HIV in Carceral Settings

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Module 6: Key Populations
Lesson 5: HIV in Carceral Settings

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Background

The United States carceral system, one of the largest in the world, consists of local and tribal jails, state prisons, federal prisons, military and immigration facilities, and community supervision, which includes probation and parole.[1]

- **Jails**: Typically, jails house persons charged with a crime who are awaiting court proceedings or transfer, as well as persons convicted of crimes with 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 usually 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 carceral system while on parole.

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

Epidemiology of HIV in Carceral Settings

Prevalence of HIV in Prisons

In 2023, there were 12,460 persons with HIV in state or federal prisons in the United States.[3] During the years 1991-2023, 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 2).[3] Since the state prison population is much larger than the federal prison population, it is not surprising that in 2023 the number of persons with HIV in state prisons (11,200) far outnumbered the number in federal prisons (1,262).[3] Epidemiologic surveys indicate the prevalence of HIV in 2023 was approximately 1.1% among persons in prison facilities, markedly higher than the 0.3 to 0.4% HIV prevalence in the general United States population.[3,4] In 2023, the prevalence of HIV in state facilities varied significantly by geographic region, with Florida and Louisiana having the highest prevalence (2.0% or greater).[3] Less is known about the HIV prevalence in United States jails.

Injection Drug Use and HIV in Prisons

The higher prevalence of HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV) within carceral facilities can be partially explained by the high percentage of persons with drug-related crimes. Injection drug use may directly result in HIV transmission and it is also associated with sexual activity that can increase the risk of HIV acquisition.[5] The number of persons who have ever injected drugs is not routinely assessed in prison populations, but a recent systematic review and meta-analysis estimated that 13.1% (10.0-16.4) of incarcerated individuals in the United States had a lifetime history of injection drug use.[6] Furthermore, data from a 2016 survey conducted by the US Bureau of Justice Statistics, estimated that 34.4% of people in a carceral facility had at least one substance use disorder.[7] Despite the high prevalence of substance use disorders among incarcerated individuals, many carceral facilities do not routinely offer medications for opiate use disorder (MOUD), and some individuals continue to use illicit drugs while incarcerated.[8,9,10]

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 that the prison population is predominantly male. In contrast, when analyzing the HIV prevalence rate in prisons, it is similar among males and females. For example, in 2023, among incarcerated persons with HIV, 94% were male, but the prevalence rate of incarcerated women with HIV (1.0%) was similar to that of all incarcerated men with HIV (1.2%).[3]

Intra-Prison HIV Transmission

Although consensual sex, rape, tattooing, and injection drug use occur within the carceral 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.[5,11,12,13] A large meta-analysis estimated the incidence rate of HIV transmission within prisons to be only 0.08 per 100 person-years for HIV.[5] In a study conducted among incarcerated male individuals in the 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.[12]

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

Many have called for a comprehensive strategy to stop HIV transmission in the carceral 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 throughout incarceration.[14] Other strategies include access to condoms, regulated tattoo parlors in prison, and facility-based needle exchange programs. These infection control strategies would also provide an opportunity to

address the prevention of hepatitis B virus (HBV) and hepatitis C virus (HCV) within the carceral system.[15] In addition, the transmission of HBV within carceral facilities could be reduced by administering the hepatitis B vaccine series to all persons who lack immunity to hepatitis B.[5,15,16] The CDC recommends hepatitis B vaccination for all persons who are incarcerated and do not have immunity to or active infection with HBV.[16]

HIV Screening in the Carceral Setting

HIV Screening Practices in Carceral Facilities

In the United States in 2015, it was estimated that approximately 22% of persons with HIV were unaware of their HIV status upon entry into jail or prison.[17] Although the Centers for Disease Control and Prevention (CDC) recommended in 2006 that carceral facilities perform routine opt-out HIV testing, the HIV screening practices and policies in carceral settings continue to vary by state and by facility.[3,18] Data on state prison HIV intake screening practices for 2023 showed only 29 states provided opt-out HIV screening (offered the HIV test and the test was performed unless declined) whereas 13 states performed mandatory HIV screening (screened everyone regardless of consent) and some still did not offer routine screening for HIV; these practices have changed some from earlier years (Figure 3).[3,19] Most jails do not routinely perform HIV screening. Jails, prisons, and community supervision are important settings in which to screen individuals for HIV, especially given that many persons involved with the carceral system often don't access routine community-based care.[20,21,22]

Studies of HIV Screening in Carceral Facilities

Studies have shown that HIV screening within the structured carceral environment is effective and feasible; the cost-effectiveness of screening incarcerated populations varies with the prevalence of undiagnosed HIV among individuals in any given geographic area, but, overall, is on par with the cost of screening in the non-carceral settings.[20,23,24,25,26] One HIV screening project, which included more than 33,000 persons who were incarcerated in four states (Florida, New York, Wisconsin, and Louisiana), identified 269 (0.8%) of individuals with previously undiagnosed HIV, 40% of whom reported heterosexual contact as their only risk for acquiring HIV, highlighting the shortcoming of risk-based screening.[26] Similarly, in a CDC study that evaluated an HIV testing project in correctional facilities from 2009 to 2013, investigators found that 0.3-0.4% of persons screened in a broad range of carceral facilities were newly diagnosed with HIV (Figure 4).[27] The CDC has released a comprehensive document to guide the implementation of opt-out HIV screening in the carceral setting.[28]

HIV Medical Care in Carceral Settings

Access to Medical Care

The landmark Supreme Court *Estelle v. Gamble* decision in 1976 provides the constitutional mandate for access to medically necessary HIV care and treatment within the carceral setting.[29,30]

Linkage to and Receipt of HIV Medical Care

Receiving a new HIV diagnosis while in jail or prison can be difficult; thus, appropriate counseling and linkage to care during incarceration are essential components of any carceral screening program, just as in non-carceral settings.[31] The 2009 CDC document on HIV Testing Implementation Guidance for Correctional Settings provides guidance on the management of persons newly diagnosed with HIV in a carceral facility, including recommendations that address immediate clinical management issues and linkage to appropriate medical care during incarceration.[28] 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.[28] Linkage to appropriate medical care during incarceration can be challenging since HIV specialists may not be available to provide on-site medical services at the carceral facility. Persons newly diagnosed with HIV within some carceral facilities may require outside expert medical consultation, especially if significantly immunosuppressed or otherwise complex.[27] Prevalence studies of incarcerated populations in the United States have found higher rates of co-morbid conditions, including viral hepatitis, mental health and substance use disorders, as well as 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.[32,33]

Use of Telemedicine for HIV Care in Carceral Settings

Persons with HIV who are in carceral settings often present complex management challenges to prison medical staff who lack HIV expertise. Non-HIV-related chronic medical conditions, such as viral hepatitis, mental health and substance use disorders, may also complicate care. Access to experts in HIV medicine is strongly correlated with better medical outcomes, solutions to the knowledge gap have been to introduce HIV subspecialty care to the prison setting through telemedicine or case-based telementoring (i.e., HIV Project ECHO).[34,35]

Antiretroviral Therapy in the Carceral Setting

Initiation and Continuation of Antiretroviral Therapy

Considering the higher prevalence of HIV in carceral 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.[8,36] Several studies evaluating the impact of directly observed antiretroviral therapy in prisons have found that it does not necessarily lead to better adherence than self-administration. Directly observed antiretroviral therapy is less convenient, decreases patient control, and may inadvertently jeopardize confidentiality.[8,37,38] In addition, directly observed antiretroviral therapy in the carceral 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. Self-administration using the “keep on person” approach is a process whereby the individual is responsible for taking their own medication and for obtaining medication refills; this approach is preferred by most individuals in carceral settings.[39]

Barriers to Antiretroviral Therapy Success in Correctional Settings

Many of the barriers to successful antiretroviral therapy within jails and prisons are similar to those outside the carceral system. These include untreated mental health conditions, medication side effects, lack of trust in the medical provider, skepticism regarding the benefits of taking antiretroviral medications, and social isolation.[40,41] In the carceral, setting, there are unique barriers to antiretroviral adherence, such as frequent transfers between facilities or assignments within the facility that can interfere with continuity of receiving medications.[41] Some additional carceral-specific barriers include unauthorized medication confiscation, medication theft, medication stock-outs, and the inability to access medications during lockdowns.[31] 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.[31,41,42]

Access to Antiretroviral Therapy in Carceral Settings

Under the constitutional mandate for access to medically necessary HIV care, antiretroviral therapy must be available to all incarcerated individuals with HIV.[29,30] Nevertheless, the ability of carceral facilities to successfully provide antiretroviral treatment for persons with HIV is variable.[22] In addition, unique financial barriers may prevent the timely initiation or continuation of antiretroviral therapy in carceral settings, particularly jails and detention centers.[7,43] Antiretroviral medications are expensive, and insurance typically does not cover the cost of these medications in the carceral 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.[44] 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, lack of communication with regular care providers, and the requirement that facilities are required to purchase a 30-day supply of the antiretroviral medication, irrespective of the individual’s duration of stay in the jail.[45] 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 Outcomes in the Carceral Setting

The HIV care cascade model has been applied to the carceral system 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 5).[17] Fewer than 30% of persons with HIV in the United States who enter the carceral system do so with an undetectable HIV RNA level.[8,17] For some persons with HIV, the carceral setting may be their first engagement with HIV care, and during incarceration, substantial gains may be made in the percentage of individuals taking antiretroviral therapy and achieving virologic suppression. In a retrospective review of 882 persons with HIV in the Connecticut Department of Corrections, virologic suppression (less than 400 copies/mL) improved from 29.8% at entry to 70.0% by release.[8] 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.[8] Unfortunately, large declines in the HIV care cascade are observed after release from incarceration.[17,46,47]

AIDS-Related Deaths Among Persons in State and Federal Prisons

As antiretroviral therapies have improved over time, the number of AIDS-related deaths in the carceral setting has plummeted since the mid-1990s, similar to the trend in the general population.[48] Since 2010, fewer than 75 AIDS-related deaths per year have occurred among persons with HIV incarcerated in state prisons (Figure 6).[3,48] In addition, since 2010, fewer than 10 AIDS-related deaths per year have occurred among persons with HIV incarcerated in federal prisons.[48]

Maintaining Confidentiality in the Carceral Setting

Privacy and Confidentiality in Carceral Settings

Medical records of incarcerated individuals are usually considered protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). There are, however, some exemptions and modifications to HIPPA in the carceral setting. For example, disclosure of health information may be allowed for the following situations: for provision of medical care; when concerns for the safety of the individual, other inmates, or employees exists; and when medical information is relevant when transferring an inmate. Maintaining confidentiality in jails and prisons can be challenging. Within a carceral 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.[49] In this setting, however, the use of universal precautions should negate the need for carceral 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 a patient and phlebotomy should be conducted out of earshot of non-medical staff, and the disclosure of protected health information should be extremely limited, since few situations 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 carceral system often perceive that accessing HIV care may increase their risk of being identified as having HIV and thus subjected to violence, maintaining adequate privacy measures within the correctional system is of paramount importance.[31] The practice of cohorting persons with HIV in one or two facilities that have the easiest access to specialists, can also compromise confidentiality as well as inadvertently limit access to specialized programs, jobs, and visitation. In a small exploratory study of 42 individuals with HIV who were recently released from carceral facilities in Illinois, only about half said they reported their HIV status at jail or prison entry, and some study participants only disclosed their HIV status when their health deteriorated.[31] Fear of interpersonal violence and lack of safety and privacy were cited as key reasons for HIV nondisclosure.

Transition from the Carceral Setting to the Community

Importance of Release Planning

The transition from a carceral facility to the community is a critical event for incarcerated persons with HIV. The CDC gives recommendations for the linkage of a person with HIV to appropriate medical care upon release from custody.[28] As part of this process, the facility should provide the incarcerated person with the date, time, and location of their first post-release appointment in writing.[28] Adequate discharge planning and linkage to community medical care upon release often fall short of practices recommended by the CDC.[17,50] Recent data from the Medical Monitoring Project suggest that post-release 66% of people with HIV were retained in care, but rates of sustained virologic suppressions are low (at about 30%).[47] Release from prison has been associated with increases in HIV RNA levels and decreases in CD4 cell counts, reflecting some of the challenges in engaging in medical care and adhering to antiretroviral therapy while trying to reintegrate into society.[41,51] Programs that enhance linkage and entry into HIV care are crucial.[17,52] Multiple potential interventions can improve linkage to care, including HIV education during incarceration, careful discharge planning, peer navigation, securing stable housing, availability of transportation, employment opportunities, and care for substance use and mental health disorders.[17,53,54] Individuals taking antiretroviral therapy at the time of release from a jail or prison should receive an adequate supply of antiretroviral medication to bridge them to their appointment with a community provider. Community clinics and carceral systems need to work together 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 sexual activity that increases their risk of transmitting HIV to others, particularly with their pre-incarceration sex partners.[55,56] 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.[57,58] This highlights the importance of a good release plan to increase the likelihood of ongoing medical engagement and continuity of HIV treatment. Therefore, in this setting, it is important to utilize a range of HIV prevention strategies that include keeping released individuals engaged in medical care, supporting adherence with antiretroviral therapy, achieving consistent suppression of HIV RNA levels, identifying and treating sexually transmitted infections, and facilitating the use of HIV PrEP for community serodifferent partners.[55,59] Although some people leaving prison who test negative for HIV may also benefit from HIV preexposure prophylaxis (PrEP) to prevent HIV acquisition after release, few jails and prisons offer HIV PrEP prior to or upon release. Preliminary studies have found that among individuals leaving a carceral facility, knowledge of HIV PrEP and perception of HIV risk is low, but willingness to use HIV PrEP is high.[60,61] Some investigators have also demonstrated that incarceration disrupts primary intimate relationships, suggesting that prison-based programs to help couples maintain their relationships during incarceration may reduce the number of sexual contacts after release.[62]

Community Supervision

Community supervision refers to adults on probation or parole.[63] At the end of 2023, among the total carceral population of 5,530,300 in the United States, approximately 3.8 million were under community supervision (Figure 7).[64] The demographics of the people who remain under community supervision closely mirror those in jails and prisons, with disproportionate representation of poor, disadvantaged, and racial and ethnic minority populations.[63] Inadequate data exist on HIV prevalence among those under community supervision, and HIV screening rates are low in this setting.[65] Nevertheless, the population in the community carceral setting represents an important target for HIV screening and prevention services. Community corrections or parole officers can often play a key role in keeping persons with HIV engaged in care, as well as providing community resources (e.g., housing, job readiness, employment, transportation, and education). These officers are an underutilized resource, perhaps because of public misunderstanding of their role, but they can help provide guidance, support, and program opportunities to persons under community supervision, in addition to keeping them accountable for their conditions imposed by the court as they enter back into the community.

Summary Points

- In the United States, the prevalence of HIV among individuals in prison is 1.1% which is significantly higher than the general population.
- Although there are many more males in prison, the prevalence rate of HIV is similar among females and males in the prison setting.
- Despite recommendations for opt-out screening in all carceral facilities, HIV screening practices during prison intake vary, but most states utilize mandatory or opt-out screening strategies.
- Incarceration offers a structured environment to initiate and continue antiretroviral therapy leading to high rates of medication continuity regardless of how it is dispensed.
- Barriers to successful antiretroviral therapy within the carceral setting include high rates of substance use and mental health disorders, lack of continuity of medical care, distrust of prison-based providers, system medication policies, custody operations, and concerns about confidentiality and safety.
- Confidentiality is difficult but particularly important in the carceral setting.
- The transition from a carceral 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 a carceral setting, secondary prevention is a critical component of transitional care planning. The community population under carceral supervision an important priority for HIV screening and prevention services.

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Figures

Figure 1 Persons Incarcerated in Prisons or Jails Over Time

Illustration: David H. Spach, MD

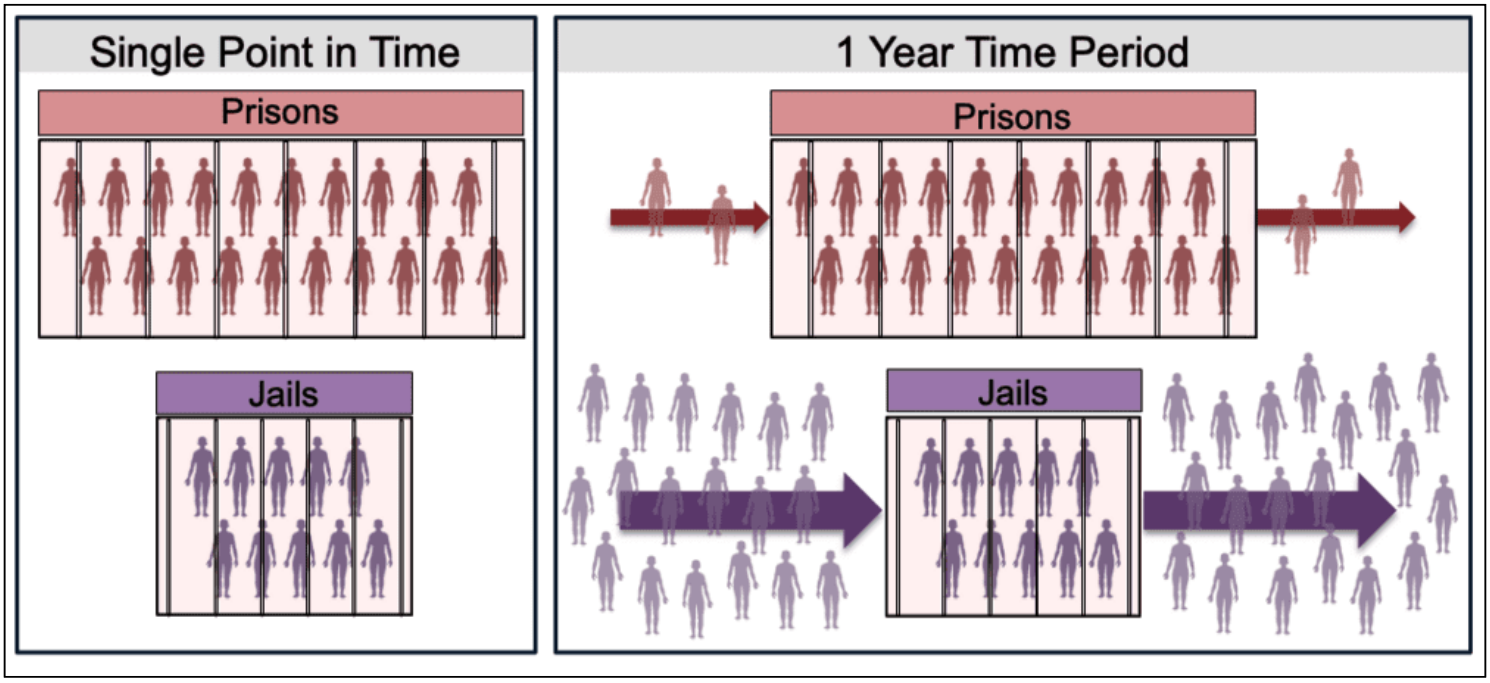


Figure 2 Persons with HIV (and HIV Rate) per 100,000 in State and Federal Prisons Combined, 1991–2023

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

Source: Maruschak LM. HIV in Prisons, 2023—Statistical Tables Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice. June 2025.

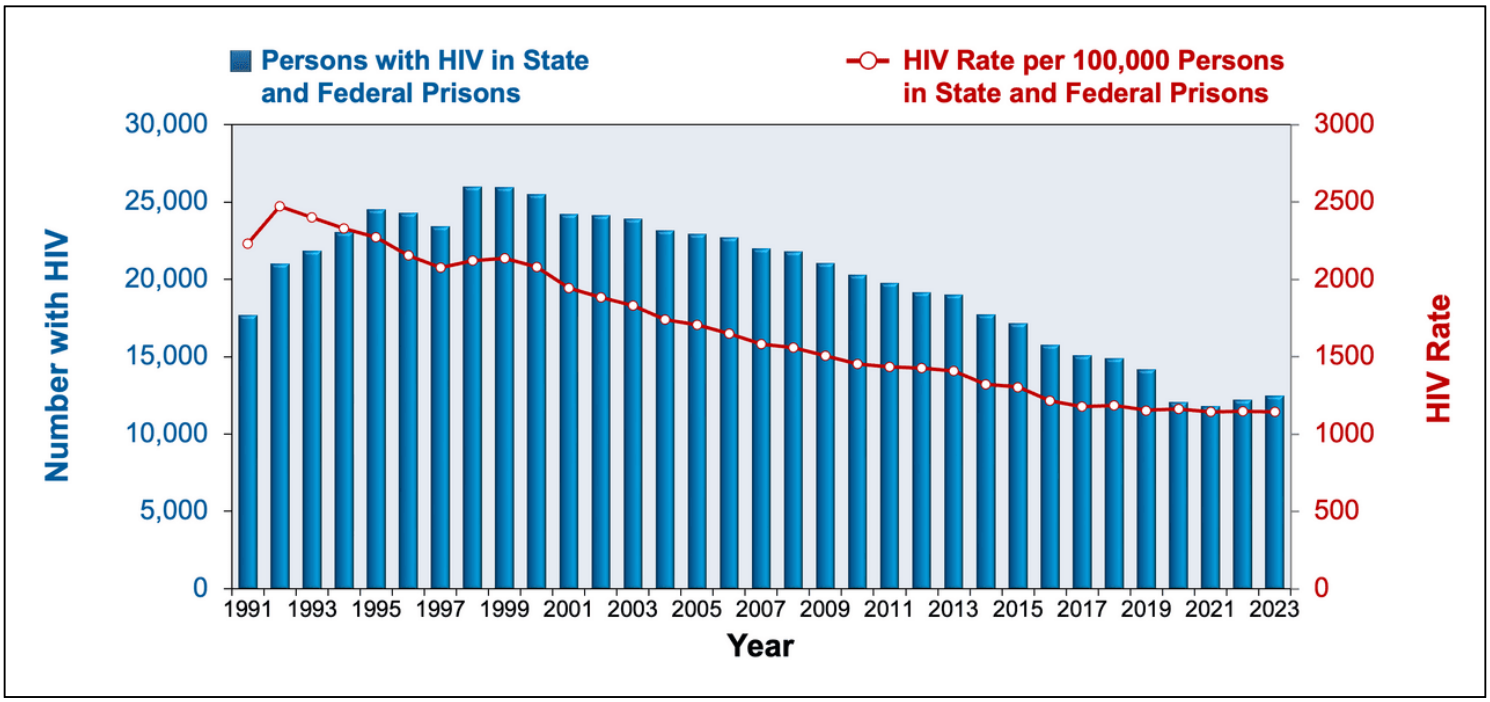


Figure 3 HIV Testing Practices During the Prison Intake Process, by State, 2023

Source: Maruschak LM. HIV in Prisons, 2023—Statistical Tables Bureau of Justice Statistics: Office of Justice Programs, U.S. Department of Justice. June 2025.Statistics: Office of Justice Programs, U.S. Department of Justice. March 2023.

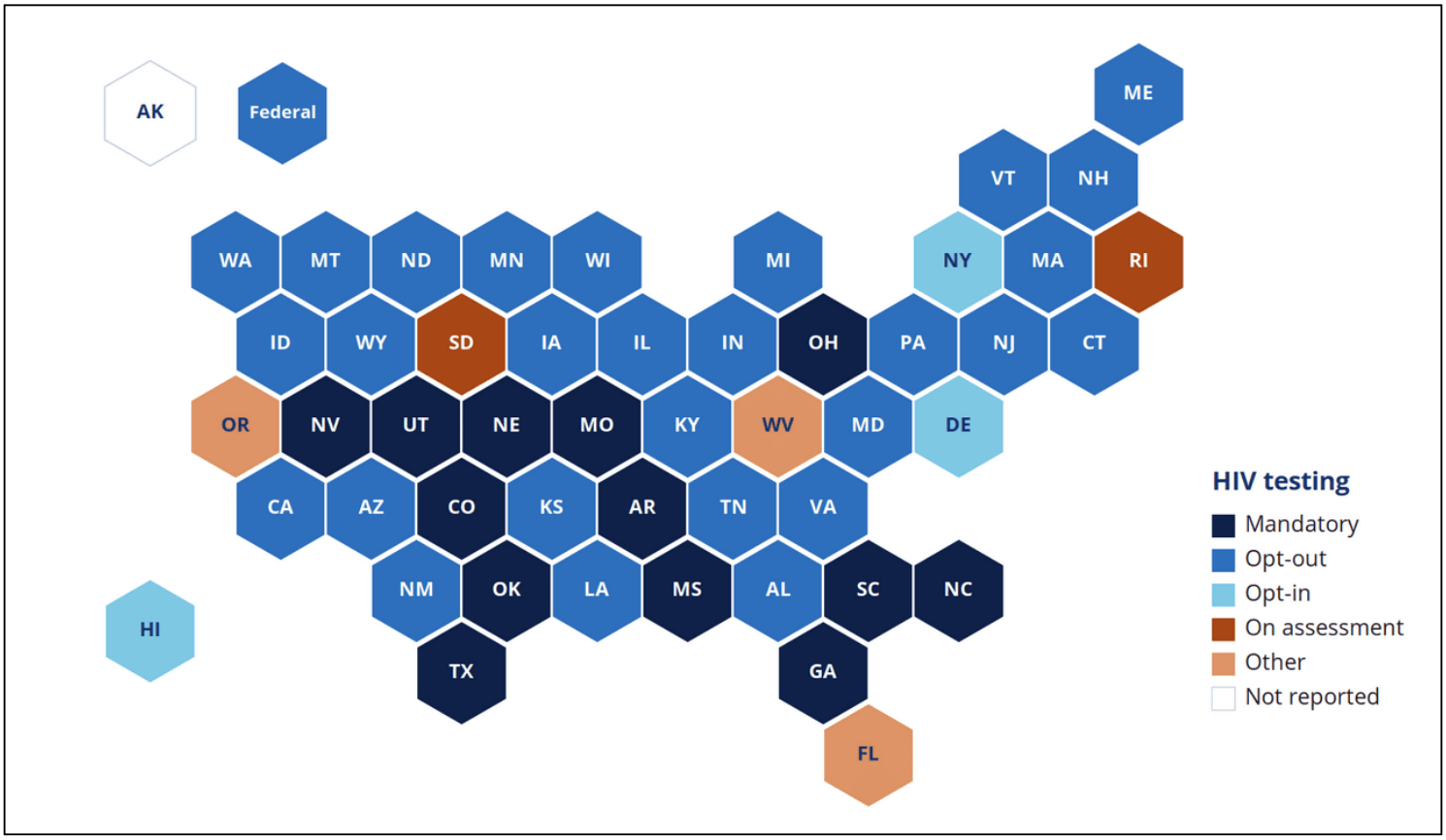


Figure 4 CDC-Funded HIV Testing in Correctional Facilities and Percentage HIV Positive, United States, 2009-2013

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.

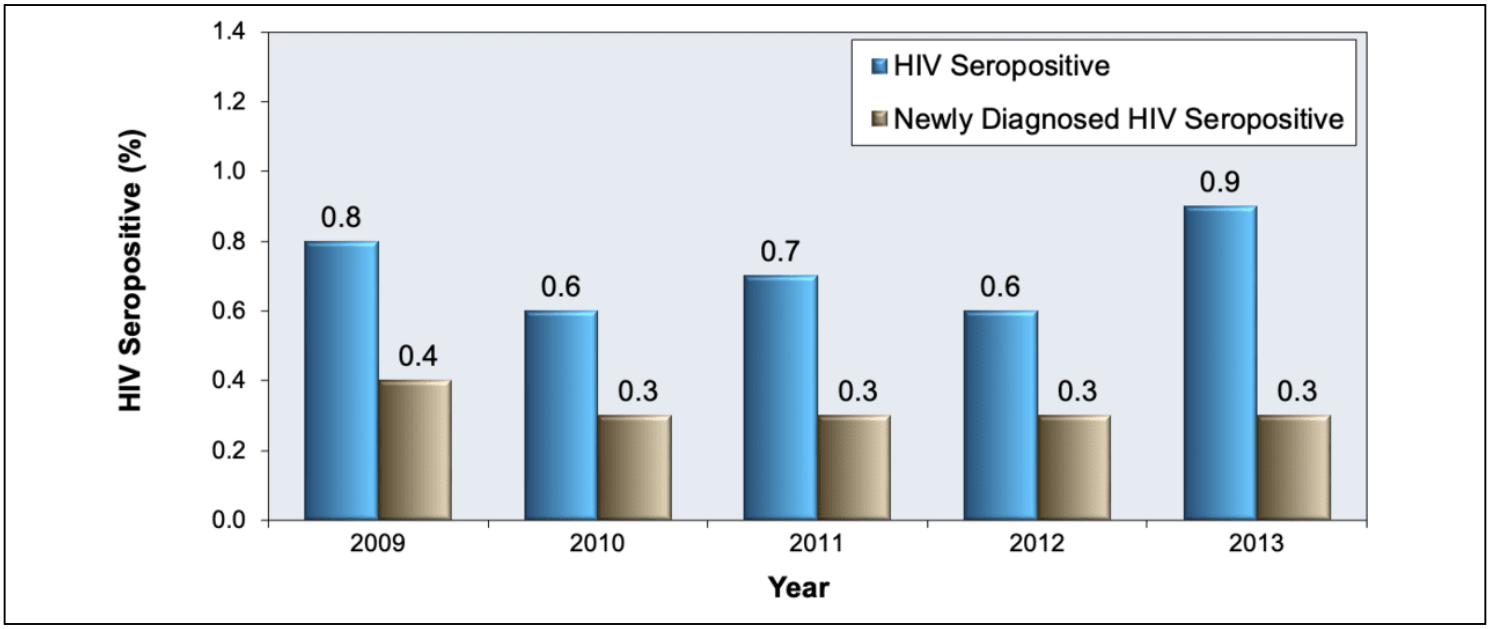


Figure 5 The HIV Care Cascade Before, During, and After Incarceration

This graphic represents a systematic review and data synthesis compiled up to January 13, 2015. For this analysis, undetectable HIV RNA was defined as an 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.

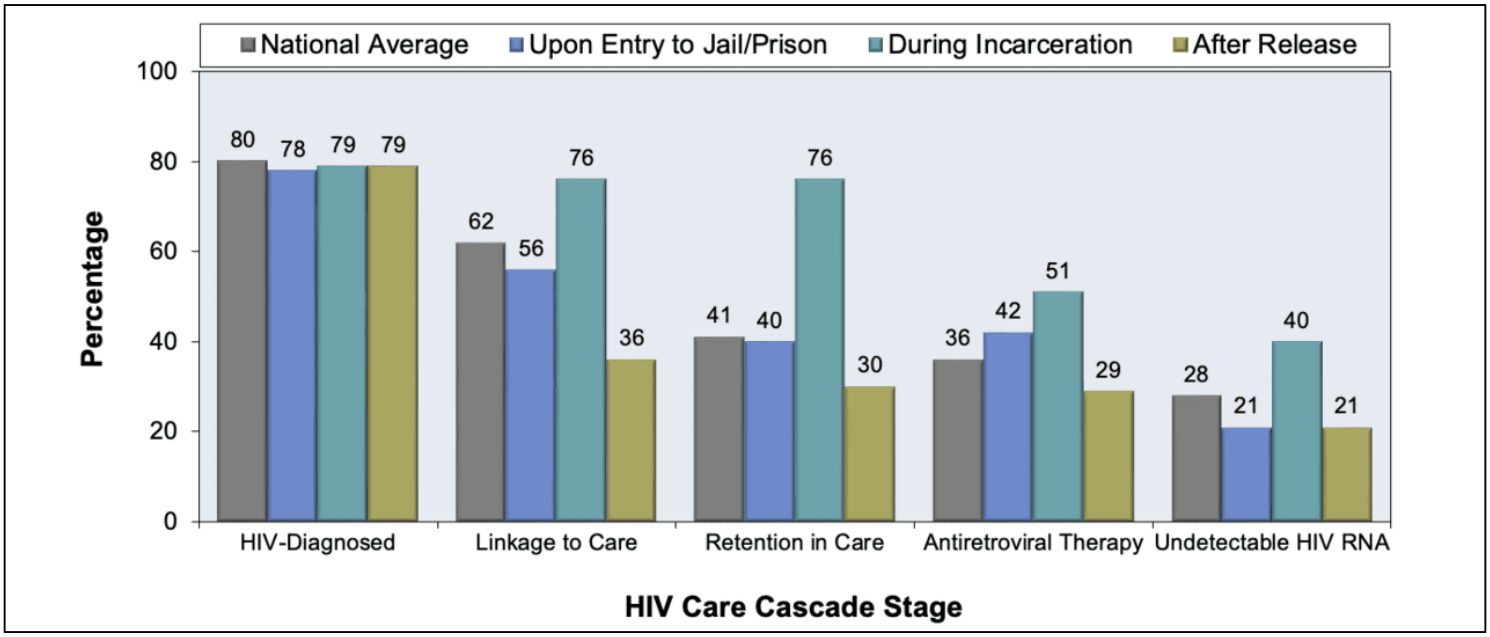


Figure 6 Number of AIDS-Related Deaths Among Persons in State Prisons, 1991–2019

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

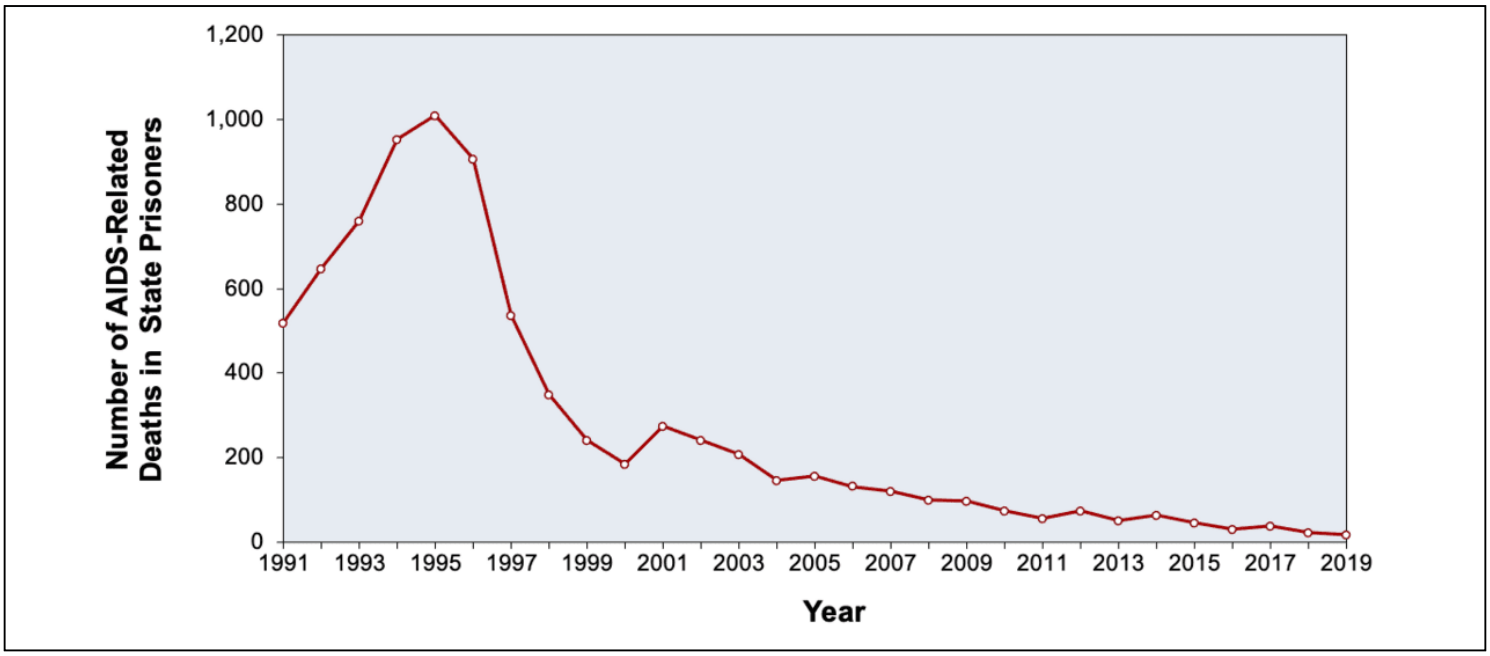


Figure 7 Estimated Number of Persons Supervised by United States Adult Correctional Systems, by Correctional Status, 2021

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

Source: Gann S and Kaeble D. Correctional Populations in the United States, 2023 – Statistical Tables. Bureau of Justice Statistical Tables. Office of Justice Programs, U.S. Department of Justice. September, 2025.

