

HIV, Incarceration and Community:



A Paramount Linkage

By Melanie Spector

HIV/AIDS is the fourth leading cause of death worldwide,¹ and researchers hypothesize that the number of people who will develop AIDS during the 21st century will continue to grow. The Centers for Disease Control and Prevention estimates that the number infected with HIV in the United States exceeds 1 million.² And because the impact of HIV disease is disproportionate in economically disadvantaged populations, it is not surprising that the estimated prevalence of HIV infection is considered to be five times higher for incarcerated male populations.³

Impact of HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms or opportunistic infections occurring from a damaged immune system. It is caused by a retrovirus commonly known as Human Immunodeficiency Virus (HIV), which attacks the immune system, leaving individuals at risk for infections, depression, declining health and untimely death. Immune-compromised people are unable to fight off organisms generally considered normal in the human body.

The social impacts of HIV are excruciating for individuals, families and communities. Those infected face decreased quality of life and loss of jobs, housing and medical insurance. Stigmatization and discrimination aimed at people living with HIV/AIDS is also well documented. Families face poverty, increased stress and dysfunction, and higher medical and legal costs. Communities face the loss of social and economic capital and increased hospital and emergency room expenditures. The astronomical costs of HIV medications pose enormous ethical burdens on communities and medical providers that turn away HIV-positive patients due to limited funding. It is not surprising that a direct correlation has been shown to exist between the prevalence of HIV infection in a country and a decrease in the country's ability to prosper.⁴

Many who are infected with HIV are unaware of the status of their infection and may unknowingly infect others.⁵ In 2004, the CDC estimated that 180,000 to 280,000 people living with HIV in the United States are unaware of their infection. More recently, the U.S. Department of Justice estimated that 25 percent of people living with HIV in the United States pass through correctional facilities each year. States with higher HIV prevalence levels often house inmates in separate dormitories to ensure access to direct observed HIV therapy (the health care provider watches the patient take each drug dose) and to preserve the dignity and safety of those infected. The DOJ further estimated that AIDS cases are three times higher in prisons, and the HIV infection rate is estimated to be five to 10 times higher in male and female prison settings than in the general population.⁶

The Need for Action

Oklahoma is among many states increasingly incarcerating people who use illegal injection drugs, further exacerbating the opportunity for HIV transmission among inmates. When HIV-positive inmates are released from prison, they are focused on reentry tasks such as finding a job and housing, and reconnecting with their families. Health care may not be a priority, increasing the chance of the interruption of medication and causing higher HIV viral load levels. Oklahoma's HIV/STD Service reported in 2004 that approximately 12 percent of HIV-positive people who requested additional information about prevention and treatment were serving time in prison.⁷ These alarming statistics highlight the need for greater collaboration between the community, medical and psychosocial service providers, and inmates living with HIV.

In response to the relational epidemics of HIV and incarceration, the Oklahoma Department of Corrections, in concert with the Oklahoma State Health Department and community-based organizations (including local and national funders), developed the HIV Peer Education Program for Incarcerated People. Eligible inmates (those who have a high school diploma or GED and volunteer to be a peer educator) receive college credit from Tulsa Community College or Oklahoma State University for successful completion of related college curricula, and they are responsible for recruiting and teaching their peers about eliminating sex and drug behaviors that enable HIV infection.

Although the program began in women's facilities in 1992, it recently matured and expanded to men's facilities. The program is considered a promising evidence-based intervention because of its methodology, rigorous implementation, fidelity to peer theory, process and outcome program-evaluation measures, and strength of efficacy for reducing the rate of new HIV infections while simultaneously increasing protective behaviors. The program uses the philosophical principles of radical education and encourages inmates to gain control of faulty thinking through dialogue, critical thinking, and envisioning the historical roots of social problems and transformation. The strength of the peer education program lies in its use of fellow inmates as teachers and its inmate-developed pedagogical materials.⁸ As peer theory comes alive through practice, peer educators who teach about eliminating risky drug and sex behaviors change their own behaviors. Undeniably, peer educators strongly identify with their own instruction. For example, one peer educator recently recalled, "In my 16 years of prison this was the most successful program I saw — namely inmates teaching inmates. We ran our own groups and the program gave us an opportunity to give back."⁹ Today, this ex-offender counsels critically ill HIV-positive clients using many of the strengths she learned as a peer educator.

The peer education program has a minimum of 20 volunteer peer educators at each facility. After inmates successfully complete the college course and become peer educators, they can begin offering information through lecture, group dialogue, videos and peer development manuals. Classes usually take place during orientation for new inmates, although some prisons provide the information during general health education classes. Each facility determines the scope and sequence of HIV information. For example, at one women's facility, peer educators provide information on the relationship between domestic violence and the inability for women to insist on condom use and the connection to HIV infection. Conversely, at one men's facility peer educators dialogue about injection drug use and its correlation to HIV.

Community Collaboration

To increase their effectiveness, female peer educators requested additional health and psychosocial information and began networking with the National AIDS Fund and AmeriCorps workers to develop health fairs inside the prison. The community and prison response was overwhelming, resulting in exemplary cooperation from prison personnel and security as agencies responded to the need with compassion and commitment.

Staff of local health agencies appeared on-site with information on diabetes, cancer, bone health, cardiovascular disease, yoga, nutrition, exercise and sickle cell anemia. The DOC's chief dental officer developed an interactive prevention station and distributed toothbrushes. Valuable medical screening services for hypertension and cholesterol were made available. Information on alcohol and drug abuse and where to access help for addiction for individuals and families were provided. Representatives from local universities and libraries promoted literacy and the lifelong search for knowledge. More important, inmates

were able to reach out and form strategic alliances with outside health, community and psychosocial providers who assured additional educational literature and support for offenders upon their release from prison. In some cases, oral HIV screening was conducted to allay fears for inmates who had put themselves at risk.

Although the health fairs were not specific to HIV, the ubiquitous information was appreciated by all inmates who attended, and the theme of health awareness and education was promoted. Lifestyle information increased attentiveness to how inmates could better prevent disease while incarcerated and demonstrated how the road to wellness would help in the reentry process. Now, health fairs are offered in facilities for both women and men.

Providing health fairs for the incarcerated is a challenge, but a surmountable one. They demonstrate an unspoken ethic of care by prison staff and the community that promotes a passion for personal responsibility in living healthy lives. Each year, the HIV Peer Education Program for Incarcerated People, funded by local and national agencies, results in both anticipated and unanticipated outcomes. Health fairs are an example of an unanticipated windfall of education and support for inmates, and they foster the linkage between living with HIV, community, health awareness and incarceration.

Health fairs for inmates are an important source of information and support that was won for fellow inmates through the encouragement of the peer educators, who play an even larger role by bringing life experiences, knowledge and a sense of realism to the prison classroom. Within this contextual milieu, marginalized people, who

traditionally lack health care and who are indisputably difficult to reach, have the opportunity to hear compelling and culturally relevant information that could alter their knowledge, attitudes, beliefs and behaviors.

Ultimately, the peer educators bring intense health communication messages, encouraging their fellow inmates to avoid behaviors that put them at risk for HIV, alcohol and drug dependency, and associated maladies. Information and outside resources to encourage a comprehensive healthy way of living are important, especially for people living in prison who may have traditionally ignored individual health care.

Prison health fairs present a unique opportunity to bridge health and community for the incarcerated. For example, at a recent health fair held at a community correctional facility, the local health department provided information and free respiration testing. Another community-based organization provided free, anonymous HIV testing. Information about hepatitis and locations for free hepatitis C testing were distributed. When inmate health and community meet, the old adage, "an ounce of prevention is worth a pound of cure" becomes an important reality.

ENDNOTES

¹ Lamptey, P., M. Wigley, D. Carr and Y. Collymore. 2002. Facing the HIV/AIDS pandemic. *Population Bulletin*, 57(3):3-38.

² Centers for Disease Control and Prevention. 2005. One million living with HIV in U.S. 2005. Retrieved from www.cnn.com.

³ CDC. 2006. HIV transmission among male inmates in a state prison system. *Morbidity and Mortality Weekly Report*, 55(15):421-426.

⁴ Piot, P., M. Bartos, P.D. Ghys, N. Walker and B. Schwartlander. 2001. The global impact of HIV/AIDS. *Nature*, 410(6,831):968-973.

⁵ Carrns, A. 2001. Twenty years of AIDS in America. *Wall Street Journal*, 30 May, p. B1.

⁶ Beck, Allen J. and Paige M. Harrison. 2005. *Prisoners in 2003*. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

⁷ Spector, M., N. Diehl, A. Shah and J. Hunter. 2004. *Results of a needs assessment for HIV positive people*. Oklahoma City, Okla.: Oklahoma State Department of Health, HIV/STD Service.

⁸ Spector, M. and K. Sleezer. 1999. Health education for women at risk: HIV peer education for incarcerated women. *Journal of Health Occupations Education*, 13(1):63-86.

⁹ Heinz, V. 2005. Speaking out to improve the health of inmates. *American Journal of Public Health*, 95(10): 1,685-1688.

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