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Considerations in HIV Prevention for Women Affected by the Criminal Justice System

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Abstract

Within the national dialogue of HIV prevention strategies, relatively little consideration is given to the millions of women and girls affected by the criminal justice system either through their own incarceration or that of their partners. Yet statistics indicate that these women and girls are disproportionately infected or at risk for HIV and other sexually transmitted infections and much of this risk is directly related to the dynamics and circumstances that led to their incarceration or relationships with incarcerated men. As we look for the link between public health and correctional health within our National HIV/AIDS Strategy, it is imperative that the risks, obstacles, and opportunities facing women and girls affected by incarceration are brought into the discussion. Gender responsive HIV prevention policies and practices must be developed to address the unique risks and opportunities for these women and girls. This paper presents data on HIV risk and other health issues specific to this community of women and girls, discusses key factors for consideration when developing gender-responsive HIV strategies for these communities, and makes recommendations for inclusion in the National HIV/AIDS Strategy and other state and local HIV prevention efforts.

INTRODUCTION AND BACKGROUND

While increasing emphasis is placed on HIV prevention programs for incarcerated men, women who are affected by the criminal justice system, either through their own incarceration or that of their partners, are often overlooked. The United States is the number one incarcerator in the world, currently housing 2.3 million adults in correctional facilities. Of this population, 115,000 are women. Including the number of women under any form of correctional supervision (prison, jail, parole or probation,) this number grows to over 1 million women, a rate that has tripled over the past decade (West, 2010).

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In addition, an estimated 20% of men in prison are married (Mumola, 2000) and studies have found that approximately 50% of incarcerated men consider themselves to have a primary female partner with whom they plan to reunite upon release from custody (Jorgensen et al., 1986; Carlson and Cervera, 1991; Grinstead et al., 1999). Furthermore, the multi-site evaluation of the Serious and Violent Offender Reentry Initiative reported that 75% of incarcerated fathers were either married or in an intimate relationship (Lattimore, Visher et al., 2008), and a study of low-income African-American women found that 22% had a current male partner who previously had been incarcerated (Battle, 1995). These findings indicate that at any given time, millions of women are either separated from a partner who is behind bars or are reuniting with a partner who is returning home from a correctional facility. As we continue to make the link between public health and correctional health, it is critical to talk about best practices and policies that serve all women impacted by the criminal justice system.

Incarcerated Women, HIV and Other Health Issues

Women affected by incarceration are disproportionately women of color. The majority come from a background of poverty and many experience homelessness. Incarcerated women are likely to have been convicted of a drug-related offense. They are often survivors of physical and/or sexual abuse, and have other family members involved in criminal justice system. In addition, the majority (61%) of incarcerated women are parents, compared with their incarcerated male counterparts, 53% of whom are fathers (Lichtenstein, 2010; Chesney-Lind, 2002; Baldwin, 2000; Owen, 1998; Richie, 1996; Maruschak, et. al., 2010).

It has been well documented that incarcerated populations in general are disproportionately impacted by multiple health conditions. Rates of HIV/AIDS in US prisons are 2.5 times the national rate while rates of Hepatitis C are estimated to be as high as 31–49% (Maruschak, 2009; Tan et al., 2008; Baillargeon et al., 2003). The data on health disparities specifically for incarcerated women, however, are even more alarming. Incarcerated women have greater health care needs than men and fewer resources are typically allocated for correctional facilities housing women. Health issues faced by incarcerated women include HIV, pregnancy, TB, hepatitis, hypertension, asthma, obesity, and diabetes.

While women comprise only 7.2% of the US prison population, they are more than twice as likely as imprisoned men to be living with HIV and 15 times more likely to be HIV positive than are non-incarcerated women (Havens et al., 2009; DeGroot & Cu Uvin, 2005). In New York state prisons, which estimates the number of HIV and confirmed AIDS cases using data from blind seroprevalence studies conducted biannually, nearly 12% of incarcerated women (compared to 5.6% of incarcerated men) were found to be HIV positive (Maruschak, 2005). The majority of HIV-infected women were most likely infected before their incarceration and had experienced factors that are associated with high risk for both HIV and incarceration (Zack, 2007). Among these risk factors are relationships with high risk partners (Centers for Disease Control and Prevention, 2008), involvement in substance abuse (Talvi, 2007), and a history of domestic and sexual abuse (Lichtenstein, 2005; Braithwaite, Treadwell, et al. 2005; Hammett and Drachman-Jones, 2006). In addition, 75% of women in US jails reported mental health issues versus 12% of women in the general population. Over two thirds (69%) of women in US jails report substance dependence or abuse, as compared to only 6% of women in the general population. (Bureau of Justice Statistics, 2006). While most infection risk behaviors occur prior to incarceration, some incarcerated women engage in risk behaviors inside correctional facilities, including syringe-sharing involved with injection drug use and tattooing and unprotected sex with same-sex relationships (Hammett and Drachman-Jones, 2006).

Prevalence of Physical and Sexual Abuse

There is a clear pathway from childhood abuse to incarceration. Many abused girls become runaways as they try to escape their abuser which leads to their arrests as status offenders; that is committing an act (in this case running away) that would not be considered a crime if it were committed by an adult. Many runaway girls become young women who are forced to live and work on the streets with no legal means of survival. These young women often become addicted to substances as they struggle to endure sex work, desperation and depression. Eventually, these women find themselves involved in the criminal justice system; arrested for economic crimes when trying to make ends meet, for drug related crimes stemming from their addiction, and/or for crimes committed against their abusers in an effort to protect themselves and their children (Gilfus, 2002).

Official reports estimate that 43–57% of incarcerated women have been victims of physical or sexual abuse prior to incarceration (American Correctional Association, 2000). Smaller, more in-depth studies indicate rates of physical and sexual abuse as high as 66–94% (Browne, 1999). Nearly three quarters (71%) of incarcerated women have been exposed to domestic violence (Green, et al., 2010).

The progression continues as incarceration further compounds women's trauma. Body searches, handcuffing, shackles and other restraints, and seclusion or solitary confinement can retraumatize women with histories of sexual or physical abuse (Green, et al., 2010). Sexual abuse can also occur behind bars. In an effort to address sexual abuse in correctional facilities, the US legislature passed the Prison Rape Elimination Act (PREA) in 2003. This law aimed to address prison rape through a "zero-tolerance" policy by developing national standards to prevent and detect incidents of sexual violence in prison, making data on prison rape more available to prison administrators and requiring corrections facilities to be more accountable for incidents of prison rape. Yet, as recently as 2010, a Bureau of Justice Statistics survey found that women incarcerated in prisons and jails were more than twice as likely as incarcerated men to report sexual victimization by another incarcerated individual during their confinement (Beck, Harrison et al. 2010). Furthermore, incarcerated women have been found to be at risk of sexual assault by -- or coercive sexual relationships with -- male correctional officers (The Members of the ACE Program of the Bedford Hills Correctional Facility 1998; LeBlanc 2003). Sexual abuse of women by correctional staff during routine medical examinations has also been documented (Braithwaite, Treadwell et al. 2005).

HIV Risk for Women Partners of Incarcerated Men

The relationship dynamics within heterosexual couples in which the male partner is incarcerated can also affect women's HIV risk. For example, open communication about sex and HIV exposure is associated with higher levels of condom use and lower levels of unprotected sex (Ahlemeyer and Ludwig 1997; Van Campenhout and Cohen 1997; Bruhin 2003; Klein, Elifson and Sterk 2004). Correctional rules and a lack of privacy can impede a couple's willingness or ability to address sexual-health issues when communicating with each other during the incarceration period. In addition, strict regulations of physical contact between incarcerated individuals and visitors disrupt women's feelings of closeness to their partner and dissuade them from discussing personal topics such as HIV testing or condom use during their visits (Comfort et al., 2005).

Communication difficulties also do not immediately abate when a man is released from jail or prison. Stress over finding employment, contributing to the household, and avoiding trouble can cause men to withdraw emotionally and become depressed (Hagan and Coleman 2001; Travis and Waul 2003; Braman 2004). As a result, difficult issues such as sexual

health and HIV risk that were not discussed during the incarceration period are left unaddressed post-release. In the meantime, the wives and girlfriends of formerly incarcerated men often do not regard correctional settings as being particularly risky in terms of acquiring illness. As a result, they may not see the need to avoid unprotected sex with a partner who has recently rejoined society (Comfort et al., 2000; Grinstead et al., 2005).

Furthermore, the incarceration of a partner may aggravate pre-existing risk factors in women's lives or push women into risk behaviors they had previously managed to avoid, particularly if their male partners had acted as a protector, advocate, or financial provider in the relationship prior to his arrest. A partner's imprisonment can cause or heighten women's feelings of loneliness, depression, anxiety, and powerlessness (Girshick, 1996) -- emotions that may weaken women's bonds to societal support structures and precipitate "entrapment" in situations of severely limited options (Richie 1996).

A partner's imprisonment may also result in a drop in women's income due to the loss of contributions he previously made to the household, including child care, food, or gifts. This loss is often compounded by the considerable financial cost of prison visiting and phone calls (Grinstead et al. 2001). As a result, some women engage in sex work to combat financial problems during a partner's prison term, while others become involved with secondary or multiple partners during a primary partner's incarceration in order to obtain financial, physical, or practical support. Indeed, one's own incarceration and the incarceration of one's partner have been repeatedly associated with greater prevalence of concurrent sexual partnerships due to the disruption of primary relationships (Gorbach et al. 2002; Manhart et al. 2002; Adimora et al. 2003b; Adimora et al. 2003a; Thomas and Sampson 2005).

The Revolving Door of Incarceration

Couples' relationships often span multiple periods of incarceration; with men or women serving several months in jail or years in prison, then spending a few weeks or months living with their partners, then going back to jail or prison for another sentence, only to return to the same partner once again (Braman 2004; Nurse 2004; Comfort 2008). Unprotected sexual intercourse has emotional and practical importance within a larger context of romantic connectedness and societal reintegration for couples coping with these cycles of freedom and confinement, as does the conception of children (Comfort et al., 2005). In this context, where demonstrations of attachment become crucial, the suggestion by either partner of using condoms upon an individual's release can be seen as disrespectful to the relationship or as negating a new level of commitment, trust and intimacy (Sobo, 1995; Stevens, 1995).

Facing Life (and HIV Risk) after Incarceration

When women leave correctional facilities, they may return to homes filled with violence. They may have lost custody of their children during their absence. They may also face stigma and negative societal expectations based on their previous behaviors that resulted in their incarceration. All of these stressors can trigger risky behaviors including substance use, unprotected sex, and/or sex with multiple partners.

Upon release, women also frequently face structural issues such as lack of work opportunity, lack of childcare, uncertain or inadequate housing and other repercussions of racism, poverty, and sexism that increase the vulnerability of women to HIV infection. Any and all of these can increase women's HIV risk through lack of health care, illegal or hazardous work, violence, domestic abuse, and exposure to street drug and sex trade cultures.

DISCUSSION

It's all about relationships

Risk factors for women are very much “gendered.” The Centers for Disease Control and Prevention surveillance data indicates that 80% of women with HIV were infected by a sexual partner (Quinn and Overbaugh, 2005). Fewer women than men acquire HIV through injection drug use, and even this risk factor is likely to occur in the context of a sexual relationship where drug paraphernalia are being shared. Women are more likely than men to be relationship-centered, seek and maintain bonds with others and avoid conflict in personal relationships (Lichtenstein and Malow, 2010). Most women are arrested because “they couldn’t or wouldn’t snitch on boyfriends, husbands, friends or causal relationships” (Talvi, 2007, pg 7). Even when faced with lengthy sentences, incarcerated women tend to build communities and social networks with other incarcerated women in an effort to survive their incarceration. Yet many times these women feel isolated and concerned for their relationships with their children and families at home. This isolation is exacerbated if their children are not able to visit these women during their incarceration because prisons are located far away from home or because the children are placed in foster homes and there is limited communication with social workers. Women whose male partners are incarcerated, also often feel isolated in their struggles to maintain relationships with their incarcerated male partners, and simultaneously expend a great deal of their limited financial and emotional resources on maintaining this relationship.

While it is clear that women naturally put a great emphasis on relationships, most HIV prevention interventions are designed for men and focus on risk reduction in individual, rather than relational, terms. Thus there is great need to develop, evaluate and disseminate more relationship-based interventions designed to strengthen the positive social support networks for women affected by the criminal justice system.

One such intervention is the Health Options Mean Empowerment (HOME) Project that was developed for women visiting their male partners at San Quentin State Prison (Grinstead, et. al, 2008; Reznick et al., 2011). The HOME Project placed HIV risk reduction in the context of women’s relationships with incarcerated men. As part of the intervention, HOME trained women visitors to be peer health educators, both for other women visiting men at San Quentin and for women in the peer educators’ home communities. The program demonstrated that peer education is a feasible means of providing HIV education to women with incarcerated partners and that flexibility and inclusiveness are important factors in designing interventions for this population. Based on the success of the HOME Project, in 2009, the US Department of Health and Human Services, Office on Women’s Health, awarded cooperative agreements to eight community-based organizations across the county to design and implement innovative and gender-responsive HIV prevention programs to meet the unique risks and needs of women within their communities who have currently incarcerated or recently released male partners.

Recognize the difficulties of women’s lives

Women and girls affected by incarceration are often juggling many of the hardships of being poor women and women of color. In addition, they face the unique stressors of balancing the emotional and financial toll of their own incarceration themselves and/or that of their male partner both during incarceration and after release. The reality of these burdens greatly hinders their ability to prioritize HIV prevention until other life issues have been addressed.

The fact that women from high risk communities (including incarcerated women and women partners of incarcerated men) have experienced elevated rates of sexual and physical abuse also greatly impacts their ability to successfully engage in standard HIV prevention

practices such as risk negotiation and condom use. Interventions designed to meet their needs must understand and prioritize the other unique life stressors that they are experiencing.

One such intervention is Project START, the first corrections- based intervention to be accepted by the Centers for Disease Control and Prevention as part of its Diffusion of Effective Behavioral Interventions (DEBI) Program (Kramer and Zack, 2009). Project START is an HIV/STI/hepatitis risk reduction program for people returning to the community after incarceration. Like other HIV prevention programs, Project START has a focus on reducing HIV/STI/hepatitis risk, yet it has been designed specifically for incarcerated populations. Thus the program recognizes that there are most often more pressing life needs for an individual returning to the community after incarceration (such as housing, employment, childcare, mental health and substance abuse) and incorporates linkages to community providers for these life needs in addition to traditional HIV/STI/hepatitis risk reduction strategies (such as encouraging safer sex practices, referrals to syringe exchange, etc.) In doing so, Project START recognizes that participants will be more likely to follow-up on their HIV/STI/hepatitis risk reduction goals when other life needs have been addressed. Project START is designed to be flexible and easily adapted to individual needs. In the case of women and girls affected by incarceration, Project START can include service linkages for issues such as child custody, support for survivors of domestic violence, or couples counseling and mental health services.

Incarceration interrupts family planning

Another reality for women affected by the criminal justice system is that many want to conceive children, either after their own release from a correctional facility or after the release of their male partner. They share the common, human desire to have children with the men they love and with whom they are in committed relationships. Incarceration for women and/or their male partners can complicate and delay this goal. After incarceration there may be a “rush” to conceive and have children without prioritizing pre-conception health (including HIV screening), pre-natal health, or HIV prevention.

Typical HIV prevention interventions focus on individual behavioral change without regard for the gender and cultural context in which the behaviors occur. HIV prevention programs designed for women and girls affected by incarceration, by contrast, must take into consideration the other priorities and stressors that feature more prominently in the lives of their target audience. These programs must take into account, and explicitly address, some women’s immediate goal of having children after they and/or their partner has been released from a correctional facility and thus, include additional risk reduction strategies other than condom usage.

Girls on the side

While very little attention has been given to women affected by incarceration, there has been even less focus on girls within the juvenile justice systems. Yet it is clear that the pathway that many women take to incarceration includes time within the juvenile justice systems. In addition, many girls have intimate partners who are incarcerated in juvenile or adult correctional systems. Not enough attention has been given to developing and evaluating programs specifically for girls affected by the criminal justice system.

An effort to address this gap is the Girls Study Group (GSG), convened in 2004 by the Office of Juvenile Justice and Delinquency Prevention and led by RTI International. GSG conducted a comprehensive review of the literature on, and programs targeting, girls’ delinquency, a review of risk-assessment and treatment-focused instruments, analysis of

secondary data, and dissemination of GSG project findings to the public. The GSG has made significant progress in understanding girls' delinquency, including patterns of offending among adolescent girls, the protective factors associated with girls' delinquency, and the importance of considering these issues when developing effective prevention and intervention programs for these girls (Hawkins, 2010).

One HIV prevention program serving girls within the juvenile justice system that showed positive impact on risk reduction is Girl Talk-2. Girl Talk-2 is a six hour, peer-led group intervention serving girls within the county juvenile justice system. An evaluation of the program demonstrated that participants in the Girl Talk-2 intervention group had significantly higher use of condoms and communication skills to defuse potentially violent situations than girls in the comparison group at 6 months follow-up (Kelly, et. al. 2007).

RECOMMENDATIONS

The following are a list of program and policy recommendations that specifically address the unique risks, obstacles and opportunities facing women and girls affected by the criminal justice system. These recommendations should be considered for implementation within the National HIV/AIDS Strategy as well as by program implementers and policy makers at the state and local level:

- Establish a cross agency DHHS community advisory board focused on encouraging and reviewing all related programming initiatives and policies for women and girls affected by incarceration.
- Ensure that all women and girls affected by incarceration (both those who are incarcerated and those partnered with incarcerated men) are counted and considered when decisions are made around the intersection between HIV and the criminal justice system.
- Ensure that all criminal justice and corrections health programs view women and girls in the context of their relationships (partners, children, family, and community).
- Develop and enforce program standards that respect the individuality and autonomy of women and girls, including sexual safety while incarcerated.
- Expand correctional health programming (including in-custody and re-entry programs) to include HIV prevention and sexual health education that cover both sexual risk and drug and syringe related risk.
- Prioritize the sexual health needs of girls and women under correctional supervision.
- Deliver integrated HIV/Substance Treatment/Mental Health programs for women and girls in correctional facilities, and routinely screen for childhood sexual abuse and trauma in connection with these services.
- All HIV prevention programs serving incarcerated women and girls and the women partners of incarcerated men must incorporate issues of gender-based violence prevention and treatment.
- Develop programs and outreach strategies that promote condom distribution and HIV counseling and testing for women planning for their male partners' return home after incarceration.

- Include condoms (male and female), hygiene items, and current information about community resources in release packets for all individuals being released from a correctional facility.

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