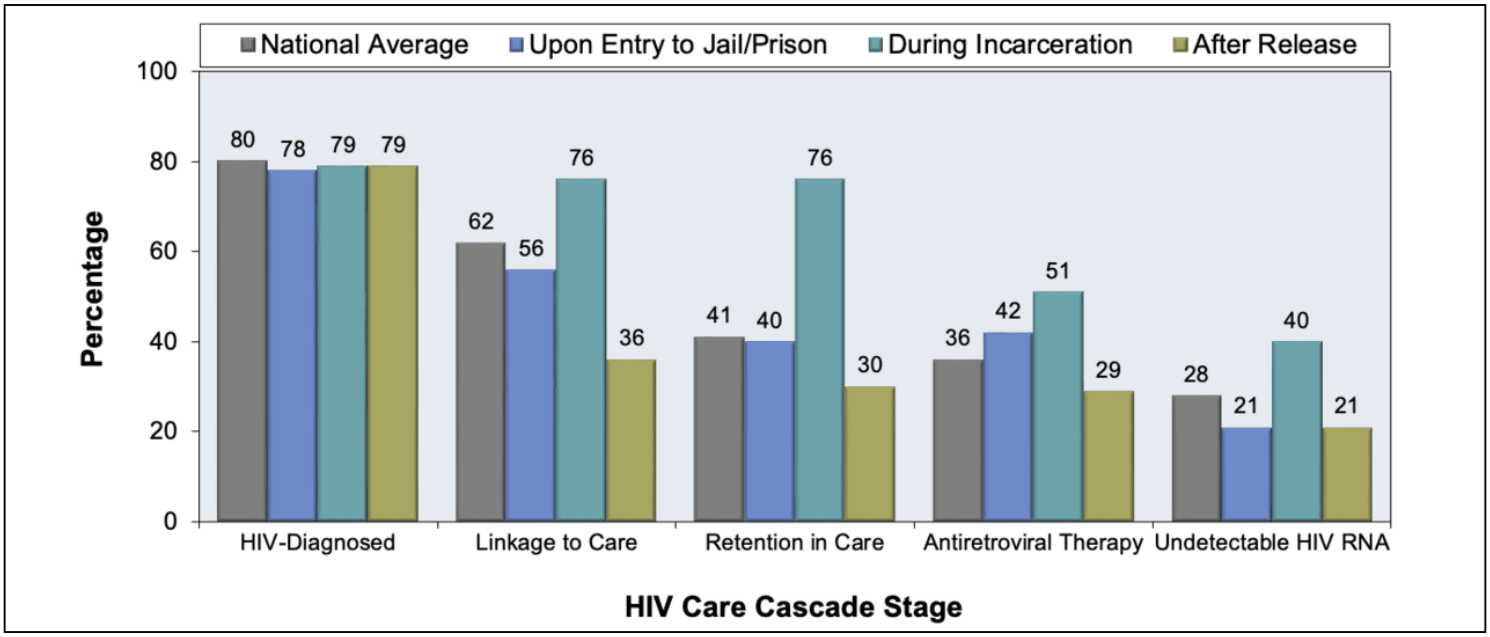

Figure 8 Number of AIDS-Related Deaths Among Persons in State Prisons, 1991–2019

Source: Maruschak LM. HIV in Prisons, 2020—Statistical Tables. Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice. May 2022.

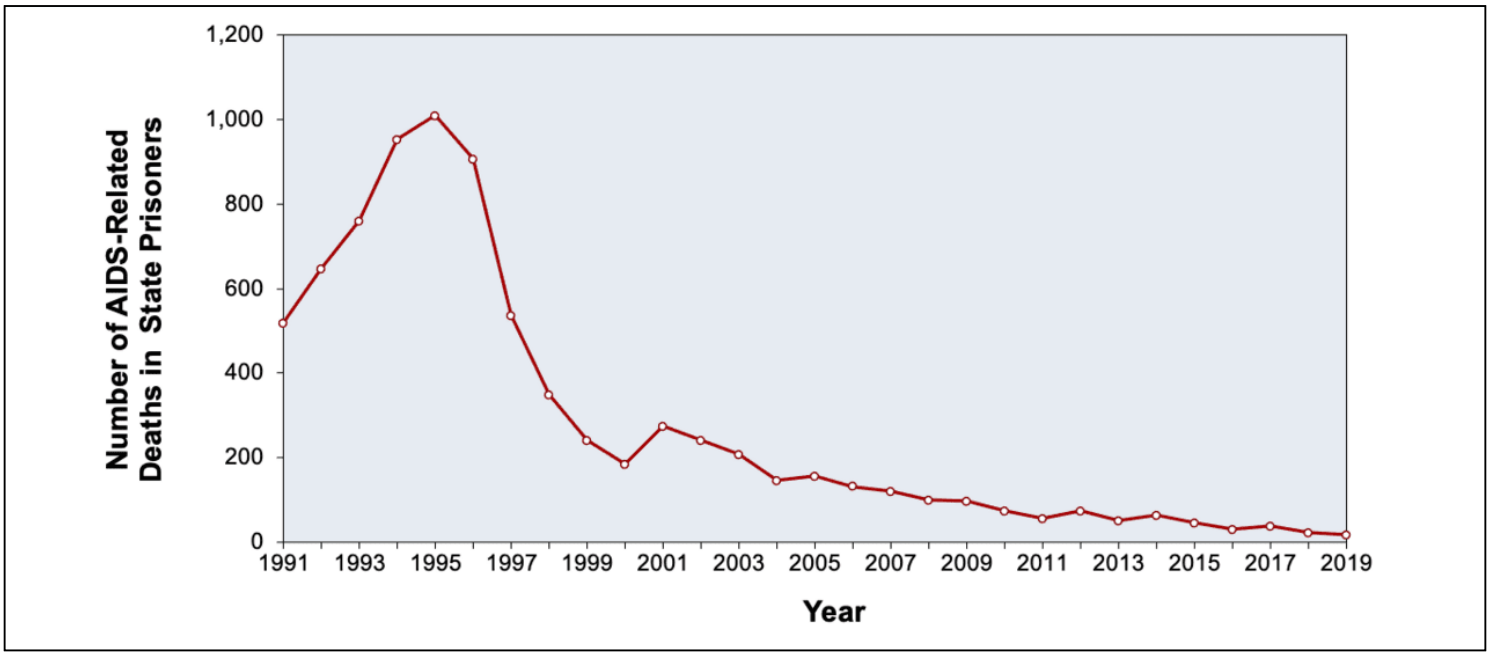

Figure 9 Estimated Number of Persons Supervised by United States Adult Correctional Systems, by Correctional Status, 2021

*The total number for community supervision is adjusted to exclude persons on parole who were also on probation.

Source: Carson EA, Klucklow R. Correctional Populations in the United States, 2021 – Statistical Tables. Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice. February, 2023.

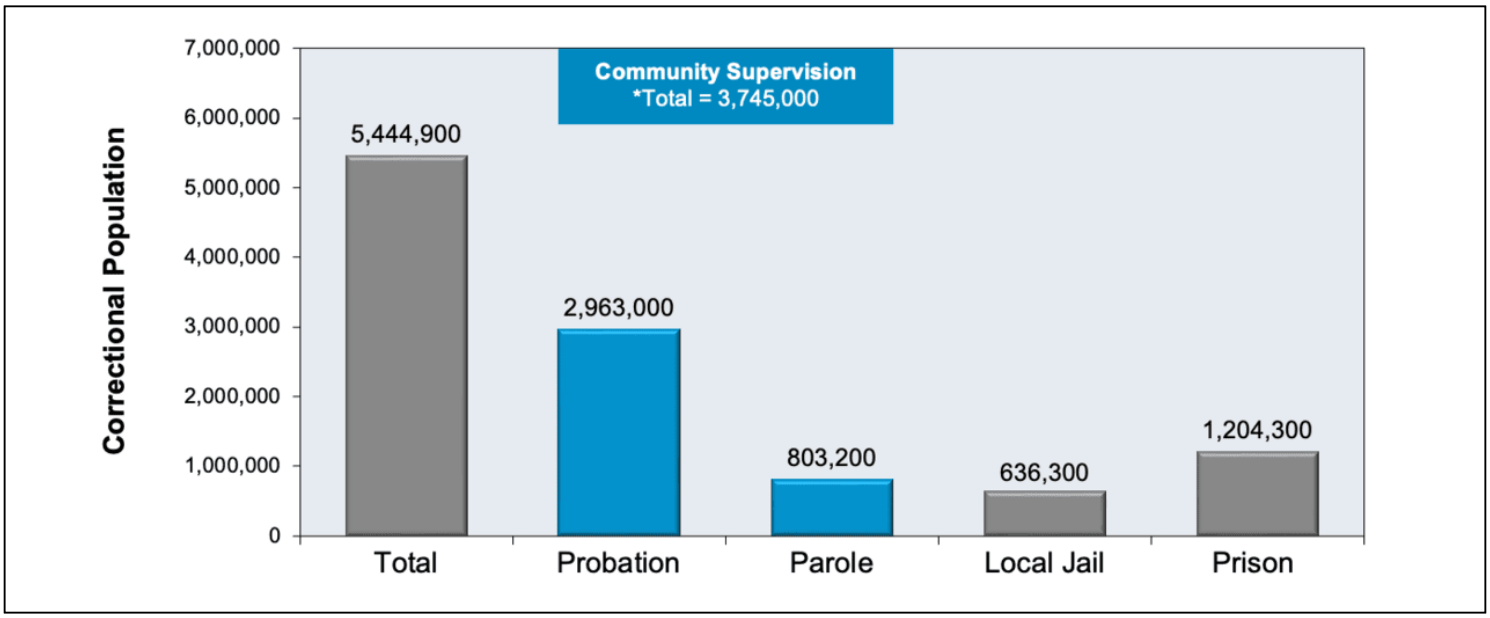

Table 1. **CDC HIV Testing Implementation Guidance for Correctional Setting**

Linkage to Services for People Newly Diagnosed with HIV in Correctional Setting: Immediate Clinical Management Issues
• HIV prevention counseling.
• Referral for mental health support as indicated.
• Medical evaluation including staging of HIV and diagnosis of comorbidities and opportunistic infections.
• Referral to an HIV provider or specialist depending on the HIV medical provider's experience, the stage of HIV, and complexity of medical issues.
• Expedited HIV care may be necessary for special clinical circumstances including acute HIV, an acute opportunistic infection, and HIV during pregnancy.

Source:

- Centers for Disease Control and Prevention. HIV Testing Implementation Guidance for Correctional Settings. January 2009:1-28. [CDC]

Table 2. **CDC HIV Testing Implementation Guidance for Correctional Setting**

Linkage to Appropriate Medical Care Upon Release from Custody
• Develop a list of medical providers in the community where the individual will be returning. Many states have resource manuals listing HIV care providers.
• Contact your local or state health department for assistance with locating providers who are willing to accept uninsured persons.
• Most people with HIV will qualify for free or low-cost medical treatment at clinics federally funded through the Ryan White HIV/AIDS Treatment Modernization Act of 2006.
• Assist the individual with scheduling an appointment with the community care provider. If possible, allow the community care provider to visit the individual before release. Research has shown that face-to-face contact before release results in increased likelihood of continuity in the community. Having the individual talk to a provider, a nurse, or a counselor at the follow-up clinic may help with concrete linkage to services. If appointments cannot be made in advance, make walk-in arrangements with clinical providers.
• Provide the person with date, time, and location of first post-release appointment in writing. Stress to inmates the importance of attending their first scheduled appointment in the community, and the appointment should be as early as possible after release.
• Provide the persons with a copy of the relevant medical record or clinical summary free of charge. Alternatively, send information to the community provider after obtaining written consent for release of information from the person.
• Collaborate with state and local offices administering benefit and entitlement programs to facilitate pre-release applications and benefit reinstatements. Some correctional systems have arranged partnerships to allow processing of Social Security Administration (SSA) and Medicare applications before release, as recommended by the SSA and the Centers for Medicare and Medical Services.
• Complete applications for medical services in conjunction with the individual who is being released from the correctional facility.

Source:

- Centers for Disease Control and Prevention. HIV Testing Implementation Guidance for Correctional Settings. January 2009:1-28. [CDC]