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What is This?
Risk, Feasibility, and Cost Evaluation of a Prisoner Condom Access Pilot Program in One California State Prison

Kimberley D. Lucas, MPH¹, Jamie L. Miller, MPH², Valorie Eckert, MPH³, Rebecca L. Horne, MPH³, Michael C. Samuel, DrPH², and Janet C. Mohle-Boetani, MD, MPH¹

Abstract
This study evaluated the safety and security impact, feasibility, and cost of a program to provide condoms to inmates. A 1-year pilot study of wall-mounted condom dispensing machines in one California state prison compared pre- and post-intervention rates of penal code violations related to sexual misconduct, contraband, controlled substances, and violence. The rates of penal code violations were unchanged or decreased compared to the pre-pilot year. Discreetly located condom dispensers were vandalized less frequently than those in plain view (p < .05). Distributing condoms using the pilot model would cost less than $2 per inmate annually. Results suggest that the use of discreetly located dispensing machines is an acceptable, feasible, low-cost option to prevent the transmission of sexually transmitted diseases and poses no safety or security risk in a typical medium-security prison setting.

Keywords
condoms, sexually transmitted disease, prison, inmates, correctional health care

Sexual activity (Abiona, Adefuye, Balogun, & Sloan, 2009; Bellatty & Grossnickle, 2004; Butler & Milner, 2003; Centers for Disease Control and Prevention [CDC], 2006; Harawa, Sweat, George, & Sylla, 2010; Lucas, Horne, & Bick, 2007; Swartz, Lurigio, & Weiner, 2004; Wohl et al., 2000), in-custody HIV transmission, and outbreaks of sexually transmitted diseases (STDs), including syphilis, gonorrhea, and hepatitis B, are well documented in correctional settings (Brewer et al., 1988; Brodsky et al., 2013; CDC, 2006; Dolan & Wodak, 1999; Krebs & Simmons,

¹Public Health Unit, California Correctional Health Care Services, Elk Grove, CA, USA
²Sexually Transmitted Disease Control Branch, Division of Communicable Disease Control, Center for Infectious Diseases, California Department of Public Health, Richmond, CA, USA
³Office of AIDS, Center for Infectious Diseases, California Department of Public Health, Sacramento, CA, USA

Corresponding Author:
Kimberley D. Lucas, MPH, California Correctional Health Care Services, Public Health Unit, Building E2-381, P.O. Box 588500, Elk Grove, CA 95758, USA.
Email: Kimberley.Lucas@cdcr.ca.gov
2002; Mutter, Grimes, & Labarthe, 1994; Tucker, Chang, & Tulsky, 2007). The World Health Organization, with the United Nations Programs on HIV/AIDS and the United Nations Office on Drugs and Crime, recommend that condoms be made available to men and women inmates throughout their incarceration and prior to release (UNAIDS, 1993; WHO/UNAIDS/UNFPA, 2004). In 2006, the CDC recommended that existing programs that provide condoms to inmates be evaluated and that correctional systems without programs assess their local laws, policies, and the potential risks and benefits of condom distribution to inmates (CDC, 2006).

Sexual activity is prohibited by law in California prisons and jails (California Code of Regulations Title 15 § 3007; California Penal Code § 286(e)), and concerns about safety and security operations have posed barriers to providing condoms to inmates. Those advocating for, or who implemented, condom distribution in correctional settings found that correctional officers and other personnel are concerned that inmates might use condoms to conceal and transport contraband or controlled substances, or as a weapon (e.g., assaulting staff with bodily fluids or excrement, or “gassing”). Custody staff in particular are concerned that making an additional “tool” widely and readily available in a setting where materials are tightly controlled could result in increased introduction of contraband into the prison, improved ability to hide and transport contraband in the prison, and increased sexual misconduct. Correctional staff may also view providing condoms as condoning illegal sex between inmates, or as sending a mixed message that undermines authority and leads to other types of misconduct, and poses a threat to safety.

Evaluations of programs that provide condoms to prisoners found that (1) following implementation, condom distribution was accepted by a majority of inmates (Dolan, Lowe, & Shearer, 2004; May & Williams, 2002) and correctional officers (May & Williams, 2002); (2) inmates approved of dispensers in discreetly accessible locations (Dolan et al., 2004); (3) there were no serious incidents involving condoms (Fraser & Gourlay, 2007; Performance Assurance Sector, 1999; Yap et al., 2007); (4) inmates used condoms for sex (Butler, Richters, Yap, & Donovan, 2013; Dolan et al., 2004; Harawa et al., 2010; May & Williams, 2002; Performance Assurance Sector, 1999; Sylla, Harawa, & Grinstead Reznick, 2010; Yap et al., 2007); and (5) self-reported sexual activity did not increase (Butler et al., 2013; Sylla et al., 2010).

Condoms are available to prisoners in most federal prison systems in European Union countries, Canada, Australia, South Africa, Brazil, Indonesia, and Iran (WHO/UNODC/UNAIDS, 2007). In the United States, condom distribution programs exist in jails in Los Angeles, San Francisco, New York City, Philadelphia, and Washington, DC; and in state prisons of Mississippi and Vermont (Braithwaite & Arriola, 2003).

In 2007, legislation introduced in California (Assembly Bill 1334) to require the California Department of Corrections and Rehabilitation (CDCR) to allow condom distribution within state prisons was vetoed. In the veto message (CDCR, 2007, p. 54.), the governor directed CDCR to determine the “risk and viability” of allowing nonprofit or health care agencies to distribute condoms to inmates in one state prison, noting that while sexual activity in prisons is unlawful, providing condoms to inmates is “consistent with the need to improve our prison healthcare system and overall public health.”

CDCR selected Facility 2 (F2), one of four quadrants of a typical modern design, medium-security level, general population men’s prison for the pilot study. F2 included a mix of housing units: one dormitory and six “celled” buildings (units with two-person cells), including two buildings for inmates who are administratively segregated with constant supervision due to safety concerns. The Center for Health Justice (CHJ) provided the condoms, condom dispensing machines, and inmate and staff education. For 1 year beginning November 2008, F2 inmates had access to condoms from wall-mounted dispensers located in the celled housing unit common areas and restrooms in the dormitory, the education building, and the medical primary care waiting area. Administratively segregated inmates were excluded from the program because of safety concerns...
and because obtaining condoms without being observed would not be possible due to the constant one-on-one custody supervision required for these inmates. Inmate education included a clear message that sex among inmates is against the law, but that use of a condom would not result in a “contraband write-up” during the pilot project.

To respond to the directive from the governor’s office, we conducted a study to (1) assess the potential impact of condom distribution on safety and security (risk), (2) assess whether condoms were readily available and barriers to accessing condoms (feasibility), and (3) estimate the costs of distributing condoms using the pilot project model.

Methods

Incident Review

To evaluate safety and security risk, we compared the rates of documented California Penal Code violations that occurred during the year before the pilot study and during the pilot year. We reviewed rule violation reports (RVR) for contraband, sexual behavior, obscenity, controlled substances/paraphernalia, and violent conduct involving a weapon or severe injury consistent with the use of a weapon that were reported and entered into the RVR database within 4 months after the year of study (pre-pilot and pilot). We abstracted the violation date and adjudication status from the RVR database. We abstracted the inmate’s housing unit, correctional officer’s narrative, and any material used (e.g., cellophane, condom) from the hard copy records. We de-duplicated records if two or more reports described a single incident.

To permit comparison of incident rates by the specific violation and housing type, custody staff provided inmate average daily population (ADP) estimates from on-site records. We calculated the number of incidents per 100 ADP for all violation and housing categories for the 1-year pre-pilot and pilot intervals. Since the dormitory was closed 5 months into the pilot, we restricted comparison to dormitory violations during the last 5 months of the pre-pilot year. Because condoms could have been indirectly accessed from the administrative segregation housing units that were not in the pilot, we also reviewed violations from these units.

Program Monitoring

During each maintenance visit, CHJ staff recorded the number of condoms required to refill each dispensing machine, condoms left in the dispenser tray, dispenser operability, damage due to vandalism, and the time required to inspect and stock all dispensers. Using this information, we calculated the number of condoms dispensed per month by location, excluding condoms left in the dispensing tray. We calculated the average number of condoms dispensed per month overall, excluding times during which a dispenser was found inoperable or not mounted, or the building temporarily closed, and excluding the first month, given anecdotal reports that uptake of condoms was likely artificially high due to the novelty of the program, curiosity (rather than use of condoms) among inmates, and condoms taken by staff or discarded. We calculated the percentage of maintenance visits during which the dispenser was found to be inoperable for each location.

Throughout the pilot, we met with inmates from the Men’s Advisory Council (MAC) health committee and the peer education program to obtain informal feedback regarding their opinions or those of the prison population in general about condom access, preferred distribution methods, key educational messages, and awareness of any problems due to condoms or the dispensers.
Inmate and Staff Surveys

We provided all prison staff with an anonymous survey before and after the pilot. We included only staff who reported spending at least 10% of their time in F2 or interacting with F2 inmates. Before and after the pilot, custody staff provided a complete list of general population inmates who lived in F2 for the entire pre-pilot or pilot year, respectively. We conducted a random sample from each list of inmates and offered participation in a confidential face-to-face survey with a trained interviewer from the health department. The inmate and staff surveys included both quantitative and open-ended questions about condom access, preferred avenues for obtaining condoms, and any misuse or negative consequences of condoms for staff or inmates.

Cost Analysis

CHJ purchased the condom dispensing machines ($200 each) and condoms ($0.22 each) from C&G Manufacturing (Grand Junction, Colorado). Based on these unit costs, the total number of condoms dispensed, the time spent ($50/hour) stocking the dispensers, and the pilot year ADP (810) in the study housing units, we estimated the cost per inmate of providing condoms from three accessibly located dispensers. Based on the cost per inmate, we calculated the total program cost for the start-up year and annual maintenance of a program for 124,977 CDCR male and female prisoners (Data Analysis Unit, 2010).

Statistical Analysis

We managed the incident review, program monitoring, and staff and inmate survey data in Microsoft Excel or Access and analyzed the data using SAS software (Version 9.2, © 2008 SAS Institute Inc.). We calculated odds ratios with exact 95% confidence intervals and/or Fisher’s exact two-sided p values for all qualitative comparisons.

Human Participant Protection

The study protocols and survey instruments were approved by the California Health and Human Services Agency, Committee for the Protection of Human Subjects. Inmate survey participants gave written informed consent. Prison staff survey participants were provided with written information describing the purpose of the voluntary survey and an anonymous means of returning written responses.

Results

Risk

After de-duplicating and excluding un-adjudicated records and incidents of violence that did not involve a weapon or result in serious injury consistent with use of a weapon, we included 398 pre-pilot and 258 pilot period eligible violations from the pilot and administrative segregation housing units in the analysis data set. We found very similar rates of adjudication when comparing the pre-pilot (89.5%) and pilot (89.2%) intervals. Eighty (20.1%) of the pre-pilot period and 23 (8.7%) of the pilot period incidents were missing the housing unit building number due to the hardcopy report not being filed and available for abstraction by the 4-month cutoff date.

We found no instances during the pilot of a condom being used to conceal contraband, controlled substances, or weapons. Custody supervisors were unaware of any incidents involving condoms during the pilot period. With the exception of one pre-pilot incident of anal sex between two administratively segregated cellmates, all pre-pilot and pilot interval sexual behavior incidents consisted of prohibited physical/sexual contact with visitors, masturbation, or indecent exposure, with no condom use mentioned.
Table 1 shows the number of eligible violations overall, including those with missing housing unit, and by violation and housing type, and the violations per 100 ADP. There were no increases in the numbers of violations overall by housing unit type or by eligible violation. The overall incidence rates declined facility-wide and in each housing category. There was a statistically significant decrease in the incident rate for F2 violations overall \((p = .001)\). The decreases in the overall rates by housing unit type were not statistically significant (celled units: \(p = .10\); dormitory: \(p = .61\); administrative segregation: \(p = .26\)). We observed no statistically significant increases in the rates of controlled substance/paraphernalia violations in the dormitory \((p = .26)\), sexual behavior in the celled buildings \((p = 1.0)\), or contraband in administrative segregation \((p = .65)\). The rates of all other specific eligible violations remained stable or declined for all housing unit types.

A total of 114/1,342 (8\%) staff and 26/242 (11\%) inmates pre-pilot and 55/1,381 (4\%) staff and 25/171 (15\%) inmates post-pilot participated in the inmate or staff survey. Pre-pilot, 85 (76\%) of staff overall and 52 (83\%) of custody staff agreed with a statement that inmates would use condoms for something other than sex that would result in serious negative consequences or injury to staff or inmates. Post-pilot, just 5 (13\%) of staff overall and 3 (13\%) of custody staff agreed. Five staff responded that they were aware of or heard about a condom-related injury during the pilot. Of three who elaborated, two custody staff made general statements that inmates may use the condoms to conceal drugs and cell phones. One medical staff person reported a heroin overdose, but did not explain how a condom had caused the overdose. None of these incidents were documented in an RVR.

Feasibility

A total of 2,061 condoms were dispensed, including 795 in the education building restroom, 457 in the medical primary care restroom, 716 in the four-celled housing units, and 93 in the dormitory before it was closed. Figure 1 presents the number of condoms dispensed by pilot month in the celled housing

Table 1. Number and Incidence per 100 Inmate Average Daily Population (ADP) of Eligible Penal Code Violations Overall and by Housing Unit Type.

<table>
<thead>
<tr>
<th>Violation (N)</th>
<th>Celled Housing Units</th>
<th>Dormitory</th>
<th>Administrative Segregation Housing Units</th>
<th>Facility 2 Overall (Including Missing Housing Unit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct: force or violencea</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Contraband</td>
<td>163</td>
<td>140</td>
<td>32</td>
<td>24</td>
</tr>
<tr>
<td>Sexual behavior</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Obscenity</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Controlled substancesb</td>
<td>85</td>
<td>45</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>252</td>
<td>188</td>
<td>38</td>
<td>33</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Violation (N/100 ADP)</th>
<th>Celled Housing Units</th>
<th>Dormitory</th>
<th>Administrative Segregation Housing Units</th>
<th>Facility 2 Overall (Including Missing Housing Unit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct: force or violencea</td>
<td>0.1</td>
<td>0.0</td>
<td>0.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Contraband</td>
<td>20.4</td>
<td>19.5</td>
<td>14.2</td>
<td>10.7</td>
</tr>
<tr>
<td>Sexual behavior</td>
<td>0.3</td>
<td>0.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Obscenity</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Controlled substancesb</td>
<td>10.6</td>
<td>6.3</td>
<td>1.8</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>31.5</td>
<td>26.2</td>
<td>16.4</td>
<td>14.7</td>
</tr>
</tbody>
</table>

aIncludes only incidents involving a weapon.
bIncludes possession or distribution of controlled substances or paraphernalia.
*Fisher exact \(p = .001\) for test comparing pre-pilot and pilot rates; all other \(p\) values \(\geq .10.\)
units, education restroom, and medical restroom. Overall uptake was highest during the first month and increased in the last 2 months of the pilot year. Excluding the first month, greater numbers of condoms were dispensed in the education \((n = 673)\) and medical \((n = 457)\) restrooms, compared to any one of the four dispensers in the celled housing units \((\text{range: 88–153; total: 431})\). The average number of condoms dispensed per month, excluding time that the dispenser was found inoperable or not mounted, or the building temporarily closed, was 15 in the dormitory, 17 in the celled housing units, 46 in the medical restroom, and 58 in the education restroom. Table 2 shows the percentage of routine CHJ monitoring site visits during which the dispenser was found inoperable. The dispensers in the education restroom \((p < .0001; \text{inoperable 3.8\% of visits})\), medical restroom \((p = .03; \text{inoperable 17.3\% of visits})\), and the dormitory restroom \((p = .04; \text{inoperable 10.0\% of visits})\) were vandalized significantly less frequently than those in the celled housing units \((34.8\% \text{ of visits})\).

Staff survey respondents more commonly preferred making condoms available confidentially during a medical visit or from dispensers rather than distribution by outside agencies during health education programs. Medical distribution was preferred for confidentiality, improved access, and because “condoms are a medical issue.” Pre-pilot, more staff felt condom dispensers should be in view of custody posts. Post-pilot, more staff preferred that dispensers not be in view of custody, for confidentiality and less impact on staff. Among inmates interviewed after the pilot, five suggested placing dispensers in less conspicuous areas for confidentiality and access, given that dispensers in discreet locations were vandalized less often. Seven inmates suggested making condoms available in clinics.

Early in the pilot, MAC representatives and peer educators relayed concern among inmates that condoms will promote sex between inmates, condoms will not prevent diseases transmitted through sharing drug or tattoo needles, correctional officers will unfairly target inmates seen taking condoms, and disturbances around the dispensers will impact all inmates. Later in the pilot, they reported that the novelty of the program had decreased, the dispensers were seldom mentioned, and they were unaware of any write-ups or disturbances. Noting that lack of privacy, vandalism, peer pressure, and stigma are barriers to obtaining condoms, they recommended additional avenues for distribution (e.g., during a medical visit, through the medication dispensing system) and education that emphasizes public health goals and integrates prevention messages into a wide range of health issues as opposed to focusing on lifestyle.

**Cost**

The pilot program cost was $1.37 per inmate including the dispensers and condoms, or $0.63 per inmate for the condoms alone. CHJ staff reported spending an average of 38 minutes per visit or 5.4 minutes per

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**Figure 1.** Number of condoms dispensed by location and pilot month.
dispenser to inspect and stock all seven dispensers. Given that 2,315 condoms were dispensed (including 254 left in the tray) from dispensers holding 144 condoms each, we estimated that three well-placed, rarely vandalized dispensers would need to be stocked 5.4 times per year taking 0.11 minutes per inmate per year. The total cost would be $182,319, or $1.49 per inmate, for the first year, including the one-time purchase of the dispensers, and a total of $78,581, or $0.72 per inmate, for subsequent years to maintain the program.

Discussion

Risk

We found no evidence that providing access to condoms posed an increased risk to inmate or staff safety or security operations during the pilot year. Our study is the first prison condom program

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**Table 2.** Proportion of Monitoring Visits With Inoperable Condom Dispensing Machine by Condom Dispenser Location.

<table>
<thead>
<tr>
<th>Dispenser Location</th>
<th>Description</th>
<th>Monitoring Visits (N)</th>
<th>Visits Dispenser Inoperable, N (%)</th>
<th>OR (Exact 95% CI)</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celled housing units</td>
<td>Common area next to drinking fountain; in direct view of half of cells and day room (least discreet location)</td>
<td>184</td>
<td>64 (34.8)</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td>Dormitory restroom</td>
<td>Inside open multiple person restroom; in direct view of one corner of building</td>
<td>20</td>
<td>2 (10.0)</td>
<td>0.21 [0.03, 0.98]</td>
<td>.04</td>
</tr>
<tr>
<td>Medical primary care restroom</td>
<td>Inside closed single-person restroom in small inmate waiting area</td>
<td>52</td>
<td>9 (17.3)</td>
<td>0.38 [0.16, 0.86]</td>
<td>.03</td>
</tr>
<tr>
<td>Education building restroom</td>
<td>Inside closed multiple person restroom (most discreet location)</td>
<td>52</td>
<td>2 (3.8)</td>
<td>0.08 [0.01, 0.33]</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

*Fisher exact p value.

**Table 3.** Recommendations for Implementing and Expanding Condom Access in California State Prisons.

Recommendation
A program to provide state prisoners access to condoms should be initiated and incrementally expanded while continuing to monitor the safety and acceptability of the program.

Planning
Peer educators and other inmates and medical, public health, and custody staff should be included in local condom program planning and implementation to ensure that concerns and needs specific to their institution are addressed.

Best practices
Condom dispensing machines should be mounted in discreet locations to provide more confidential distribution and prevent vandalism. To increase access, other avenues of obtaining condoms confidentially, such as during a medical or mental health visit, in addition to condom dispensing machines, should be considered.

Further evaluation
Additional pilot studies in settings that may pose a serious health or safety risk (e.g., higher security facilities or housing units for inmates with severe mental health conditions) should be considered.
evaluation to compare the pre- and post-intervention rates of sexual misconduct, contraband, controlled substances, and weapon use to adequately address the safety concerns that have presented the main obstacles to providing condoms or implementing other harm-reduction measures such as syringe exchange in correctional settings. Only a few evaluation studies have been published previously. These consist primarily of convenience sample surveys of inmate or staff opinions, accessibility, sexual activity, and condom use (Dolan et al., 2004; Harawa et al., 2010; May & Williams, 2002; Performance Assurance Sector, 1999; Sylla et al., 2010; Yap et al., 2007). Two prison evaluations outside the United States included a systematic search of custody records for incidents involving condoms following program implementation (Performance Assurance Sector, 1999; Yap et al., 2007).

Feasibility

Condom distribution in the prison setting using dispensing machines appears to be a feasible method provided there are multiple discreet locations. Our observation that dispensers in plain view in the celled housing units were frequently vandalized and dispensers in the other locations were vandalized less supports the need for discreet locations. This finding is consistent with open-ended comments made by staff and inmate survey participants and MAC representatives and inmate peer educator feedback throughout the pilot.

Cost

Our study demonstrates that providing condoms using dispensing machines is of very low cost and requires minimal maintenance. The estimated cost of treating one HIV-infected patient ranges from $2,100 per month if diagnosed early to $4,700 per month with progressed disease (Schackman et al., 2006), or $25,200 to $56,400 per year. At less than $2 per inmate or $78,581 for the entire inmate population annually to sustain the condom dispensing program, very few HIV infections would need to be prevented to cover all costs. In addition, we expect that STDs other than HIV infection would be prevented by a condom distribution program.

There were 41 HIV seroconversions between July 2003 and February 2005 in the Georgia state prison system, among an approximate inmate ADP of 45,000 (CDC, 2006). The most common HIV risk factor reported by the seroconverters was male-to-male sexual contact. We could not measure pre- and post-intervention HIV/STD transmission rates due to the short duration of the pilot program. There may also be a number of factors influencing HIV risk behaviors and transmission rates that differ between the Georgia and California state prison systems. However, given that prisoners in general are at higher risk for HIV infection and STDs, it is reasonable to assume that HIV transmission occurs frequently enough in California prisons for a cost-neutral or cost-saving condom program. Given that several program evaluations found that when condoms are available prisoners use them during sex (Butler et al., 2013; Dolan et al., 2004; Harawa et al., 2010; May & Williams, 2002; Performance Assurance Sector, 1999; Sylla et al., 2010; Yap et al., 2007) and that sexual activity has been documented in California prisons (Brodsky et al., 2013; Lucas et al., 2007), the transmission of HIV infection and STDs would likely decrease.

Limitations

Our study has several limitations. Because the pilot program took place in a typical general population men’s prison, the findings may not be generalizable in different settings (e.g., a maximum-security level or mental health care units). Conducting and evaluating interventions is challenging in correctional settings where it is not possible to anticipate or control population changes or program access. We found a significantly reduced overall incident rate during the pilot year. Violations
may have been discouraged or disrupted during the pilot period when inmates were temporarily moved out of each of the celled housing units for 1 month for building maintenance. The education and medical restroom dispensers were not accessible to all F2 inmates. These locations were also accessible to inmates from excluded facilities. Therefore, we cannot conclude based on uptake levels alone that the restroom locations were more accessible to F2 inmates. The low inmate and staff survey response rates limited our ability to measure changes in attitudes and behaviors. Inmates in particular may have been discouraged from participating due to peer pressure from disapproving inmates or unwillingness to disclose involvement in prohibited or illegal behaviors while incarcerated. We treated the survey responses as convenience samples and include only notable open-ended responses and anecdotal trends.

Conclusions

Our study demonstrates that condoms can be distributed in a general population medium-security prison without increasing the incidence of contraband or drug-related violations or violent or sexual misconduct that could pose a safety risk. The use of condom dispensing machines, if placed in discreet locations, is a feasible and acceptable option to prevent sexual transmission of HIV and STDs. Such a program may save medical costs of HIV and STD treatment both during incarceration and in the community. Table 3 summarizes our recommendations and suggestions for condom program implementation and expansion drawing on our findings during the pilot study.

Authors’ Note

Kimberley D. Lucas was the principal investigator, designed and coordinated the study, collected and analyzed the rule violation and staff survey data, and drafted the majority of the article. Janet C. Mohle-Boetani was the coprincipal investigator and provided advice on the study design and analysis of the data, and draft of the report. Jamie L. Miller abstracted rule violation reports, interviewed inmate survey participants, and contributed to drafting the introductory section. Rebecca L. Horne conducted literature review and developed the inmate and staff survey instruments. Valorie Eckert abstracted rule violation reports and analyzed the inmate survey data. Michael C. Samuel provided statistical consultation and input on the presentation of the results. All authors reviewed and contributed to revising the article.

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The Center for Health Justice purchased the condom dispensing machines and provided the condoms. We especially wish to acknowledge Mary Sylla, JD, MPH, founder of the Center for Health Justice, for giving educational presentations to prison staff prior to the pilot start date, for working with the inmate peer educators to develop an educational flyer and video for inmates, and for ensuring that condom dispensing machines were carefully monitored and stocked throughout the pilot year. The pilot project could not have succeeded without constant support and facilitation provided by the California Department of Corrections and Rehabilitation administration at both the headquarters level and in the pilot facility for program implementation and evaluation research activities. We are grateful to our colleagues in the California Department of Public Health, Office of AIDS and STD Control Branch, and the California Department of Corrections and Rehabilitation, Special Projects Unit for consultation on the evaluation objectives and measures.

Declaration of Conflicting Interests

The authors disclosed no conflicts of interest with respect to the authorship and/or publication of this article. For information about JCHC’s disclosure policy, please see the Self-Study Exam.

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California Penal Code § 286(e).


