HIV/AIDS and Incarcerated Women:

Policy Implications for Prison Systems within the United States

Jessica Retka
Global Policy Intern- The AIDS Institute
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I. Introduction:

Inmates, particularly women, are afflicted with a concentration of the epidemics that face the general population. The concentration of diseases, sexually transmitted infections, mental disorders, and HIV/AIDS is exponentially higher among inmates and the highest among incarcerated women. While women are not a majority of the inmate population, their concentrated population is plagued with the abovementioned issues at staggering rates- and these women are at increased risk due to the lack of resources consistently and uniformly provided to them in their need.

The incarcerated population, in general terms, is not on the forefront of America’s conscience. In terms of safety, yes, America likes to protect the general population from threats, however, America’s prison and healthcare infrastructure is not tailored to protect the incarcerated population from the increased health risks they face.

Currently, in America’s correctional facilities, across the country, there are no consistent healthcare regulations; instead, procedures for processing and protecting, educating and counseling are left up to the individual states. Those state budgets and funding tend to dictate what exactly is done for this lost population behind bars. The Federal Department of Corrections has no standing procedure or consistent regulations passed down into the local, community, and regional correctional facilities. As a result of this obviously neglected system, correctional facilities have seen drastic rises in the percentage of the incarcerated population suffering from the same diseases seen in the general population, yet at higher rates and with more severe repercussions.

The number of women incarcerated in the United States, globally the country with the largest number of incarcerated individuals, has seen an explosion in the number of women in the penal system, from 1980-1998 the number of women rose 500%. Currently, there are approximately 92,000 women incarcerated in America’s state and federal institutions. Amongst this new female inmate explosion, women of color are disproportionately represented, 3 times more likely than Latina women, and 6 times more likely than Caucasian (Non-Hispanic) women to be arrested and incarcerated. The difference in the number just being arrested and those being incarcerated is that all correctional facilities tenants have to be processed first, with some posting bail and being
released back into the community, while others are taken into the system. However, there is no common reporting, processing, or documentation of these people- leaving their health and serostatus undocumented and the rest of the community unprotected from these people and their high risk behavior.

A report by the AIDS Alliance for Children, Youth and Families, in conjunction with a Government Accountability Office report, found that “Women inmates are much more likely than the general population of women to have HIV disease, as well as Hepatitis C and STDs. They are much more likely also to suffer from other serious health problems, including substance abuse and depression, and to be victims of past physical and sexual abuse.” The conclusion of these reports, in relation to HIV among incarcerated women, states: “Overall, women in jails and prisons have an HIV infection rate that is 35 times that of American women in general.”

As this information reveals and as this paper will clearly explain, female inmates are a lost population- one in which the risk for terminal illness and disease runs exponentially higher than in the general population, and ironically, also one in which treatment has been, for the most part, a complete failure. Women in the correctional system need health care services, that are reproductive health focused, with pressure put on the administrators to offer testing to all processed people, including an attempt to counsel inmates and educate them through the process.

II. The Current Situation:

The Resources Available to the Incarcerated Population

A recent study has approximated that roughly 3 percent of American adults are under some facet of the criminal justice system, about 4 million on parole or probation, while approximately 1.4 million live in state or federal correction centers and a little less than half that number are in local jails. This impacted proportion of the population is guarded by the Bureau of Prisons, which is charged with the maintenance of facilities, codes of conduct, and regulations to be upheld at all levels.

While it is merely a bureaucratic entity- the Bureau of Prisons does have, within its responsibility, the livelihood of 3% of America’s men and women. In its capacity as a “correcting” institution, the Bureau of Prisons describes the mission statement of its facilities nationwide as such:

“The Bureau of Prisons provides services and programs to address inmate needs, structure use of leisure, and facilitate the successful reintegration of inmates into society. Each Bureau facility offers a set of programs and services that vary based on the characteristics and needs of its specific inmate population. Upon arrival at a new institution, an inmate is interviewed and screened by staff from the case management, medical, and mental health units. Later, an inmate is assigned to the Admission and Orientation (A&O) Program, where he or she receives a formal orientation to the
programs, services, policies, and procedures of that facility. This program provides an introduction to all aspects of the institution.”

Nowhere in this entire operation, nor in the orientation, does the Bureau mention precisely what they do for inmates’ health, screenings, tests, counseling, etc. It is stated rather ambiguously- and thus its implementation falls equally short of the actual needs of the community. In terms of those men and women incarcerated in America, for the most part, these inmates represent the “high risk” community- injection drug users, sex workers, people who express “at-risk” sexual behaviors, etc. and for the most part, these men and women may have never had the opportunity to be screened or tested for any communicable diseases. It is the duty of the correctional system, in light of their stated mission to make the community at large safer, to ensure that they are not allowing the released inmates into the community without the proper tools to handle the prevention, care, or treatment of any medical issues they may have.

One exceptional program that seeks to take control of the leading causes of death for women in America is the WISEWOMAN Program, exemplified in the South Dakota prisoner population. “Heart disease and stroke are the leading causes of death for women in the United States… They are also major contributors to morbidity and decreased quality of life.” The WISEWOMAN Program stands for “Well-Integrated Screening and Evaluation for Women Across the Nation” which was started and funded in 1995 by the Centers for Disease Control and Prevention. The program strives to provide “heart disease screening and intervention services to low-income women who participate in the National Breast and Cervical Cancer Early Detection Program, a cancer screening program for underinsured and uninsured women.” The goal of this program is to prevent as many new cases of some of the biggest threats to the female population, in terms of disease, and diagnose and treat, as effectively as possible, cases caught early by their detection equipment. However, one must surely notice the limitations. “WISEWOMAN provides standard preventative services, including blood pressure, cholesterol, and blood glucose testing; referral services; access to medications; and lifestyle interventions to help women develop a healthier diet, increase physical activity, and quit using tobacco.” There is no mention of reproductive health screening, no gynecological examination or screening, especially no mention of HIV/AIDS testing, prevention, treatment, or care.

As the name denotes, this legislation was intended for use across the nation, and while it has had very successful results in female correctional facilities of a smaller size, there are no procedures for handling HIV/AIDS in the correctional setting, let alone woman specific medical examination upon entering the system. Women are left with the bare minimum, enough to satisfy the lowest common denomination of medical services, but not even beginning to examine the specific needs, the different requirements of women, in general, not even just in the incarcerated population. What the Federal Bureau of Prisons espouses as their medical care policy provides only “essential medical, dental, and mental health (psychiatric) services by professional staff in a manner consistent with acceptable community standards for a correctional environment.” In other words, it is at the whim of the community and how much funding they have to spend on their specific incarcerated population- of which healthcare funding may not be proportional.
Women make up a very unique part of any stated population where they are included. They have specific needs, not extraordinary in any capacity, but actual needs that exceed the bare minimum application of medical care if they are to remain healthy and prevent serious illness or disease. Albeit, there are some behaviors that the incarcerated community either took part in that landed them in jail, or has taken part in since their incarceration that would leave outsiders with the impression that these men and women do not care about their health and do not want to stay or become healthy. However, as a community, it is in our best interest to assist those that cannot assist themselves and ensure that when these men and women are released back into our communities, they do not pose a threat anymore to themselves or to the rest of us. Therefore, current procedures, or lack thereof, and regulations need to take into account prevention, testing, care, and treatment for HIV/AIDS and other communicable diseases, as well as educating and counseling inmates while they are quite literally a captive audience. Not only does this issue need to be addressed amongst the general incarcerated population, but incarcerated women have special needs, are at added risk, and need additional services to be available to them.

III. Treatment and Prevention:

The Specific Needs of Women in the Corrections System

To all the arguments saying that inmates are the invalids of society and don’t deserve a hand out such as medical care, screening, education, counseling, and re-entry assistance- a thought to keep in mind is this- at one point or another these very same people are going to be members of a community with or without medical assistance or the knowledge of their serostatus. Either we make a priority of taking care of the problem in an organized and logical manner in the corrections atmosphere- thinking of that captive audience- or we wait until the issue hits the streets and becomes an issue for the entire community.

Women outside of the corrections system, insured and able women, seek gynecological health examinations- ensuring that everything in their system is healthy or seeking assistance if there is something at issue. Incarcerated women, generally low-income and un/underinsured do not have that luxury, and as stated before, being incarcerated and facing the “medical care” that is standard in the Bureau of Prisons may be their first encounter with a medical professional and thus we ought to make the most of it and provide them with as much information as we possibly can. “For many women living with HIV, being incarcerated represents their first real encounter with access to health care…the 1976 Supreme Court decision in Estelle v Gamble- established that inmates have a Constitutional right to health care, the only Americans determined to have such a right.”xii With the term “health care” left undefined in its specific limitations, as well as under funded, there has been a lag in implementing current and effective practices among the incarcerated community.

While 3% of the general population does not seem like a huge number, there is an estimate that 22 million people pass through some aspect of the criminal justice system
each year, and “despite comprising about 10% of the overall imprisoned population in the US, women represent the fastest growing population within jails and prisons.”

Their increasing representation reveals that the needs of incarcerated women have to be met while they’re still marginally manageable. More women are being arrested, more of those arrests are drug-related, and more of these sentences are longer and harsher than previous terms served for the same crime. For the needs of this community- we must go directly to the source-

“Women in prison complain of lack of regular gynecological and breast exams and argue that their medical concerns are often dismissed as over-exaggerations. Additionally, many imprisoned women are survivors of physical and sexual abuse and have lacked previous health care in their communities, two factors which puts them at even greater risk for having high-risk pregnancies and for developing life-threatening illnesses such as HIV/AIDS, Hepatitis C and HPV/cervical cancer. Moreover, despite being imprisoned and presumably safe from harm, in multiple prisons throughout the United States, women are victims of sexual abuse by prison staff, at times during routine medical examinations... Women also note that they do not receive regular pelvic exams or sonograms, that they receive little to no education about prenatal care and nutrition, that they have the inability to alter their diets to suit their changing caloric needs, and that they can be disempowered by remaining shackled during delivery and by being denied labor support from family members... imprisoned women may also have a higher prevalence of depression than imprisoned men.”

Not only do women have these complaints, but mental health, in terms of depression, and pre/post-natal care are severely lacking (which is somewhat mentioned in the above quote). What is evident- in the complaints of women, as well as the demonstrated services presently provided- is that women are severely overlooked. What women need are: gynecological and breast exams, adequate counseling, routine medical examinations, regular pelvic exams/sonograms, nutrition education, pregnancy assistance, and mental health counseling.

IV. Linking the System:

Integration of Reproductive Health Services in Conjunction with HIV/AIDS

The needs of women in terms of their reproductive health directly relates to the care, treatment, testing, and prevention of HIV/AIDS. HIV/AIDS is a reproductive health issue. Alongside the aforementioned needs of women, there is a benefit to tagging on HIV/AIDS medical care alongside other women’s health needs in terms of cost as well as effectiveness. HIV/AIDS is not an isolated health need.

“The spread of these [communicable] diseases [i.e. HIV, hepatitis C, hepatitis B, TB and other infectious diseases] is exacerbated by overcrowding of prisons, by poor health education intervention in prison and by weak community based public health programs for people with these infections. Additionally, since condoms and bleach are illegal materials within prison walls, many prisoners who have unprotected sex (consensual or
not) or who share needles (for tattooing or injecting illegal drugs) are at risk for transmitting these life-threatening diseases.”

There are many serious trouble spots in prisons that put all prisoners, not just women, at risk for contracting HIV/AIDS. Some institutions have responded to the HIV/AIDS epidemic in their facilities and through their efforts have “demonstrated that developing health care treatment policies in response to disease epidemics can prove successful in correctional institutions.” Women’s issues, same as infectious diseases and other medical illnesses, are necessary concerns of the correctional facilities and are not to be ignored. “Unfortunately, in most cases, these health care initiatives are limited by funding, which in turn limits the timely diagnosis and treatment of HIV positive prisoners.” While it seems to be a difficult situation for prisons to be in, they have to take control of their own incentives. Their funding from the state and in some cases the federal government should be used in ways that guarantee the safety of those incarcerated as well as those who will be impacted once inmates are released. “It is again vital to screen, diagnose, treat and follow-up the course of disease progression. This approach to treatment is even more important in correctional institutions, as prisoners are at high-risk for many communicable diseases prior to and during incarceration.”

It is much easier to predict that HIV/AIDS disease prevention programs will soon be incorporated in our prisons- far more likely than it is to foresee the implementation of women’s health programs. Women comprise a smaller portion of the prison population than men do- albeit they are an exponentially growing demographic in the system. It does not help that many women who enter the system know very little about their own health needs- having fallen through the cracks of any health care system, due to any number of reasons, before becoming incarcerated. Women have distinctly different medical needs than men, and the current provisions provided in correctional facilities do not cater to these differences, rather choosing to only pinpoint a handful of concerns, the lowest denominator of care. While there is a concern over dwindling funding, the overall community must realize that these people do not “stay inside” forever, with more than 22 million people being processed through the system every year, these are members of our communities at one point or another- and it would serve the best interests of both those inside and those outside the system to take control of the situation and allot appropriate funds to the prison system- ensuring that all inmates have adequate screening for medical concerns such as heart disease, diabetes, etc, but at the same time, are tested for communicable diseases, such as HIV/AIDS, tuberculosis, Hepatitis C, etc, while ensuring the needs of women in testing for these diseases and addressing their certain vulnerabilities for prevention and treatment are met.

While HIV/AIDS is not a specific concern of only women, ensuring that the women’s reproductive/mental/physical health concerns are linked to HIV/AIDS prevention, testing, treatment, care, and education will ensure that where there are women, they are being tested and taken care of adequately. If women’s health concerns and HIV/AIDS could be linked to the standard health provisions in correctional facilities that would be the best for all involved- reaching as many inmates, as comprehensively as possible.
V. Re-entry and Keeping Women in Good Health:

Protecting the Community, Inside and Out

To further develop a key point mentioned above, there inevitably comes the time when those who have been incarcerated rejoin the larger community. Re-entry is a traumatic experience for those who have been receiving medical care inside the institution. In many cases, inmates’ medications are being suspended or lost in the relocation to another community, or treatment is suspended as the responsibility of finding a medical facility falls to the inmate, a new member of the community, who has not yet gotten their bearings. In terms of those dealing with terminal illnesses or communicable diseases, the suspension of medicinal treatment and care can put the newly released in a very dangerous situation, along with their surrounding community.

The Bureau of Prisons does have several options for placement, once an inmate has completed their sentence. Community based programs, half-way homes, and “Comprehensive Sanction Centers” all are espoused by the Bureau of Prisons and are a guided exit from the system of correctional incarceration. They assist with the transition by weaning prisoners off of confined and routine lifestyle of living in that type of facility and into the community at large. Halfway homes, “residential reentry centers,” provide housing, employment assistance, substance abuse treatment/counseling, medical/mental health treatment, while continuing to monitor the actions of the released 24 hours a day. However, during this adjustment period, these released inmates are required to give up 25% of their income in order to continue funding the programs they take part in. While at the same time they are under restrictions to get a job within 30 days of release. In some cases, released inmates have to find adequate housing for themselves, while still under this program. The programs that are administered under the “medical health and treatment” heading are very limited, mostly geared toward encouraging the released to find appropriate community administrators to assist with their needs. However, the Bureau does supply a provision to extend medications for up to 30 days, only if conditions are considered necessary or an emergency, during the relocation process. However, in the 6 regions of the prison system in the U.S., there are only 28 community corrections management field officers- 168 field officers employed faced with 22 million inmates being processed. Seems like understaffing might just be the beginning of the lack of resources in this critical area- with funding coming from the very inmates that are being processed through this system and with no secondary plan for situations where the inmates do not find employment or substantial support within the 30 days allotment.

While it is a relief that the Bureau of Prisons at least has some sort of community integration program for re-entry, there are always issues of funding and adequate resources for those inmates in need. Inmates are starting their lives over after being inside a heavily controlled environment for any amount of time. They need as much assistance as possible when becoming reincorporated into the community, especially those with special medical needs who may need treatment and medication that goes above and beyond the limited resources of the community corrections management offices.
What needs to be done to facilitate a smooth transition is for each inmate on probation, parole, or being released, to be screened before leaving the correctional facility, ensuring that all their health concerns are addressed, and the medical assistance they are to acquire outside the facility is fully known to them. Also, medications need to be available to inmates for the amount of time it takes them to become familiar enough with their community to know where and how they can obtain what they need. While the community re-entry programs already provide assistance with job placement and monitoring inmates, substance abuse counseling and treatment, mental as well as medical treatment, need to be assured for any inmate, not simply for those fortunate enough to be in the right facility at the right time when they have enough funding to provide for everyone. Community integration also must be a priority- not leaving inmates in uncomfortable circumstances is a must, as being subjected to stress and unfamiliarity may cause them to take on high risk behaviors again. Inmates are as much a part of the community as is anyone residing in it; however, they do have specific needs and a certain amount of hand-holding is necessary to insure that they are as prepared as possible and as in control and familiar with their situation as possible. That means improvement in resources, funding, and accountability needs to be injected into the system. Such improvements are in the best interests of the community they’re about to join.

VI. Policy Recommendations:

Advocates and Legislative Fixes

So after all the lists and complaints of what’s wrong with the system, one must be asking-“well, what’re we going to do about it?” There are piecemeal legislation that target certain aspects of the problem, for example Senate bill 1060, offered by Sen. Joe Biden “to reauthorize the grant program for reentry of offenders into the community in the Omnibus Crime Control and Safe Streets Act of 1968, to improve reentry planning and implementation” which provides for pharmalogical drug and re-entry assistance for inmates, as well as the Justice Act (HR. 178) introduced by Rep. Lee which aims “to reduce the spread of sexually transmitted infections in correctional facilities” specifically HIV/AIDS, yet there is no truly comprehensive program or legislation targeting women. The most focused bill and the one with the most chance of making a difference in this situation is the Stop AIDS in Prison Act of 2007 (HR. 1943) introduced by Rep. Waters. This legislation specifically targets almost all the important points made in this paper. It lists the purpose as “to stop the spread of HIV/AIDS among inmates, to protect prison guards and other personnel from HIV/AIDS infection, to provide comprehensive medical treatment to inmates who are living with HIV/AIDS, to promote HIV/AIDS awareness and prevention among inmates, to encourage inmates to take personal responsibility for their health, and to reduce the risk that inmates will transmit HIV/AIDS to other persons in the community following their release from prison.” This bill specifically delegates tasks and cooperative efforts. The Bureau of Prisons will find itself involved in developing “a comprehensive policy to provide HIV testing, treatment, and prevention for inmates within the correctional setting and upon reentry”
which will make the guidelines and regulations of this bill common throughout this correctional system.xxv

The United States previously instituted a travel ban on HIV positive people traveling into the United States from abroad. Some people, in search of treatment came to the United States, others simply for family purposes, or traveling for leisure as we all do, all were met with the same travel ban. Medications that some of these people needed-their therapies and anti-retrovirals, were destroyed by authorities, putting these people at extreme risk. However, thankfully, Congress has seen the destructive outcome of this act, which instead of isolating the U.S. from the epidemic, has only manifested itself in discrimination and abuse. Right before the August 2007 recess, the HIV Nondiscrimination in Travel and Immigration Act of 2007 (H.R. 3337) was introduced by Rep. Lee. This act seeks to strike the travel ban previously described and currently still in place. The specific purpose of the bill is listed as “to remove from the Immigration and Nationality Act a provision rendering individuals having HIV inadmissible to the United States.”xxvi Lifting the travel ban will make it possible for HIV positive people to move around the world, into and out of the U.S. as they do in most countries. While this was seen as putting Americans at risk of contracting HIV/AIDS, it was more harmful in that it promulgated discrimination and stigma, as well as putting international travelers through very trying, unnecessary, and dangerous situations.

The two previously mentioned bills (S. 1060 and H.R. 178) have been deferred to the Committee on the Judiciary, while the Stop AIDS in Prison Act of 2007 was voted out of the Committee on the Judiciary unanimously without amendment before the August 2007 recess. The HIV Nondiscrimination in Travel and Immigration Act of 2007 will meet up with the 2 previous bills in the Committee on the Judiciary where all are currently being reviewed and evaluated for amendment.

While this legislation slowly winds its way through the many nuts and bolts of the federal legal system, states and local government have made laws themselves governing the incarcerated community. For the most part, these laws only focus on mandatory testing and reporting of status if an inmate has committed a sexual crime or some sort of physical or sexual abuse. In those cases, both victim and aggressor are to be tested by most states’ standards. Education also takes a portion of the legislation at the local and state level. Funds are being appropriated for schools, as well as state agencies, to prepare materials and curriculum for students, as well as the general public, to spread awareness. Teaching students at a young age is very difficult; however, children do need to be aware of the risks. Abstinence is a touchy issue in the education arena, but most legislation focuses on comprehensive education, if it mentions it at all. State legislation has a huge impact on the criminal justice system and the correctional facilities run under its purview. The fact that these regulations change state to state and institution to institution means that not all inmates are getting the same treatment or the same quality. The discrepancies will hopefully be overcome by the new legislation once it is voted into action-which will adjust the policies of the Federal Bureau of Prisons. All testing that has been legislated is to be administered with an opt-out requirement. There should be no measures that would force a prisoner to take a test if they do not want to. As prisoners still have their rights to privacy, it would be considered a Constitutional infringement.
As a matter of personal opinion, I do not feel that the opt-out procedures in anyway assist in solving the growing problem of HIV/AIDS in prisons. While only approximately 10% opt-out of taking the test, that is only a valid statistic per prison and also per prison that actually administers an HIV/AIDS rapid test.\textsuperscript{xvii} With the long standing stigma surrounding HIV/AIDS, there are a great many of reasons people could think of to opt-out of taking the test- loss of insurance, medical costs, discrimination, loss of housing, loss of family, etc. I feel that it would be in the best interests of our global human community if everyone was tested, without the option of opting-out. HIV/AIDS poses a threat to all of us, those infected as well as those not infected, yet. There are many conduits for this disease, and allowing individuals to ignore and escape the consequences of dealing with their disease inherently puts all of us at risk. When people understand their status, they can have a better gauge of their actions; their behavior may become modified if they understand the risks involved. It is a social obligation that we all have to one another as long as we share this planet to not put one another at risk or knowingly destroy each other; however, allowing people to plead ignorance when HIV/AIDS is an avoidable disease and doesn’t have to end one’s life pre-maturely anymore, is a human rights violation.

I believe that everyone should be tested and know their serostatus. Consistent and universal testing would not only serve as a prevention tool, but would also economically drop the price of testing materials and equipment, fuel research and development in low-cost, fast results, effective, and mobile testing facilities. Discrimination and stigma surrounding being tested would virtually disappear if everyone was tested. I believe we all want to be safe and avoid as much hardship as we possibly can, and this is one way in which I see HIV/AIDS being run from this earth, if we could all work together to understand and take accountability for what needs to be done, individually and collectively.

Internationally, there are no universal declarations or movements to look at HIV/AIDS as a collective effort, there are local advocacy groups as well as coalitions which work together to educate and spread the word to achieve awareness. However, as inmates are a generally not well-accepted nor frequently observed community, there are not very many groups advocating and being heard for prisoners’ rights and medical treatment- let alone for incarcerated women. As a matter of fact, recent reports presented by the coalition of authors for the Jacobs Institute of Women’s Health official publication \textit{Women’s Health Issues}, specifically focused on incarcerated women, could not answer any questions about the treatments provided for women incarcerated nor could they provide any information on the specific reproductive health programs provided to women while incarcerated. It is not a widely investigated concern of the rest of the population; and thus we see inmates, particularly women, forgotten and left behind by the system. While it would be helpful for these women to have advocates and supporting lobbyist, what is more important to them is to have a standard of health care that would address their specific concerns about reproductive health, pregnancy, general physical and mental health, as well as HIV/AIDS and other infectious/communicable diseases.
V. Final Thoughts- Conclusion

Without any specific knowledge of this issue, I have found it particularly hard to research information on what exactly incarcerated women need in terms of their health. But through doing research, I’ve found that this isn’t due to my lack of experience, it is because inmates, specifically women, are silent captives in a male dominated and tailored-to environment. It is not the fault of women that they comprise a smaller portion of the prison population than men, and they shouldn’t be made to suffer for it. Even women-only facilities have very little resources to provide for women’s reproductive health needs. HIV/AIDS not just in the incarcerated community, but in our general population, is an issue few people know about and even fewer people talk about. Inmates are not heard from, nor seen for the most part during their incarceration, which is why so little is known about what is the real story, what is or isn’t provided for them. They are “out of sight and out of mind” to the community at large. Once they re-enter the community, not only do inmates wear the burden of the designation, ex-convict, but if they also are HIV positive, they have added a scarlet “+” to their already heavy burden.

Our culture must understand that the best way to protect ourselves is to protect those who do not have control over their current circumstances. Legislation is in development that could strike at the very core of the problems the criminal justice system suffers from. What we need is a more consistent legal framework that protects and support inmates, testing them on both intake and release, educating them on prevention and treatment tools while incarcerated, teaching them the consequences of high risk behavior, working through substances abuse treatment, counseling for mental health and potential serostatus results, and well as overall health care, including woman-oriented reproductive health services standards as well as uniform HIV/AIDS testing. In the short term, this seems like a lot to fund and appropriate for, most likely re-vamping the entire Bureau of Prisons- however; in the long run, it could save us more money in health care expenses, Medicaid and Medicare funding, and community services. The short term worries fall painfully short of the long term benefits. The incarcerated community is still a community, and is still a part of our overall community, and women should not be overlooked- we don’t stand for it in the outside world, why should we make those unfortunate enough to wind up in correctional facilities deal with it in their world?

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\(^{2}\) Ibid.

\(^{3}\) Ibid.

\(^{4}\) Ibid.

\(^{5}\) Ibid.


\(^{7}\) Khavjou, Olga A. MA, Jacy Clarke, MPH, Roberta M. Hofeldt, RN, Patty Lihs, BS, Ryan K. Loo, PhD, Malavika Prabhu, BS, Norma Schmidt, MA, Chrisandra K. Stockmyer, MPH, RD, and Julie C. Will, PhD,

viii Ibid.

ix Ibid.

x Ibid.


xiii Website Designer Melissa Minor. “Understanding Prison Health Care- Women’s Health.”

xiv Ibid.

xv Ibid.

xvi Ibid.

xvii Ibid.

xviii Ibid.

xix Ibid.


xxi Ibid.

xxii Ibid.


xxiv Ibid.

xxv Ibid.
