Academy of Medicine of Washington, D.C. Bioethics Essay Contest Submission:

An Argument for the Distribution of Condoms to the Incarcerated Male Population

Fredrick S. Martyn
M.D. Candidate Class of 2020
The George Washington University

Fredrick S. Martyn
March 13, 2020
An Argument for the Distribution of Condoms to the Incarcerated Male Population
Academy of Medicine of DC Bioethics Essay

The nineteenth century Russian novelist, Fyodor Dostoevsky, once wrote that "*the degree of civilization in a society can be judged by entering its prisons".* A former prisoner himself, having spent four years in a Siberian prison camp, Dostoevsky understood that the prison population was an extension of the general population.

Prisoner health is a matter of public health. As per the United Nation's *Mandela Rules*[i], prisoners are to be afforded the same basic human rights as the general population. Even if deprived of their freedom as part of their punishment for their crimes, prisoners are still human beings, deserving basic rights, including adequate access to healthcare. This is increasingly important in the incarcerated population where the burden of mental illness, substance use disorder, communicable disease, noncommunicable disease, and cognitive disability is greater compared to the general population[ii].

It may seem counterintuitive to consider prisoner health an issue of public concern, given that this cohort of people are quite literally sectioned off from the general population. However, prisons are a place where the health needs of these underserved populations can be addressed and where public health interventions can be implemented to reduce disease burden and health disparities[iii]. Prisons also provide an opportunity for prisoners to make connections with community support such as substance use services, health care facilities, and social services which can promote health and well-being upon their release[iv]. As many prisoners return to the general population after completing their sentences, the prisoner population eventually become members of the public. In the United States for example, 95% of state prisoners eventually return

to society[v]. This is particularly important in the consideration of communicable diseases such as sexually transmitted infections (STIs), which can be transmitted between prisoners, and from former prisoners to the general public. Consequently, the control of STIs in prison has become a topic of increasing public interest and concern.

One well-established method for controlling the transmission of STIs in prisons is the distribution of condoms to the inmates. However, given that sexual activity is prohibited in most prisons, such an intervention can be seen as controversial and unethical. In this paper, I will provide evidenced-based arguments based in the medical ethic principles of beneficence, non-maleficence, justice and autonomy, to support the distribution of condoms among the incarcerated male population, on the basis that it is viable, cost effective, and successful means of mitigating STI risks in prisons. I will also provide evidence to debunk common arguments against prison condom programs, including the assertion that such an intervention would increase sexual activity and misconduct among male prisoners.

The discussion over the necessity for distribution of condoms in prisons starts with highlighting the need for communicable disease control in the incarcerated male population. At least 90% of prisoners worldwide are adult men, many of who tend to be socio-economically marginalized[vi]. Moreover, the prevalence of major infectious diseases is substantially higher among prisoners than the general population. It is approximated that 389,000 prisoners or 3.8% of total prisoners worldwide, are living with HIV/AIDS, as well as 1,546,500 prisoners living with Hepatitis C (15.1%) and 491,500 with chronic Hepatitis B (4.8%)[vii]. The rates of STIs

including chlamydia, gonorrhea, syphilis is also higher among adults and juveniles entering correctional facilities[viii]. Some of the high-risk behaviors specific to the male incarcerated population that lead to transmission of these diseases include 'brotherhood rituals' and 'penile implants"[ix]. Other behaviors however are non-specific to the incarcerated population including the sharing of needles, unsafe tattooing and piercings and most relevant to this discussion, unprotected sex. Again, despite it being considered illegal in most prisons, unprotected sexual intercourse happens in most prisons. Domestically this is demonstrated by the numerous outbreaks that have been previously reported throughout American prisons, for example Syphilis in Alabama prisons, Gonorrhea in New York and Hepatitis B in Georgia[x]. Suffice it to say there is without a doubt a need for sexually transmitted infection control in the male prison system.

It is generally accepted that the use of condoms reduces the risk of infection in the general population[xi]. Thus, it be would expected for prison condom programs to be a well-established practice in such a high-risk population. However, only 30% of the world's nations have prison systems that offer condoms to its inmates. In the United States, less than 1% of the jails and prisons allow inmates access to condoms[xii]. Prison condom programs are in the minority despite research showing that they can effectively control the spread of STIs in prisons. In one study performed in prisons in Victoria, Australia, the incidence and prevalence of STIs was evaluated after the implementation of a condom distribution program coupled with opt-out STI screening in their male population[xiii]. The results suggested that condoms reduced the annual incidence of syphilis by 99%, gonorrhea by 98%, hepatitis B by 71%, chlamydia by 27% and HIV by 50%. The study concluded that condom availability would virtually eliminate new

infections of syphilis and gonorrhea. Globally, there is limited data on STI incidence and prevalence after prison condom interventions, however the successes in the incarcerated Australian male population, illustrate that this simple intervention could be an effective way of mitigating STI risk.

The introduction of prison condom programs could also reduce inmate healthcare costs in the long term, as preventing STI transmission would decrease the need for subsequent medical treatment. This could make a meaningful difference in many countries including the United States, where the average annual healthcare cost in certain states is over $10,000 USD per inmate. The estimated annual cost of treating one HIV-infected patient ranges from $25,200 if diagnosed early to $56,400 with progressed disease. In contrast, one California state prison found that it would cost less than $2 per inmate or $78,581 for the entire inmate population annually to sustain its condom dispensing program[xiv]. Through these pro-active preventive measures, prison condom programs could reduce the transmission of HIV other STIs between prisoners, thereby reducing prison medical treatment costs. Such a program could effectively pay for itself.

A major source of disinclination towards prison condom programs is the concern that it will promote intra-prison sexual activity. For prison authorities, this acts as a major deterrent for the introduction of condoms since current policies in the majority of prisons maintain that sex in prison is illegal. However, research has shown that in reality, an increase in prisoner sexual activity does not take place in prisons that adopt condom programs. Another study involving Australian prisons compared sexual behavior in a New South Wales prison where condoms were

freely distributed and a Queensland prison where condoms were not permitted[xv]. Through computer-assisted telephone interviews to survey randomly selected male prisoners, it was found that the proportion of prisoners reporting anal sex in prison was equally low in the New South Wales and Queensland prisons. Furthermore, a much higher proportion of prisoners who engaged in anal sex in New South Wales (56.8%) than Queensland (3.1%) reported they had used a condom if they had had anal sex in prison. These findings provide evidence that contrary to popular belief, the introduction of condoms into prisons is not associated with an increase in sexual activity.

An additional barrier towards the adoption of prison condom programs on the global scale, is the denial from prison authorities that their male prisoners are participating in sexual acts with other male prisoners. To accept a need for condoms in a single-sex prisons, not only means accepting that sexual activity occurs in prison but more specifically that MSM (men who have sex with men) activity occurs. This is something many prisons around the world deny, often due to cultural and religious beliefs. In India for example at Tihar Jail in New Delhi, doctors during site visits reported that two-thirds of inmates acknowledged engaging in MSM acts[xvi], which subsequently led to the doctors advocating for the introduction of condoms in the prisons. This proposal however was quickly rejected as the prison authorities denied existence of MSM activity in the Tihar prison and reiterated that condom provision in prison would encourage homosexuality among the prisoners. A similar situation exists in Malawi where the Malawi Interfaith AIDS Association attempted to launch a prison condom program and was met with opposition from the Evangelical Association of Malawi. Currently there are no known prison

condom programs in Malawi[xvii]. This trend also exists in countries that are historically considered more liberal. In Australia for example the president of the Prison Officers' Association at one-point voiced opposition towards prison condom programs concerned that prisons would become perceived as "*homo*" jail[xviii]. Needless to say, some of the resistance towards prison condom programs stems from homophobic-steeped ignorance. It is not based in the reality of the prison behavior and therefore not a justifiable reason to withhold condom distribution programs.

Despite many prison authorities' opposition towards prison condom programs, studies have shown that male prisoners themselves are open to the idea of condoms. Prisoner surveys of a Washington, D.C. prison with an existing condom distribution program, showed that the majority of inmates supported the availability of condoms, primarily to stop the spread of disease[xix]. The majority had knowledge of sexual activity between inmates, and believed prevention of disease was important. This offers evidence that prisoners are not apprehensive towards condom programs. Thus, it can be projected that while condom use amongst prisoners should not be enforced so as to preserve patient autonomy, they would likely utilized by prisoners, resulting in a higher rate of safer sexual encounters than at present.

Another source of disinclination from prison condom programs is the suspected increase in condom-related misconduct. Commonly voiced concerns include a purported increase in sexual assaults, that prisoners could use condoms to hide and store drugs and that prisoners could use condoms as weapons. However, an additional Australian study also investigating the condom

program in New South Wales prisons suggests otherwise[xx]. In these Australian prisons, inmate surveys showed that there was in fact a decrease in reports of male sexual assaults 5 years after the introduction of condoms into the prisons in 1996. Inmates however did admit to repurposing condoms for non-sexual uses, most commonly for the storage of contraband items and tobacco. It should be noted that while the contents of condom kits were used to store drugs, there was no difference in the proportion of prisoners who reported injecting drugs while in prison from 1996 and 2001. It should also be noted that condoms were repurposed for more benign uses as well, the second most common use being the making of water balloons, followed by lubricant hair gel. Other less common conventions included using the flavored condoms to improve the taste of milk. With respect to the concern that condoms would be used as weapons, the New South Wales prisons reported only three minor incidents of condoms being used against prison officers between 1996 and 2001. All three cases involved a prisoner throwing a condom filled with shampoo or possibly ejaculate at a prison officer. Again, such occurrences were mainly mischievous in nature and rare compared to the number of more serious assault charges against prisoners each year. Similar findings were found in the United States in a one-year pilot study at a California state prison upon installation of wall-mounted condom dispensing machines[1]. The study found that the rates of penal code violations related to sexual misconduct, contraband, controlled substances, and violence were unchanged or decreased compared to the year prior to the introduction of the condoms. In all, these cases suggest that in reality condom distribution in prisons pose no safety or security risk.

To conclude, the distribution of condoms amongst male prisoners is an effective means of controlling the spread of sexually transmitted infection in this high-risk population. Prioritizing beneficence to the patient, there is quantitative evidence to suggest that prison condom programs are an effective way of reducing STI rates and that such programs are an inexpensive way of reducing prison healthcare costs in the long term. Furthermore, in accordance with non-maleficence to the patient, data has also shown that the introduction of condoms, contrary to much concern, does not increase sexual activity among male prisoners nor does it increase condom-related misconduct in general. Barriers still exist however against the implementation of condom program, namely ignorance associated with accepting the reality of MSM activity in male prison, despite the fact that many incarcerated populations are accepting of condom programs. This compromises justice to the patient and is an issue requiring further social intervention. A condom distribution program involving discretely placed vending machines for example, coupled with enhanced, regular opt-out STI screening can be an effective means of tackling this global health issue while respecting patient autonomy. Such a public health intervention would benefit community members on either side of the bars.

References

[i] Comm'n, A. C. (1975). The United Nations Standard Minimum Rules for the Treatment of Prisoners. *Crim. L. Bull.*, *11*, 637-637.
[ii] McLeod, K. E., Butler, A., Young, J. T., Southalan, L., Borschmann, R., Sturup-Toft, S., ... & Martin, R. E. (2020). Global Prison Health Care Governance and Health Equity: A Critical Lack of Evidence. *American Journal of Public Health*, *110*(3), 303-308.
[iii] Kinner, S. A., Southalan, S., Janca, E., Butler, A., Young, J. T., & Lindner, S. R. (2018). The role of prisons, jails and youth detention centres in addressing health inequalities in the Americas: Submission to the PAHO Commission on Equity and Health Inequalities in the Americas. *Melbourne, Australia: University of Melbourne*.
[iv] Freudenberg, N. (2001). Jails, prisons, and the health of urban populations: a review of the impact of the correctional system on community health. *Journal of Urban Health*, *78*(2), 214-235.
[v] Brooks, M. (2018, October 11). Prison Health Is Public Health. Retrieved March 15, 2020, from https://www.positivelyaware.com/articles/prison-health-public-health
[vi] Unaids, H. I. V. (2017). Addressing a blind spot in the response to HIV—reaching out to men and boys.
[vii] Dolan, K., Wirtz, A. L., Moazen, B., Ndeffo-mbah, M., Galvani, A., Kinner, S. A., ... & Hellard, M. (2016). Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *The Lancet*, *388*(10049), 1089-1102.
[viii] Wiehe, S. E., Rosenman, M. B., Aalsma, M. C., Scanlon, M. L., & Fortenberry, J. D. (2015). Epidemiology of sexually transmitted infections among offenders following arrest or incarceration. *American journal of public health*, *105*(12), e26-e32.
[ix] Moazen, B., Dolan, K., Bosworth, R., Owusu, P. N., Wiessner, P., & Stöver, H. (2019). Availability, coverage and barriers towards condom provision in prisons: a review of the evidence. *Frankfurt am Main/Germany: Institut für Suchtforschung (ISFF), Frankfurt University of Applied Sciences*.
[x] Scott, N., McBryde, E., Kirwan, A., & Stoove, M. (2015). Modelling the impact of condom distribution on the incidence and prevalence of sexually transmitted infections in an adult male prison system. *PloS one*, *10*(12).
[xi] Holmes KK, Levine R, Weaver M. Effectiveness of condoms in preventing sexually transmitted infections. Bulletin of the World Health Organization. 2004; 82(6):454–61. PMID: 15356939
[xii] Moazen, B., Dolan, K., Bosworth, R., Owusu, P. N., Wiessner, P., & Stöver, H. (2019). Availability, coverage and barriers towards condom provision in prisons: a review of the evidence. *Frankfurt am Main/Germany: Institut für Suchtforschung (ISFF), Frankfurt University of Applied Sciences*.
[xiii] Scott, N., McBryde, E., Kirwan, A., & Stoove, M. (2015). Modelling the impact of condom distribution on the incidence and prevalence of sexually transmitted infections in an adult male prison system. *PloS one*, *10*(12).

[xiv] Lucas, K. D., Miller, J. L., Eckert, V., Horne, R. L., Samuel, M. C., & Mohle-Boetani, J. C. (2014). Risk, feasibility, and cost evaluation of a prisoner condom access pilot program in one California state prison. *Journal of Correctional Health Care*, *20*(3), 184-194.
[xv] Butler, T., Richters, J., Yap, L., & Donovan, B. (2013). Condoms for prisoners: no evidence that they increase sex in prison, but they increase safe sex. *Sexually transmitted infections*, *89*(5), 377-379.
[xvi] Friese, K. (2013, July 9). Tihar jail bans condoms. Retrieved March 15, 2020, from https://www.indiatoday.in/magazine/indiascope/story/19940531-tihar-jail-bans-condoms-809220-1994-05-31
[xvii] Moazen, B., Dolan, K., Bosworth, R., Owusu, P. N., Wiessner, P., & Stöver, H. (2019). Availability, coverage and barriers towards condom provision in prisons: a review of the evidence. *Frankfurt am Main/Germany: Institut für Suchtforschung (ISFF), Frankfurt University of Applied Sciences*.
[xviii] Yap, L., Butler, T., Richters, J., Kirkwood, K., Grant, L., Saxby, M., ... & Donovan, B. (2007). Do condoms cause rape and mayhem? The long-term effects of condoms in New South Wales' prisons. *Sexually transmitted infections*, *83*(3), 219-222.
[xix] May, J. P., & Williams Jr, E. L. (2002). Acceptability of condom availability in a US jail. *AIDS Education and Prevention*, *14*(5 Supplement), 85-91.
[xx] Yap, L., Butler, T., Richters, J., Kirkwood, K., Grant, L., Saxby, M., ... & Donovan, B. (2007). Do condoms cause rape and mayhem? The long-term effects of condoms in New South Wales' prisons. *Sexually transmitted infections*, *83*(3), 219-222.