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HIV Education Prison Project

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HEPP NEWS

HIV
EDUCATION
PRISON
PROJECT

April 2000 Vol. 3, Issue 4

Sponsored by the Brown University School of Medicine Office of Continuing Medical Education and the Brown University AIDS Program.

ABOUT HEPP

HEPP News, a forum for correctional problem solving, targets correctional administrators and HIV/AIDS care providers including physicians, nurses, outreach workers, and case managers. Published monthly and distributed by fax, HEPP News provides up-to-the-moment information on HIV treatment, efficient approaches to administering HIV treatment in the correctional environment, national and international news related to HIV in prisons and jails, and changes in correctional care that impact HIV treatment. Continuing Medical Education credits are provided by the Brown University Office of Continuing Medical Education to physicians who accurately respond to the questions on the last page of the newsletter.

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HIV INFECTION AMONG INCARCERATED WOMEN: AN EPIDEMIC BEHIND THE WALLS

Anne S. De Groot, M.D.*

Co-chair, HIV Education Prison Project, Director, TB/HIV Research Lab, Brown University

Even though women are less likely to be incarcerated than men (one in 10 inmates in US prisons and jails is a woman), incarcerated women are three times more likely to be HIV infected than incarcerated men. The proportion of inmates with HIV (US prisons: 2.3% of men and 3.5% of women) is much higher than the proportion of HIV infected persons in the general population (US free population: 0.6% of men, 0.1% of women). This difference is amplified in the Northeast, where HIV prevalence among incarcerated men is 7% and 13% among incarcerated women.¹

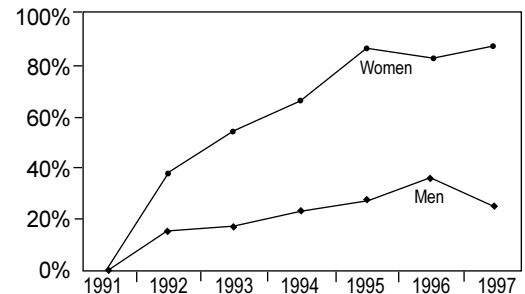
In addition, the number of HIV infected women in prison has risen steadily since 1980, due in part to the steady increase in the total number of women who are incarcerated (figure 2).² The prevalence of HIV infection among incarcerated women rose 88% in 1995, while the rate among men rose 28% (figure 1).³

WHY SO MUCH HIV AMONG INCARCERATED WOMEN?

In most prison systems, the prevalence of HIV among women is two- to three-fold higher than in men. Numerous studies have shown that the same behaviors that lead to incarceration put women at increased risk for HIV infection.^{4,5,6,7} Links between drug use, sex work, victimization, poverty, race and HIV explain the prevalence of HIV infected women behind prison walls. Recent reports on the status of women inmates in the US have revealed the following:

- 84% of the total US female inmate population, or 65,338 women, reported a history of "ever" using drugs. 74% used drugs regularly.⁸
- Most of the 84,400 women who were in prison in 1998 were incarcerated in state facilities (63,735). 37% of state women inmates were charged with drug-related offenses, while 72% of women in federal prisons were charged with drug-related offenses. Since 1980, the rate of incarceration of women for drug charges has increased three-fold, (11% to 34%), while the rate of incarceration for violent offense has declined by half (49% to 28%).⁹
- Almost two-thirds of women in prison are women of color.¹⁰ Black women are twice as

FIGURE 1. Increase in HIV+ Inmates Since 1991, by Gender



This graph describes the increase in HIV-infected inmates by gender for each year between 1992 and 1997, compared to the 1991 baseline. The number of HIV-infected incarcerated women has been rising steadily while the number of HIV-infected men has leveled off and appears to be declining. Adapted from the GAO Report on Women in Prison, December 1999.

likely as Hispanic women and eight times more likely than White women to be in prison. HIV has disproportionately impacted women of color in recent years.¹¹

● According to self reported data, between one half and two thirds of incarcerated women have been physically or sexually abused before incarceration. These figures probably underestimate the prevalence of such histories among incarcerated women.^{12,13}

Incarcerated women frequently report histories of sexual and physical abuse. As many as two in three incarcerated women (33-65%) report prior sexual abuse and as many as two in five (19-42%) report a history of childhood sexual abuse.^{14,15} More than 80% of women in prison have experienced significant and prolonged exposure to physical abuse by family members or intimates.¹⁶ In contrast, in studies of women who

Continued on page 2

WHAT'S INSIDE

Spotlight	pg 5
HEPPigram	pg 6
Save The Dates	pg 7
HIV 101	pg 8
Self-Assessment Test	pg 9

HIV INFECTION...

(continued from page 1)

are not currently incarcerated, approximately one in seven women reported a history of forced sex, one in five women (20%) report a history of childhood sexual abuse, and about one in four (25%) women report a history of physical abuse. (Note that these studies of women in "free living" communities did not explore histories of incarceration, thus there may be some overlap between the populations). The impact of prolonged sexual and physical abuse prior to incarceration on incarcerated women's health care, mental health care, and risk behaviors is thought to be profound.^{17,18}

Incarceration represents an opportunity for health care and mental health care that may reduce the long-term sequelae of physical and sexual abuse. Although unproven, it is likely that selected interventions (such as HIV education, sexual abuse recovery, mental health care) in the appropriate setting may also reduce HIV risk behavior among these high-risk women after release from prison. For those women that are already HIV infected, incarceration represents an opportunity to initiate a comprehensive HIV care plan and to build a framework for continuity of care that extends to the community to which she will return.

MANAGEMENT OF THE HIV-INFECTED INCARCERATED WOMAN

The life circumstances of this population, as described above, are a critical reminder that an HIV-infected incarcerated woman has many concerns that affect her ability and willingness to engage in the complex course of intervention that is characteristic of effective HIV treatment. An incarcerated woman's experiences and concerns are the framework within which a provider must construct her HIV management plan.

MAKING THE DIAGNOSIS

Especially in state prison systems, there may be elective or mandatory HIV testing at the beginning or the end of incarceration. Most systems allow elective testing when medically indicated at any time during incarceration as well. In prisons or jails where there is no mandatory testing, the issue of convincing female prisoners to be tested becomes very important. When approached in a sensitive manner, incarcerated women are often willing to be tested for HIV. Factors that can encourage women to be tested include the impact of HIV infection on their present or future children and concerns about having acquired HIV infection in the context of other sexually transmitted diseases. Many of these women may have been tested in the course of prior pregnancies and may therefore be familiar with the concepts and procedures related to performing the HIV test. However, younger women (who have had fewer arrests, fewer pregnancies, and may have had fewer opportunities for interacting with HIV testers and counselors) may be more resistant to testing.

Given the high prevalence of HIV infection and HIV risk behaviors among incarcerated women, it is extremely important to use every opportunity to discuss HIV testing and to promote safer lifestyles. The following clinical situations indicate HIV testing and HIV education:

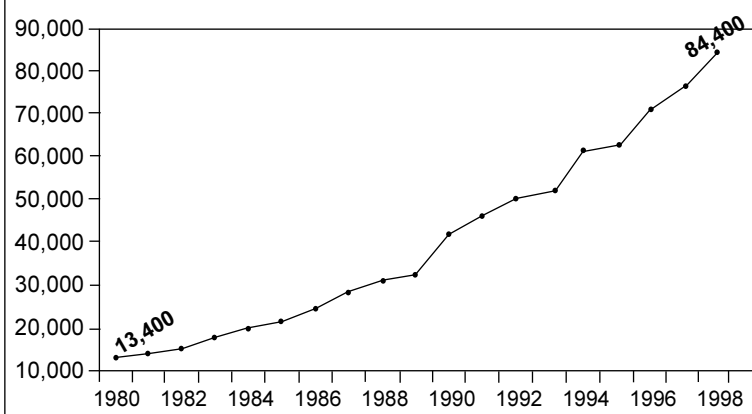
- Diagnosis of another (non-HIV) sexually transmitted disease
- Requirement for detoxification after admission to jail (discussion of HIV risk and test is recommended after the detoxification period is over)
- History of treatment for a sexually transmitted disease
- Presence of Hepatitis B or C infection (suggesting other blood/sexually transmitted infections may be present)
- History of sexual abuse (can be associated with HIV risk behaviors)
- History of sex work¹⁹
- Request for pregnancy testing

The incarcerated woman's fear of stigmatization by her peers and by correctional staff has a markedly negative impact on testing programs in prisons and jails. The closed setting of correctional institutions makes confidentiality difficult to maintain (particularly if a clinic or care provider is identified as being associated with HIV). Peer education programs that reduce stigmatization and increase the general awareness of HIV (and the prevalence of infection among their peers) in the female prison or jail population appear to have a positive impact on a woman's willingness to be tested.²⁰

INITIATING AND MANAGING TREATMENT

Once the diagnosis of HIV is made, clinicians should discuss treatment with the patient. It is becoming increasingly important to spend a great deal of time educating patients prior to initiating therapy. Some correctional facilities for women schedule an initial discussion with the HIV physician specialist, followed by an additional one to two visits at two-week intervals prior to the initiation of therapy. Clinicians and patients should address timing of medication, special meal restrictions, and side effects prior to instituting therapy. The physician or nurse case manager should provide a written description, in the appropriate language, of the regimen, accompanied by pictures of the pills. For illiterate patients, instructions that include pictures of their pills accompanied by drawings of clocks (showing dosing times) are usually very helpful. The patient should be asked

FIGURE 2.
Number of Female Inmates in Federal and State Prisons 1980-1998



Since 1980, the number of women in federal and state prisons has grown more than six-fold. Adapted from the GAO Report on Women in Prison, December 1999.

to recite the medication regimen from memory at each visit. Incarcerated women are usually ready partners, once treatment is initiated, and exhibit better adherence while incarcerated than has been reported among patients in the community.²¹

CARE OF PREGNANT INCARCERATED WOMEN

In 1998, 1,400 women gave birth within prisons, but the number of those who were HIV infected is unknown.²² The extent of prenatal screening for HIV infection performed in federal and state prisons is also unknown at this time. Transmission of HIV infection to the fetus has been all but eradicated in the US due to the success of pre-natal HIV testing programs in the community. However, leading pediatric HIV researchers have raised concern about reaching high risk women who seek care late in the course of pregnancy.²³

The correctional setting provides a critical opportunity to reach a group of women who may not have accessed pre-natal testing in the community. Therefore, incarceration represents an opportunity to intervene, should maternal HIV infection be diagnosed, and an opportunity to teach women about the need for HIV testing and treatment during future pregnancies. According to standards set forth by Centers for Disease Control and Prevention,²⁴ thorough and non-judgmental discussion of HIV testing and antiretroviral therapy is a required component of pre-natal care.

MANAGEMENT OF HIV-INFECTED WOMEN IN CORRECTIONAL SETTINGS: ESTABLISHED GUIDELINES

The high prevalence of HIV infection among incarcerated women has had a dramatic impact on the type of care provided in correctional health units and on the cost of providing that care. Health care budgets for women's correctional facilities can be two-fold higher than budgets for men's correctional facilities. Those institutions that provide care for women populations where HIV is highly prevalent rank among the most expensive health care programs in the country.²⁵

Continued on page 4

LETTER FROM THE EDITOR

Dear Colleagues,

The high prevalence of HIV infection among incarcerated women in some correctional institutions, particularly those located in Delaware, Pennsylvania, New Jersey, New York, Connecticut, and Massachusetts, is a striking reminder of Jonathon Mann's adage: HIV strikes hardest among the most vulnerable populations. Linkages between histories of childhood sexual abuse, physical abuse, drug use, sex work, and HIV risk behaviors are believed to explain the disproportionately high prevalence of HIV infection among incarcerated women. Clearly, correctional institutions for women provide a unique access point for interventions designed to reach high-risk women populations. However, despite the critical position correctional institutions occupy in the AIDS epidemic, HIV prevention and management services are all too often considered onerous budgetary and personnel burdens.

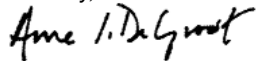
Here I would like to take my prerogative, as HEPP News editor, to propose that we rethink this situation. I propose that we, as correctional HIV providers, try to view our position at the nexus of the AIDS epidemic as a distinct advantage. Correctional institutions for women have, at this point in time, a unique opportunity to intervene by reducing HIV infection rates and diminishing the impact of HIV on women who are already infected, their children, their family members, and the communities to which they return. I would argue that efforts to contain or dramatically reduce HIV-related expenditures in correctional facilities for women may be misplaced. Rather than attempt to diminish the impact of the high prevalence of HIV in these populations on personnel effort, programming needs, and medication expenditures, correctional institutions might benefit from seizing this opportunity for leadership and develop "centers of excellence" for HIV care of women.

The good news is that some institutions for women have already taken this opportunity, and have even been able to take advantage of public health funding streams to support their leadership activities. Some of those programs (the list is incomplete) are summarized in this month's HEPPigram. When more institutions follow the example set by these leaders, and when their efforts are given the support and recognition they deserve by the public sector, all members of the correctional community, including the women who are affected, will benefit.

After reading this month's HEPP News readers will be able to cite recent statistics and findings, describe the linkage between histories of sexual abuse, drug use, and HIV infection among incarcerated women, describe the management of pap smears among incarcerated populations, and list the components of existing models of HIV care for incarcerated women.

Please continue to send us feedback!

Sincerely,



Anne S. De Groot, M.D.

The editorial board and contributors to HEPP News include national and regional correctional professionals, selected on the basis of their experience with HIV care in the correctional setting and their familiarity with current HIV treatment. We encourage submissions, feed-back, and correspondence from our readership.

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HIV INFECTION...

(continued from page 2)

Due to the recent increase in HIV patients within corrections, some institutions have developed flexible approaches to providing medications that address women inmates' needs. For example, women who are expected to be poor adherers can "graduate" to keeping their medications on person if they demonstrate adherence by attendance at the medline window. In some other institutions, a "strip pack" containing a one-day supply of medication is provided. This diminishes medline staffing needs while allowing for monitoring of medication and avoids the distribution of excess medication. (Release of strip packs is approved by a licensed doctor over the phone.)

Weekend admissions, dietary requirements and the timing of administration make adherence to and continuity of medications formidable tasks. One correctional facility for women recently addressed the problem of weekend admissions by making a three-day supply of medications available in "contingency" for use during weekends and extended holidays when less experienced M.D.s are covering the HIV infected patients.

Continuity of access to medication after release is addressed by providing a supply of medication at discharge that is sufficient, in theory, to cover the time period between release from incarceration and the first clinic visit post release. Some facilities provide a thirty-day supply of medication at discharge, recognizing how difficult it may be for women to locate a place to live, to reconnect with their

families, and to attend to their medical needs after release from prison or jail. In fact, discharge planning programs have by now become a widely accepted component of correctional HIV management, helping incarcerated women make smoother transitions into the community and continue to access HIV medical and related services after incarceration. A number of innovative inmate release plans have been devised to ensure continuity of HIV care, such as the StadtRelease plan formulated for various prison systems by a national medication distributor, Stadtlanders. Other states, like Georgia, have created similar plans with the assistance of a number of ART drug manufacturers.

HIV EDUCATION IN CORRECTIONAL SETTINGS

In recognition of the important role that HIV education plays in the reduction of HIV risk behaviors, many women's correctional facilities offer an array of HIV and safer sex education programs, peer led groups, drug treatment, counseling, and vocational training programs for their incarcerated female population. Bedford Hills in New York paved the way for future and existing models of HIV care by offering sexual and physical abuse recovery as a component of its program, AIDS Education and Counseling (ACE).

Programs that provide basic understanding of the virus, the disease, and build skills that diminish HIV risk are critically important in correctional settings. Programs that include these components have been published in detail.²⁶ Providers and patients need to have the same points of reference if the patient is ever to understand concepts of bacteria and viruses.

Incarceration is also an excellent opportunity to discuss risk reduction practices.²⁷

CONCLUSION

Correctional management of HIV can be viewed as a network of interconnected services that can address the various needs of an incarcerated woman infected with HIV. By testing for HIV infection and screening for gynecologic infections among incarcerated women, correctional health care providers can play a critical role in public health strategies for treating and reducing the spread of infectious diseases. By diagnosing HIV and instituting a plan for treatment, correctional facilities for women can play a critically important role in the reduction of morbidity and mortality among HIV infected women in high risk populations. By instituting comprehensive prenatal diagnosis and treatment protocols, correctional facilities can reduce vertical transmission. By diagnosing and treating sexually transmitted diseases, and using every sexually transmitted infection as an opportunity to teach about HIV, correctional facilities for women can reduce susceptibility to HIV and may also reduce horizontal transmission.

Overall, incarceration provides a critical opportunity for the education, diagnosis, and medical care of HIV-infected women and high-risk HIV seronegative women. Education and empowerment of these women who live with HIV and who are at risk of HIV, will help reduce their vulnerability. Above all, if we can address their HIV care and engage them as partners in an HIV management plan, it will not only benefit the women as individuals, but also the communities to which they may return.

* Speaker's Bureau: Agouron Pharmaceuticals, Bristol-Myers Squibb, Dupont

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TREATMENT NEWS

New Drug Targets: Updates from the 7th Conference on Retroviruses and Opportunistic Infections

David Paar, M.D.*

At the 7th Conference on Retroviruses and Opportunistic Infections, scientists identified new targets for HIV medication development. Three HIV-1 enzymes are necessary for viral replication: reverse transcriptase, protease, and integrase. Current antiretrovirals include nucleoside and non-nucleoside reverse transcriptase inhibitors (NRTIs, NNRTIs) and protease inhibitors (PIs). Identifying effective inhibitors of HIV-1 integrase, the enzyme responsible for inserting viral DNA into the DNA of host lymphocytes and macrophages, has challenged researchers for years. Integrase activity is complex and requires at least three sequential steps: binding of integrase to viral DNA, processing of viral DNA by the bound integrase, and, insertion of the viral DNA into the host cell DNA. Previously identified compounds that blocked steps 1 or 2 were not sufficient to stop viral replication in tissue culture. Scientists have identified two new compounds that block the third step in integrase activity, and both inhibit HIV-1 replication in tissue culture suggesting that they might be useful antiviral drugs. Neither of these specific compounds may pass the rigorous pre-clinical and clinical evaluations for safety and efficacy. However, identification of the crucial step for integrase inhibition represents a significant advance in the search for a clinically useful integrase inhibitor. (Session 22. Symposium. *New Drug Targets: Integrase Inhibitors*).

Bushman, et al, presented a study regarding the identification of clinically useful RNase H inhibitors. Reverse transcriptase (RT) is another enzyme whose function is a multistep process. After HIV-1 entry into a lymphocyte or macrophage, the DNA polymerase activity of RT uses single-stranded viral RNA as a template to produce double-stranded viral DNA. Intermediate products of this process are double-stranded RNA/DNA hybrids. Since only double-stranded viral DNA can be integrated into host cell DNA, the RNA portion of these hybrids must be removed before double-stranded viral DNA is produced. This is accomplished by the RNase H activity of reverse transcriptase, which hydrolyzes the RNA template. Bushman et al have identified several classes of compounds which inhibit this RNase function. Although all of the specific compounds tested so far are relatively weak inhibitors and unsuitable for further development, the identification of clinically useful RNase H inhibitors seems certain. An interesting aside is that the three dimensional structure of RNase H inhibitors is very similar to that of integrase inhibitors despite a lack of similarity in amino acid sequences. Whether this similarity will translate into compounds with both integrase and RNase H activity remains to be seen. (Presented by: Frederic Bushman, The Salk Inst., La Jolla, CA; Daria Hazuda, Merck Res. Labs., West Point, PA; and Stuart LeGrice, NCI, Frederick, MD)

*Speaker's Bureau: Roche Pharmaceuticals

SPOTLIGHT

Donna Bell - Rikers Island Correctional Center, New York City

by Michelle Gaseau, Managing Editor, *The Corrections Connection*
(www.corrections.com)

Working with pregnant inmates is a difficult job: the offenders often have multiple medical complications, don't understand the importance of proper medical care and resist most suggestions to improve their health and that of their unborn children. At Rikers Island, where Donna Bell, M.D. OB/GYN sees about 1,000 pregnant inmates a year, HIV treatment and testing also plays a role in the care of these women. HEPP News interviewed Dr. Bell about her work in 1999.

HEPP News: *What is your approach with pregnant inmates when they come to the clinic?*

Dr. Bell: Three days a week I provide obstetrical care and the other two days gynecological care. We might provide a colposcopy to find out why they might have an abnormal pap. Most of our population is prostitutes and drug addicts. They trade sex for drugs. They have all the Sexually Transmitted Diseases; warts is the biggest [disease]. We are mandated to test for and treat STDs and it is done on admission. If they desire it, HIV testing is voluntary. Most of them don't want it. The pregnant HIV-positive inmates we send to a counselor. We can't make them take the test, but we sit them in there with the counselor. We give it a try. I probably see about 1,000 inmates a year, but we have only 100 deliveries a year. They range from 16 to 44 years old. We try to send them to the city hospitals to deliver. We evaluate them in the clinic and send them out.

HN: *What kind of testing and treatment is available to HIV-positive pregnant inmates?*

DB: The fact that there are any resources at all is amazing. A lot of times the girls who are HIV positive haven't even had a viral load test. We did a blind study here where 25 to 30 percent were found to be HIV positive. CD4 testing is initiated here and the inmates are connected to a liaison on the outside. A social worker will set them up with HIV housing, social security, clinics on the outside, drug programs; they try to streamline the paperwork for them. We also have a syphilis-testing program. If they test positive then they are treated on the spot. That helps drop the syphilis numbers way down.

HN: *How do you get pregnant inmates, including those who are HIV-positive, to participate in medical care?*

DB: Girls will test you and try to push you. They will try to harass you, they cajole you, and they are hyperactive. You have to let them know you won't be pushed around. I argue with people all day long. When you get through all of that, you are doing the same thing you are doing on the outside. We provide everything here. We try to do as much here as we can. We have a high-risk pregnancy doctor who comes in. It's very hard and frustrating, but I always tell myself that a baby could someday be the President of the United States. You never know.

HN: *Are the pregnant inmates and new mother inmates housed separately at Rikers?*

DB: They are segregated where there are pregnant and post-partum inmates. Every third day they have prenatal classes. We have a nursery program here, [which they participate in] if they pass a psych exam. We have about seven inmates in the nursery now. They take care of their babies there and the babies can stay up to 18 months. Inmates can conceivably be here six to 12 months.

HN: *What is frustrating about your work?*

DB: I wish there were some way to make them take advantage of the programs. When they do utilize them, they do it to get out. I have girls who can be in [the jail] four times during the same pregnancy. It's 'Three hots and a cot.' They don't have a job, they don't have any skills, and they already have a record, so they come. [We] get up to 35 girls a day. You never really know who you can make a difference with.

HN: *What is rewarding about your job?*

DB: I'm definitely serving an underprivileged community. You have to yell and scream, but once you get over that, they start to come to you and pay attention and go to prenatal classes. It's nice to see them start to become real mothers. One of my patients was bouncing off the walls when she came in. Of course she had a complicated pregnancy. They put her on medication and two months later she was transferred to Bedford State Correctional Center. I received a letter from her after that and it was so clear with insight. It was a page and a half letter. We sent a postcard back to her. I'm proud to be here. I can work in other places outside, but I'm happy to be here.

HEPPIGRAM

Summary of Standard of HIV Care for Incarcerated Women in Three Northeastern Prisons

Name & Location	York Correctional Institution, Niantic, CT [^]	Massachusetts Correctional Institution at Framingham, MA ^{^^}	Bedford Hills Correctional Facility, Bedford Hills, NY ^{^^}
Method of HIV testing	Voluntary	Voluntary	Voluntary
WOMEN INMATES (1998) -Sentenced -Awaiting trial	1200 840 360	643 100-150 (county) 100-150	800 (up to 900) 800 0
% known HIV+ women inmates	9*	9-12%	9**
HIV+ women under treatment	80-100	40-60	60
MEDICAL STAFF: -Physicians -Nurses -Case Managers -Language skills	4 PT HIV specialists 2 nurses 1 case manager 2 M.D.s speak eng/spa	2 PT HIV specialist (1 day each) 1 nurse nurse acts as CM at least 1 eng/spa counselor	1 PT HIV specialist (3x/wk) nurse administrator N/A 2 eng/spa M.D.s
Available HIV-related medical services and treatment: -On-site -Off-site services -Medications	HIV & eye clinics, intermediate care unit, viral load monitoring UConn Medical Center HAART	HIV & eye clinics, infirmary, viral load monitoring Lemuel Shattuck Hospital HAART	HIV clinic, infirmary, viral load monitoring St. Agnes Hospital, and Westchester Medical Center HAART
On-site ob/gyn care	Gyn care, cyrosurgery, obstetric care	Gyn clinic (2x/wk), colposcopy	Gyn care, colposcopy, cryosurgery, prenatal care
MEDICATION POLICY: -Keep on person (KOP) -Medline -Provisions for continuity of Medications	Yes Yes 2 week supply upon discharge	Yes (revoked upon non-adherence) Yes 1 week supply upon discharge	Yes Yes 30 day supply upon discharge & Rx for additional 2 wks
RISK REDUCTION, EDUCATIONAL AND SUPPORT SERVICES SUCH AS: -HIV & safer sex education -Peer support/education -Physical & sexual abuse recovery -Drug treatment -Mental health -Skills building & vocational training	Yes Yes No Yes Yes Yes	Services provided by CBO (Great Brook Valley Health Center) Yes Yes No Yes Yes Yes (collaboration with Boston University allows some women to obtain degrees)	Services provided by AIDS Counseling & Education (ACE) Yes Yes Yes Yes Yes Yes
Discharge planning	Project Transitional Case Management (TLC)	Discharge planning provide by CMS and contractors (including Great Brook Valley Health Center) and is overseen by the DOC	Discharge planning with parole and community based health agencies
Oversight-review by external institution to ensure quality care	Doe vs. Meechum-court mandated level of HIV care w/ DOC oversight	State appointed AIDS Task Force	DOH oversight body

Adapted from the *Journal of Correctional Health Care*, Fall 1998; 5(2): 150-151. Updated for *HEPP News* in March, 2000,
 * intake seroprevalence is not equivalent to sentence seroprevalence due to release of unsentenced inmates** 9% seropositivity of women inmates under custody at BHCF, 18% intake seroprevalence based on 1997 blind study of reception at all NY women's correctional facilities

SAVE THE DATES

HIV Pathogenesis, Antiretrovirals, and Other Selected Issues in HIV Disease Management

April 19, Chicago, IL
April 25, San Francisco, CA
May dates TBA, Dallas, TX and Washington, DC
Call: 415.561.6725
Fax: 415.561.6740

E-mail: cme@iasusa.org

Visit: www.iasusa.org

Sponsor: International AIDS Society

HIV Prevention with Incarcerated Persons

A Public Health Training Network
Satellite Broadcast
April 27, 2000 1:00-3:00 PM EST
Call: 800.458.5231 or
TTY 800.243.7012

Visit: www.cdcnpi.org/broadcast

Sponsor: CDC's National

Prevention Information Network

10th Annual Clinical Care Options for HIV Symposium

May 4-5, 2000
Scottsdale, AZ
Call: 888.391.3996
Fax: 508.528.7880

Email: registration@mail.medscape.com

Visit: <http://hiv.medscape.com/symposium2000>

Sponsors: N.W. Univ. Medical School Comprehensive AIDS Center

Drug Use, HIV and Hepatitis: Bringing it All Together

May 7-10, 2000
Baltimore, MD

Call: 877.565.3693

Fax: 301.565.3710

www.chhatt.net/conference.html

Sponsors: CSAT of SAMHSA, NIDA of NIH, and the CDC.

HIV Prevention Strategies for Incarcerated Populations

June 20, 2000

Central Maryland, MD

Call: 410.328.8674

Fax: 410.328.9106

Email: sholland@medicine.umaryland.edu

Fee: \$20

Sponsors: Institute of Virology at the University of Maryland at Baltimore, AIDS Education & Conference Center. Maryland Department of Health & Mental Hygiene, AIDS Administration. Mid-Atlantic AIDS Education and Training Center (AETC). Baltimore STD/HIV Prevention Training Center (PTC)

NEWS FLASHES

Results from the Women's Interagency HIV Study

The Women's Interagency HIV Study (WIHS) collected data on the baseline behaviors of 561 HIV seronegative and 2040 HIV seropositive women. Self-report interviews revealed prevalence of various sexual and contraceptive behavior. Women with HIV were less likely to report heterosexual activity in the previous 6 months (65% HIV-positive, 76% HIV negative). There was no differences in the proportion of women reporting vaginal or anal sex, although women with HIV were less likely to report cunnilingus (41% HIV positive, 70% HIV negative) and fellatio (48% HIV positive, 57% HIV negative). 63% of women with HIV always used condoms during vaginal sex (versus 28% HIV negative) with lower rates of condom use reported during other sexual activities. The study concluded that although women with HIV exhibit lower levels of sexual risk behavior than uninfected women, many remain to be reached in terms of learning about and adopting safer behaviors. (Wilson-Tracey E, et al. *AIDS-Hagerstown*, 1999 April 1; 13(5): 591-598.)

Clinical Trials in Florida DOC Come to the Spotlight

Recent media coverage has raised a previously dormant discussion concerning the ethics of inmate participation in clinical trials for HIV medication. Articles printed in the *St. Petersburg Times* (FL) have made arguments both for and against such trials. *HEPP News* spoke with Dr. David Thomas, Assistant Chief of Health Services of the Florida Department of Corrections. "All of our inmates are informed volunteers without coercion. The [St. Petersburg Times] article cited one inmate on abacavir who could not recall whether or not he had been told about hypersensitivity reactions. We have several levels of internal, external and Federal review. We have demonstrated this objectively on multiple occasions. The Office of Health Services of the Florida Department of Corrections permits our inmates to engage in research opportunities with a world class investigator and from this interaction fundamental scientific principles have emerged that have been published internationally. We are satisfied that our inmates are under no coercion, are truly informed and are absolute volunteers with the ability to remove themselves from any study at any time without consequences."

Reaching Long-Term Success in the Treatment of HIV Infection

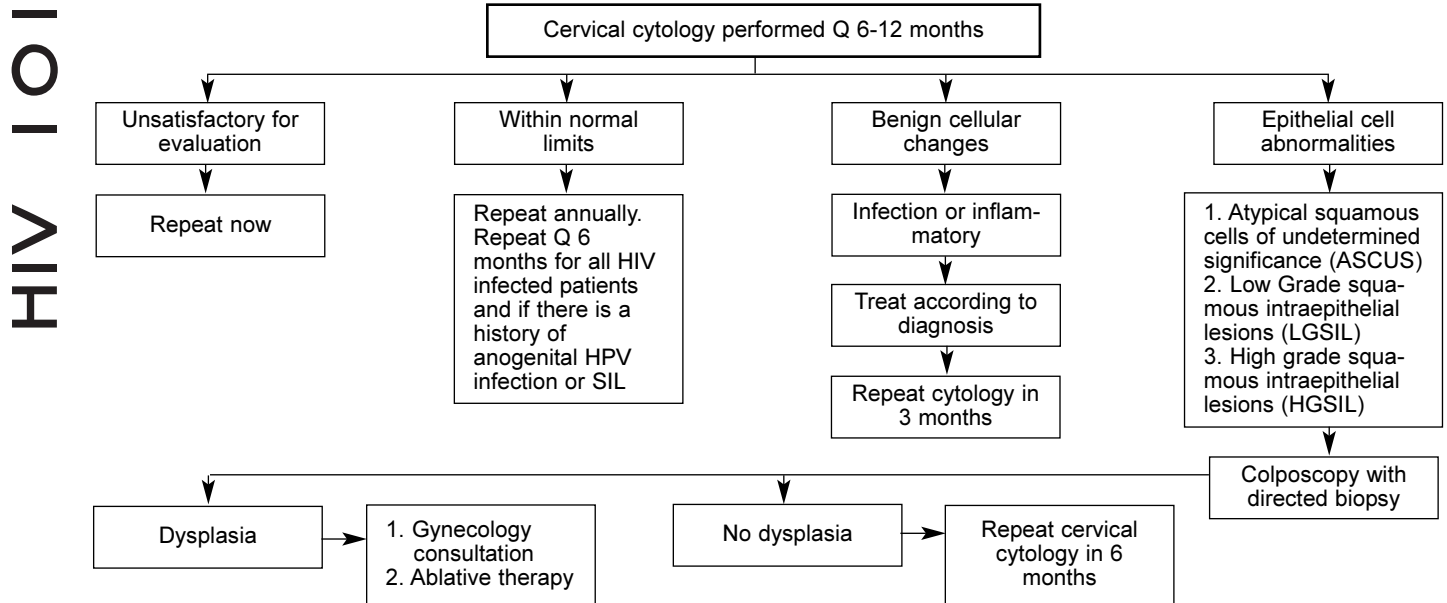
Joel E. Gallant, from the Johns Hopkins University School of Medicine in Baltimore, recently wrote in *JAMA* that expert care should be given to designing an HIV treatment regimen that will be fully followed and tolerable. Without this required expertise, regimens become less effective because of cross-resistance between the three drug classes. Genotypic and phenotypic resistance assays can help determine an effective salvage regimen if cross-resistance occurs. Viral load testing is now useful in determining a patient's status in relation to a CD4 cell count. It is up to patients and qualified physicians to make the best informed decisions in order to suppress viral load and prevent drug resistance. (Gallant JE. *JAMA*. 3/08/00; 283(10): 1329.)

ART Dosing Update

The FDA has approved a new twice daily dosing of Nelfinavir mesylate (1250 mg BID 5tablets) (Viracept, Agouron). The new tablets feature a gel coating to facilitate administration. Also, delavirdine mesylate (Rescriptor, Agouron) is now available as a 200mg tablet, instead of 100mg, which cuts the pill count in half and the new 200 mg pills are two-thirds the size of the 100mg tablets.

News from the National AIDS Update Conference

The 12th Annual National AIDS Update Conference was held in San Francisco, California last month. While HIV in the correctional setting was not discussed in any of the plenary speeches, a number of workshops addressed the current issues. At an intensive workshop before the official opening of the conference, four groups from California prison projects presented insights into improving HIV prevention, testing, counseling, and education in prisons and jails. The presenters emphasized the importance of involving inmates and ex-inmates in the education and counseling aspects of HIV intervention programs (Abstract 19). In one of the conference workshops, John Miles of the CDC's National Center for HIV, STD and TB Prevention presented data showing the burden of disease among inmates, emphasizing that 17% of the current cases of HIV in this country are reported from correctional facilities. Margaret Winter of the National Prison Project at the ACLU summarized the lawsuit involving Mississippi Department of Corrections' mandatory HIV testing and HIV-status-based segregation.



HIV 101 Gynecologic Care: An Integrated Component of HIV Care

The increase in development and progression of cervical dysplasia is believed to occur because HIV-infected women have decreased tumor surveillance capacity because of their altered immunoregulatory mechanisms. Therefore, management of pre-malignant lesions should be more interventional than with non-immunocompromised patients. Studies of the overall incidence of cervical cancer in HIV infected patients with squamous cell lesions are on going and these recommendations may be modified (*personal communication, S. Cu-Uvin, HERS Study*).

In the prison or jail setting, a more interventional approach is favored because 1) inmates do not necessarily remain in the correctional environment for prolonged periods; 2) should inmates be released to the community they may not be living in stable circumstances, and 3) it is unlikely that the individual will have her gynecologic issues addressed in the community while facing issues such as securing stable housing, meeting basic needs, providing for children and addressing issue related to treatment of her HIV/AIDS. Thus, for women in the correctional setting who have squamous cell lesions, it is prudent to go directly to colposcopy with directed biopsy and offer treatment if necessary. *Source: Puisis M. Clinical Practice in Correctional Medicine. D.O. Mosby: St. Louis, IL, 1998.*

HIV-infected incarcerated women have particularly high rates of cervical cytological abnormalities, sexually transmitted diseases and certain gynecologic infections. Research indicates that vaginal infections are slightly more common among HIV-infected incarcerated women than HIV-noninfected incarcerated women, while the prevalence rates of STDs are high among incarcerated women compared to free-living women overall.

RESOURCES

Journal of the Association of Nurses in AIDS Care (JANAC) is an excellent resource for care providers who work with HIV infected patients. There are chapters of the association in most states. The November/December 1999 issue focused on HIV policy and care in correctional facilities. The journal can be obtained from Sage Publications, Inc. or via ANAC Dept.203, Washington DC 20055-0203

WOMEN-SPECIFIC WEBSITES:

Medscape: Women and HIV
<http://hiv.medscape.com/medscape/hiv/clinicalmgmt/cm.v09/public/index-cm.v09.html>

The Body: Women Specific HIV Treatment Issues
<http://www.thebody.com/treat/women.html>

Journal of the American Medical Association Women's Health Information Center
<http://www.ama-assn.org/special/womh/womh.htm>

High rates of syphilis among incarcerated women nationwide have prompted a number of studies assessing methods of syphilis screening and treatment in the correctional setting. Several studies have shown the efficacy of administering qualitative (or STAT) rapid plasma regain (RPR) testing for syphilis. A recent study conducted at a New York City jail found that qualitative nontreponemal syphilis testing (STAT RPR), on line access to the local syphilis registry and immediate treatment (if indicated) following admission medical evaluation increased syphilis treatment from 7% to 84%.

Furthermore, high rates of HPV infection, of cervical cytological abnormalities and of invasive cervical cancer have been found among high-risk HIV-seronegative women and HIV-infected incarcerated women. Most correctional HIV programs have adopted an increased level of vigilance for cervical cancer, leading to the institution of biannual pap smears (every six months) as a routine component of care for HIV infected women. (See HIV 101 for more information)

Since many incarcerated women have experienced childhood sexual abuse and adult sexual trauma, gynecological and obstetric examination takes special care and sensitivity. Some of the issues that may interfere with the examination of sexually abused women include their need to trust the examiner, their need for control (wishing to control the time and place of the gyn exam), their fear of disclosure, and their fear of having their body touched during the examination. Insensitive gynecological providers can become a major barrier to obtaining the routine gynecological screening that is so critically important for this high risk population. Sensitive gyn providers should be considered critical members of the correctional HIV management team.

HIV TREATMENT WEBSITES:

HIV/AIDS Treatment Directory
<http://www.amfar.org/td>

Medscape HIV/AIDS
<http://hiv.medscape.com>

Johns Hopkins AIDS Service
<http://www.hopkins-AIDS.edu>

JAMA HIV/AIDS Information Center
<http://www.ama-assn.org/special/hiv>

International Association of Physicians in AIDS Care (IAPAC)
<http://www.iapac.org>

AEGIS-AIDS Education Global Information System
<http://www.aegis.com>

SELF-ASSESSMENT TEST FOR CONTINUING MEDICAL EDUCATION CREDIT

Brown University School of Medicine designates this educational activity for 1 hour in category 1 credit toward the AMA Physician's Recognition Award. To be eligible for CME credit, answer the questions below by circling the letter next to the correct answer to each of the questions. A minimum of 70% of the questions must be answered correctly. This activity is eligible for CME credit through May 31, 2000. The estimated time for completion of this activity is one hour and there is no fee for participation.

1. What are the latest targets for HIV medication development?
 - a) single-stranded viral RNA
 - b) double stranded RNA/DNA hybrids
 - c) HIV 1 integrase
 - d) reverse transcriptase
 - e) none of the above

2. What proportion of women inmates report a history of childhood sexual abuse?
 - a) 10%
 - b) 20%
 - c) over 1/4
 - d) up to 1/3
 - e) up to 2/3

3. Indicate true or false.
 - Once treatment is initiated, incarcerated women show better adherence than patients in the community.
 - In most prison systems, the prevalence of HIV among women is two to three-fold higher than among men.
 - The Centers for Disease Control states that thorough discussion of HIV testing and antiretroviral therapy is a required component of standard pre-natal care.

4. Correctional facilities in Niantic, CT, Framingham, MA, and Bedford Hills, NY have an average patient to HIV specialist ratio of:
 - a) 1:30
 - b) 1:60
 - c) 2:100
 - d) 1:100

5. Cervical Cytology should be performed every 6 months on patients with which of the following conditions?
 - a) history of anogenital HPV infection
 - b) history of SIL
 - c) HIV infection
 - d) a and b
 - e) a and c
 - f) all of the above

6. Which protease inhibitor dosing schedules are correct?
 - a) Amprenavir- 800mg BID
 - b) Nelfinavir- 1250mg BID
 - c) Ritonavir- 600mg TID
 - d) Saquinavir- 600mg BID

HEPP NEWS EVALUATION

5 Excellent 4 Very Good 3 Fair 2 Poor 1 Very Poor

1. Please evaluate the following sections with respect to:

	educational value	clarity
Main Article	5 4 3 2 1	5 4 3 2 1
HEPPigram	5 4 3 2 1	5 4 3 2 1
HIV 101	5 4 3 2 1	5 4 3 2 1
Spotlight	5 4 3 2 1	5 4 3 2 1
Save the Dates	5 4 3 2 1	5 4 3 2 1

2. Do you feel that HEPP News helps you in your work?
Why or why not?

3. What future topics should HEPP News address?

4. How can HEPP News be made more useful to you?

5. Do you have specific comments on this issue?

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