

## Mass Incarceration in the United States and HIV/AIDS: Cause and Effect?

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The year 2011 marks the thirtieth year that we have acknowledged the existence of an infectious disease crisis in our midst. On June 5, 1981, an article appeared in the *Morbidity and Mortality Weekly Report* (MMWR)—a publication of the U.S. Centers for Disease Control—that presented the cases of five homosexually active gay men with *Pneumocystis carinii* pneumonia at three different hospitals in Los Angeles. This condition was, at that moment in our history, sufficiently rare that it occasioned both comment and publication. The authors speculated about the possibility that this pneumonia was the result of suppressed immune system function as well as the possibility that a homosexual lifestyle was responsible for exposing five men who did not know each other to the same set of conditions that occasioned a problem with their immune systems.

From that point on, a succession of observations and publications would confirm the existence of an infectious disease epidemic that was generating an increasing prevalence of *Pneumocystis* in injection-drug users, hemophiliacs, Haitians, and homosexually active men. Although public health professionals are careful not to cite 1981 as the actual beginning of the epidemic, June 5, 2011, will be remembered in future years as an important milestone. It will be both a milestone of our recognition that this is when we entered the era of AIDS, and it will, sadly, mark our recognition of our failure to contain the devastation wrought by this retrovirus.

In this paper I want to mark another milestone. This April marks my twenty-fifth year as a researcher working in the field of HIV/AIDS. It is a period that has been marked by important shifts in the course of this pandemic in the United States. It is an era that has seen HIV/AIDS progress from a condition that was largely confined to gay white men in the 1980s to an epidemic whose newest cases every year are increasingly African American and Hispanic. Consider this excerpt from the Kaiser Family Foundation's 2011 fact sheet on HIV/AIDS in African Americans: "Today, there are approximately 1.1 million people living with HIV/AIDS in the U.S., including more than 500,000 who are Black. Analysis of national household survey data found that 2% of Blacks in the U.S. were HIV positive, higher than any other group."<sup>1</sup>

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In 1985, African Americans were 12% of the U.S. population but 25% of all Americans diagnosed with AIDS. In 2009, they represented 45% of all Americans diagnosed with AIDS, and Black Americans were more likely to die from AIDS-related conditions than any other race/ethnic group in this nation. AIDS in 2009 was the third-ranked leading cause of death for Black women and the fourth-ranked leading cause of death for Black men.<sup>2</sup>

In this paper, I want to examine the role of U.S. policies and practices of mass incarceration in the HIV/AIDS epidemic. I hope to demonstrate that such policies and practices were more than just an important factor in this epidemic; I hope to show that our incarceration of so many Black men in the United States was one of the principle causes of the increasing levels of devastation that HIV disease has wreaked in the Black community in the United States. I hope to demonstrate that as the face of AIDS in the United States was becoming increasingly black and brown, our state and federal prisons were themselves becoming increasingly black and brown. The most important factor contributing to these twin epidemics of AIDS and incarceration was a third epidemic: dramatic increases in the sales and use of heroin and cocaine in the United States.

Drug use exposed significant numbers of Americans to HIV. More importantly perhaps, drug-related arrests and imprisonment that were a part of our national War on Drugs put large numbers of drug users—a group at great risk for HIV infection—behind bars. During the late 1980s and 1990s, more than 40% of new HIV infections among blacks and Hispanics were among injection-drug users, and, as I hope to show, putting them behind bars created the perfect engine for generating new infections and for disseminating the virus throughout the communities from which these men and women were taken.

## I. HIV AND DRUGS

In order to understand the connection between mass incarceration in the United States and HIV/AIDS, it is important to understand key features of the HIV epidemic and its etiology. HIV disease begins as a rather innocuous infection that lays dormant in the body for ten to fifteen years before it creates the end stage of HIV disease and the condition that is known as Acquired Immune Deficiency Syndrome (AIDS). During this period, those living with the condition are asymptomatic. They appear to be in good health, and those who are living with the infection are largely unaware that their immune systems are engaged in a deadly struggle with a retrovirus that is slowly but surely undermining the cells of the immune system.

Because these persons are asymptomatic, their illness goes unnoticed and their sex and/or drug-using partners will not be suspicious or wary. As a result, in the days before we knew of HIV's existence, the virus was able to infect new hosts with virtual impunity.

When the five men whose pneumonia occasioned that fateful 1981 MMWR article presented for treatment, they were in the end stages of the disease process;

they were seeking care for a condition that they had acquired as early, perhaps, as 1966. Thus, the true beginnings of our experience with HIV are to be found in events that transpired long before this infection had become AIDS.

So what was going on?

The 1960s saw the development of increased tolerance of “recreational drug use” and the return of many drug-addicted Vietnam-era veterans to the United States. Using illicit substances had become an important part of daily life for many young people during this period, and changes in lifestyle that were occasioned by drug use became an increasingly interesting topic for the media. The era of “make love, not war” and “tune in, turn on, drop out” had begun, and drug use had, for many Americans, become a part of the 1960s scene.

More importantly, perhaps, heroin was already making its way into the Black community with increasing force. Claude Brown’s epic novel, *Manchild in the Promised Land*, is, among others, a stark description of what would later become widespread drug dealing—and increasing levels of drug use in many poor communities of color in the United States. As future events would show, increasing rates of arrest, conviction, and imprisonment of drug users in these communities would follow increasing sales and use of drugs and an increased police presence to deal with the collateral damage associated with drug use.

The beginning of this period of increased criminal justice response to drug use has its origins with the passage of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Along with its passage, President Nixon declared war on what he described as the nation’s “Public Enemy Number One.” Then, with the creation of the Drug Enforcement Administration (DEA) in 1973, the first step toward a federal and local criminal justice approach to America’s drug use problem was initiated, and the mass incarceration of drug users began.

The most comprehensive examination of the impact of these events is, in my mind, Michelle Alexander’s superb work, *The New Jim Crow*. As she notes in her chapter *The Lockdown*, “Approximately a half-million people are in prison or jail for a drug offense today, compared to an estimated 41,100 in 1980—an increase of 1,100 percent. Drug arrests have tripled since 1980. As a result, more than 31 million people have been arrested for drug offenses since the drug war began. Nothing has contributed more to the systematic mass incarceration of people of color in the United States than the War on Drugs.”<sup>3</sup>

As noted by the Sentencing Project, a non-profit agency that studies the impact of incarceration in the United States, by 2003 African Americans were 3.4 times more likely to be arrested for a drug-related offense than whites. “More than 60% of the people in prison are now racial and ethnic minorities. For Black males in their twenties, 1 in every 8 is in prison or jail on any given day. These trends have been intensified by the disproportionate impact of the ‘war on drugs,’ in which three-fourths of all persons in prison for drug offenses are people of color.”<sup>4</sup>

## II. DRUGS, SEX, AND INCARCERATION

The War on Drugs was also a war on those whose drug use exposed them to HIV. How does this happen? First, it is important to understand the mechanics of drug use and HIV transmission.

The sharing of injection drug equipment provides an effective and efficient method for spreading this rather fragile virus from one host to another. Injection heroin and cocaine users who began sharing needles in shooting galleries in major urban centers such as New York as early as 1970 were among the first Americans to be exposed to HIV. With the arrival of crack cocaine, a drug that is smoked rather than injected, widespread practices of engaging in unprotected sex-for-crack exchanges (also known as crack-related sex work) provided a means for the sexual transmission of HIV. There is evidence, for example, that excessive smoking of crack creates lesions in the gums because of the heat generated by a glassine crack pipe. These lesions are sites that provide entry for HIV if crack-related sex work involves oral sex with ejaculation.<sup>5</sup>

But most importantly of all, perhaps, is the fact that an HIV infection was not visible to either those living with the virus or to those who interacted with them. The AIDS cases that appeared in 1990, for example, were among folks who had been infected with HIV as early as 1975. Folks who were being infected and who were infecting others did so without any suspicion that they were caught up in this epidemic. Undetected and silent, a population that was often on the move because they were cycling in and out of jail and prison carried the virus along with them, infecting others as they moved.

As more and more men and women entered prisons from communities that had both high rates of arrest for drug-related convictions and high rates of HIV infection, the nation's state and federal prisons began housing greater numbers of HIV-infected persons than were present in the U.S. general population. At its peak, HIV infection rates were three to five times those found in mainstream America, and in 1997, based on a study conducted by Hammett and colleagues (2002), it is estimated that 22–31% of all persons living with an HIV infection passed through a correctional facility in the United States. Significantly, the authors estimate that up to 43% of all Americans living with hepatitis C and up to 40% of all Americans living with a tuberculosis infection passed through such a facility as well.<sup>6</sup>

I contend that our nation's prisons did more than simply house these individuals; I believe the system of mass incarceration that put them there was materially responsible for driving this epidemic to unprecedented proportions in the communities from which these inmates were taken. The loss of so many men from their communities created social chaos and undermined the social structures of their neighborhoods. Without the usual social controls that limit levels of anti-social behavior, the risk behaviors that expose individuals to HIV became the norm for many community members. In such communities, I would contend, HIV found the perfect ecological niche.<sup>7</sup>

### III. HIV, JAILS AND PRISONS, AND POOR COMMUNITIES OF COLOR

While we are prone to see an HIV infection as a problem for the infected individual, particularly an African American individual, it is also clear that the HIV pandemic in the United States has a distinct geographical character as well. HIV in Black America does not strike those affected and infected at random; rather, it is highly concentrated in the poorest Black and Hispanic neighborhoods. As a result, a Black man living in Topeka, Kansas, is much less likely to be exposed to HIV than a white man living in New York City, an urban center with more than 100,000 of its residents living with the virus:

New York City remains the epicenter of HIV/AIDS in the U.S. More than 107,000 New Yorkers are living with HIV, but thousands more don't know they're infected. New York City's AIDS case rate is almost 3 times the U.S. average, and HIV is the 3rd leading cause of death for New York City residents aged 35 to 54.<sup>8</sup>

In the 1990s, seven neighborhoods in New York City accounted for more than two-thirds of the inmates serving time in a New York State correctional facility. These neighborhoods were also the neighborhoods that had some of the highest HIV infection prevalence rates in the nation. As a consequence, the city at the epicenter of the U.S. epidemic was responsible for housing more than a third of all the prisoners in the United States living with HIV/AIDS. Because so many of these inmates were in prison for drug-related offenses, it comes as no surprise that many of them were HIV infected.<sup>9</sup>

For years, there was speculation that HIV was being spread by men having sex with other men in prison. While high rates of unprotected sexual behavior have been reported among prison inmates, I would contend that the greatest engine driving the epidemic was the cycling of inmates in and out of prison and in and out of their communities of origin. The chaos created in families, in particular, and in communities, in general, when significant portions of their young men were caught up in the criminal justice system did as much to drive HIV/AIDS into these settings than any other single factor.

### IV. COMMUNITIES IN CHAOS

One of the most comprehensive reviews of the literature on incarceration and its impact on families and communities, *Incarceration and the Family: A Review of Research and Promising Approaches for Serving Fathers and Families*, was published by the U.S. Department of Health and Human Services in 2008. Much of my thinking and my speculation about the collateral damage done to communities that I present below was informed by this excellent publication.<sup>10</sup>

In communities where the majority of men in the nineteen to twenty-nine age group are in jail or prison, on parole, or under the supervision of the courts,

dramatic changes will occur in the rituals of courtship, in the nature and duration of sexual relationships, in the intimate lives of husbands and wives, and, most certainly, in the lives of the communities' children. More and more "concurrent sexual partnerships" will be created.<sup>11</sup> As one young man put it,

[Y]ou go away to the joint, you leave your lady behind. You might take up with a dude while you away and she might take up with someone too. You come back and ya'll get back together, and if you do another bid [another prison term], it'll happen all over again, but this time, there might be new people in your mix.<sup>12</sup>

Adimora and colleagues (2003) and Morris (1997) have identified this pattern of concurrent partnerships as a major contributor to HIV infection rates.<sup>13</sup> If someone in this "mix" is infected, the network of sexual relationships will provide the perfect engine to spread the virus to other members, particularly if safe sex and safe drug-using practices are absent.

In communities where significant numbers of men are absent because they are doing time away from home, condom use may suffer. Women who are interested in keeping a man might be more than willing to engage in risky sex—viz. sex without a condom—if that is what it takes to keep him around.

Similarly, the absence of so many men will have a strong impact on the adolescent boys who are left behind. When "doing time" is the community norm, many of these youngsters may begin to think that being arrested and doing time is normal, that it is a rite of passage to which they must submit. Having large numbers of community men in prison does not, I would contend, serve as a deterrent; instead it becomes an expectation, a norm, that limits the aspirations of young men who are struggling in school and who believe that "going to the joint" is inevitable.

Finally, there is evidence that children of incarcerated parents are at risk for being incarcerated themselves. Imagine what happens in a community where more than half the adults have done time. I submit that a variety of risk behaviors from experimenting with drugs to engaging in precocious, unprotected sex will be commonplace, and these are precisely the behaviors that will propel the HIV pandemic to significant levels of devastation in the community. In short families, the mainstay of community life and function are heavily impacted.

Our review yields consistent themes that incarceration harms opportunities for marriage, increases the likelihood for marital/partner dissolution, and lessens the chances for father involvement. Women separated from their partners experience a host of daunting tasks, which may include single parenting; subsisting on a diminished income; facing social stigma, loneliness, and isolation; and dealing with the emotional turmoil of having a loved one incarcerated. Children may face similarly challenging ordeals, including feelings of abandonment, economic

deprivation, changes in caregivers and residence, and increases in emotional problems.<sup>14</sup>

Consider, as well, the fact that access to medical care is difficult in communities where there are large numbers of poor, uninsured individuals. Our national prevention strategy for HIV infection has centered, since the arrival of antiretroviral medications, on sexually active individuals getting tested for an HIV infection. But screening is often problematic for people who cannot pay for medical care, so though Black Americans are tested for HIV antibodies more frequently than whites in the United States, Black Americans often enter HIV care late in the infectious process, when an AIDS-defining condition is present and when they are admitted to care via the emergency department.<sup>15</sup>

As a result, African Americans die from HIV-related illness at far greater rates than any other ethnic group, and their medical care is highly problematic, particularly in communities where access to medical care is difficult.<sup>16</sup> These are often precisely the communities that have high rates of incarceration. There, significant numbers of adults are away, and the “social glue” that holds communities together will be missing. In these communities, the roles that family, friendship, and social networks play in urging people who are at risk for illness to seek medical care will be minimal because these networks are fractured, broken, and not able to do for its members what needs to be done to assure optimal levels of care for one’s health.

HIV prevention in the United States since the development of effective antiretroviral treatments has depended on people at risk getting tested for HIV, learning their status, and pursuing treatment if they are HIV positive. In these communities, I would contend, lack of access to medical care, lack of health insurance, and lack of the kind of community support that encourages community members to get screening will have significant problems. Specifically, there will be low levels of HIV testing, many people who should enter treatment for HIV disease will not do so, and the rates of AIDS-related mortality will be higher than those in mainstream communities.

Simply put, in poor communities of color with high rates of incarceration, the social chaos created by having so many men cycling in and out of prison has been the single most important determinant of their disproportionately high HIV infection rates, of disproportionately high AIDS rates, and of the disproportionately high mortality rates.

## V. CONCLUSIONS

I have tried here to connect mass incarceration policies and practices in the United States to this nation’s HIV/AIDS epidemic. Our failure to attend to the consequences of imprisoning so many poor men of color will, I have suggested, have negative consequences for the health of the communities from which they are taken. Can this dynamic be altered?

I believe that it can. I am impressed by the Pew Center on the States report “One in 31”, which details many of the social costs associated with having one in thirty-one Americans involved in the criminal justice system. The report recommends that the nation’s policies and practices for parole be revamped and improved, arguing that successful rehabilitation—as opposed to re-incarceration—will end high rates of recidivism and will provide returning prisoners with real opportunities to be reintegrated back into their communities.<sup>17</sup>

I would suggest that such a system would also have extremely important health benefits for those who are re-entering as well as for the communities to which they will be returning. If we attended to their health care needs by assuring that they are provided with screening and entry into treatment, the horrific consequences of HIV and a host of other chronic disease conditions will be positively and significantly affected.

I cannot imagine how we can, as a nation, afford to do otherwise.

<sup>1</sup> *Fact Sheet: Black Americans and HIV/AIDS*, THE HENRY J. KAISER FAMILY FOUNDATION (2011), <http://www.kff.org/hiv/aids/upload/6089-09.pdf>.

<sup>2</sup> *Id.*

<sup>3</sup> MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* 59 (2010).

<sup>4</sup> *Racial Disparity, THE SENTENCING PROJECT*, <http://www.sentencingproject.org/template/page.cfm?id=122> (last visited Oct. 8, 2011).

<sup>5</sup> Sairus Faruque, Brian R. Edlin, Clyde B. McCoy, Carl O. Word, Sandra A. Larsen, D. Scott Schmid, Jennifer C. Von Bargen & Yolanda Serrano, *Crack Cocaine Smoking and Oral Sores in Three Inner-City Neighborhoods*, 13 J. ACQUIR. IMMUNE DEFIC. SYNDR. & HUMAN RETROVIROLOGY 87, 87–92 (1996).

<sup>6</sup> Theodore M. Hammett, Mary Patricia Harmon & William Rhodes, *The Burden of Infectious Disease Among Inmates of and Releases from US Correctional Facilities*, 1997, 92 AM. J. PUB. HEALTH 1789, 1789–94 (2002).

<sup>7</sup> ROBERT E. FULLILOVE, NATIONAL MINORITY AIDS COUNCIL, *AFRICAN AMERICANS, HEALTH DISPARITIES AND HIV/AIDS: RECOMMENDATIONS FOR CONFRONTING THE EPIDEMIC IN BLACK AMERICAN* (2006).

<sup>8</sup> *Stop HIV in NYC*, N. Y. CITY DEP’T HEALTH & MENTAL HYGIENE, <http://www.nyc.gov/html/doh/html/ah/ah.shtml> (last visited Oct. 8, 2011).

<sup>9</sup> PETER M. BRIEN & ALLEN J. BECK, U.S. DEP’T JUSTICE, BUREAU OF JUSTICE STATISTICS, *BULLETIN: HIV IN PRISONS, 1994* (1996), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/Hivip94.pdf>.

<sup>10</sup> MINDY HERMAN-STAHN, MARNI L. KAN & TASSELI MCKAY, U.S. DEP’T HEALTH & HUMAN SERVS., *INCARCERATION AND THE FAMILY: A REVIEW OF RESEARCH AND PROMISING APPROACHES FOR SERVING FATHERS AND FAMILIES* (2008), available at <http://aspe.hhs.gov/hsp/08/MFS-IP/Incarceration&Family/report.pdf>.

<sup>11</sup> Martina Morris & Mirjam Kretzschmar, *Concurrent Partnerships and the Spread of HIV*, 11 AIDS 641, 641–48 (1997).

<sup>12</sup> Robert E. Fullilove, unpublished study (2010).

<sup>13</sup> Adaora A. Adimora, Victor J. Shoenbach, Francis E. A. Martinson, Kathryn H. Donaldson, Tonya R. Stancil & Robert E. Fullilove, *Concurrent Partnerships Among Rural African Americans*



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with *Recently Reported Heterosexually Transmitted HIV Infection*, 34 J. Acquir. Immune Defic. Syndr. 423 (2003).

<sup>14</sup> HERMAN-STAHLE ET AL., *supra* note 10.

<sup>15</sup> THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 1.

<sup>16</sup> *Id.*

<sup>17</sup> ONE IN 31: THE LONG REACH OF AMERICAN CORRECTIONS, THE PEW CENTER ON THE STATES, (2009), [http://www.pewcenteronthestates.org/uploadedFiles/PSPP\\_1in31\\_report\\_FINAL\\_WEB\\_3-26-09.pdf](http://www.pewcenteronthestates.org/uploadedFiles/PSPP_1in31_report_FINAL_WEB_3-26-09.pdf).

