African Americans, HIV, and mass incarceration

The disproportionate rates of HIV infection among African Americans are perplexing. In 2014, about 44% of new HIV infections and 48% of AIDS diagnoses in the USA were among African Americans, although they represent just 12% of the overall population.1 The US Centers for Disease Control and Prevention (CDC) reports, in 2016, that the HIV incidence rate for black men is more than six times that of white men, and more than twice that of Hispanic men.2 The HIV incidence rate for black women is 20 times that of white women, and nearly five times that of Hispanic women.2 Furthermore, African Americans represent close to half of all patients with AIDS in the USA who have died during this epidemic.3

HIV/AIDS prevention and treatment services in the USA have largely focused on individuals with a history of high-risk behaviours, such as injection drug use or unprotected sex. Although white young adults who engage in such high-risk behaviours are at increased risk for HIV, young black adults without these usual risk factors are nevertheless at higher than average risk for HIV. One 2010 study showed that condom use was, in fact, higher for black and Hispanic individuals than for other racial groups.4 To explain the higher rates of HIV/AIDS among African Americans, we need to examine structural factors, such as access to health care or disease prevalence within communities.

African Americans differ from other groups mainly with regard to socioeconomic vulnerability—that is, their probability of living in poverty, being homeless, or spending time in a detention facility. A 2016 study showed that, by 2011, the incarceration rate for black men was six times that of white men and more than twice that of Hispanic men.5 The incarceration rate for black women was 2.5 times higher than the rate for white women and roughly twice the rate of Hispanic women.6 Rates of incarceration and of HIV/AIDS have skyrocketed for African Americans during the past three to four decades. These two issues are linked for several reasons.

First, people at increased risk for HIV, such as injection drug users and sex workers, often end up in prison due to zero-tolerance policies in the USA for these activities.5,7 As a result, HIV prevalence is 3-5 times higher in prisons and jails than in the general population.8 Second, harm-reduction programmes—eg, provision of condoms and clean needles to high-risk populations—are almost non-existent in US correctional facilities.8 Yet, many prisoners engage in consensual sex, drug use, and tattooing while in detention. Third, many prisons have high rates of violence, including sexual assault.9 Fourth, incarceration can limit or interrupt a person’s access to health care. Effective HIV services that allow for preventing, testing, and treating infection are often absent.10 Individuals whose infections are detected and treated while detained are likely to find their treatment is interrupted upon release, or if they are re-detained.10 Most of these people quickly rebound with a high HIV viral load during treatment interruptions, rendering them infectious for sexual partners.9 With some 14% of all Americans living with HIV cycling through the criminal justice system each year, these common treatment interruptions may play the most important role in the markedly increased likelihood for African Americans to encounter a sexual partner with HIV and who is not virally suppressed.11

Since women represent less than 10% of the prison population in the USA, the disproportionately high incarceration rates for African American women do not explain the sharp increase in HIV/AIDS rates among this group. Instead, one influential study concluded that the disparity in HIV/AIDS rates between black and white populations is best explained by the hyperincarceration of black men.12 The spike in HIV/AIDS rates among black women seems to be due primarily to their increased risk of having an infected partner. The CDC estimates that 87%
Comment

of African American women with HIV become infected through heterosexual sex, and only a small percentage through injection drug use or other pathways. Incarceration rates have quadrupled in the USA in the past several decades, and this has reduced the number of men in black communities, and therefore the number of available partners for heterosexual black women. This fact, together with ongoing racial segregation, contributes to the formation of insular sexual networks with overlapping, concurrent partners. Moreover, heterosexual African American women are more likely to have sexual partners in high-risk groups, notably men with a history of incarceration and, therefore, men who have sex with men—a category that refers to a person’s behaviour not someone’s sexual orientation. Men who have sex with men include sexually active men in single-sex settings, such as prisons, who do not identify as gay or bisexual. Heterosexual African American women have about twice the rate of HIV infection compared with heterosexual African American men (men who report no sexual activity with other men), and this difference could be because of women’s greater biological vulnerability and also because the partners of heterosexual black men come from groups with lower HIV risk. Importantly, the so-called down low theory, which is often invoked to explain the high rates of HIV/AIDS among African American women, puts the spotlight on the wrong contributing factors. This theory posits high numbers of secretive bisexuals in African American communities and erroneously focuses on a person’s sexual orientation rather than his history of incarceration. It is a pernicious theory because it can lead to inappropriate interventions and stigmatise a sexual minority for the spread of HIV/AIDS.

To reduce HIV/AIDS rates among African Americans we need to focus on structural factors, such as reducing incarceration rates and improving access to health care. For instance, all prisons and jails should initiate regular opt-out HIV testing and increase prison counselling and education programmes. Such practices generally improve participation in testing, adherence to treatment, and reduce risky behaviours. Also, correctional facilities should develop harm-reduction strategies such as needle-exchange and condom distribution programmes. Perhaps most importantly, better linkages between community and correctional health-care systems are essential to reduce treatment interruptions in HIV treatment upon detention, and after release, including assistance with enrolling in health insurance programmes. Finally, we need to evaluate the public health effects of adopting zero-tolerance policies to deter recreational drug use, adult sex work, and other non-violent offences, since these policies may do more harm than good.

Laurie Shrage
Philosophy Department, Florida International University, Miami, FL 33199, USA
lshrage@fiu.edu
I declare no competing interests. I thank Chris Bayer for helpful suggestions on this Comment, and the Edmond J Safra Center for Ethics at Harvard for supporting my work on this topic.


17 Solomon L, Montagut BT, Beckwith CG, et al. Survey finds that many prisons and jails have room to improve HIV testing and coordination of postrelease treatment. Health Aff (Millwood) 2014; 33: 434–42.