

# A Collaborative Effort to Enhance HIV/STI Screening in Five County Jails

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## SYNOPSIS

Funding from the Centers for Disease Control and Prevention and the Health Resources and Services Administration (HRSA) supports collaborations among health departments (CA, FL, GA, IL, MA, NJ, NY), correctional facilities, and community-based organizations to improve services to HIV-infected inmates, particularly as they return to the community. Additionally, HRSA funded the Evaluation and Program Support Center to guide the implementation of a multi-site evaluation of the Corrections Demonstration Project (CDP). The authors present a model approach to the problem of health disparities that involves forging collaborations among federal funders, public health departments, corrections, community-based organizations, and the scientific research community. They show how such collaboration can promote the reduction of racial/ethnic health disparities. The authors examined disease screening activities in five county jails. Screening for HIV and other sexually transmitted infections (STIs) was offered during the medical intake process and during HIV prevention education sessions. One thousand twenty inmates were tested from July 1, 2000, through December 31, 2000, for HIV infection, and 171 (17%) positive cases were identified (largely due to confirmatory testing). Of HIV-positive inmates, 83 (49%) were started on antiretroviral treatment. Additionally, 2,160 were tested for chlamydia, 1,327 for gonorrhea (largely duplicated), and 937 (duplicated) for syphilis. Across all three STIs, 78% of those who tested positive were treated. The remaining 22% either declined treatment, were released prior to notification of results, or were released prior to starting treatment. The CDP offers a model approach for addressing the poor health status of members of racial/ethnic minority groups by developing collaborations between corrections, public health departments, community-based organizations, and academia. An outgrowth of this collaboration is the improved capacity to detect and treat disease, which is a necessary component of a comprehensive HIV risk reduction program.

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In the past 20 years, the jail population in the United States has grown more than threefold.<sup>1</sup> The dramatic rise is largely due to the federal government's "War on Drugs."<sup>2</sup> In 1998, U.S. prisons and jails held more than 1.8 million people, while six million people were under some form of criminal justice supervision.<sup>3</sup>

People of color are disproportionately detained in correctional facilities: African Americans and Hispanics constituted almost 60% of jail inmates in 1999.<sup>4</sup> In 1999, about 12% of black non-Hispanic men 25–29 years of age were incarcerated; the same year, just 1.5% of white men of the same age group were in prison.<sup>4</sup> Thus, there is overwhelming evidence that the prison population is growing at an alarming rate and that people of color are disproportionately represented.

People of color also share a disproportionate burden of the nation's ill health. The gap in health status between blacks and whites in the United States continues to widen,<sup>5</sup> and initiatives continue to be developed to address the problem of health disparities.<sup>6,7</sup>

HIV/AIDS was one of six priority areas targeted to eliminate health disparities by Surgeon General David Satcher. The epidemiology of HIV/AIDS supports the need for treating this disease as a priority: as of 1999, non-Hispanic blacks represent 48% of new AIDS cases and 52% of all cases of HIV infection.<sup>8</sup> Ethnic and racial minorities constitute approximately 30% of the United States population, yet they represented 62% of those living with AIDS in 1999.<sup>9,10</sup>

These statistics suggest that correctional settings offer an important venue for HIV/AIDS prevention, treatment, and care. When properly implemented, these services have the potential to improve the health outcomes of members of racial/ethnic minority groups. Interventions in this setting can affect inmates, their families and partners, and the health of the general public. Such interventions are most effective under conditions that involve collaboration among corrections, public health practice, academia, and community-based organizations.<sup>11</sup> This article presents a model approach to the problem of health disparities by forging this type of collaboration. It also presents preliminary findings based on disease screening and treatment data as an illustration of how collaborative relationships can promote the reduction of racial/ethnic health disparities.

## THE CORRECTIONS DEMONSTRATION PROJECT

It has been argued that "Prisons and jails provide a critical opportunity to provide life-saving HIV prevention services to a population that might otherwise be

missed."<sup>12</sup> Correctional settings offer an ideal opportunity for prevention and treatment of HIV/AIDS because inmates are easy to reach, there is a concentration of people who engage in risky behavior (such as injection drug use and commercial sex work), and most inmates will eventually return to their communities.<sup>2,13,14</sup>

For some inmates, the period of incarceration offers the first opportunity to receive comprehensive medical, dental, and mental health services. However, the health care advances that are achieved as a result of these services are contingent upon follow-up once the inmate returns to the community. Research suggests that being released from prison may indeed have a negative impact on disease progression when there is no post-release follow-up,<sup>15</sup> perhaps due to a lack of access to care in the community and lack of health insurance. Thus, there are potential health benefits for inmates who receive coordinated HIV/AIDS prevention, treatment, and care that is initiated inside the correctional facility and extends into the community once the inmate is released.<sup>12</sup> Ideally, these services would integrate correctional and community-based prevention, primary care, and other supportive services.<sup>16</sup>

## Developing the collaboration

The Centers for Disease Control and Prevention (CDC) National Center for HIV, STD, and TB Prevention and the Special Projects of National Significance Program Office of the Health Resources and Services Administration (HRSA) have partnered to create an initiative that seeks to integrate correctional and community-based health care services. The purpose of this initiative is to "support demonstration projects within correctional facilities and the community that develop models of comprehensive surveillance, prevention, and health care activities for HIV, sexually transmitted diseases, tuberculosis, substance abuse, and hepatitis."<sup>17</sup> Inmates in jails, detention centers, prisons, and transitional halfway houses who are soon to be released into the community are targeted for this initiative. More specifically, African Americans and members of other racial/ethnic minority groups who are overrepresented among those affected by HIV/AIDS and disproportionately detained in the criminal justice system are targeted for these services.<sup>17</sup>

The demonstration project seeks to increase access to HIV/AIDS primary health care and prevention services, improve HIV transitional services between corrections and the community, and develop organizational supports and linked networks of comprehensive HIV health and social services for ex-offenders.

The seven funded health departments are in California, Florida, Georgia, Illinois, Massachusetts, New Jersey, and New York. Each grantee has appointed a local evaluator to coordinate evaluation activities at the state level. HRSA has also funded the Rollins School of Public Health of Emory University, with assistance from Abt Associates of Cambridge, Massachusetts, as a subcontractor, to serve as an Evaluation and Program Support Center to conduct a multi-site evaluation of the programs. Thus, this large collaborative effort depends on the federal funders; the correctional partners, which allow access to the facilities; the public health departments, which coordinate efforts across facilities and channel funds to the appropriate institutions; the community-based organizations, which provide services both inside and outside of facilities; and members of the academic and scientific research community, who evaluate such services.

To ensure grantee support for success of the multi-site evaluation effort and cooperation among participating entities (that is, the grantees, funders, local evaluators, and service providers), the Evaluation and Program Support Center has continually sought input from its partners in developing the multi-site evaluation—via conference calls, e-mail listservs, site visits, and semiannual grantee meetings. The success of the evaluation effort has required ongoing communication among all involved parties.

The organizational structure consists of three committees, which began meeting via conference call. The first is the core management committee (the federal funders and the Evaluation and Program Support Center). The second is the steering committee (the core management group, the state project directors, and technical assistance providers). The third is the evaluation committee (the core management group and the state evaluators). This type of organization allows the Evaluation and Program Support Center to propose ideas and solicit feedback from the grantees and funding agencies on a regular basis. In addition, the federal collaborators have funded three technical assistance providers with expertise in areas that would benefit the grantees (Southeast AIDS Training and Education Center, Correctional Technical Assistance and Training Project; National Minority AIDS Council; Hampden County Correctional Facility Health Care Unit).

As with any collaboration of this nature, certain barriers to implementing the multi-site evaluation have been encountered. For example, several of the grantees initially allocated insufficient monetary and human resources to the collection of evaluation data. Most states have since been able to reallocate funds

and obtain additional funding to improve evaluation. Another challenge has been to openly and effectively communicate pertinent information to the appropriate parties. Lines of communication have been kept open through regularly scheduled committee conference calls, e-mail listservs, grantee meetings, and site visits.

However, ensuring that all necessary individuals are involved in decision-making continues to pose a challenge. This is because in addition to the national collaboration, each state grantee coordinates a state-level collaboration, and all members of the state collaboration are unable to participate in decision-making at the national level. Finally, competing priorities of the program staff have also posed a challenge to the multi-site evaluation effort. This is an ongoing challenge, which has been addressed by emphasizing the importance of evaluation, offering training as needed, and seeking to minimize the effort required to implement the multi-site evaluation.

## DISEASE SCREENING

The public health department grantees have formed local partnerships with community-based organizations, state corrections departments, county jails, offices of community corrections, and juvenile justice departments to implement programs promoting continuity of care for HIV-positive and at-risk inmates who are soon to be released. Across the seven grantees, four service components exist: pre-release discharge planning and community-based case management services; HIV prevention and peer education programs; training of correctional, medical, and community-based organization staff; and disease screening. Disease screening activities at five adult county jails that collaborate with five of the grantees are highlighted here because of the availability of data.

Before funding was granted, HIV and sexually transmitted infection (STI) screening in each of these facilities varied greatly (Table 1). At the Georgia jail, for example, no chlamydia or gonorrhea screening was offered. In New York, inmates were offered an array of services, including HIV and STI screening at intake.

Grantees have used the new funding to increase the number of diseases screened for, expand the population to which screening is offered, expedite the receipt of results, and better coordinate referral to treatment. All of the facilities have focused on recruiting recently incarcerated inmates, ensuring that services are provided on a voluntary basis, and integrating disease screening services into the process of treatment and care. Under this initiative, disease screening

activities occur largely during the medical intake process soon after inmates arrive at the jail. In certain facilities (such as New Jersey), an additional offer for screening is made during the HIV prevention education offered by a community-based organization.

As a form of secondary prevention, disease screening activities seek to make people aware of their disease status before clinical manifestations occur.<sup>18</sup> This early awareness must be followed by treatment and care if these activities are to be effective and ethical.

Screening for infectious diseases is an integral part of correctional health care because of the ease with which such diseases are spread and the high prevalence of infectious diseases in these settings.<sup>13</sup> Initiating treatment in a correctional facility and (if necessary) ensuring continuous treatment after release benefits both the health of the inmate and the health of the larger community. Such an approach promotes several Healthy People 2010 goals for HIV, including increasing the number of people with HIV who know

their serostatus; the proportion of inmates in state prison systems who receive voluntary HIV counseling and testing during incarceration; the proportion of adults with tuberculosis who have been tested for HIV; and the proportion of HIV-infected adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines.<sup>7</sup> The Corrections Demonstration Project (CDP) can further these goals by developing collaborations that enhance the capacity for disease screening within correctional settings, with prevention, treatment, and care as the ultimate goals.

**DATA COLLECTION PROCEDURES**

New inmates who enter county jails in the United States undergo some form of intake screening. In the vast majority of jails, this process includes a medical assessment, which varies across facilities. Ideally, this assessment includes disease screening in an effort to

**Table 1. Jail-based HIV/STI screening activities by grantee before and after participating in the Corrections Demonstration Project funding**

State grantee	<i>HIV, chlamydia, gonorrhea, and syphilis testing and HIV prevention education</i>	
	<i>Before receiving funding</i>	<i>After receiving funding</i>
Florida	HIV/STI screening is available only for commercial sex workers on a mandatory basis.	All inmates are offered HIV/STI education testing at medical intake, three days after admission.
Georgia	Chlamydia and gonorrhea screenings are not offered.	Female inmates are offered voluntary chlamydia and gonorrhea screening at intake. Education and community referrals are provided to inmates who test positive.
Massachusetts	Chlamydia screening is offered to symptomatic males only.	All male inmates are offered voluntary screening for chlamydia at intake.
New Jersey	Inmates are offered HIV/AIDS and STI testing during initial medical examination.	In addition to the initial offer for testing by jail medical staff, a community-based organization offers HIV education to inmates in group sessions and individually, based on self-referral.
New York	Inmates are offered testing for HIV/AIDS and STIs during initial medical examination. Orientation sessions are offered to new inmates by civilian employees with limited access to the jail.	In addition to the initial offer, a grant-funded correctional officer who has complete access to all areas of the jail conducts orientation sessions for new inmates. Sessions seek to recruit inmates into HIV/AIDS testing as well as other grant-funded activities to better integrate available services.

STI = sexually transmitted infections

prevent the spread of infectious diseases while inmates are incarcerated and link inmates to the needed medical treatment and care during incarceration.

Perhaps the greatest impediment to this ideal is that inmates are often released into the community before results come back, follow-up counseling occurs, or follow-up medical treatment is provided. In addition, inmates who decline screening may later request screening, but there is often no clear procedure for inmates to request such testing. Thus, an approach that offers disease screening at various times during an inmate's stay would be most effective.

Under the CDP, inmates are recruited into disease screening services using a variety of different methods; these services are provided to different subpopulations of inmates (Table 1). Evaluation data are gathered by jail medical staff, who complete the data collection instrument, drawing on logs of disease screening activity. These data are then submitted to the local evaluator, who assessed the completeness and accuracy of the data. The local evaluator took the lead responsibility for submitting the data to the Evaluation and Program Support Center on a quarterly basis.

### **Instrument**

Based on a detailed review of the grantees' projects, the Evaluation and Program Support Center developed a draft evaluation design, which was distributed to collaborators. After three months of modification to reflect the concerns of collaborators, agreement was reached regarding the multi-site evaluation design.

The next major task was to develop instruments that would measure the common program elements. In conjunction with collaborators, the Evaluation and Program Support Center developed a draft set of evaluation instruments and distributed them for comment. Using site visits, conference calls, a grantee meeting, and e-mail listservs, the Evaluation and Program Support Center solicited feedback on the forms until agreement was reached. After five drafts of the instruments, collaborators were able to agree on 10 data collection forms (five that capture aggregate-level data and five that capture client-level data). One of the five aggregate-level forms captures disease screening activities.

Grantees completed one form for each participating county jail in which activities were carried out in two consecutive quarters (July 1–December 31, 2000). This form captured information about the number of inmates tested, the number who tested positive, the number of new (not previously identified) cases, the number who received post-test counseling, the number who used partner notification/contact tracing services, the number who did not receive their results

(among those who were HIV-positive), and the number who started treatment or were treated (among those who were positive for STIs). Information on the number of inmates with AIDS among inmates with HIV was also collected. All of this information was requested for HIV, AIDS (based on the CDC case definition), tuberculosis infection and disease, syphilis, gonorrhea, and chlamydia. Each grantee determined which disease entity to screen for based on the needs of inmates within a particular facility.

Demographic data were also collected on inmates who were screened for HIV. Information gathered included the demographic characteristics of inmates who: were tested for HIV, tested positive for HIV, were diagnosed with AIDS, and were started on antiretroviral therapy. Demographic information included age group (adult, adolescent or juvenile, unknown); gender (male, female, transgender, unknown); ethnicity (Hispanic, non-Hispanic, unknown); and race (white, black, Asian, American Indian or Alaskan Native, Native Hawaiian or other Pacific Islander, other, unknown). Only data for adult inmates are presented here.

### **EVALUATION FINDINGS**

Initial analyses compared the number of inmates who underwent HIV testing before and after the grantees received funding. Among the three grantees that offered grant-funded HIV testing in county jails in the period from July 1 through December 31, 2000, 1,020 inmates were tested for HIV as a result of grant-funded recruiting. At all three facilities, the number of inmates tested rose as compared to previous testing.

In Florida, 515 inmates were tested for HIV in the second quarter of 2000, as compared to 697 between July 1, 2000, and September 30, 2000, which was during the implementation of the CDP. In New Jersey, 159 individuals were tested for HIV during the first half of 2000, as compared to 187 during the second half, which was also during the implementation of the CDP. In New York, 929 individuals were tested in 1999, and 951 were tested in 2000 using non-grant-related funding streams. With the 136 who were tested due to the CDP, a total of 1,087 inmates were tested at this particular county jail in New York. Thus, there is evidence to suggest that in addition to other non-grant-funded activities, the grantees are screening more individuals for HIV and STIs in county jails than would have been screened otherwise.

Much of the HIV testing performed in county jails is confirmatory testing. An HIV antibody or a CD4 cell count test is used to confirm self-reported illnesses before treatment options are offered. In New York, for

example, virtually all testing is confirmatory testing. However, under the CDP, most grantees are also seeking to increase the number of new cases of HIV identified. Of the 1,020 inmates tested for HIV, 171 (17%) tested positive and 83 (49% of those who tested positive) were started on antiretroviral therapy (Table 2). Among the 171 inmates testing positive, 75 (44%) were newly identified as HIV-infected.

The demographic characteristics of county jails suggest that a large proportion of inmates accessing disease screening services will be African American and male, and indeed this was the case. Of the 1,020 inmates tested for HIV, 573 (56%) were described as African American and 735 (72%) were male (Table 3). Similarly, the majority of inmates who tested positive for HIV (64%) were male, as were the majority of those who were diagnosed with AIDS (69%) or started antiretroviral therapy (75%). The majority of inmates who were tested for HIV were non-Hispanic (935, or

92%), and a majority were African American (573, or 56%).

More than 4,400 tests were performed for STIs during the six-month period reported here, with 199 positive results. Among those tested, 6% had chlamydia, 3% had gonorrhea, and 2% had syphilis. As a result of this testing, 111 inmates were treated for chlamydia (79% of those testing positive), 27 inmates were treated for gonorrhea (66% of those testing positive), and all 18 of those who tested positive for syphilis were treated. Across the STIs, 78% of cases were treated.

## DISCUSSION

The CDP was funded to improve services to inmates with HIV and those at high risk of contracting HIV, especially inmates transitioning back to community settings. The screening data indicate that services provided under this initiative resulted in more than 5,400

**Table 2. Inmates screened for HIV and other sexually transmitted infections at five county jails**

State grantee	HIV	Chlamydia	Gonorrhea	Syphilis
Florida				
Number tested	697	—	—	918
Number of positive cases	34	—	—	18
Number treated <sup>a</sup>	0	—	—	18
Georgia				
Number tested	—	1,327	1,327	—
Number of positive cases	—	83	41	—
Number treated	—	54	27	—
Massachusetts				
Number tested	—	833	—	—
Number of positive cases	—	57	—	—
Number treated	—	57	—	—
New Jersey				
Number tested	187	—	—	—
Number of positive cases	1	—	—	—
Number treated	1	—	—	—
New York <sup>b</sup>				
Number tested	136	—	—	—
Number of positive cases	136	—	—	—
Number treated	82	—	—	—
All sites				
Number tested	1,020	2,160	1,327	918
Number of positive cases	171	140	41	18
Number treated	83	111	27	18

NOTE: Data are for July 1, 2000, to December 31, 2000, except for Florida (July 1, 2000–September 30, 2000).

<sup>a</sup>Treated for syphilis and started on treatment for HIV

<sup>b</sup>Only confirmatory testing performed

**Table 3. Demographic characteristics of adult inmates screened for HIV at one of three participating county jails**

Characteristic	Tested for HIV		Positive for HIV		Diagnosed with AIDS		Started on antiretroviral therapy	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<b>Gender</b>								
Male	735	72	109	64	70	69	62	75
Female	263	26	62	36	32	31	21	25
Unknown	22	2	0	—	0	—	0	—
Total	1,020	100	171	100	102	100	83	100
<b>Ethnicity</b>								
Hispanic	85	8	50	29	39	38	27	33
Non-Hispanic	935	92	121	71	63	62	56	67
Unknown	0	—	0	—	0	—	0	—
Total	1,020	100	171	100	102	100	83	100
<b>Racial category</b>								
African American	573	56	67	39	57	56	53	64
White	309	30	11	6	6	6	3	4
Asian American	2	0	0	—	0	—	0	—
Indian	2	0	0	—	0	—	0	—
Other	67	7	49	29	39	38	27	33
Unknown	67	7	42	25	0	—	0	—
Total	1,020	100	171	100	102	100	83	100

NOTE: Data are for July 1, 2000, to December 31, 2000. County jails are located in Florida, New Jersey, and New York. The remaining four grantees did not report grant-funded HIV screening activities at the participating county jails for the time period under study. Percentages may not add to 100% due to rounding errors.

tests for HIV and STIs in five county jails within a six-month period. Positivity rates varied across diseases, but generally ranged from 2% for syphilis to 17% for HIV. The majority of individuals who tested positive were also treated or started on antiretroviral therapy for all diseases with the exception of syphilis. The collaborators are seeking to treat 100% of inmates. Doing so remains a daunting task in a jail setting, however. Jails process thousands of inmates every year (ranging from about 12,000 to 20,000 across the five jails studied), with about half of these inmates released back to the community within three days of arrival. Because many of these people return to the jail at a later time as a result of other charges, jails are often referred to as revolving doors. All of these factors make tracking and treating positive cases very difficult.

The grantees sought to address some of these difficulties by contracting with laboratories that could return results rapidly and by offering community follow-up to inmates released before receiving notification of positive test results. More inmates were treated for STIs (78%) than were started on antiretroviral therapy (49%), possibly because of the high level of patient

commitment required before initiating HIV therapy, the importance of relying on clinical indicators when deciding whether to initiate therapy, and the importance of adherence.<sup>19</sup>

Being diagnosed with an STI puts a person at increased risk for contracting HIV and serves as an indicator of HIV risk behaviors.<sup>20-22</sup> Thus, providing HIV prevention education for people diagnosed with STIs has the potential to reduce the risk of HIV transmission. However, the level of STI screening and treatment that occurs in correctional settings varies; even within the five jails studied, the availability of HIV counseling and testing varied greatly.

Hammett, Harmon, and Maruschek report the HIV testing policies for county jails in the United States.<sup>3</sup> In 1997, no city or county jail system had mandatory testing policies for incoming inmates, and one out of 41 jails surveyed had routine testing (that is, informing patients that they will be tested unless they refuse). Most of the facilities had either active or passive voluntary approaches to testing. The active approach, where testing is offered, occurred in 14 out of the 41 jails surveyed. Nineteen used the passive approach, in which the inmate had to request testing. Seven of the jail

systems did not have a policy regarding HIV-antibody testing.

The policies were slightly different for testing of pregnant inmates in the city and county jail systems. One system had a mandatory testing policy, and six systems offered routine testing. However, HIV testing for pregnant women was voluntary in 30 of the 41 facilities surveyed.

County jails often face difficulties finding funding for HIV and STI testing and for HIV education. Grantees addressed this need with funding under the current initiative. For example, in the Jacksonville/Duval County Jail in Florida, HIV counseling and testing is offered following single and multiple HIV prevention/education sessions.

These improved screening efforts have important implications for a system's ability to continue to offer treatment and care. Increased screening is expected to increase the number of individuals requiring medical treatment. Some correctional health care systems are not in a position to pay for the increased treatment and care. One contracted correctional medical provider within a facility offering enhanced disease screening under this initiative is having difficulty serving all of the clients now being identified. Under a capitated health care system, the contract between the Department of Corrections and private medical providers was based on the expected number of identified cases before this funding was received. However, this grantee is using supplemental funds to increase treatment efforts and improve the availability of transition planners. As a result, the in-facility medical provider will continue to grapple with the problem of an increased caseload until the original contract expires or is amended. Thus, grantees are faced with the challenge of incorporating their demonstration projects into a larger health care system and coordinating services that cut across multiple funding sources. Undoubtedly, other correctional systems attempting to increase their disease screening efforts will experience similar problems.

There are other limitations to disease screening activities. It is difficult to work in a correctional setting that inhibits offering services in a systematic manner. Because safety and security are the first priorities, shift changes, lockdowns, and processing of special inmates can interfere with the daily activities of recruiting, tracking, and treating infected individuals. These logistical difficulties make it difficult to identify the total number of inmates eligible to receive screening, which would be useful information when evaluating these activities. For example, of the 34 inmates who tested positive for HIV at the county reception center in

Florida, none appeared to have been started on anti-retroviral therapy. Medical staff contend that treatment was started at another jail facility, something not captured in the data submitted to the Evaluation and Program Support Center. To prevent such discrepancies, the Evaluation and Program Support Center will continue to work with grantees to ensure that comprehensive data are being submitted, with written explanations regarding relevant data submitted to facilities in which no grant-funded activities are taking place.

Through collaboration, the CDP is seeking to improve the health of inmates, especially those who are people of color. Each state grantee independently responded to a request for proposals and crafted its programs to meet the requirements of the request while filling in service gaps at the local and state levels. However, once funded, the state grantees entered into collaborative relationships with their local service providers, community-based organizations, and correctional facilities in addition to the federal funders, technical assistance providers, and the Evaluation and Program Support Center to help develop and implement a multi-site evaluation of these projects. This is a crucial component of the projects because these data are expected to be used to generate political support at the state, local, and national level; justify program spending; and generate new knowledge of effective models of service delivery. The funded demonstration projects along with other model projects (such as that in Rhode Island<sup>23</sup>) are expected to lead correctional health care into an arena of improved and better-coordinated medical and social services to inmates.

The disease screening activities carried out by this collaboration are likely to affect correctional health care at two levels. At the individual level, inmates are informed of their disease status before clinical manifestations appear, allowing them to start treatment earlier and reducing the potential for spread of disease. At the systemic level, these projects have the potential to shape policy, because the multi-site data generated by the projects are expected to be used to advocate for political and economic support for related initiatives in the future.

This collaboration serves as a model of how the public health community can join forces with correctional facilities to improve public health. The fields of public health and corrections have very different missions. Corrections seeks to ensure safety and security; public health seeks to improve health status. The competing missions need not impede the development of collaborations, however. The state grantees affiliated with the project have developed lasting partnerships between public health and corrections that are likely

to affect the health of those within and outside of the facilities. Collaborations that result in improved services may affect inmates' health care decision-making so that once they return to the community a lasting change will be evident. Collaborations involving public health, academia, corrections, and community-based organizations have the potential to affect the communities to which inmates return, which are largely communities of color. The CDC/HRSA Corrections Demonstration Project provides useful models for addressing the problem of health disparities by developing a multi-disciplinary, multi-site collaboration that can directly influence the health outcomes of people of color.

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