

The Impact of African American Male Incarceration Rates on the Racial Disparity in HIV/AIDS Rates

Michelle Aelion
DePaul University

Abstract: In the United States, HIV/AIDS disproportionately impacts African Americans and African American communities. The nature of this national health disparity is complex and cannot be explained simply by one factor or an individual's behavior within a given community. This paper suggests that the disparity in African American male incarceration rates is among the most important factors to consider in the racial disparity of HIV/AIDS rates. Existing studies on relevant subjects were examined and used to create a conceptual model of factors. This model presents an outline of factors during pre-incarceration, incarceration, and post-incarceration that contribute to the racial disparity in HIV/AIDS rates. Recommendations are made based on these findings.

Introduction

African Americans are affected by HIV/AIDS in the United States disproportionately when compared with any other race or ethnicity. In 2014, the Centers for Disease Control and Prevention (CDC) estimated that almost half of those newly diagnosed with HIV/AIDS in the U.S. were African American, who only comprise 12% of the U.S. population. As a result of these staggering numbers, many research studies and articles attempt to address the structural and social factors associated with the prevalence of HIV/AIDS amongst African Americans. Although these numbers may be attributed to many factors, this paper suggests that African American male incarceration rates in the U.S. is among the most important factors to consider. Unprotected male homosexual activity, which often occurs in prison, is associated with the highest probability of HIV infection through sexual contact (Johnson & Raphael, 2009). In 2014, male-to-male sexual contact accounted for 67% of all new HIV diagnoses (About HIV/AIDS, 2016). In addition, men are incarcerated at significantly higher rates than women (Mauer, 2011). Taking these factors into account, this paper focuses on how the incarceration rates of African American men specifically, affect the HIV/AIDS rates of both African American men and women. The large increase in African American male incarceration rates between 1970 and 2000 were not comparable among white men (Johnson & Raphael, 2009). At the same time, the AIDS infection rate among African American women had an annual rate increase between 2000 and 2003 that was 19 times higher than that of white women (Johnson & Raphael, 2009). Previous

research studies and data have been compiled to support this thesis and these data are used to make recommendations for important policy applications.

Pre-incarceration

I. Racial disparity in those incarcerated

No convincing evidence suggests that individual behaviors of African Americans can be attributed to the existing racial disparity in incarceration rates (Blankenship et al. 2005). Looking at drug use as an example, African Americans reported less life-time use of illicit drugs than their white counterparts in a 2002 study (Blankenship et al. 2005). However, African American males are disproportionately affected by incarceration. African Americans now constitute almost 1 million of the 2.3 million incarcerated, and are incarcerated at nearly 6 times the rate of whites (Criminal Justice, 2016). When looking specifically at males, a trend exists where 1 in every 6 African American men has been incarcerated as of 2001 (Criminal Justice 2016). If this current trend continues, 1 in every 3 African American males born today can expect to go to prison in his lifetime, in comparison to 1 in 17 white males (Mauer, 2011). These overwhelmingly disproportionate rates can be attributed to a number of factors including skewed laws and sentencing policies, and room for bias in certain law enforcement practices.

In 1968, the Nixon administration decided that efforts needed to be maximized to stop the distribution and consumption of illicit drugs in the United States. The “War on Drugs” became a priority for the Justice system, resulting in many laws and sentencing policies with skewed racial effects. Many of the laws put in place have severely increased the number of people incarcerated, without having a comparable decrease in drug use, which was the reason for implementing these laws in the first place (World Drug Report, 2015). School zone drug laws are an example of laws that attempt to decrease the rate of drug use and distribution, but end up unevenly affecting the African American population (Mauer, 2011). Urban areas that are more populated than suburban areas are more likely to be affected by these laws. Taking into account that African Americans and other minorities make up the majority of the population in these areas, these are the people that are more likely to be affected by these laws. This does not suggest that they are more likely to involve themselves with drugs than their white counterparts, but they are more likely to get

caught and incarcerated. Many of these drug arrests can be directly translated to incarceration due to mandatory sentencing policies applies to drug offenses that set a “mandatory minimum,” for sentencing (Mauer, 2011). The extent to which African Americans are arrested on the basis of race is difficult to precisely measure; however, recent data from the Bureau of Justice Statistics (BJS) provides evidence for some type of bias, and unconscious or not, this is another factor that may contribute to the disparity in incarceration rates (Mauer, 2011). National data from 2011 indicates that relatively more African American drivers were pulled over in a traffic stop than whites and Hispanic drivers (Langton & Durose, 2013). More importantly, of those stopped, white drivers were ticketed and searched at lower rates than African American and Hispanic drivers (Langton & Durose, 2013).

II. HIV/AIDS stigma

Prisons are a high-risk environment for the transmission of HIV/AIDS, and the stigma associated with HIV/AIDS contributes to the prevalence of it within prisons. More is being done to criminally prosecute those affected by HIV/AIDS, rather than educating and providing knowledge to the public about exposure and prevention of HIV. This creates a dangerous stigma in which those affected may be afraid to get tested or disclose information about their HIV status. “Prosecutions for exposure, nondisclosure, and/or transmission of HIV have occurred in at least 39 states,” (Fenced In, 2012). Many of these prosecutions occurred regardless of whether or not the person actually transmitted the virus, with cases involving prosecution for spitting and consensual sex (Richardson, 2014). Once HIV is introduced into the prison environment, factors such as high-risk sexual behavior and drug use within correctional facilities directly contribute to the spread of HIV/AIDS. This factor, coupled with the racial disparity in those incarcerated, only contributes to the growing health disparities within prisons.

Incarceration

High-risk activities and the prevalence of HIV/AIDS within prisons makes the prison environment an incubator for HIV transmission. Multiple vectors of infection will be discussed. Health care systems within prisons may both directly and indirectly affect the prevalence of

HIV/AIDS. Direct factors that contribute to the spread of infection include high-risk sexual behavior and high-risk drug use, specifically injection drug use.

I. Health care systems within prisons

Many correctional facilities within the United States are more focused on implementing rules that prohibit high-risk behavior than on implementing prevention programs or providing resources that serve to reduce risk (Braithwaite & Arriola, 2003). High-risk behaviors include both sex and illicit drug use. Because of these prison policies, prison officials may be hesitant to make prevention programs and resources available as this contradicts the very policies in place. For example, the misconception that condom availability leads to an increase in the amount of sexual activity that takes place within prisons may preclude the distribution of condoms (May & Williams, 2002). In a 2001 study, inmates and correctional officers in a Washington, DC correctional facility completed anonymous surveys pertaining to their satisfaction with the condom availability at their facility (May & Williams, 2002). Most inmates (58%) did not believe that making condoms available was linked to increased sexual activity within the facility. The majority (64%) of correctional officers thought it was a good idea to distribute condoms in the facility. It is also worth noting that 94% of the 307 inmates surveyed were African American. Condoms are made available only in two prison systems (Washington, DC and Vermont) and four jail systems (New York City, Philadelphia, San Francisco, and Washington, DC). These facilities make up less than 1% of correctional facilities within the U.S. Interestingly, no facility that has implemented these policies has reversed them (May & Williams, 2002).

Considering the prevalence of injection drug use and tattooing within prisons, the lack of access to adequate prevention methods such as sterile needles are also an issue. The World Health Organization (WHO) has specified in their preventative measure guidelines that bleach (or other effective agents) and/or clean syringes and needles should be provided to prisons housing injection drug users (1999). This is of course, only applicable if they are made available in the first place. The issue is, much like condom distribution, such preventative resources are scarce within prisons. Successful syringe exchange programs (SEP) have been implemented in other countries in Europe and Asia and the majority of these programs have led to decreases in syringe sharing (Dolan et al., 2003). In addition, in the evaluation of three countries (Switzerland,

Germany, and Spain) that participated in pilot prison SEPs, no new cases of HIV were reported in blood tests or medical reports (Dolan et al.,2003). This same study of three different countries found that many of the participating correctional facilities had either decreased or stable rates of drug use (Dolan et al.,2003). Unfortunately, a misconception exists in many United States correctional facilities that providing inmates with adequate resources will directly increase or condone certain prohibited behaviors. According to a recent global harm reduction report, there are no SEPs being funded or operating in U.S. prisons (Stoicescu, 2012).

Methadone maintenance therapy (MMT) programs have been shown to reduce injection drug use rates, syringe/needle sharing, and mortality rates (Fenced In, 2012). Iran is a good example of a country that has had success in implementing MMT programs, and other harm reduction programs of the same nature. In a study involving several Iran prisons, both participants and officials felt that the program helped reduce drug abuse and the rate of needle/syringe sharing (Moradi et al., 2015). In addition, many participants and officials also felt that the reduced rate of drug use also directly reduced the rate of using sex as a means of trade for drugs. Despite the convincing research and success shown through several pilot programs, there is minimal access to MMT and other substitution treatment programs in U.S. prisons (Stoicescu, 2012).

Budgeting constraints and competing programs may also be a factor contributing to the lack of preventative health care within prisons. In 2010 Governor Schwarzenegger was an advocate for a constitutional amendment prohibiting the state budget marked for prisons from exceeding what is set aside for the public university system in California (Mauer, 2011). The Federal Bureau of Prisons has released its most updated version of clinical practice guidelines for preventative health care (2013). Inmate education and preventative services which both play an important role in controlling the transmission of HIV/AIDS, are funded only locally, if funded at all, by volunteers and community-based organizations. With a limited budget, the focus and funding of health care systems within prisons remains on treatment rather than prevention. However, focus on treatment may not prove to be as successful as anticipated. A nationwide survey of U.S. federal and state prisons in 2004 showed that treatment of chronic medical problems and access to medical services were not accessed by many inmates (Wilper et al.,2009). The overwhelming majority of inmates surveyed were male and disproportionately black or Hispanic, which is

important to recognize. Results showed that first, chronic conditions were prevalent amongst inmates, including a positive HIV status. Of these inmates with chronic medical conditions, 13.9% of federal inmates and 20.1% of inmates were not examined by medical personnel. An HIV positive inmate doing well on antiretroviral drugs (ARV) may have a reduced viral load within his bloodstream, and thus a lower chance of transmitting HIV. Highly active antiretroviral therapy (HAART) for example, has been shown to result in dramatic viral load suppression and increase in CD4⁺ T-cell counts for HIV-infected prisoners (Wakeman & Rich, 2010). With that in mind, every person with HIV/AIDS who is left untreated or cannot access medication can affect the rest of the prison population. These numbers may result from the limited privacy in prisons, making inmates reluctant to seek treatment. Some inmates on HAART may require dosing of medications several times a day, which means being called to the medication line multiple times a day (Wakeman & Rich, 2010).

II. High-risk sexual Behavior

Engaging in sexual activity in an HIV-prevalent environment with lack of access to adequate prevention methods contributes to the spread of HIV in prisons. Sexual activities may include consensual sex, sex in exchange for favors, and rape. Due to the fact that many studies depend on self-reported data, not only do numbers vary greatly between studies, but sexual activity may be underreported. The method used to obtain data also contributes to the wide range of numbers. For example, researchers administering surveys to inmates may fail to take into account those who are illiterate. Two studies done in the early 1990s show that 60-75% of U.S prison inmates are functionally illiterate (Hensley et al., 2003).

Data on consensual sex is rather sparse because it may be seen as less of a threat to the health and security of the inmates and facilities. However, it is important to note that it still occurs. Given the scarcity of available condoms in prisons, even consensual sex is a mode for transmission of HIV/AIDS. In a study of a California male correctional facility, about 65% of the 200 inmates surveyed had engaged in consensual sex during incarceration (Hensley et al., 2000). In a more recent study by the CDC in a Georgia male correctional facility, 72% of inmates reported consensual sex while incarcerated (HIV Transmission, 2016). In this same study, only 30% of those who partook in consensual sex reported using a condom.

Many inmates are also coerced into having sex as means of trade or providing favors. Sex also may involve blackmail or physical threats. Both of these examples constitute as sexual victimization. A 2011 national report from the BJS revealed 6,253 allegations of sexual victimization in public federal and state prisons (Beck & Hughes, 2014). Just looking at the 902 substantiated claims of inmate-on-inmate sexual victimization, the majority of data (approximately 80% for both federal and state prisons) involved male victimization. The results showed that 45.1% of victims were subject to force or threat of force, 11.8% were persuaded, 5.9% were bribed/blackmailed/given drugs or alcohol, 2.2% were offered protection, and the rest were identified as other. Sexual victimization also includes staff-inmate encounters, estimated in the same BJS report to include 1,393 inmate victims and 1,286 staff perpetrators. Sexual victimization constitutes as rape in cases where the act is nonconsensual. These incidences are usually found to be rough and may result in sustained injuries by the victim and this too may increase the chance of transmission. It is also important to note that this data, although very inclusive, is dependent on reports from correctional authorities. Due to a possible lack of trust between authorities and inmates, and a fear of facing abuse or punishment for reporting the incident, sexual victimization may be underreported.

III. Risky drug-use

A high risk of HIV transmission is associated with injecting drugs within prisons. One might be quick to assume that prison walls are enough to keep drugs out of the equation, but drug use is actually quite prevalent within prison walls. A large-scale 1993 study of 22 cities found that 60% of those arrested tested positive for drugs at the time of arrest (Gillespie, 2005). Prisoners with a history of drug use prior to incarceration are likely to use drugs while incarcerated as well (Rowell et al., 2012). Taking into account the lack of access to both disinfecting agents and clean needles within U.S. prisons, injecting drugs becomes a potential vector of HIV infection. A 2012 study in a U.S. state correctional facility of 1,100 black male inmates showed that 20% of participants reported using drugs while incarcerated and injection drug users comprised half of this population (Rowell et al. 2012). Another large-scale study conducted in Vancouver is worth mentioning because much like U.S. prisons, Canadian prisons have yet to adopt any SEPs (Stoicescu, 2012). The Vancouver Injection Drug Users Study (VIDUS) collected data from over

a 6-year period of injection drug users (Werb et al. 2008). Of the injection drug users studied, 50% reported being incarcerated at least one during this period, and 14.7% admitted to injecting drugs while incarcerated. Within this same study, 4.1% of individuals studied became HIV positive after the study began. Taking into account the prevalence of injection drug use in prisons, and the lack of preventative methods and treatment programs such as SEP and MMT, injection drug use within U.S. prisons may continue to be a primary vector in HIV transmission.

To summarize, once HIV/AIDS is introduced into the prison environment, several vectors of transmission exist that contribute to the prevalence of the virus within prisons. Whether infected prior to incarceration or during incarceration, the barriers to effective treatment may increase an individual's viral load. With an increased viral load, and lack of preventative methods such as condoms and clean needles, transmission of HIV becomes very likely through high-risk behaviors. New cases of HIV within prisons then contribute to this ongoing cycle.

Post-Incarceration

Testing for HIV/AIDS within U.S. prisons varies by location. According to the Federal Bureau of Prisons Clinical Practice Guidelines, HIV testing is routinely encouraged but not required unless an already-sentenced inmate has certain HIV risk factors (Federal Bureau of Prisons, 2013). Examples of risk factors include males who have had sex with males, and injection drug users (Federal Bureau of Prisons, 2013). Both these factors rely on the assumption that an inmate is fully disclosing his personal history which may not be the case. Many inmates may be reluctant to get tested because of the stigma surrounding HIV/AIDS or homosexuality. This stigma may result in underreporting. A 2006 study which estimated the share of HIV/AIDS among releases from correctional facilities showed that 18.7-23.7% of black men releases were HIV positive (Spaulding et al., 2009). This number can be compared to the considerably lower 9.5-14.4% of white male HIV positive releases. The CDC also states that statistically, African American men are 5 times as likely to be diagnosed with HIV among jail populations. The release of these HIV positive individuals back into home communities may pose several issues that contribute to the existing racial disparity in HIV/AIDS rates.

I. Released and unknowingly infected

Due to the fact that HIV testing is often voluntary, many inmates may be released and unknowingly infected. Flu-like symptoms may present themselves 2-4 weeks after an individual is infected with HIV (About HIV/AIDS, 2016). Once the symptoms subside, a person can be infected with HIV without any symptoms. Without knowledge of the infection, an individual may be less cautious of his actions and more prone to unknowingly transmitting the virus. Of the estimated 1.2 million people living with HIV in the U.S., approximately 13% are unknowingly infected (About HIV/AIDS, 2016). Of the nearly 45,000 people diagnosed with HIV every year, 30% of those HIV infections are transmitted by people who were undiagnosed at the time (About HIV/AIDS, 2016). This is first and foremost a factor in contributing to the spread of HIV/AIDS outside of prison walls. This also may be a way of re-introducing the virus within prisons, due to the laws that criminalize those who may unknowingly infect another with HIV, as previously discussed.

II. Difficulty reintegrating into society

The odds will likely not be in an ex-offender's favor concerning relationships, future employment opportunities, and healthcare. Research shows that long periods of incarceration are correlated with the destabilization of existing relationships. Incarceration may pose challenges for existing relationships considering limited visitation hours, a feeling of loneliness or lack of support by a partner, and a lack of privacy (Incarceration, 2001). In a 2005 study, 51 men were interviewed in Utah and Oregon minimum security prisons (Incarceration, 2001). Sixty-five percent of the men in this study reported not receiving any visits from their spouse or partner. Incarceration may also serve as an obstacle in forming future relationships. In a study of 4,591 men between 1983 and 2000 using hierarchical linear modeling, the likelihood of marriage was reduced by 39% for current incarceration and 8% for prior incarceration (Huebner, 2005). The studies mentioned, specifically examine heterosexual relationships. With existing relationships and future relationship dynamics being destabilized, the number of lifetime partners an inmate has may increase as a result. This could contribute directly to the spread of HIV/AIDS among both men and women in a given community outside of prison.

A barrier to employment is another obstacle faced by former inmates. Many states still permit employers to deny employment on the basis of an existing criminal record (Fenced In, 2012). In many fields, such as law and medicine, knowingly hiring an ex-offender is prohibited (Blankenship et al., 2005). Even in cases where the state or field allows for the consideration of ex-offenders, many employers are usually reluctant to hire a person with a criminal record (Fenced In, 2012). A study analyzing the National Longitudinal Survey of Youth indicates that incarceration is associated with a 66% decline in employment (Incarceration, 2001). Lack of employment as a result of incarceration significantly reduces income. By the age of 48, incarceration has been shown to reduce African American male wage earnings by 44% (Western & Pettit, 2010). The lack of government assistance for an ex-offender also amplifies economic instability. In many states, a person “convicted of a state or federal felony offense involving the use or sale of drugs are subject to a lifetime ban on receiving cash assistance and food stamps,” as introduced by the Work Opportunity Reconciliation Act of 1996 (Blankenship et al., 2005). Involvement in illegal activities to earn money may result from this economic instability. Illegal activities may involve drug use or other high-risk behaviors that contribute to the spread of HIV/AIDS among both men and women.

Reduced wages or economic instability may pose a barrier for accessing healthcare. Proper drug treatment services and ARV treatment for HIV may have been easier to access and adhere to within prisons than after release (Fenced In, 2012). For those inmates who were aware of their HIV status and were provided treatment for the virus, treatment may have been easier to not only access but to consistently follow with in a structured environment. In a large scale study of U.S. jail and prison populations, more than 1 in 5 inmates were taking prescription medication when they entered prison or jail. Of these inmates, 26.3% of federal prison inmates and 28.9% state inmates stopped their medication once released (Wilper et al., 2009). Healthcare also may be difficult for inmates to access once released, just based on their crime. Medicaid may be able to assist ex-felons in health care coverage, but this may take time and it is possible that the application may not even go through. Some states with limited Medicaid eligibility for adults may ultimately opt out the Medicaid expansion that provides coverage for ex-offenders (Ollove, 2013). In this case, an ex-offender’s Medicaid application would not be considered. Without

access to ARV treatment, an HIV positive individual will have increased viral load and this increases the likelihood that they will transmit the virus if engaging in high-risk activities.

III. Segregation

Taking into account the likelihood of transmitting HIV/AIDS as a result of the obstacles mentioned above, segregation may further increase the likelihood that HIV is transmitted within African American communities. A study using 2010-2014 national data shows that within the nation's 52 largest metropolitan areas, segregation levels are between 50 and 70 (Frey, 2015). Segregation levels refer to the percentage of blacks that would have to move in order to match the distribution of whites (Frey, 2015). With segregation levels ranging from 0 to 100, levels of 50 to 70 mean that over half of the blacks in these areas would have to move to achieve full integration. In addition, statistics show that the majority of sexual relationships and marriages exist between people of similar age, race, ethnicity and geographical location (Johnson & Raphael, 2009). With this in mind, an HIV positive African American male is more likely to transmit the virus within a predominantly African American community.

Recommendations and Conclusion

The conceptual model in this paper examines the relationship between the disproportionate African American male incarceration rate and the disparity in HIV/AIDS rates of both African American males and females. After recognizing this relationship, recommendations for policy makers include promoting an end to the policies in and out of prisons that contribute to an ongoing cycle, as well as making suggestions for future policies.

A major contributing factor to the racial disparity in men being incarcerated are the many skewed laws and sentencing policies currently in place. Laws that allow for racial bias in both arrests and sentencing should be eliminated. The majority of these laws involve drug-related crimes which in an attempt to fight the "War on Drugs," disproportionately affects African American men in urban areas. In addition, many of the policies involving drugs have minimum sentencing policies. Research shows that prosecutors are twice as likely to pursue a mandatory minimum sentence for people of color than for white people charged with the same offense (The

Drug War, 2016). Resources should be redirected to help individuals involved with drugs through educational programs and/or treatment.

Laws that unjustly affect individuals with HIV/AIDS contribute to the introduction of HIV/AIDS within prisons. For example, many of these existing laws would allow for an HIV positive individual to be criminalized for spitting on someone, even when they could not and did not attempt to infect the other person through this act. These laws feed the existing stigma associated with HIV/AIDS. The intent to infect another person is a crime which is why laws and policies should be adjusted to better reflect this fact.

Within prisons, a lack of preventative healthcare contributes to the prevalence of HIV/AIDS. Adequate prevention methods be considered and provided in more U.S. prisons. Prevention methods include, but are not limited to, educational programs, the distribution of condoms, SEPs and MMTs. Sex and drug-use occur in prisons. Many prison officials and policy makers who rely on policies that prohibit high-risk behavior are under the false impression that these policies prevent these behaviors. In reality, these high-risk behaviors will occur regardless, but prevention methods may reduce the risk of transmission when these actions take place.

Once released, the overwhelming majority of African American men face obstacles with reintegrating into society and accessing medical care for HIV/AIDS treatment. These obstacles contribute to the transmission of HIV/AIDS within the communities to which these men are released. It is recommended that the policies in place which pose these obstacles be re-considered or eliminated. These policies include those that prevent ex-offenders from employment opportunities, and public assistance (including health care). It is understandable that restrictions to future policies may still apply, but policies that completely deny these rights to ex-offenders only contribute to the cycle of this health disparity.

The goal of this paper is not to suggest that the disparity in African American male incarceration rates is the only factor contributing to the racial disparity in HIV/AIDS rates. The incarceration rate does not act alone, but can be seen as the first domino to fall and affect other factors that in turn affect the disparity in HIV/AIDS rates. Using a conceptual approach, this paper outlines

several factors during pre-incarceration, incarceration, and post incarceration that both directly and indirectly affect HIV/AIDS rates. This outline helps highlight the relationship that exists between African American male incarceration rates and the racial disparity in HIV/AIDS rates. With this relationship in mind, recommendations for policy applications were made in hopes of reducing mass incarceration and racial health disparities.

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