The Status of HIV Prevention Efforts for Women in Correctional Facilities

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Abstract

In the United States, women are a significant proportion of the correctional population. Women also account for an increasing proportion of newly diagnosed human immunodeficiency virus (HIV) cases. When compared with white women, black women have higher incarceration rates and represent more of the newly diagnosed HIV cases. Correctional facilities offer an opportunity to provide women with HIV testing and prevention services so that they will know their status and receive HIV/sexually transmitted disease (STD) risk-reduction counseling and other preventive services. In this report, we describe incarcerated population statistics and HIV surveillance epidemiology for women. We also describe HIV prevention activities undertaken by the Centers for Disease Control and Prevention's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Additional research, program development, and implementation are needed to improve HIV prevention efforts for high-risk women.

Introduction

WOMEN HAVE BECOME a significant proportion of the corrections population in the United States, resulting in a gender disparity in incarceration.¹ From 2000 to 2009 the number of women incarcerated in state or federal prisons rose by 21.6%, compared to a 15.6% increase for men.¹ Since 2000, the racial/ethnic disparity in incarceration rates and the proportional burden of incarceration has decreased for black and Hispanic women compared to white women.¹ In 2011, the majority (49.3%) of women in state and federal prisons were white, yet black and Hispanic women (25.1% and 17.4% respectively) were overrepresented in corrections populations² in proportion (13.6%³ and 16.3%⁴) to their numbers in the U.S. population.

Incarcerated women are often poor, have limited access to health care in both jails and prison settings, and are convicted primarily of drug-related crimes.^{1, 5,6} The circumstances where these women live, work, and age—the social determinants of health (SDH)—affect their life and directly and indirectly affect their health.⁷ Specifically, these women have an increased risk for being infected with human immunodeficiency virus (HIV).⁸

The Centers for Disease Control and Prevention (CDC) has outlined its vision for promoting health equity by moving

beyond individual interventions to incorporate community-level approaches to prevent HIV transmission.⁷ To achieve this vision, HIV preventive health services^{9–11} are recommended for correctional settings.¹² As part of the National HIV/AIDS Strategy¹² to address the HIV epidemic, CDC recommended that correctional facilities screen all adults for HIV^{13,14} and has also advocated the use of effective evidence-based strategies to reduce new infections.¹³ In this report, we present both data from the Bureau of Justice Statistics (BJS) and the current HIV epidemiology from the National HIV Surveillance System, discuss hepatitis C comorbidity, describe CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) HIV prevention activities for women in correctional facilities, and conclude with future directions to address this public health problem.

Correctional Population Statistics and HIV Epidemiology

As of December 31, 2011, the most recent data available, there were 111,387 women in the state and federal prison population (6.7% of the total).² A substantial number of women in this population had sentences longer than one year. Of the 111,387 women, 103,674 of them had sentences longer than a year or more. Of the sentenced women prisoners, 25.1% were black. Moreover, the estimated imprisonment rate for all

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black women was 129 per 100,000 compared with 51 per 100,000 for white women (as of December 31, 2011). Among state and federal prisoners, 1,756 female inmates reported to be HIV-positive or have confirmed AIDS (8.7% of all inmates who reported being HIV-positive or have confirmed AIDS cases).¹⁵ The 2010 data do not include HIV-positive or confirmed AIDS cases by race. It is possible that more of these cases may be white.

Women with long sentences in state and federal prisons often spend time in local jails before and during their trial and while awaiting sentences. The population of female inmates in local jails has increased from 70,987 (11.4% of the total inmate population) in 2000 to 93,300 (12.7%) in 2011.¹⁶ Of the female inmates in jails in 2011, 5,900 of them (12.6%) were juveniles. In 2002, the most recent data on HIV in jails (and the only data that describes HIV status by race and sex), 2.3% of women jail inmates who were ever screened for HIV tested positive.¹⁷ By race, 3.0% of black women tested positive compared with 1.6% of white women. Because this data are from 2002, we do not know the current state of this disparity.

Women in correctional facilities are often released into their communities they came from. While it is important to appreciate the context of correctional facilities, it is equally important to understand the HIV disease burden for women in this nation. National HIV surveillance data suggest that women, especially black women, have an increased risk for HIV acquisition. At the end of 2010, approximately 25% of people living with HIV were women.¹⁸ Women also accounted for 20% of new HIV infections in 2010.¹⁸ Although the number of new infections among black women decreased 21% since 2008, the rate of new HIV infection among black women was 20 times that of white women.¹⁸

About 25% of HIV-infected individuals in the United States are coinfecting with hepatitis-C virus (HCV).¹⁹ HCV is a significant comorbidity complicating HIV care because of HCV-related liver disease.²⁰ Thus, HCV prevention is an important part of HIV prevention. Together HIV and HCV are important chronic infections affecting the correctional population. Among prison inmates, 16%–41% have serologic evidence of HCV infection and 12%–35% have chronic disease.²¹ HIV/HCV coinfection is correlated with being female and black and Hispanic race/ethnicity, the demographic characteristics of many incarcerated individuals.²²

2012 NCHHSTP HIV Prevention Activities for Women in Correctional Facilities

NCHHSTP HIV prevention activities for incarcerated women have focused on health education and behavioral interventions. The Division of Viral Hepatitis implemented the Hepatitis C Peer Health Education Prevention Program (PHEP) using peer-driven HCV health education and prevention interventions for incarcerated women.²³ Hepatitis C PHEP was implemented in the Central California Women's Facility (Chowchilla, CA) and the Valley State Prison for Women (Chowchilla, CA).²³ Women were trained as primary and secondary prevention peer health educators; received education classes about HCV risk factors, prevalence, transmission and primary, secondary, and tertiary prevention issues; and were referred for HCV screening. A hepatitis awareness event was also conducted at each institution.

The Division of HIV/AIDS Prevention (DHAP) investigated the efficacy of evidence-based HIV/sexually transmitted infection (STI) prevention interventions (EBI) that addressed social, behavioral, and emotional risk factors—key factors to HIV prevention for incarcerated adolescent girls and women. Through the Adoption and Demonstration of Adaptation Prevention Techniques project,²⁴ DHAP funded two research sites (University of North Carolina Chapel Hill School of Nursing and Emory University) from 2007 to 2012. These sites adapted the existing EBIs and used a systematic process to test the efficacy of the EBIs. The University of North Carolina Chapel Hill School of Nursing adapted the multi-session group-level EBI, Project SAFE (Sexual Awareness for Everyone),²⁵ for incarcerated adult women in the rural South, and called their intervention project POWER (Providing Opportunities for Women's Empowerment, Risk Reduction, and Relationships). Project SAFE was chosen because of its strong emphasis on gender and power in relationships, social support, and empowerment, and was implemented using the CDC map of the adaptation process.^{25–27} Project POWER included eight 1.5-hour sessions over 8 weeks in the facility and two intervention booster phone calls post release. The intervention content focused on empowerment, personalized HIV/STI risk reduction, condom use, substance use, relationships, interpersonal violence, mental health, reentry, and social support. Project POWER was tested for efficacy in a randomized controlled trial (RCT) among women in a medium security prison with 6 months or less remaining on their sentences.

Emory University adapted the multisession, group-level EBI, Horizons, for African American adolescent girls in juvenile detention centers using the Assessment-Decision-Administration-Production-Topical experts-Integration-Training-Testing (ADAPT-ITT) model of intervention adaptation.^{28–30} Horizons focused on gendered factors in HIV prevention and its cultural appropriateness for adolescent African American girls. The final adapted intervention, IMARA (Swahili for power, strength or perseverance) included one individual session in the detention center and two individual sessions and four health educator phone calls post release. The intervention content focused on personal values and goal setting, gender and ethnic pride, STI knowledge, condom skills, communication with sex partners, emotion regulation, and decision-making steps. IMARA previously was tested for efficacy in an RCT among African American adolescent girls ages 13–17 years in a short-term juvenile detention center in Georgia. Manuscripts describing formative research, lessons learned in adaptation, and RCT results for POWER and IMARA are forthcoming.

One lesson learned from these EBI adaptations is that working within correctional settings requires flexibility on the part of researchers to adjust to the schedules and structures within the facilities. Getting buy-in and involvement from prison administration in every step of the intervention implementation is essential.²⁵ Having established relationships mitigates some of the potential barriers to provide prevention services in these settings.

Future Directions

The NCHHSTP Office of Health Equity is supporting a journal special issue in *Women and Health* entitled, "Infectious and Other Disease Morbidity and Health Equity among Incarcerated Adolescent and Adult Women," to help fill the gaps in the literature on this population to be published in

June 2014. More research and program development and implementation are needed to better understand this context, so that structural interventions might be applied to address the increased burden of disease. Such interventions addressing SDH must consider issues related to reentry, linkage to care, and other areas related to prevention. Addressing the public health disparities may warrant an increased focus on social services for these women and their families. Finally, corrections research requires particular attention to the structure and system of correctional facilities. Building relationships is vital to the future of this kind of research. Creating partnerships with key stakeholders in the public health, justice, and community are important to making progress to address the health disparities of these women.

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