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Collaborations between Corrections and Public Health

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Sound Public Health Policy

John R. Miles, MPA



Correctional Population

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- More than 1.7 million persons in the United States are behind bars
- America has the highest rate of incarceration in the world
- 1995 Federal and State spending on prisons was \$27 billion

Why has such an increase in corrections occurred?

- America is relying too much on incarceration to combat our drug problem
- America's prison population has tripled between 1980 and 1996 due to criminal activity linked to drug and alcohol abuse
- Incarceration rate for drug offenders today is 145 per 100,000 persons

Correctional Demographics

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- Mostly men
- Approximately 70% have a history of substance use within the past year
- Many lack access to health care services

Number of Federal/State
prisoners by sex, 1997



Substance Abuse Among the Incarcerated

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- 1.14 million arrests for drug law violations in 1994; of these 75% were for drug possession
- In state prisons 41% of first offenders have used drugs regularly; 63% of those with two prior convictions; 81% with five or more
- Inmates who are alcohol and drug abusers/addicts are the most likely to be reincarcerated

Disease Burden Among Incarcerated

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- BJS statistics show that the AIDS case rate among inmates is seven times higher than that of the US general population
- Minimal data exists for STDs because most STD testing is done on request by the inmate or the physician
- TB rates are decreasing for corrections, but rates in FBOP are increasing because they house many foreign-born inmates
- Corrections is concerned with hepatitis, as rates of infection (1-1.5% for HBV) are high and treatment costs are very high

Why should public health work with correctional health care?

- • • • •
- Corrections has limited resources available to prioritize health care services
 - Inmate populations are associated with substance abuse and high-risk sexual activity
 - Public health can offer technical assistance to work within corrections for monitoring infectious diseases

Impact on the Community

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- Recidivism rates are higher than ever, and sentencing stays are shorter
- Circulation of high-risk individuals between correctional facilities and the community
- Studies show that recidivism is reduced when inmates participate in treatment/prevention programs for disease and substance abuse

**We cannot allow
incarceration to
become a public
health crisis.**

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How to Enhance Collaborations

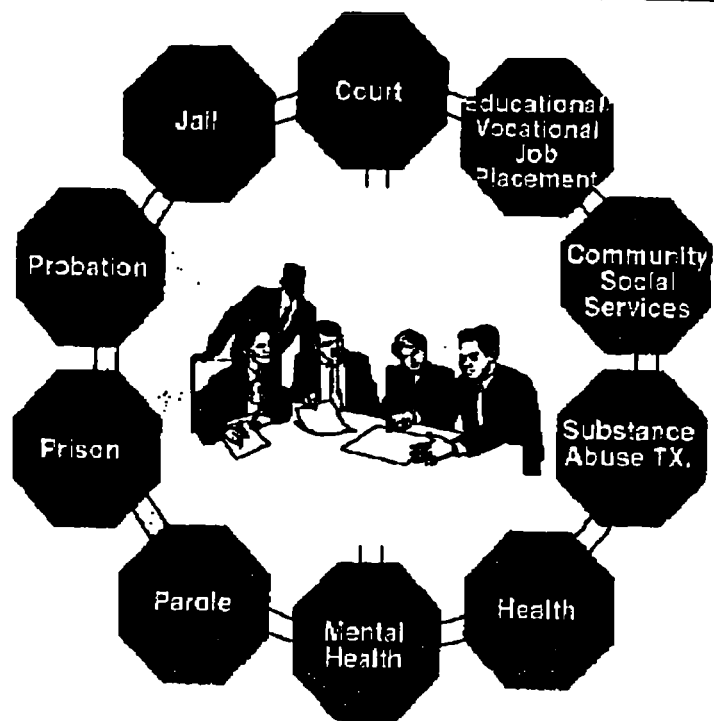
- Liaison between corrections and public health
- Regular meetings for information sharing
- Screening, treatment, and policy guidelines
- Computerized medical records
- Cross-training of staff

Model Collaborations

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- Disease screening and treatment models
 - Chicago
 - Los Angeles
- Comprehensive care models
 - Rhode Island
 - Hampden County, Massachusetts
- Integration of substance abuse treatment and preventive care
 - Delaware
 - Memphis

Range of Agency Partnerships for Treatment





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Research in Brief:

Public Health/ Corrections Collaborations: Prevention and Treatment of HIV/AIDS, STDs, and TB

Final Draft

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reproduction, or distribution*

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Introduction

Public health and correctional agencies appear to have very distinct missions and interests. However, their missions become highly complementary if one accepts the premises that correctional facilities and inmate populations are part of the larger community and that public health is, in fact, integral to public safety. As a result of such realizations, public health and correctional agencies are increasingly working together to improve health interventions for inmates and, at the same time, achieving benefits for the health of the larger community.

There are almost two million people incarcerated in the prisons and jails of the United States—close to one percent of the nation's total population. Inmates suffer disproportionately from infectious diseases, substance abuse, and a constellation of socio-economic problems. In particular, HIV/AIDS, sexually transmitted diseases (such as syphilis, gonorrhea, and chlamydia), and tuberculosis are far more prevalent among incarcerated persons than in the total U.S. population. Based on figures from a 1994 survey co-sponsored by the Centers for Disease Control and Prevention and the National Institute of Justice, AIDS is almost six times more prevalent among inmates than in the total population¹ and, based on reports of known HIV infections in state correctional systems, two percent of all asymptomatic HIV infections in the country are found among state correctional inmates.² Comparisons are more difficult to make regarding TB, but the numbers themselves are telling. Based on 1994 data from 31 state prison systems, the PPD skin test positivity rate (indicating TB infection) among inmates was almost 14 percent, while 25 prison systems reported a total of over 5,600 PPD skin test conversions in the two years prior to the CDC/NIJ survey.³ Incidence rates of gonorrhea in 1994 were 152 times higher among confined female juveniles and 42 times higher among confined male juveniles than among girls and boys of equivalent age in the total U.S. population.⁴ In addition to the actual infection and morbidity, rates of risk factors for these diseases are much higher in incarcerated populations than in the population at large.

Adult inmates and confined juveniles represent a large, highly at risk population that could benefit greatly from health interventions. Moreover, such interventions could also greatly benefit the overall public health.^{5 6} Many correctional systems have responded to this need

and opportunity by instituting a variety of health interventions. Yet, CDC/NIJ survey results reveal that numerous gaps remain. For example, the percentage of state and federal correctional systems providing instructor-led HIV/AIDS education programs decreased from 96 percent in 1990 to 75 percent in 1994. In 1994, less than half (48%) of state and federal facilities were providing instructor-led HIV/AIDS sessions and only seven percent were providing peer-led programs.⁷ Other apparent gaps in services include discharge planning and continuity of medical services from correctional facilities to the community. Overall, there seems to be insufficient coordination between services in these two spheres.

Collaborations between public health and correctional agencies represent potential means of filling these and other gaps in health-related services for inmates. Public health departments may have funds, staff, expertise, and other resources to help prisons, jails, and juvenile facilities address the serious health needs of their inmates and thereby advance the cause of public health in their communities.

Consistent with their overall public safety and security missions, prisons and jails can provide opportunities for interventions with underserved populations who are at high-risk for HIV/AIDS, STDs, and TB. Correctional administrators can provide access to these populations and otherwise facilitate interventions, such as by including language requiring early disease detection and treatment in health protocols. Such language may be particularly important where health services are being privatized through contracts.

The study reported on in this report examined the extent and nature of public health-corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB. As expected, we found state health departments collaborating primarily with state correctional agencies while city/county health departments work primarily with county jails. However, we also identified numerous interactions between state health departments and county jails. We also found that collaborations between state correctional systems and county jails are very important, but sometimes inadequate, particularly in the area of information exchange.

The study occasionally touched on collaborations between corrections and other entities such as community-based organizations and academic medical centers. Indeed, there is a range of potential collaborators that might be explored in future research.

Study Methodology

This report is based primarily on a series of eleven site visits to the following state and city/county level jurisdictions undertaken during the winter and early spring of 1997 by teams from Abt Associates, the Centers for Disease Control and Prevention, and the National Institute of Justice:

- Six states
 - Rhode Island
 - New York
 - Washington
 - Florida
 - Missouri
 - Illinois
- Five city/county jurisdictions
 - Houston (Harris County), Texas
 - Memphis (Shelby County), Tennessee
 - Rochester (Monroe County), New York
 - San Francisco, California
 - Chicago (Cook County), Illinois

The sites were chosen based on screening telephone interviews with over 20 jurisdictions identified primarily on the basis of information known to Abt Associates project staff and CDC staff. The final site selections was made with a view to having geographic diversity and a roughly even mix of state and city/county jurisdictions.

The visits were two days in duration and included interviews with correctional and public health staff as well as visits to correctional and juvenile confinement facilities. In general, we sought to meet with key public health staff in HIV/AIDS, STDs, and TB and with correctional health services staff and others in the correctional systems who were involved in collaborations with the public health department. In city/county visits, we were able to visit

the major jail facility in each site, while on state visits, we were only able to visit one or two facilities.

Report Organization

This report summarizes the collaborations reported to the 1997 CDC/NIJ survey and identified during the site visits, presents two brief case studies of collaboration, describes important factors in successful collaboration, and concludes with recommendations for improving and expanding collaborations.

Collaborative Efforts

Collaborations between public health and correctional agencies encompass a wide variety of activities in the prevention and treatment of HIV/AIDS, STDs, and TB (see Table 1).

Responses to the 1997 CDC/NIJ survey of correctional systems show that collaborative efforts are common and wide-ranging. Virtually all state and federal prison systems (98%) and city/county jail systems (93%) reported at least some collaboration with a public health department in the surveillance, prevention, and treatment of HIV/AIDS, STDs, or TB. Most common are collaborations in case reporting, testing/screening, TB treatment/prophylaxis, and staff training. However, a substantial number of systems reported collaborations in each area listed.

Table 1**Areas of Collaboration between Correctional and Public Health Departments**

Areas of Collaboration	Percent of Systems Reporting Collaborations					
	HIV/AIDS		STDs		TB	
	State/ Federal	City/ County	State/ Federal	City/ County	State/ Federal	City/ County
	(n=50)	(n=30)	(n=50)	(n=30)	(n=50)	(n=30)
Educational Programs	83%	78%	70%	63%	79%	56%
Other Prevention Programs	76	70	62	46	69	54
Testing/Screening	79	78	77	89	78	86
Case Reporting	94	85	98	93	100	96
Counseling	81	71	60	58	55	52
Partner Notification	83	54	87	73	87	65
Outbreak Investigation	60	51	72	59	93	86
Treatment/Prophylaxis	71	69	70	77	87	93
Discharge Planning	91	85	73	62	91	89
Staff Training	95	81	86	70	98	85

Source: 1997 NJ/CDC Survey Responses

Table 2 summarizes the diverse collaborative efforts identified during the eleven site visits, under the following broad headings:

- Administration and infrastructure;
- Policy development; and
- Service delivery.

Table 2 indicates, in general, that there are numerous collaborations in testing/screening/follow-up, education/prevention programs, staff training, legislation and policy development, and treatment services, but relatively fewer in surveillance, discharge planning and transitional services. Most of the collaborations identified in this study involve public health departments providing funding, staff, and/or services to correctional departments. Such

arrangements require interaction and cooperation between public health and correctional agencies, as well as access to inmate populations, in order to succeed. However, some collaborations go well beyond health departments providing services in prisons and jails. Below, we present two brief case studies of more thoroughgoing collaborations.

Two Case Studies of Collaboration

Rhode Island

Rhode Island has developed a state-of-the-art model of collaboration involving the state health department, the correction department, an academic medical center (the Miriam Hospital, affiliated with Brown University), and some 40 community-based organizations and service agencies. Figure 1 displays an organization chart for Rhode Island's AIDS Services After Prison (ASAP) program, a centerpiece of the state's collaborative efforts.

In Rhode Island, there are regular meetings and interactions between all of the organizational partners in the collaboration. They also work together on policy, legislative proposals, and union issues in the facilities. There is a demonstrable commitment to working together. In the words of the administrator of the Rhode Island health department's office of HIV/STD, there is no sense of "our problem versus your problem."

Initial collaboration between the Rhode Island health and correction departments led, in 1986, to one of the first correctional AIDS policies in the U.S. Important early foci of this collaboration were treatment and supportive services for inmates with HIV disease, with continuity of care between providers in prison and in the community.

Subsequently, important components on pre/post-test counseling, discharge planning, transitional services and community linkages for HIV-infected inmates and at-risk HIV-negative inmates were added. Post-release services include medical treatment, housing, substance abuse treatment, job development, psychosocial support, and long-term case management.⁸ Initial results reveal reduced recidivism rates among female inmates

Table 2 : Summary of Collaborative Efforts Identified During Site Visits

Sites	Administration and Infrastructure							Policy Dev.
	PH Dept. Responsibility	Surveillance	Database Support	Inspection of Assessments	Quality Assurance	Staff Training	Linkage Development	Legislation / Policy
Rhode Island								HD and DOC collaborate on DOC's HIV/AIDS policy. jointly drafted legislation. HIV testing in response to incidents, disclosure of status.
New York		HD collaborates on blinded HIV seroprevalence studies—improved AIDS case counting. HD funded demonstration TB screening projects at DOCS intake facilities. 10 regional public health representatives work with DOCS staff on TB screening, and do all surveillance, case tracking and contact investigations in DOCS facilities.		HD assisted with investigation of MDR-TB outbreak in prisons. HD assessed air handling in DOCS facilities.	AIDS Institute and DOCS collaborating on HIV/AIDS case review.	HD provides TB training and technical assistance for staff of DOCS.		
Washington		HD collaborates on blinded HIV seroprevalence studies, documents STD morbidity in adult and juvenile facilities.	HD provides DOC staff access to TB treatment and prevention therapy databases.	HD surveyed HIV, STD, TB services in prisons—inspects all prisons each year and helps justify requests for resources.	HD reviews treatment of all active TB cases.	HD provides slots for DOC at annual STD clinical updates. HD provides training to DOC staff on HIV counseling/testing.		HD helped draft/review DOC infection control manual; reviews other policies. Helped draft legislation on disclosure HIV status.
Florida		Health department-funded staff prepare TB case reports on inmates.		HD funded staff monitor TB treatment logs in prisons.	Collaborative TB case review conferences.	HD provides annual health update conferences—training on HIV counseling and testing.	Quarterly meeting between DOC and HD staff.	
Missouri				HD assisted with investigation of TB outbreak in a prison.	HD teams monitor STD treatment in state prisons monthly TB case review meetings.	HD provides training to probation and parole staff on HIV risk assessment and community linkages.		HD and DOC collaborate on point scoring assessment of TB isolation, developed guidelines for TB screening and treatment, compromise on condom distribution at release.
Illinois			HD access to DOC database on inmate movement/locations facilitates TB tracking.	HD assisted in response to small MDR-TB outbreak in prison.	HD reviews STD morbidity reports to assess treatment.	HD trains DOC staff on STD interviewing and counseling techniques, also on TB.		
Houston (Harris County)				HD surveyed HIV, STD and TB services in jails.		HD provided STD training to jail clinicians.		
Memphis (Shelby County)	Public HD responsible for health services in jails.							Health officer mandated universal PPD screening jails.
Rochester (Monroe County)						HD trains clinicians at jail and juvenile detention center.	HD funds women's jail committee. HD serves with jail staff on Jail Health Advisory Committee.	
San Francisco	Public health department responsible for health and mental health services in jails.	HD does HIV/AIDS, STD, TB surveillance and disease tracking.					HD launched and coordinates Bay area TB control group bringing together health and correction staff.	HD and sheriff's dept. worked out compromise HIV testing/disclosure policy.
Chicago (Cook County)	Cermak Health Services, a unit of county government provides all jail health services.		HD staff have access to jail computer and county syphilis registry.			HD provides training on TB at correctional officer's academy.		

HD = Health Department

DOC = Department of Corrections

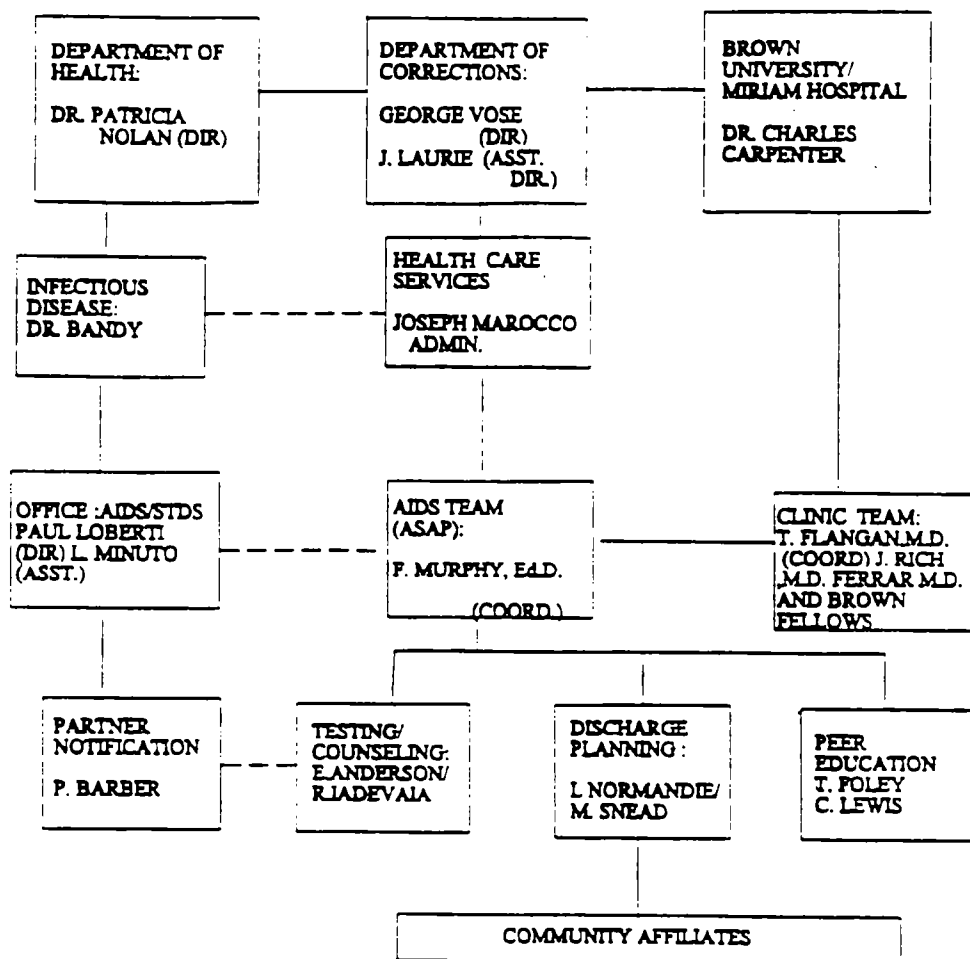
DOCS = Department of Correctional Services

Policy Development		Service Delivery				
Initiative / Policy	Clinical Protocols	Education/Prev. Programs	Testing / Screening / Followup	Treatment	Discharge Planning / Transitional Services	Lab Services
DOC collaborated HIV/AIDS policy- drafted legislation on HIV in response to disclosure of		HD (CDC) funding of prevention staff in prisons who offer HIV orientation and multi-session programs and coordinate the inmate peer program	HD funds HIV pre/post-test counseling, partner notification in prisons, provide TB outreach and followup for persons released from jail/prison	Joint HD/DOC funding- continuity of care, involvement of academic medical center	Joint HD/DOC funding- discharge planning, community linkage	
	Joint development of HIV/AIDS treatment protocols, also TB control policy	AIDS Institute provides \$3 million per year for HIV/AIDS services in prisons, juvenile facilities, and division of parole. Peer-led programs. Regional teams from AIDS Institute present HIV educational programs	AIDS Institute regional teams provide HIV counseling and testing. HD (With CDC funding) supports STAT syphilis screening/treatment programs in several county jails. HD worked with DOCS to develop and implement mandatory TB screening for inmates and staff	HD funded demonstration directly observed preventive therapy for TB at the DOCS intake facilities. Public health reps do TB case management at DOCS facilities	AIDS Institute supports transitional services for inmates with HIV/AIDS- also Prisoners Hotline	
HD drafted/reviewed TB control policies, reviews other policies, helped draft legislation on disclosure of		HD distributes STD prevention literature to state prisons; funds CBO that does some HIV prevention work in prisons	HD provides HIV/STD partner notification services in prisons- also special STD screening in 2 county juvenile detention centers, chlamydia screening at women's prison			
		HD funds peer-based HIV prevention program at Lawley Correctional Facility	State/County health depts provide STD screening, followup, and partner notification in many county jails and juvenile facilities. HD funded staff to do TB followup	County HD follow up on TB treatment of released inmates		HD provides STD testing for many county jails
DOC collaborated on TB screening assessment. B. Isolation development. Guidelines for TB and treatment. Use on condom use on release		HD provides training for inmate HIV peer educators in 2 DOC facilities	HD funds partner notification services in prisons. 3 regional HD teams conduct followup interviews with syphilis-positive inmates. HD assists with TB screening and followup in prisons	Joint project with DOC/parole provides incentives to refill TB prevention medication prescriptions		
		HD funds HIV education programs at pre-release centers. Funds/provides training for peer HIV prevention program in almost all facilities. 100 peers trained. 17,000 inmate contacts in 1996	HD staff conducts STD contact investigations			State public health lab provides all STD testing for state prisons
		State HD Funded VCRs and TVs to show HIV prevention videos in city jail	County HD offers HIV counseling/testing. City HD offers HIV partner notification and follow-up. City HD jail team provides STD screening, follow-up interviews in county jail and 5 probation facilities. Contact investigation on all active jail TB cases	HD jail team provides STD treatment in jail. County provides DOT for persons with TB released from jail		
Prisoner mandated PPD screening in		HD jail team offers HIV/STD educational services at county jails	HD jail teams provide HIV counseling, testing, partner notifications in jails, also STD screening, followup interviews, partner notification, evaluate all PPD-positives			
		HD provides jail inmates with education on TB preventive therapy	HD teams provide HIV counseling and testing and STD testing and followup in jail and juvenile facilities. HD TB staff do followup on PPD-positives in jail and community		HD hired discharge planner to work in jail	
Prisoners dept: not compromise on HIV disclosure		Forensic AIDS Project (FAP)(HD) Provides HIV education and prevention programs, distributes condoms in jails	FAP provides HIV counseling and testing. HD does STD screening in jail, community followup, also TB screening and followup	FAP provides medical and psychological services for inmates with HIV	FAP provides discharge planning, community linkages for inmates with HIV	
		Chicago HD provides \$340,000 per year for HIV prevention programs-funds 7/10 HIV educators in county jail	HD funds STD screening staff at jail (with CDC funding); provides STAT syphilis screening; treatment for women in jail followup in community and provide PPD results	HD provides directly observed therapy to jail releasees with TB		

MDR = Multi Drug Resistant

Figure 1

ASAP (AIDS Services After Prison) Organization Chart

AIDS SERVICES

FACTS
PROJECT AIDS
SUNRISE HOUSE
HOUSE OF COMPASSION
ST FRANCIS CHAPEL

CASE MANAGEMENT

TRAVELERS AID
PROVIDENCE CENTER
COMMUNITY OUTREACH
THUNDERBOLT
HOSPICE CARE OF RI
PROJECT HOPE

MEDICAL

RHODE ISLAND HOSPITAL
ROGER WILLIAMS HOSPITAL TB CLINIC
LANDMARK HOSPITAL
MIRIAM HOSPITAL IMMUNOLOGY CLINIC
STATOGEN HEALTH
WOMEN'S AND INFANTS (PROJECT LINK)
NORTHWEST HEALTH CENTER

STATE/FEDERAL AGENCY

VETERANS ADMINISTRATION
RI DEPT
OF EMPLOYMENT /TRAINING
SOCIAL SECURITY

HOUSING

OXFORD HOUSE
SUNRISE HOUSE
ARNOLD SHELTER/URBAN LEAGUE
SALVATION ARMY
AMOS HOUSE

DRUG TREATMENT

CODAC
MARATHON
TALBOT
STARBITT
EASTMAN HOUSE(WOMEN)
TRU-BAB

associated with program participation.⁹ There have also been dramatic increases in compliance with post-release medical and other appointments for services. Program staff participate in a weekly case assignment meeting to discuss community linkages and placements for inmates nearing release. Four key CBOs that specialize in the following populations and services participate in these meetings: 1) mentoring for employable women; 2) services for cocaine and/or alcohol involved persons; 3) services for long-term sex workers and/or IDUs; and 4) services for HIV-infected persons.

A health department-funded disease investigation specialist, based at the correctional facility, does partner notification and outreach, primarily on HIV. He also locates HIV-positive individuals who have been released to the community before receiving their test results and links them with services at the Miriam Hospital or comparable provider of HIV services.

With CDC funding of two public health educator positions in the correction department, there has been increasing emphasis on HIV prevention. These educators provide HIV/STD orientation classes for all incoming inmates, multi-session programs for current inmates and educational sessions for staff, and coordinate inmate peer education programs.

While there are some differences of opinion regarding how the collaboration between the Rhode Island health and correction departments began, there is no dispute regarding a major feature of the collaboration: the health department provided much of the initial funding for staff, but over time the program has become institutionalized and the DOC has picked up an increasing share of personnel costs, currently funding two public health educator positions from its regular budget.

Health department staff have met with the correctional officers' union to address issues of disclosure of inmates' HIV status. The union has favored disclosure to all correctional officers but DOH has been working to achieve a compromise whereby disclosure would occur only in the case of potential transmission incidents, which is really the primary concern of the union. Incident-based disclosure could be accomplished through administrative action,

thus avoiding any legislation mandating universal or other broader disclosure policies. At the time of our site visit, a compromise solution seemed very likely.

New York State

Collaborations between the New York State Department of Health (NYSDOH) and the Department of Correctional Services (DOCS) on HIV/AIDS and TB involve almost constant interaction between the two agencies at central office and facility levels. Collaborations on STDs have been primarily between NYSDOH and county jails because NYSDOH staff believe that the key opportunity for STD intervention is at the jail level and is essentially lost once inmates move on to DOCS facilities.

The AIDS Institute of NYSDOH and DOCS began collaborating in 1987. The Institute is currently involved in a comprehensive array of HIV/AIDS services in DOCS facilities, including counseling and testing (offering anonymous HIV testing, with the patient's option to convert it to confidential), education (including peer education programs provided by ex-offenders and current inmates), and supportive and transitional services for inmates with HIV disease. This collaborative project is collectively known as the Criminal Justice Initiative (CJI). Institute staff emphasize that their involvement has been and remains dependent on the cooperation of individual facilities' superintendents which, with the substantial assistance of DOCS central office staff, they have been quite successful in winning and maintaining. The Institute and DOCS have also collaborated on HIV/AIDS surveillance and on the development of medical protocols and collaborative quality review of HIV medical services. An MOU between DOCS and the AIDS Institute for ongoing case-based quality review of HIV medical services is under development.

In 1989, the AIDS Institute and DOCS initiated a joint project in which DOCS funded the Institute to form regional teams to do HIV counseling and testing and HIV educational programs for inmates and correctional staff. This project was closely coordinated by the central offices of both agencies. DOCS reviewed and approved the educational curricula. Funding was also provided for AIDS Counseling and Education (ACE) a peer-based prevention and support program at the Bedford Hills women's facility. In 1992, the

Women's Prison Initiative was established by the AIDS Institute. Its objective, now largely accomplished, was to replicate the ACE model at the other women's facilities—Albion, Taconic, and Beacon.

The AIDS in Prison Hotline, funded by the AIDS Institute and operated by the Osborne Association in New York City, provides a clearinghouse for referrals and community-based services for inmates. Inmate collect calls are encouraged and accepted. 1993 saw an expansion of the regional teams serving DOCS facilities to include CBOs. Funds for these efforts come from DOCS, CDC, the AIDS Institute budget, and other sources. The total amount available for CJI activities is currently about \$3 million per year. A new set of contracts with CBOs to provide services in DOCS facilities was effective on March 1, 1997. Almost all DOCS facilities now receive at least some services through the AIDS Institute's Criminal Justice Initiative.

AIDS Institute staff reported that relations between the regional teams, the CBOs, and DOCS central office and facility staff are generally good. Since a substantial part of the funding for the CJI comes from DOCS, interdepartmental communication and collaboration at the central office level is absolutely necessary. At the facility level, the regional teams and CBOs are often accepted as part of the facility's staff. Initial and ongoing meetings on AIDS Institute programs at the facility level help to ensure mutual understanding of roles and expectations and address emerging issues. Correctional officers' union representatives are also included in these meetings.

In the late 1980s, the AIDS Institute began collaborating with DOCS on a series of blinded studies of HIV seroprevalence among incoming inmates at the reception centers—Downstate and Ulster for men, and Bedford Hills for women. When it became clear that seropositivity rates among inmates accepting voluntary testing were substantially lower than rates found in the blinded studies, the AIDS Institute and DOCS collaborated on a pilot study at Ulster to investigate these discrepancies. The 1994 study revealed that many inmates were not accepting voluntary testing because they were in denial about, or underestimated the seriousness of, their risk factors.

AIDS surveillance for DOCS inmates was essentially passive until 1997. That is, cases were often not known to NYSDOH or counted in state surveillance figures until an autopsy report was received. Early in 1997, however, the DOCS medical director authorized sending copies of all inmate AIDS case reports to NYSDOH. This facilitates cross-checking case registries, thereby helping to increase the accuracy of case counts.

Beginning in 1988, the TB control division of NYSDOH and DOCS have had extensive and, according to NYSDOH staff, “exemplary” collaborations with DOCS in screening, treatment, case management, surveillance, outbreak investigation, education and training of staff and inmates, and technical assistance to staff. TB cases in DOCS have declined steadily since a major outbreak in 1991. There have been no TB outbreaks in DOCS facilities since 1993.

In 1988 and 1993, NYSDOH’s Bureau of Occupational Health assessed air handling systems in DOCS facilities. Training on environmental infection control measures and monitoring of negative pressure rooms is also provided. NYSDOH staff worked closely with DOCS and CDC staff to investigate and respond to the 1991 multi-drug resistant TB outbreak. This included development and implementation of mandatory annual inmate and staff PPD screening, education and training, and other measures to prevent recurrent outbreaks.

From 1991-1995, NYSDOH collaborated with DOCS on the HIV-Related TB Project (H RTP). This established a demonstration screening and directly observed preventive therapy program at DOCS intake facilities. NYSDOH did the TB surveillance at DOCS facilities and DOCS carried out all screening and treatment.

Currently, 10 NYSDOH Public Health Representatives (PHRs) are “constantly” in the prisons where they have been generally well integrated with the facility’s staff. The PHRs work closely with the DOCS infection control nurses at the facilities on TB control, screening, and treatment issues. DOCS is considered a “distributed county” in the NYSDOH TB control scheme. NYSDOH staff do all surveillance, case tracking, contact investigations, and case management in DOCS facilities. Worksheets are automated so the appropriate PHR can be notified and receive case records efficiently when an inmate is transferred to a facility

in a different region of the state. Regular meetings and interactions between NYSDOH and DOCS staff are devoted to surveillance, including reconciling case counts, and other matters. NYSDOH's TB nurse coordinator meets every two weeks with the DOCS director of Communicable Disease Control. The director of Communicable Disease Control supervises the Infection Control Nurses in the facilities, with whom NYSDOH's Public Health Representatives work very closely.

As mentioned above, collaborations on STD services have largely occurred between the state health department and county jails. In a demonstration project funded by CDC at the Nassau County jail, NYSDOH staff provided rapid syphilis screening of jail intakes and treatment of all inmates with reactive serologies and no record of prior treatment. This intervention had a significant positive effect on syphilis morbidity in the overall community. The STD control division of NYSDOH is working on similar programs with jails in Monroe, Westchester, and Chautauqua Counties, as well as in New York City.

Factors in Successful Collaboration

Factors in successful collaborations between public health and corrections may be categorized as follows:

- Data and events demonstrating need for collaboration;
- Contextual factors;
- Attitudes and philosophies;
- Program funding and operations; and
- Communication and information exchange.

Data and Events Demonstrating Need for Collaboration

Successful public health/corrections collaborations are much easier to develop and sustain when there are readily available **data documenting the burden of disease** in the inmate population. Indeed, it might be suggested that such data are a virtual prerequisite for successful collaborations. Public health departments could be much more proactive in

disease surveillance among correctional populations. Better surveillance might have a whole series of positive effects: more resources for correctional health programs; better services; a safer and more healthy environment for inmates and staff; less disease returning to the community; and, ultimately, improved public health.

In Rhode Island, for example, the health and correction departments were able to demonstrate that 42 percent of all new HIV infections in the state were identified in correctional facilities. This convinced the HIV prevention planning group to endorse continued substantial funding of collaborative HIV programs in the prisons. Until these data were available, the planning group had expressed skepticism about the value and importance of prison-based programs. In Florida, data showing that 13 percent of the state's syphilis morbidity was identified in correctional facilities provided an important impetus to collaborative STD screening programs. Similarly, in Chicago, the finding that almost one quarter (24%) of the city's syphilis cases were diagnosed at Cook County jail led directly to CDC's funding (through the city health department) of a rapid syphilis screening and treatment program there. In Washington, the state health department documents and publishes periodic reports on STD morbidity in adult juvenile facilities, thus helping to justify the department's continued involvement in STD screening and follow-up programs in these facilities.

By contrast, without hard statistics on the incidence and/or prevalence of HIV/AIDS, STDs, and TB, it becomes much more difficult to interest correctional and health departments in collaborating on interventions. It is also more difficult to justify requests for funding and other resources if the scope of the problem is unknown or undemonstrated. In some visited jurisdictions, for example, staff of jail medical services and of the public health department have no clear picture of the levels of morbidity among the inmates. The lack of this information is, in their view, a major stumbling block to more effective and better supported collaborative efforts.

Dramatic events may call attention to the need for collaboration. For example, concern raised by the 1991 outbreak of multi-drug resistant TB in New York state and by local outbreaks were mentioned in a number of jurisdictions as a factor promoting collaborations

between public health and corrections. For example, the New York outbreak prompted the formation of a city/county TB task force in Chicago.

In New York state itself, health department involvement in TB interventions that helped to protect correctional staff smoothed the way for other collaborations regarding HIV/AIDS and STDs. Indeed, staff in several jurisdictions identified collaborations in TB prevention, with their strong employee protection focus, as the “foot in the door” for other collaborative efforts.

Contextual Factors—Organizational, Legislative, Regulatory

An important contextual factor already noted is assignment of **responsibility for health services in correctional facilities to the health department**, as is the case in San Francisco and Memphis. Such arrangements require at least some interaction and may help foster fuller collaborations, as occurred in San Francisco. There, for example, the director of Forensic Services, the health department unit responsible for jail health services, sits on several committees with sheriff’s department staff and, in turn, involves custody staff on health services committees. Nurses also have regular meetings with custody captains to address issues in the delivery of health services.

Another important contextual factor promoting collaboration lies in **legislative and regulatory provisions**. Strong state legislation in New York called for establishment of an interagency AIDS task force and required the health department’s AIDS Institute to take a strong role in criminal justice settings. California state law requiring notification to health departments of all TB cases was a spur to collaborations with correctional systems in the development of reporting procedures. Also in California, a legislatively created state Board of Corrections has the power to regulate local and county jails. The Board’s regulations require each jail to have a communicable disease control plan jointly created by jail officials and the local health officer. A Texas state law enacted in 1993 requires all jails with 100 or more beds to submit TB control plans to the local health department.

The Memphis-Shelby County health officer used the powers granted him under Tennessee law to mandate PPD screening in the jails. Indeed, the jail director who also favored PPD screening asked the health director to order it so as to provide stronger justification and gain the cooperation of jail staff. A Washington state law of 1988 provides for court-ordered HIV testing of inmates involved in potential transmission incidents, as well as convicted injection drug users and sex workers. The correctional and juvenile agencies sought and obtained the involvement of the state health department in providing this mandated testing and reporting its results.

Attitudes and Philosophies

Three important attitudinal and philosophical factors on the part of key actors in public health and corrections appear to facilitate successful collaborations:

- Strong commitment;
- Willingness to open facilities to outside agencies; and
- Mutual sensitivity to the concerns of corrections and public health.

At the level of agency and facility leadership, there must be a **strong commitment** to collaborative approaches. This may involve a realization and declaration that infectious diseases among correctional inmates represent both a correctional and a public health problem. As the county jail director in Memphis emphasized, public health is a part of the public safety that correctional facilities exist to protect. The Florida Department of Corrections' medical director stated that "the health problems of our inmates are public health problems because inmates go back to the community." In Illinois, the director of the corrections department was willing to write a letter to all of the facility superintendents endorsing a health-department sponsored inmate peer education program.

Commitment to collaborative approaches will generally lead to correctional officials' **willingness to open their facilities to outside organizations**. This is not always easy for correctional administrators to do, in view of their primary concern with security. They may also be suspicious of outsiders, based on perception and/or experience that such people's

main purpose in coming into the correctional facility is to find and expose fault. Indeed, even when central office leaders in a correctional system direct that there be open collaborations, individual superintendents may still prevent it from occurring in their facilities.

However, numerous superintendents are open to the involvement of outside agencies. Some, like the warden of Rhode Island's women's facility, see the involvement of outside organizations as essential. She welcomes outside medical providers, community-based organizations, student interns and others to her facility, believing that prisons are part of the community and that there should not be impenetrable walls between them. Moreover, she believes that outside providers are more helpful to inmates in making transitions back to the community.

If correctional and public health agencies are to work together successfully, they must have **mutual sensitivity to each other's concerns**. It is important, for example, that public health staff understand that security is, and always will be, the first priority of correctional systems. Public health activities must be accommodated within the overall correctional structure and procedures. As a public health investigator from the Houston health department's TB section put it, you must "ease in" and "don't butt heads" with security staff, but rather play by their rules and try to build one-on-one relationships. By taking this approach, this public health investigator is now accepted as "one of them [the deputies]" and enjoys their full cooperation. Similarly, the San Francisco health department's TB control staff person working in the jails has gained good cooperation from the custody staff by "requesting rather than demanding" assistance. In Washington state, the correctional department credits health department staff with being extremely collegial, focusing on finding solutions rather than finding fault.

Another way to demonstrate mutual concern and sensitivity is to be willing to compromise on policy issues. For example, the Missouri health department strongly favors availability of condoms to inmates in the state's correctional facilities but understands the difficult position the corrections department finds itself in on this issue because of the political climate and the existence of a state anti-sodomy law. Therefore, the health department has been willing to work first for distribution of condoms to persons being released from prisons and then

perhaps to move on later to within-facility condom availability. The director of Forensic Services in the San Francisco health department, which is responsible for jail health services, was willing to compromise with the sheriff's department regarding implementation of a state referendum on disclosure of inmates' HIV status to correctional officers. The compromise limits disclosure to cases of potential transmission, carefully restricts recipients of the information, and provides for coding of the information to minimize possibility of unauthorized disclosure.

While the factors elucidated above can help facilitate successful collaborations, it is important to realize that there are **real differences between the philosophies, perspectives, and priorities of public health and correctional agencies** which can make collaboration difficult if not sensitively handled. These differences may apply to jail medical staff as well as security staff. In Rochester/Monroe County, New York, health department staff reported that when they first began providing services in the jail, there appeared to be a "clash of cultures" between them and jail health staff. Since that time, however, a mutual realization of and respect for the different perspectives and challenges of each organization has led to very collaborative and collegial relations. In Rochester, important improvements occurred after a public health nurse spent time in the jail observing the work of her counterpart on the jail health staff. Through this experience, the public health nurse gained an appreciation of the danger, stress, and other challenges associated with working in the jail and developed great respect for the jail health staff. The jail health staff's focus is on emergency medicine and providing needed care firmly within the context of maintaining safety and security. Public health activities and objectives such as disease tracking and follow-up are not high priorities for jail health staff. By contrast, the health department staff who work in the jail place their highest priority on proactive, public health activities such as screening, disease tracking, follow-up, and research. Nevertheless, the Rochester experience demonstrates that through mutual understanding, common ground can be discovered and effective collaborations can be developed.

To be successful in the correctional environment, health department staff need to be able to work within the system and the rules. They cannot expect to go into the jail, be

confrontational with the jail staff, demand cooperation and expect to succeed. According to the assistant health director in this same city, health department staff should beware of becoming inmate advocates and denouncing the system. Rather, they should keep their focus on advancing the overall public health.

The differing perspectives were described by the director of medical services at the county jail in Houston using the metaphor of a spoked wheel. To health services and public health staff, everything revolves around providing patient care and addressing health issues. To correctional staff, health issues represent but one spoke of the wheel and sometimes only a “small spoke” at that.

A **lack of mutual respect and sensitivity** can undermine collaborations. For example, health services and public health staff should not dismiss or ignore the concerns of correctional staff regarding occupational exposure to HIV and other diseases. Rather, so long as these concerns are based on legitimate possibilities of transmission, they should be addressed with respect and seriousness. Correctional officers unions are often in the forefront on issues of occupational risk. On security grounds, unions may oppose inmate peer education programs or other programs that involve ex-offenders coming into facilities. A willingness to take these concerns seriously and to be open to compromise on them is essential. In New York State, a compromise was reached whereby ex-offenders could present educational sessions for inmates but not for correctional staff.

Collaborations also suffer if public health staff devalue the skills and expertise of correctional medical staff and other correctional staff. In several jurisdictions, correctional health care staff reported being treated with disrespect by health department personnel. At one facility, the correctional health services staff who are employed by the correctional department resent what they view as an **inappropriate supervisory and oversight approach** taken by state health department staff coming into the prison. In other words, the correctional health services staff wanted acknowledgment of and respect for their expertise instead of suspicion that they would not perform properly unless closely supervised. The nurse administrator at this facility declared that “until you treat people as equals, you can’t collaborate, you can only

dictate.” At the central office level in this jurisdiction, key health services staff expressed concern about wording suggesting similar disrespectful and suspicious assumptions that were included in proposed terms of a memorandum of understanding between the departments of health and corrections.

Health services staff of several other state correctional systems reported county health department personnel treating them with disrespect, stigmatizing them as inferior practitioners who could not find jobs elsewhere, demanding cooperation, and refusing to work within correctional rules and regulations.

Conversely, **obstructionism and lack of cooperation** on the part of corrections staff can undermine collaborative efforts. Related problems involve security staff blocking inmate access to health services. In one city, it was alleged that correctional officers prepare the sick call lists and sometimes deny access to inmates needing services. Reportedly, there have been inmates held in this jail for months with symptomatic syphilis who remained undiagnosed because they were not permitted to attend medical services. At another county jail, gate clearance problems sometimes make it difficult for health department staff to provide services efficiently.

Program Funding and Operations

Funding and operational factors facilitating collaboration include the following:

- Health department funding of programs in corrections;
- Presence of health department staff/programs in correctional facilities;
- Presence of a single liaison person;
- Formal agreements for collaborations;
- Long-standing relationships.

Funding is almost always a facilitator of collaboration. The director of medical services at the county jail in Houston said that collaboration can be based on the health department’s

ability and willingness to fill and pay for gaps in services and expertise. In Rhode Island, the health department provided much of the initial funding for the collaborative HIV/AIDS programs in the correctional facilities, but the DOC has subsequently been able to institutionalize the program and bring at least some of its costs into their budget.

By contrast, perhaps the most pervasive barriers to collaborative efforts are funding and resource constraints. In the current political climate emphasizing punitive over rehabilitative functions of corrections, even the most powerful arguments for public health interventions, no matter how well grounded in data, may be denied adequate support. Most of the collaborative programs observed in this study were working under serious constraints of funds, staff, and space. In one jurisdiction visited, the public health department suggested that jail health staff resisted more aggressive screening for HIV and STDs because sufficient funds were not available to treat all the patients who might be diagnosed.

It was reported in one jurisdiction that there is **no infrastructure or space** available in the city jail to provide expanded disease screening and other health services in which the health department might collaborate. It was also reported that staffing shortages at this same city facility would prompt resistance to escorting inmates to attend health services even if such services could be provided. A jail director interviewed for the study acknowledged that the available staff and facilities were inadequate to support more proactive health services.

Public health staff working in several other correctional facilities reported endemic **problems associated with the call out and escort of inmates** to attend medical services. These problems were attributed to a combination of staff shortages and obstructionism or lack of interest on the part of security staff.

The **physical presence** of public health programs and staff in correctional facilities has promoted—in many cases necessitated—collaboration. As described earlier, jail teams and staff from public health departments are regularly in the correctional facilities of the visited jurisdictions performing a variety of functions including screening, surveillance, education and training, contact investigation and partner elicitation, and follow-up.

A **single liaison** at the central office and/or facility level often makes collaborative efforts easier to manage and sustain. In New York state, each facility designates a single liaison for state health department programs. This is usually the nurse administrator or deputy superintendent for programs. This individual can arrange gate clearances, set up appointments, and ensure inmates' access to services. In Illinois, the DOC's public health coordinator serves as the liaison for all health department programs. This has worked extremely well, with the coordinator often assisting in the acceptance of programs at the facility level. A similar DOC liaison to the state health department in Florida proved to be very useful.

The embodying of collaborations in **formal agreements** has been helpful in several jurisdictions. Memoranda of understanding (MOU) and similar instruments help to institutionalize collaborative efforts, rendering them less dependent on purely personal relationships. Rhode Island's broad-based HIV/AIDS collaborations involving the health and correctional departments, an academic medical center, and numerous CBOs, are formalized in written agreements. New York's AIDS Institute has memoranda of understanding with the Parole Division (covering transitional services for HIV-infected inmates) and the Division for Youth (covering education and counseling and testing services). In Washington state, MOUs between the health department and the corrections department and juvenile agency specify roles and responsibilities regarding court-ordered HIV testing. Other documents can also formalize collaborative efforts. For example, the strategic plan of the Florida correctional department requires it to collaborate with the health department and with community resources.

In several visited jurisdictions it appeared that **staff characteristics** made collaborations easier to forge and maintain. For example, in Houston, both the director of medical services in the county jail and the supervisor of the health department's jail team mentioned the importance of jail health services staff having backgrounds in security. The jail team supervisor worked in corrections and criminal justice prior to assuming his current role and noted that this background both helped him negotiate the system and win quicker acceptance from security staff. The director of medical services in Houston had worked for many years

in security before taking his present position. He believes that having the director of medical services be a sheriff's department employee rather than an employee of another agency or a contracted organization has meant that he has more leverage and authority to advance public health objectives in the jail setting.

In both New York State and Illinois, the key health department liaison in the correctional department previously worked for the health department. This background not only helped these staff to understand and commit to a public health approach, but also to develop working relationships with health department staff more easily.

Finally, the passage of time and **long-standing relationships** are often required to perfect collaborative efforts. In Washington state, for example, the health and correctional departments were at one time part of the same state agency, so they have a long history of working together. In Rhode Island, the collaborative HIV program has been developed and refined over a period of ten years.

Communication and Information Exchange

Having and using opportunities to discuss issues and exchange information are important to the development and sustenance of collaborations. Four factors in this area were identified:

- Correctional representation on HIV prevention planning groups;
- Health and correctional department service on other joint committees;
- Regular meetings at leadership and operational levels; and
- Exchange of important clinical and other patient-level information.

The most important factor in this category is that correctional perspectives be represented on **HIV prevention planning groups**. These groups are funded and mandated by CDC in all states and cities receiving CDC HIV prevention funds [check]. The prevention planning groups often have substantial influence on the allocation of HIV prevention funding. The absence of correctional representation in prevention planning groups, which is the case in

most of the jurisdictions visited for this study, almost inevitably means that programs in correctional facilities receive insufficient attention and support. In turn, a critical impetus for collaborative programs will be missing.

There can be valuable educative opportunities on these panels. The Florida Department of Corrections' infection control coordinator serves on the statewide prevention planning group where she believes her most important function has been to educate the other members about the correctional environment and the needs of inmate populations.

Service on other standing committees provides opportunities to develop and enhance collaborations. The Illinois and New York, the public health and correctional departments are both represented on state interagency AIDS task forces, while in Missouri and Washington both departments serve on the governors' advisory councils on AIDS. Also in Missouri, the health department's medical director serves on the DOC's review committee for its health services contract. The Florida DOC's medical director serves on the state TB elimination committee and the DOH's medical director for HIV sits on the correctional department's medical ethics panel. A task force comprising staff from the jails and the health department was convened in Memphis to address TB screening in the jails. It has been proposed to keep this group in existence to provide a forum for discussion of other health issues in the jails. In Rochester, a Jail Health Advisory Committee has brought together high-level managers at the jail and in the health department to address issues of common concern.

In addition to serving together on standing committees, it is important for public health and correctional staff to have **regular meetings at both leadership and operational levels**. In Florida, there are quarterly coordination meetings of DOC and DOH staff on TB issues, as well as collaborative TB case review conferences. Monthly TB case review meetings are also held in Missouri. These meetings have identified errors, including a case in which treatment was erroneously terminated.

By contrast, a barrier to collaboration may be the absence or infrequency of meetings at central office and facility levels. In one of the visited jurisdictions, the lack of meetings between the heads and high-level management of cognizant departments has led to a somewhat fragmented approach to the provision of public health interventions in the jails, characterized by overlapping functions, poor communication, and “turf” disputes.

Access to and **exchange of patient-level information** is often critical to the success of collaborative efforts. This is particularly true when correctional or health department staff must continue patients on medications following their transfer or release or provide follow-up regarding test results or partner notification. Inmates can be transferred frequently from housing unit to housing unit within a facility as well as between different facilities. Inmates may also be released on short notice. In many of the visited jurisdictions, procedures have been developed to transfer medical records and provide interagency access to important clinical or locator information. In New York State, for example, health department staff have partial access to the DOCS inmate information system so they can track transferred inmates within the system and ensure that PPD results and medication status are provided to the new facility. In Illinois, the health department was able to track and respond appropriately to a TB outbreak in the correctional system because their staff had access to the DOC’s database on inmate movement and transfers. The work of Missouri health department staff who do follow-up interviews and partner elicitation in the prisons is facilitated by access to the DOC’s HIV and syphilis case logs and to inmates’ automated medical records. Similarly, Chicago health department staff doing STD screening and treatment in Cook County jail are dependent on access to the jail’s database on inmates’ locations and court dates as well as the Cook County syphilis registry to determine treatment history.

Correctional department access to health department databases can also be very useful. In Washington state, the DOC can check health department databases on patients receiving medications for TB disease and patients receiving preventive therapy to determine the status of inmates being transferred or released.

On the other hand, **problems with the availability and exchange of information** have impeded collaborative efforts and undermined inmate health care in many places. In many instances, vital medical records, including test results and medication status, on transferred or released inmates have never been sent to the new health care provider or only sent after long delays. Some facility health services staff reported having to restart inmates' regimens because no information was available. HIV antibody tests and PPD skin tests have had to be readministered because there is no record of previous testing. At one juvenile detention facility, the county health department is responsible for HIV counseling and testing but does not furnish test results to the facility's medical director. Inmates on combination antiretroviral therapy for HIV disease may arrive at a new facility without written records of the specific regimen and the new facility may be unable to obtain records from the previous facility within a reasonable period. Therefore, medications may need to be restarted.

Recommendations

This study identified many effective and promising public health/corrections collaborations to address problems of HIV/AIDS, STDs, and TB in correctional facilities, as well as gaps, shortfalls and weaknesses in collaborative efforts. In general, the study found that services and collaborations in the following areas could benefit from expansion and enhancement:

- Behavioral prevention programs;
- Inmate peer-based programs; and
- Discharge planning and transitional services, including provision for continuity of care, support for adherence to medication regimens, and social services to ease transitions to the community.

The study also found that most current collaborations involve public health departments providing or funding services in correctional facilities. This is, to be sure, an important aspect of collaboration which requires granting access as well as some interchange and discussion between public health and correctional agencies. But more is required to achieve fully collaborative relationships. The following specific recommendations are designed to help agencies develop more thoroughgoing collaborations.

Four Key Facilitators of Collaboration

- Public health departments should be more proactive in the **collection and dissemination of data demonstrating the disease burden in correctional and criminal justice populations**. Without these data, it may be very difficult to convince decision makers of the need for more resources and expanded collaborations;
- **All HIV prevention community planning groups should include correctional representatives**. Such representation can help to ensure that correctional and criminal justice settings receive their fair share of attention and resources; and
- **Public health departments should initiate or expand funding of services and staff in correctional facilities** and other criminal justice settings. Such funding support can be a necessary first step in the development of full collaborations.
- **Public health and correctional agencies should recognize the importance and potential benefits to the health of the larger community of interventions in correctional settings**, and particularly of screening, early detection, and early treatment.

Beyond these key recommendations, there are additional, more specific, suggestions. These fall under the major categories of factors in successful collaborations discussed in the previous section of this report.

Improve the context for collaborations:

- Health departments and correctional agencies should attempt to include specific roles and requirements for collaborative efforts in appropriate legislation and regulations;
- Health departments and correctional agencies should formalize collaborative relationships in memoranda of understanding or other written agreements; and
- Health departments should establish and use the legal powers of health directors to require disease screening and other interventions as appropriate and consistent with ethical principles.

Through cross-training and expanded opportunities for discussion and interchange, health departments and correctional agencies should attempt to engender the following attitudinal and philosophical facilitators of collaboration:

- Commitment to the principle that public health is part of the larger public safety;
- Realization that correctional facilities are part of the community because virtually all inmates return to the community;
- Correctional facilities' openness to outside organizations that can provide valuable resources and expertise to address health issues;
- Mutual respect among correctional and public health staff for the respective missions, priorities, concerns, and capabilities of each other (for example, addressing the legitimate concerns of correctional employees regarding occupational exposure to TB, HIV and other diseases); and
- Health department staff must be willing to compromise and work within the reasonable rules and constraints of the correctional facility in order to achieve larger goals.

Establish operational features that foster collaboration:

- Health departments should attempt to locate staff and programs in correctional facilities;
- Health departments and correctional agencies should establish single, regularly accessible liaisons for collaboration at the central office and facility levels; and
- Correctional facilities should seek to resolve logistical issues such as gate clearance for health department program staff, and call out and escort for inmates attending health services.

Improve communication and information exchange:

- Health departments and correctional agencies should develop and implement better systems for the accessibility and exchange of important clinical and locator information at all jurisdictional levels;
- Health departments and correctional agencies should establish joint committees at the leadership and operational levels; and
- Staff of correctional, health department, and other involved agencies should hold regular meetings at the central office and facility levels, as appropriate.

Collaborative efforts should be expanded to include other organizations besides public health and adult correctional agencies, so as to take in a broader range of criminal justice

populations and organizations offering needed services and linkages. Other types of organizations to include in comprehensive collaborations include probation and parole agencies, juvenile systems and facilities, community-based organizations, AIDS service organizations, substance abuse treatment programs, academic medical centers and universities, and other service providing agencies.

Clearly, state and local government agencies and service providers in the affected communities bear the primary responsibility for development of collaborations. However, Federal agencies such as CDC and NIJ may be able to support expanded and enhanced collaborations in some ways. These include funding demonstration projects (as CDC already does in enhanced STD screening and treatment) and sponsoring conferences and forums that offer opportunities for staff of correctional and public health departments and other pertinent organizations to meet and discuss collaborations.

The development and distribution by appropriate government agencies of guidelines for the prevention of HIV/AIDS and STDs in correctional settings might be helpful in fostering collaborations between public health and correctional agencies. Guidelines, such as these developed by CDC for controlling TB in correctional facilities, could provide a framework for discussion of the benefits of appropriate prevention, control, and treatment procedures.

In sum, correctional facilities offer important access points for high-risk, underserved populations and opportunities to reach these populations with important health interventions. As the examples included in this report demonstrate, collaborative efforts can be successful in improving the health of inmates and benefitting the overall public health as well.

Endnotes

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NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE

Results of the 9th National Survey of HIV/AIDS, STDs, and TB in Correctional Facilities



Prepared by
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November 10, 1997

Overview

- Data Sources
- Extent of the Problem
- National Patterns of Policy and Practice
 - Education and Behavioral Interventions
 - Precautionary and Preventive Measures
 - HIV Antibody Testing
 - Confidentiality and Disclosure
 - STD Testing
 - TB Screening
 - Housing
 - Early, Compassionate Release
 - Discharge Planning
 - Medical Care
 - Psychosocial and Supportive Services

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Data Sources

- Abt Associates surveys of HIV/AIDS, STDs, and TB in Correctional Facilities, sponsored by National Institute of Justice and Centers for Disease Control and Prevention, 1985-1996
- Bureau of Justice Statistics surveys of HIV in Prisons and Jails, 1991-1995

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HIV/AIDS Among State/Federal Prison Inmates

- At least 5,600 cumulative AIDS deaths through 1995
- Over 5,000 inmates living with AIDS in 1995 (prevalence more than six times that in total U.S. population)
- Over 24,000 HIV-seropositive inmates in 1995 (prevalence more than four times that estimated in total U.S. population)
- About 3% of HIV-seropositive people in the U.S. are State/Federal prison inmates
- HIV seroprevalence rates range from <1% to 14% (jails up to 20%)
- HIV seroprevalence rates generally higher for women than for men
- Few studies of HIV transmission in correctional facilities; these generally show that transmission occurs, but at low rates.

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Prevalence of HIV/AIDS Among State/Federal Prison Inmates, 1985-1995

Year	HIV-seropositive inmates		Inmates with Confirmed AIDS	
	n	% of inmates	n	% of inmates
1985	n/a	---	144	0.02%
1986	n/a	---	174	0.03%
1987	n/a	---	295	0.05%
1988	n/a	---	445	0.07%
1989	n/a	---	1,351	0.2%
1990	n/a	---	1,312	0.2%
1991	17,551	2.2%	1,682	0.2%
1992	20,651	2.5%	2,644	0.3%
1993	21,475	2.4%	3,765	0.5%
1994	22,717	2.4%	4,849	0.5%
1995	24,226	2.3%	5,099	0.5%

Sources: 1985-1990: NIJ/CDC Surveys; 1991-1995: Bureau of Justice Statistics Reports

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HIV/AIDS Education and Prevention Programs in Adult Correctional Systems, 1992-1996

Programs	Percentage of State/Federal Prison Systems providing in at least one facility			Percentage of City/County Jail Systems providing in at least one facility		
	1992 (n=51)	1994 (n=51)	1996 (n=51)	1992 (n=31)	1994 (n=28)	1996 (n=41)
Instructor-led Education	86%	75%	94%	58%	62%	73%
Peer-led Programs	33	35	41	10	7	7
Pre/Post Test Counseling	N/A	N/A	96	N/A	N/A	83
Multi-session Prevention Counseling	N/A	N/A	59	N/A	N/A	41
Audio Visual Materials	96	88	84	90	66	78
Written Materials	96	94	96	71	72	90

Source: NIJ/CDC Surveys

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HIV/AIDS Education and Prevention Programs in Adult Correctional Facilities, 1994-1996

Programs	Percentage of State/Federal facilities providing		Percentage of City/County facilities providing	
	1994 (n=1,297)	1996 (n=1,488)	1994 (n=152)	1996 (n=152)
Instructor-led Education	48%	61%	66%	
Peer-led Programs	7	13	3	
Pre/Post Test Counseling	N/A	86	84	
Multi-session prevention counseling	N/A	31	33	

Source: NIJ/CDC Surveys

National Conference on Correctional Health Care
November 10, 1997

"Comprehensive" HIV/AIDS Education and Prevention Programs in Adult Correctional Systems, 1996

% With "Comprehensive" Programs	
State/Federal Prison Systems (n=51)	10%
City/County Jail Systems (n=41)	5%

*Provides all of the following in all of its facilities: instructor-led education, peer-led programs, pre/post-test counseling, and multi-session prevention counseling

Source: NIJ/CDC Survey

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HIV/AIDS Education and Prevention Programs: Summary

- Some increases in percentages of correctional systems offering key services
- Coverage across individual facilities remains thin
- Few systems offer comprehensive HIV/AIDS prevention programs in all of their facilities
- Very few programs have been rigorously evaluated

National Conference on Correctional Health Care
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Availability of Condoms and Bleach, 1996

Policy	State/Federal Prison Systems (n=51)		City/County Jail Systems (N=41)	
	n	%	n	%
Make condoms available for use within facility	2	4%	4	10%
Make Bleach available for any purpose	10	20	8	20

Source: NIJ/CDC Survey

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HIV Antibody Testing Policies for Incoming Inmates, 1996

Policy	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n	%	n	%
Mandatory	16	31%	0	--
Routine	1	2	1	2%
Offered	18	35	14	34
On Request	16	31	19	46
No Policy	0	--	7	17
Total	51	99%*	41	99%*

*Due to rounding

Source: NIJ/CDC Survey

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Selected Policies Regarding Notification of Inmates' HIV Antibody Test Results, 1996

Policy is to Notify:	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n	%	n	%
Inmate	51	100%	36	88%
Attending health-care provider	51	100	33	83
Correctional Management (Central Office)	21	41	6	15
Correctional Management (Institution)	19	37	6	15
Correctional Officers	6	12	3	7
Public Health Department	46	90	29	70
Victims of Sexual/Physical Assault by Inmate	24	47	10	24
Parole Agency	15	29	0	--
Spouse/Sexual Partner(s)	16	31	6	15
Needle-Sharing Partner(s)	14	27	4	10

Source: NIJ/CDC Survey

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Decline of Segregation Policies in State/Federal Systems (N=51) 1985-1996

Systems With Segregation Policies for:

Years	HIV-infected inmates		Inmates with AIDS	
	No. of Systems	%	No. of Systems	%
1985	8	16%	38	75%
1986	8	16	30	59
1987	5	10	41	80
1988	6	12	20	39
1989	4	8	16	31
1990	4	8	9	18
1992/1993	2	4	5	10
1994	2	4	4	8
1996	2	4	3	6

Source: NIJCDC Survey

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Housing Policies for Inmates with AIDS and Asymptomatic HIV Infection, 1994-1996

State/Federal Prison Systems

Housing Policy	AIDS				Asymptomatic HIV			
	1994 n	%	1996 n	%	1994 n	%	1996 n	%
General Population No restrictions	8	16%	17	33%	28	55%	31	61%
General Population With precautions	3	6	1	2	4	8	1	2
Permanently Segregated	4	8	3	6	2	4	2	4
Case-by-Case Determination	36	71	30	58	17	33	17	33
Total	51	101%*	51	100%	51	100%	51	100%

*Due to Rounding

Sources: NIJCDC Surveys

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Policies Regarding Compassionate Release and Medical Furlough, 1996

Policy	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n	%	n	%
Early/Compassionate Release	30	59%	13	32%
Medical Furlough	19	37	4	10

Source: NIJCDC Survey

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Discharge Planning Services, 1996

Services	% of State/Federal Prison Systems providing (n=51)		% of City/County Jail Systems providing (n=41)	
	Referral Made	Appointment Made	Referral Made	Appointment Made
Discharge planning for HIV+ inmates	92%		76%	
Medicaid/Related Benefits	78%	35%	56%	29%
CD4 Monitoring	71	24	54	17
Viral Load Monitoring	61	22	46	20
HIV Medications	82	31	66	27
Substance Abuse Treatment	75	22	63	24
HIV Counseling	73	27	61	32
Psychosocial Support	73	24	54	27
STD Prevention and Treatment	65	22	46	17

Source: NIJCDC Survey

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Discharge Planning Services: Summary

- Immediate post-discharge period is critical for relapse/recidivism
- Most correctional systems offer some discharge planning services
- Most systems do not make appointments for releasees to obtain services in the community

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Medical Care: Availability of HIV Therapies and Monitoring, 1996

Policy is to Provide	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n	%	n	%
Protease Inhibitors	46	90%	38	93
Combination Therapy (Protease inhibitors with anti-retrovirals)	46	90	37	90
Bactrim (Prophylaxis for PCP)	50	98	41	100
ZDV for Pregnant Women	47	92	38	93
CD4 Monitoring	51	100	38	93
Viral load monitoring	41	80	24	59

Source: NIJCDC Survey

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Psychosocial and Supportive Services for Inmates with HIV/AIDS, 1996

Policy is to Provide	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n	%	n	%
Peer Support Groups	17	33%	2	5%
Support Groups Led by Correctional Staff	32	63	13	32
Support Groups Led by Outside AIDS Organizations	34	67	25	61

Source: NJJCDC Survey

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Areas of Collaboration between Correctional Systems and Public Health Departments, 1996

Areas of Collaboration	Percent of Systems Reporting Collaborations				10			
	HIV/AIDS		STDs		State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
Educational Programs	78%	83%	67%	83%	78%	49%	71%	71%
Other Prevention Programs	69	69	66	39	61	41	71	71
Testing/Screening	73	68	48	33	71	71	71	71
Care Reporting	90	66	92	68	92	88	92	88
Counseling	78	61	83	46	47	37	47	37
Partner Notification	76	46	78	69	78	64	78	64
Outbreak Investigation	61	37	61	44	82	73	82	73
Treatment/Prophylaxis	66	69	46	62	60	66	60	66
Discharge Planning	84	71	66	84	84	83	84	83
Staff Training	82	68	73	69	87	76	87	76

Source: NJJCDC Survey

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HIV/AIDS Education and Prevention Programs for Inmates, 1996

Results of the Validation Study (VS)

Policy	Systems in VS with this Policy	Facilities from these Systems in VS	% in Agreement
Instruction-led Education in all Facilities	7	20	76%
Peer-led Education in all Facilities	1	1	100
Pre/post Test Counseling in all Facilities	10	28	100
Multisession Prevention Counseling in all Facilities	8	17	69
Videotape/Audiovisual Materials in all Facilities	11	28	76
Written Materials in all Facilities	12	31	87

Source: NJJCDC Survey

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Topics Covered in HIV/AIDS Education for Inmates, 1996

Results of the Validation Study (VS)

Topics	Systems in VS that Cover Topic			Facilities from these Systems in VS		
	n	%	% in Agreement	n	%	% in Agreement
Basic HIV information	16	40	98%	0	—	—
Basic STD information	15	38	99	1	2	8%
Meaning of HIV test results	16	40	90	0	—	—
Meaning of STD test results	16	39	91	1	2	8
Safe sex practices	12	28	68	3	4	58
Regulation skills for safer sex	7	20	45	8	16	50
Safe injection practices	9	23	35	6	12	67
Tattooing risks	13	32	76	2	4	25
Sharpening risks	14	33	82	1	2	8
Self perception of risk	11	28	66	4	8	38
Identifying barriers to behavioral change	10	23	56	5	12	67
Triggers for behavior relapse	9	22	45	6	14	71
Referral to other services	16	40	98	0	—	—

Source: NJJCDC Survey

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Mandatory and Routine Testing of Incoming Inmates for STDs, 1996

Policy	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n	%	n	%
Syphilis:				
Mandatory	31	61%	9	22%
Routine	14	27	8	20
Gonorrhea:				
Mandatory	8	16	1	2
Routine	6	12	2	5
Chlamydia:				
Mandatory	4	8	1	2
Routine	6	12	1	2

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Notification of HIV Antibody Test Results, 1996

Results of the Validation Study (VS)

Person or Group	Systems in VS that Notify			Facilities from these Systems in VS		
	n	%	% in Agreement	n	%	% in Agreement
Inmate	16	40	100%	0	—	—
Attending Health Provider	16	38	95	0	—	—
Correctional Management (Central Office)	8	14	43	8	25	64
Correctional Management (Institution)	1	14	50	6	25	60
Correctional Officers	2	5	60	14	34	100
Public Health Department	14	33	83	2	4	50
Victims of Sexual/Physical Assault by Inmate	8	12	33	6	17	76
Spouse/sexual Partner(s)	8	15	27	6	12	87
Needle Sharing Partner(s)	8	15	27	6	12	83

Source: NJJCDC Survey

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Screening Inmates for TB, 1996

Screening Policy	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n	%	n	%
All incoming inmates screened for TB disease	37	73%	30	73%
All incoming inmates screened for TB infection (mandatory)	46	92	21	51
All inmates screened at regular intervals for TB infection (mandatory)	43	91	17	41

Source: NJCDC Survey

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Active TB Disease Among Inmates, 1996

Inmates Under Treatment	State/Federal Prison Systems (n=51)		City/County Jail Systems (n=41)	
	n systems	%	n systems	%
0	12	24%	13	32%
1 - 10	16	29	17	41
11 - 50	6	10	4	10
51 - 100	1	2	2	5
> 100	2	4	0	—
Did not report	16	31	6	12
Total	61	100%	41	100%
Drug-resistant TB cases		36 (7%)		29 (10%)

Source: NJCDC Survey

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Results of Inmate Syphilis Screening, 1996

% Positive	State/Federal Prison Systems*		City/County Jail Systems*	
	n	%	n	%
< 5%	13	29%	5	29%
5 - 9.99%	1	2	4	24
10 - 20%	2	4	3	18
> 20%	0	—	0	—
Did not report	29	64	5	29
Total	45	99%**	17	100%

*Includes only systems with mandatory or routine testing for all incoming inmates
**Due to rounding

Source: NJCDC Survey

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TB Infection Among Inmates, 1996

% with Positive PPD	State/Federal Prison Systems		City/County Jail Systems	
	n systems	%	n systems	%
< 5%	21	41%	12	29%
5 - 9.99%	3	6	11	27
10 - 20%	1	2	5	12
> 20%	0	—	0	—
Did not report	26	51	13	32
Total	51	99%*	41	100%

*Due to rounding

Source: NJCDC Survey

National Conference on Correctional Health Care
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STDs Among Adult Correctional Inmates and Confined Juveniles

- Many Systems do not maintain aggregate statistics on STD test results
- Available data show low positivity rates
- 24% of Chicago's syphilis cases diagnosed in Cook County Jail
- 13% of Florida's syphilis morbidity identified in correctional facilities
- Incidence rates for gonorrhea in 1994 were 152 higher for confined female juveniles and 42 times higher for confined male juveniles than for corresponding female and male age groups in U.S. population

Sources: NJCDC Surveys

National Conference on Correctional Health Care
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TB Among Inmates

- Many systems do not maintain aggregate statistics on TB
- 768 inmates under treatment for active TB disease in 1996, down from 919 in 1994
- PPD-positive rates higher than 10% reported in six prison/jail systems in 1996

Source: NJCDC Surveys

National Conference on Correctional Health Care
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CCCWG Projects/Initiatives Inventory

Correctional facilities are critical settings for monitoring the cutting edge of the HIV/AIDS epidemic and for intervening to address problems of TB, STDs, hepatitis, and other infectious diseases. Inmate populations probably represent the largest concentration of persons infected with, or at high risk for, HIV due to drug use-related and sexual risk factors. Transmission of HIV and TB has been documented in correctional settings. The overcrowded and poorly ventilated correctional facilities are highly conducive for transmitting disease, especially if corrections lacks effective programs of disease screening, prophylaxis, and prevention.

Mostly in jails but in prisons as well, the vast majority of inmates return to the community after short stays, where they may resume or continue high-risk behavior, placing themselves and others at risk. With high recidivism rates, many of these individuals will return repeatedly to jail or prison. There is a substantial population of high-risk individuals circulating between correctional facilities and communities in the “free world,” already beset by poverty, drug use, violence, and disease.

If not recognized soon, this could potentially become a serious public health problem. At the same time, correctional facilities offer significant opportunities for intervention. They are ostensibly controlled settings where populations can be efficiently accessed and programs implemented with literally “captive audiences.” Nevertheless, findings of Abt Associates, Inc.’s survey of HIV/AIDS, STDs, and TB in correctional facilities, conducted for CDC and the National Institute of Justice (NIJ), demonstrate that the opportunity to provide comprehensive education and prevention programs in prison, jails, and juvenile facilities, has been missed to a great extent.

A potentially important method of addressing HIV/AIDS, STDs, and TB in jails and prisons is through collaborations between public health and corrections agencies. Public health offers scientific and programmatic expertise in disease prevention and control, while corrections has the population in need of services and, commonly, a desire to save scarce resources by finding other sources for necessary functions. Thus, such collaborations seem natural, however, they have not frequently occurred. Public health and correctional officials have different perspectives and perceptions of each others’ motives and agendas which frequently breed suspicion and conflict. Simultaneously, the most recent NIJ/CDC survey suggests that many correctional systems are interested in receiving assistance from public health departments with disease prevention programs.

At CDC, a cross-center working group has developed to address these health care issues, and its mission is to help focus and stimulate disease prevention activities in correctional settings. Since the Cross-Center Corrections Working Group’s (CCCWG) inception, its members have been working to include corrections language in their Division’s initiatives and projects and to receive funding from various CIOs for studies in correctional facilities. To date, the CCCWG’s biggest accomplishment is developing partnerships with other federal agencies (NIJ, Bureau of Justice Statistics, and the Federal Bureau of Prisons), and with non-governmental agencies (American Corrections Association, National Commission on Correctional Health Care, and American Jail Association). It is the collaborative efforts between CDC and other agencies that will begin to reveal solutions for this growing high-risk population that circulates through correctional systems.

ONGOING

NIJ/CDC Inter-Agency Agreement (National Center for HIV, STD, and TB Prevention – NCHSTP/Office of the Director)

A. National Survey on HIV/AIDS, STDs, and TB in Correctional Facilities

Objective: To obtain information on prevalence of HIV/AIDS, STDs, and TB, educational and behavioral interventions, precautionary and prevention measures, counseling and testing procedures, housing policies for HIV-positive inmates, and medical care and psychosocial services offered in federal prisons, state prison systems, and city/county jails.

Study design: Cross-sectional

B. Research in Brief – Public health/ corrections collaborations: Prevention and treatment of HIV/AIDS, STDs, and TB.

Objective: To examine the extent and nature of public health and corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB.

Study design: Study consisted of site visits to the jurisdictions which included interviews with correctional and public health staff and others in the correctional systems who were involved in collaborations with the public health department. Interviews addressed collaborations regarding educational programs, other prevention programs, testing/screening, case reporting, counseling, partner notification, outbreak investigation, treatment/prophylaxis, discharge planning, and staff training.

Jail STD Prevalence Monitoring Project (Division of STD Prevention -- DSTDP/Epidemiology and Surveillance Branch)

Objective: To develop standardized methods for collecting STD screening data from jails, to assist programs in implementing these data collection systems, and to report these results locally and nationally.

Study design: Health Departments collect STD prevalence data from large jails and juvenile detention facilities in a standardized format. Sites report information on either serologic tests for syphilis or urine ligase chain reaction (LCR) tests for chlamydia and gonorrhea.

STD Screening for Women in Jails (DSTDP/Epidemiology and Surveillance Branch)

Objective: To assess the feasibility of testing urine for STDs in women admitted to

correctional institutions, determine the prevalence of gonorrhea and chlamydia among these women, assess the health department's ability to locate and treat women testing positive who have left the facility before test results are available, and test for pregnancy and refer all pregnant women to appropriate medical care.

Comparing the advantages of using different types of diagnostic tests for women admitted to a county jail (DSTDP/Epidemiology and Surveillance Branch)

Objective: To determine if more women with gonorrhea and chlamydia will be treated by using rapid on-site tests, making possible immediate treatment, or by using more sensitive off-site urine tests, with subsequent follow-up and treatment.

Study design: Will conduct rapid on-site testing for Chlamydia trachomatis by the Biostar Optical Immunoassay and Neisseria gonorrhoeae by Gram Stain. Women testing positive will be treated on site. Will also collect a urine specimen from all women to test for chlamydia and gonorrhea by ligase chain reaction tests, which must be performed at a qualified laboratory with a 3-4 day wait for results. Diseases intervention specialists will attempt to locate and ensure treatment for women testing positive who are released before the results are available and who were not treated based on results of on-site tests. Women still in jail will be treated on site. Will compare the treatment rates for infected women (using LCR test results as the indication of infection) achieved by on-site testing with treatment rates achieved by urine testing and follow-up. Women will also receive a urine pregnancy test so that those testing positive may be referred to appropriate medical care and treated properly for STDs.

Collaboration with National Commission on Correctional Health Care (NCCCHC)

NCCCHC was awarded a grant by NIH to study the health status of soon-to-be-released inmates. They have contacted CDC for technical assistance and input on this study; John Miles accepted an invitation to be a member of the study's steering committee. Several CDC staff knowledgeable on corrections issues have participated on "Expert Panels" which discussed communicable disease, chronic disease, and mental health.

Collaboration with Department of Justice, Office of Justice Programs, Corrections Program Office (CPO)

Working with CPO to develop strategies for TB prevention within corrections, especially ways to improve collaboration between state and local correction and public health both at entry and discharge into the community. One collaboration project involves a conference co-sponsored by the California Tuberculosis Controllers Association, California Department of Corrections, and other related state agencies. John Miles will be chairing a session at this conference.

DSTDP Jail Inventory (DSTDP/Program Development and Support Branch)

DSTDP Program Development and Support Branch has developed and administered an inventory of STD activities in each project area's largest jail facility. The survey examines surveillance, access to care, and prevention services. Preliminary data reveal: 1) gaps in STD services in jail settings; and 2) areas for CDC to provide technical assistance and training for public health and correctional staff. An article summarizing the results of this inventory will be published early summer 1998.

HIV and STD Intervention Research for Young Men in Prison (Division of HIV/AIDS Prevention-Intervention, Research, and Support -- DHAP-IRS/Behavioral Intervention Research Branch)

Objective: To evaluate the effectiveness of a yet to be designated HIV/STD intervention among ex-prisoners.

Target population: Young men (18-25 years old) who are leaving prison

Study design: Descriptive interview data collected during the first two years of formative research. After implementation of an intervention, effectiveness of intervention will be evaluated in a randomized, controlled trial conducted among ex-prisoners randomly assigned to an intervention group or a control group.

Baltimore Syphilis Outbreak (DSTDP; NCHSTP/Office of the Director)

CDC EIS officers discovered an outbreak of syphilis in Baltimore and detected that a majority of the cases were passing through the intake center of Baltimore's jail system. CDC has implemented outbreak control measures: 1) federal staff was placed at the intake center to provide technical assistance and support for a syphilis screening/treatment program, and 2) CDC/NCHSTP and SAMHSA/CSAT have begun discussing a coordinated effort to address the outbreak through the city's drug treatment centers.

Survive Outside: Juvenile Corrections HIV Infection Prevention (Division of Adolescent and School Health -- DASH)

Objective: To assess individual risk behavior of confined youth and to provide either short term discussion groups or a formal multi-session curricula (depending on population of facility) addressing HIV risk reduction, and to provide referral information and materials upon release.

Target population: Youth confined within the juvenile correction system ages 9-20

Study design: Regional trainings will prepare juvenile detention and corrections staff to implement screening interview and re-entry interviews. National trainings will teach staff to implement discussion groups and/or curricula.

HIV Prevention Train-the-Trainers (DASH)

Objective: Peer AIDS educators will develop and implement ways to present HIV prevention messages to their peers in a meaningful and stimulating manner.

Target population: Youth under the age of 24 in juvenile confinement and detention facilities, jails, and prisons.

Study design: Workshops held throughout the United States will train correctional staff. Trained staff will select 10-15 youth in each facility to be trained as Peer AIDS Educators.

Evaluation of Reporting of Prison Inmates in New York State (Division of HIV/AIDS Prevention-Surveillance and Epidemiology -- DHAP-SE/Surveillance Branch)

Objective: To assess the completeness of reporting of prison inmates in the New York State Correctional System

Study Design: Medical records from the New York State Department of Corrections (NYSDOC) containing information on inmate demographics and AIDS diagnosis will be matched with the New York State AIDS case registry. For matched cases, the case registry will be updated to reflect any additional information contained in the NYSDOC file. For unmatched cases, surveillance (medical record reviews) will be initiated to obtain all possible information on these new cases.

Cost-Effectiveness Analysis of Screening for Tuberculosis in Prisons and Drug Treatment Programs (Division of TB Elimination – DTBE)

Objective: To determine the effectiveness, costs, and cost-effectiveness of TB screening in prisons and drug treatment programs, and to provide an economic basis for decision making in establishing screening programs in prisons and drug treatment centers.

Study design: Study will use existing data from the HIV-related TB Prevention Program to determine the cost-effectiveness of screening in prisons and drug treatment programs in New York State and New York City. Data on the outcomes of screening programs will be analyzed from H RTP data and cost estimates will be collected from the two programs.

Preventing Alcohol-Exposed Pregnancies (National Center for Environmental Health/Developmental Disabilities Branch)

Objective: To prevent alcohol-exposed pregnancies among women released from Harris County Jail, Houston, TX.

Target population : Females ages 18-44, fertile, sexually active, not effectively contracepting, and drinking an average of 7 or more drinks/week, or 5 or more drinks/occasion

Study design: "Brief intervention" with "motivational interviewing." Three visits total, with the initial visit having comprehensive assessment, decisional balance exercise, brief education/advice, and referral for gynecological visit. Second visit is two weeks later, preferably after the separate gynecologic visit, with personalized feedback and review of decision exercise. Third visit is after one month, with motivations exploration or skill building for adhering to chosen goal. The evaluation will include 3- and 6-month follow-up measures.

COMPLETED

CDC's Dr. Satcher as Keynote Speaker at the American Correctional Association's 127th Congress of Corrections, August 1997

UPCOMING

1998 HIV Prevention Summit

Members of the Corrections and Substance Abuse Unit will be presenting two poster sessions on corrections issues: 1) "Results of the Ninth National Survey of HIV/AIDS, STDs, and TB in Correctional Facilities," and 2) "How to Create Successful Collaborations Between Public Health and Corrections Agencies." Furthermore, a roundtable discussion on "The Prison System and Nonprofit Community-Based Organizations: The Role of Public Health, Municipalities, and the Philanthropic Sector" will be presented by CDC's Office of Minority Health.

Hepatitis B Vaccination Initiative (National Center for Infectious Disease/Hepatitis Branch and National Immunization Program)

Hepatitis B is the only vaccine-preventable STD, and vaccination for the hepatitis B virus (HBV) prevents one cause of liver cancer. An article expressing the need for HBV vaccination interventions will be published in the American Correctional Association's journal, *Corrections Today*. Current strategies for immunization of high-risk individuals include the identification of locations where they can be reached.

High-risk adolescents can be accessed through juvenile detention facilities and half-way houses. These juveniles are eligible to receive vaccine through the Vaccine for Children (VFC) program. Model programs for immunizing juvenile offenders for HBV can be found in Oregon and Los Angeles.

Additionally, high-risk adults can be effectively immunized for HBV, and similarly, prison

settings are identified as valuable intervention sites for the vaccine. Implementation of HBV vaccination programs in Hawaii and Michigan have shown promising results in reaching these high-risk adults. Additional sites for vaccination programs are being evaluated to promulgate a national policy for HBV vaccination of high-risk individuals.

Collaboration with the Federal Bureau of Prisons and the National Institute on Corrections

This project will develop a training curriculum for FBOP correctional officers on communicable disease transmission and how to detect symptoms. With involvement from NIC, potentially this curriculum could be utilized in other state and local correctional systems.

NIJ and Drug Court Program Office (NCHSTP)

CDC has been invited to collaborate in the Drug Court Program.

Arrestee Drug Abuse Monitoring (ADAM) Project (NCHSTP)

NIJ has offered CDC participation in this project. CDC would develop testing and data collection protocol for STDs with urine-based testing of the program's participants. This project is still in the planning phase, and will begin in the fall.

Surveillance Activities Within Correctional Facility Settings (DHAP-SE/Prevention Services Research Branch)

These surveys will be done in collaboration with the local health department and will commence in the summer/fall of 1998.

- 1) Unlinked HIV Seroprevalence Surveys Among Inmates Entering Correctional Facilities.
- 2) HIV Prevalence and Incidence Among IDUs in the King County Correctional Facility. Will collect information on risk behaviors, migration patterns to Vancouver BC, incidence, and prevalence among inmates accepting voluntary HIV counseling/testing.
- 3) Bloodborne Pathogens in Incarcerated Drug Users. Will estimate the incidence and prevalence of HIV, hepatitis B, and hepatitis C among inmates in Rhode Island State Corrections through a collaboration with CDC, Johns Hopkins University, and the Miriam Hospital in Rhode Island.

DeKalb County Juvenile Court and DeKalb County Board of Health (NCHSTP/Office of the Director)

Both of these agencies have begun to address the STD and HIV disease burden in the youth of DeKalb County, Georgia. The Board of Health has asked for technical assistance from CDC.

**National Center for HIV, STD, and TB Prevention
Corrections Plan**

February 27, 1998

National Center for HIV, STD, and TB Prevention

Corrections Plan

This document outlines a comprehensive, science-based, multi-faceted Center-wide corrections plan that will maximize prevention and intervention opportunities for Center programs and activities. This plan is linked to NCHSTP's current prevention and intervention program activities (collaboration, and multi-disciplinary programs of research, surveillance, technical assistance, and evaluation).

In corrections, multiple issues intertwine to create an emerging public health crisis (increases in disease, increases in the number of women and youth being incarcerated, drugs, managed care/privatization and the capacity of communities to effectively intervene). Addressing this crisis is compounded by the fact that corrections is a system of systems (jails, prison, detention, parole/probation, and sanctions) and that each system is individualized and very complex in every facility. Health and prevention issues are secondary to incarceration and security.

Providing timely and appropriate HIV/AIDS, STD and TB prevention and intervention activities in correctional settings are an emerging public health issue. It is critical that we have a coordinated prevention focus in correctional settings because of the following information:

- **Approximately 70 percent of people in prison have a history of injection drug use or substance abuse.** According to the U.S. Department of Justice, the prison population has tripled in the last 18 years with much of the increase occurring after 1993. In 1993 drug trafficking laws changed to enforce stricter sentences on drug dealers and drug users. Over 50% of all incarcerated persons were charged with a drug offense. In 1995, 51-83% of male arrestees tested positive for drugs and 41-84% of female arrestees.
- **Correctional settings provide an opportunity for early intervention and prevention. Inmates represent high risk populations who have been underserved or missed by the health care system.** Most prisoners are from disenfranchised communities that historically lack access to adequate health care services. These individuals do not have health-seeking behaviors. Incarceration for many is their first interaction with the health care system.
- **Disease surveillance (HIV, STDs, TB, etc.) in this population is generally inadequate and inaccurate.** Although facilities are finding seroprevalence rates for incarcerated persons to be higher than for the general population, only 16 out of the 51 state and Federal correctional systems require mandatory HIV testing of all inmates, as of 1994. This is inadequate considering the fact that there are over 4,000 facilities (including both jails and prisons) across the US.
- **Improvements are needed in discharge planning and aftercare linkage services.** Because of high rates of recidivism and the increased likelihood of disease transmission

to uninfected persons in the community, discharge planning is critical. Although many prison and jail facilities offer discharge planning for HIV+ releasees, the percentage of persons that followed through with their referral (i.e., an appointment) is extremely low, ranging between 17-39%.

The overall goal of this plan is to improve community health through improved access to HIV, STD and TB health care and prevention services within correctional settings and transitional programs in communities. This plan focuses on seven program areas with high populations of incarcerated individuals (California - Florida - Georgia - Illinois - New York - Texas - District of Columbia). Objectives to achieve this goal are to be completed by the end of Calendar Year 1999.

Objective 1 Provide a database for decision makers to improve disease prevention services for incarcerated populations

Activities:

1. Establish baseline disease prevalence rates in jails and prisons (national/regional).
2. Profile current *surveillance and reporting practices for HIV/STD/TB in jails and prisons.
3. Develop guidelines for disease/behavioral risk surveillance and reporting in corrections.
4. Develop and disseminate epidemiologic/behavioral risk profiles for policy and program planning.
5. Work with NCHSTP's divisions to incorporate correctional health as a prevention focus in program announcements, guidance, etc.
6. Establish corrections-based demonstration projects in seven project areas.

* Surveillance is defined as the collection and analysis of data on disease, behavioral risk factors, and programs.

Objective 2 Promote the availability of transitional services and continuity of care through partnerships

Activities:

1. Provide technical assistance on *"How to Work Within Corrections"* at all major NCHSTP meetings and national conferences.
2. Develop and distribute a *"Prevention in Correctional Settings"* guide for Center grantees (community planning groups, program managers, NGOs, etc.)
3. Fund three demonstration projects to develop policy and "best practices" guidance for corrections and public health in collaboration with the American Corrections Association (ACA) and the National Commission on Correctional Health Care (NCCHC).
4. Fund one demonstration project that supports capacity development for carrying out effective corrections-based prevention programs.
5. Establish and support new "public health liaison" positions within key correctional

systems.

6. Conduct frequent "Pulse Check" consultations to identify barriers and facilitators of collaboration between health departments, NGOs and correction.

Objective 3 Establish opportunities for information and technology transfer between corrections and public health

Activities:

1. Develop model policy, legislative language and memoranda of understanding that promote the formalization of collaborative relationships between public health and corrections.
2. Document the number of health departments and corrections agencies that have intra - agency agreements and liaisons at the leadership and operational levels.
3. Document the incidence of correctional representation/involvement on HIV prevention planning groups.
4. Include a correction component in all future community-based technical assistance materials distributed to grantees and prevention partners.
5. Following the "Skills Building" concept, use existing corrections-based NGO partners (ACA/NCCHC) to co-sponsor corrections forums that incorporate health issues.
6. Develop and implement cross training programs for public health and corrections staff.

file
Attended
AZT Studies

2-19-98

WORLD

By MARLENE CIMONS -
TIMES STAFF WRITER

WASHINGTON—In findings that could prove important for controlling the spread of AIDS in developing nations, short-term use of the drug AZT for infected women late in pregnancy and during delivery reduced transmission to infants by half, U.S. and Thai health officials announced Wednesday.

This is significant because the therapy involves a shorter duration and much less expensive regimen of the drug than that typically prescribed for infected pregnant women in the United States.

Thus, it offers "real hope" to countries that previously had no realistic treatment options to prevent HIV transmission from infected mother to fetus, said officials from the Centers for Disease Control and Prevention in Atlanta and the Ministry of Public Health of Thailand.

CDC estimates that every day, 1,600 HIV-infected babies are born worldwide.

The short course of treatment administered to women in the study costs about \$80, compared to the \$800 to \$1,000 for the standard recommended therapy given in the United States.

In the United States, oral AZT therapy is started as soon as possible after 14 weeks' gestation and continues throughout pregnancy in doses taken five times daily. The drug also is administered intravenously during labor and then given to the newborn orally four times a day for six weeks.

In the study, women took higher doses of the drug orally twice a day for the last four weeks of pregnancy and continued taking the drug orally during labor. The drug was not given to the infants.

The preliminary results were so compelling that all pregnant women enrolled in the study—which also

Short-Term AZT Use in Pregnancy Is Hailed

includes a group of women in Abidjan, Ivory Coast—will now be offered the drug.

Despite the vast differences between the two regimens, access to AZT still could prove formidable in developing countries, officials acknowledged. The cost is "still much higher than a lot of countries can afford," said Dr. Martha Rogers, associate director for science in CDC's AIDS division. But, she added, the study results likely would boost efforts to "pressure the developing world, donor agencies and drug companies to provide these resources. Hopefully, that's going to happen."

The United Nations has scheduled a meeting in Geneva at the end of March among international agencies and governments of both developing and developed nations to discuss ways to implement "the results of this and other trials into public health policy," a U.N. statement said.

The study of pregnant Thai women was criticized earlier over the ethics of using a placebo control group. But researchers defended it as necessary to find

alternatives to therapies that are otherwise too costly or unavailable to women in poor nations.

Dr. Peter Lurie of the advocacy group Public Citizen, which had been a chief critic of the study, called it a "tragedy," saying that "precious time and money have been wasted" and dozens of infants "unnecessarily" infected. Public Citizen had argued that the study should not have had a placebo group but instead should have compared the short course to the longer regimen.

But CDC's Rogers said that if the study had compared the two regimens, the results would not have been as striking and "the country wouldn't know if it [the short regimen] was different from what they currently had in place, which was no therapy. They wanted to know: do you have something better than what we can give women now? Which is nothing. Now we have something we can really offer people."

Of the 391 babies born to women in the study, 198 were born to mothers who took a medically worthless placebo and 193 to those who took AZT.

There were 35 infected babies in the placebo group, compared to 17 in the AZT group—roughly half, which Rogers called "a remarkable difference."

These results were not as dramatic as those in the 1994 landmark study of the longer treatment, which showed a 70% reduction in transmission.

But "the short-course . . . is more . . . feasible [for] the developing world," and could have "a significant impact" on mother-to-fetus transmission, the United Nations said.

Women in the study did not breastfeed, a practice that can transmit the virus. Thus, "it is possible that efficacy of the shortened regimen may be lessened in countries where breastfeeding is the norm," the U.N. statement said.

Placebo Use Is Suspended In Overseas AIDS Trials

By SHERYL GAY STOLBERG

Saying they have finally found a cheap way for developing nations to use the drug AZT to reduce mother-to-infant transmission of the AIDS virus, Government health officials announced yesterday that they were suspending the use of dummy pills in a series of controversial overseas experiments on pregnant women.

The announcement, by the Centers for Disease Control and Prevention, left people on both sides of the debate elated, but for different reasons.

Defenders of the Government-financed studies said the findings — that \$80 worth of AZT given during the last four weeks of pregnancy could cut transmission of the virus in half — will have a major impact on many developing nations, which have been devastated by AIDS. Critics, who had called the use of the placebo unethical, pronounced themselves vindicated because the women in the experiments will now get AZT instead of dummy pills.

"I'm delighted," said Dr. Marcia Angell, editor of *The New England Journal of Medicine*, who in an editorial last year likened the studies to the infamous Tuskegee experiments, in which treatment for syphilis was withheld from poor black men. "Better late than never."

The AIDS studies, which have involved 12,211 women in seven countries, were based on one of the most impressive discoveries of the epidemic: the finding, four years ago, that use of AZT during pregnancy could cut the risk of mother-to-infant transmission of H.I.V., the AIDS virus, by two-thirds.

Today, as a result of that discovery, H.I.V.-infected women in the United States are routinely given AZT during the last 12 weeks of pregnancy. They also receive intravenous infusions of the drug during delivery, and their babies take the medicine for six weeks after being born. This is commonly called the "076 regimen," after the number assigned to the Federal study that proved it effective.

But the 076 regimen is expensive — \$800 a patient, including the infusions and drugs for the babies — and too complicated for use in developing countries, where access to medical care is poor. Yet every day, an estimated 1,600 H.I.V.-infected babies are born worldwide, most of them in developing nations. So when the 076 results were published, officials at the United Nations, the World Health Organization, the National Institutes of Health in Bethesda, Md., and the disease control centers in Atlanta set out to find a way to translate the results to those countries.

They settled on experiments in which half the women were given a short course of AZT and half were given dummy pills. The studies were controversial even among the Government's own researchers; most recently, the debate cast a shadow over the confirmation of Dr. David Satcher, the new Surgeon General who previously headed the centers.

Now, the first of those studies, conducted on 393 women in Thailand, is complete. The study found that women who were given AZT during the last four weeks during pregnancy, as well as during labor and delivery, had half the risk of giving birth to an H.I.V.-positive baby as those who received the placebo.

"We are very pleased," said Dr. Phillip Nieburg, a centers official involved with the experiments. "The controversy was unfortunate, but we feel that the placebo-controlled trial that we did was very necessary."

Others echoed Dr. Nieburg's sentiments. "It's just wonderful news," said Mark Harrington, policy director for the Treatment Action Group, an advocacy organization. "If we can get this incredible health benefit for 80 bucks a pop, then we can really make a difference around the world."

How much difference the study will make, however, remains to be seen. While \$80 may sound inexpensive, it is eight times what most developing nations spend per capita on health care each year.

Mr. Harrington called on the manufacturer of AZT, Glaxo-Wellcome, to provide the drug to developing nations at a steeply discounted price. And Dr. Joseph Saba, who heads the international working group that coordinated the experiments, said he was trying to "set up plans on how we move on and who does what."

But the advocacy group Public Citizen, long a critic of the project, said researchers should have known the answer to the most pressing question — whether a short course of AZT would work — all along.

Dr. Sidney M. Wolfe, who directs Public Citizen's Health Research Group, obtained data on a subset of patients from the original 076 trial. Dr. Wolfe said that among those who received AZT for an average of seven weeks, the risk of transmission was cut by two-thirds. Government officials said those data were unreliable, but Dr. Wolfe maintained that the figures should have been taken into account.

"This is inexcusable, sloppy research," he said. "They have wasted a large number of lives and a huge amount of money."

February 19, 1998

U.S. Ends Overseas H.I.V. Studies Involving Placebos

Related Article

☐ [Plan to Use Placebo in African Test on H.I.V. Is Scrapped \(Oct. 24, 1997\)](#)

By SHERYL GAY STOLBERG

Saying they have finally found a cheap way for developing nations to use the drug AZT to reduce mother-to-infant transmission of the **AIDS** virus, U.S. government health officials announced Wednesday that they are suspending the use of dummy pills in a series of controversial overseas experiments on pregnant women.

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The controversial studies -- which have involved 12,211 women in Thailand, the Dominican Republic, Ethiopia, Ivory Coast, Uganda, Tanzania and South Africa -- were based on one of the most dramatic discoveries of the **AIDS** epidemic: the finding, four years ago, that use of the drug AZT during pregnancy could cut the risk of mother-to-infant transmission by two-thirds.

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But the 076 regimen is expensive -- \$800 per patient, including the infusions



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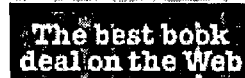
AZT's Success in Pregnancy May Help Expand AIDS Treatment for Poor

By David Brown
Washington Post Staff Writer
Thursday, February 19, 1998; Page A10

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A short, relatively inexpensive course of the drug AZT works almost as well as a long, expensive course in preventing mother-to-child transmission of the AIDS virus, federal health officials announced yesterday.

That conclusion, deduced from a nearly completed study in Thailand, raises the possibility that many of the half-million cases of human immunodeficiency virus (HIV) infections occurring at birth each year may be avoidable.

The search for a cheap and practical method of preventing "perinatal" HIV transmission has been an urgent priority in AIDS research in recent years. It has also been a subject of intense ethical debate. Some observers criticized studies that used placebos, or inactive pills, saying that Western scientists were denying poor Third World women treatments known to work.

Simultaneous with yesterday's announcement, officials of the Centers for Disease Control and Prevention, the United Nations AIDS program and the National Institutes of Health said they will recommend that use of placebos be stopped in all the mother-to-child transmission studies. There are about a half-dozen underway around the world.

CDC is now running a study in Ivory Coast. Although data on the effectiveness of AZT in that country are not available, there is evidence the drug is safe for those West African women. The need to determine the safety of the drug in women subjected to malaria, anemia and poor diets was one of the justifications for using placebos in Ivory Coast.

"Clearly I think it is no longer appropriate to study this same question with a placebo," said Helene Gayle, director of CDC's HIV program.

The treatment used in the Thailand study costs about \$50 per woman, based on the current price of AZT. The more intensive and prolonged course used in the United States and other wealthy countries costs about \$800.

While the shorter, cheaper treatment is still too expensive for many poor countries, international AIDS officials hope that a combination of donations and price breaks will bring the cost of treatment down to

an affordable level. Between 2 million and 3 million women a year would need to be treated.

In anticipation of findings like the ones announced yesterday, various donor agencies and international health officials have been meeting to put together a plan to get AZT to pregnant women in the developing world in the next few months.

"I do not think cost will be an issue," said Joseph Saba, a physician with UNAIDS, who has helped direct these discussions. He would not provide any other details, except to say that the relative ease of the Thai treatment "makes it more attractive to donors." UNAIDS is the combined AIDS program of the United Nations, the World Health Organization and the World Bank.

The Thailand study involved about 400 women. Half received AZT pills twice a day during the last four weeks of pregnancy, and every three hours during labor and delivery. The other half took placebo pills on the same schedule. None of the women breast-fed her infant. HIV infected 18.6 percent of the infants whose mothers were taking the inactive pills but only 9.2 percent of the infants whose mothers were taking AZT.

In the United States, women with HIV are commonly given AZT pills for up to six months of pregnancy, and then an intravenous dose during labor. The infant is then given AZT for six weeks after birth. A study completed four years ago this month showed this strategy reduced HIV infection in infants from 23 percent to 8 percent. That amounted to a reduction of about 66 percent, compared with the 50 percent seen in the Thai study.

While the new findings appear to offer great hope, they are unlikely to alter the risk posed by breast-feeding, which is the other main source of infection to infants.

Roughly 20 percent of infants of untreated, HIV-positive mothers acquire the AIDS virus either in late gestation or during delivery. If the baby is breast-fed for a significant period of time, that rises to about 33 percent.

In industrialized countries, HIV-positive mothers are strongly advised to bottle-feed their children. In poor countries, where clean water is unavailable and the cost of formula is prohibitive, most women with HIV are advised to breast-feed.

The theory is that the nutritional and immunological benefits of breast milk (and the avoidance of the risks associated with formula) outweigh the risk of passing the AIDS virus to the child. Few people are very comfortable with this trade-off, however.

For that reason, several studies are underway in African countries in which antiviral drugs are given to the newborn for some period of time. Although the ones using placebo during pregnancy and delivery will be changed, the studies themselves will not be abandoned, Saba said.

"The new findings do not really mean that all the problems are solved

and all the issues addressed," he said. "We still do not have any data on the effect of [short-course] AZT in the context of breast-feeding, and we have no data on very short regimens of AZT, in people who come to the clinic just a few days before labor."

Most of the studies using placebos were designed, their ethical ramifications discussed, and permission from host countries sought, several years ago. Last spring, however, their morality became an issue when Public Citizen's Health Research Group, an activist organization headquartered in Washington, declared all perinatal transmission studies using placebos unethical.

The organization argued that because the long course of AZT had been proved beneficial, any shorter, more economical strategies should be compared to it. Defenders of the placebo studies countered that a new treatment (such as short-course AZT) should be compared to the "standard of care" in a country. In very poor countries, that standard was no AZT treatment at all, which would be simulated by a placebo.

Furthermore, some argued that because of the poor nutritional status of many poor pregnant women, and their large "burden" of other diseases, AZT -- which occasionally has serious side effects -- might turn out to be harmful. For that reason, AZT couldn't be assumed to be better than nothing, they said.

Last fall, Public Citizen researchers learned that the original U.S. study of long-course AZT contained many women who took the drug only for the last seven weeks of pregnancy. Those women benefited as much as women who took the drug for much longer. Public Citizen argued that finding made the Thailand study not only unethical but also unnecessary, because the American study had basically answered the question that was posed by the Thai study.

"I think that if CDC and NIH had paid attention to the results of their own study [in 1974], the babies in Thailand who died during this placebo-controlled trial wouldn't have died," Sidney Wolfe, a physician and head of Public Citizen's Health Research Group, said yesterday.

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and drugs for the the babies -- and too complicated for use in the Third World, where access to medical care is poor. Yet every day, an estimated 1,600 **HIV**-infected babies are born worldwide, most of them in developing nations. So when the 076 results were published, officials at the United Nations, the World Health Organization, the National Institutes of Health in Bethesda, Md., and the CDC in Atlanta set out to find a way to translate the results to the Third World.

They settled on experiments in which half the women were given a short course of AZT and half were given dummy pills. The studies were controversial even among the government's own researchers; most recently, the debate cast a shadow over the confirmation of Dr. David Satcher, the new surgeon general who previously headed the CDC.

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But the advocacy group Public Citizen, which has repeatedly condemned the project, said researchers should have known the answer to the most pressing question -- whether a short course of AZT would work -- all along.

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October 24, 1997

Plan to Use Placebo in African Test on H.I.V. Is Scrapped

By SHERYL STOLBERG

WASHINGTON -- A team of researchers at Johns Hopkins University has abandoned plans to use dummy pills in an experiment on Ethiopian women who are pregnant and infected with the AIDS virus. The use of the dummy pills as a placebo has renewed intense debate over the ethics of a series of federally financed studies in the Third World.

The study, which is to begin in late February or early March and will be paid for by the National Institutes of Health, was initially designed to see whether a short course of the anti-viral drug AZT is more effective than a placebo in reducing transmission of the AIDS virus, HIV, from a pregnant woman to her baby. But because it is routine for pregnant women in the United States to receive AZT, there has been bitter controversy about the use of dummy pills in the foreign studies.

A spokeswoman at the Johns Hopkins School of Public Health said Thursday that the researchers did not change the design of the Ethiopian study in response to the controversy. Rather, said Liz Pettengill, the spokeswoman, the scientists are expecting that a study under way in Thailand will prove that a short course of AZT is more effective than placebo.

If that is the case, she said, there is no need for the Johns Hopkins researchers to employ the dummy pills in their study.

According to Jack Killen, who directs the Division of AIDS at the National Institute on Allergy and Infectious Diseases, preliminary results from the Thailand study are expected in January. At that point, he said, all the studies will be re-evaluated, including current tests in the Ivory Coast and Tanzania and one planned for Uganda. If the short course of AZT is proved effective, none of the studies will continue to use placebo, he said.

"This has been part of a plan from the very beginning," Killen said. "It's not like a light bulb just went off: 'Oh, my goodness, we've got to look at the Thai study.'"



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EN ESPAÑOL

Study: Low levels of AZT could reduce number of HIV-positive babies

Finding would have key impact in developing world

February 18, 1998

Web posted at: 11:17 p.m. EST (0417 GMT)



ATLANTA (CNN) -- Low levels of the anti-HIV drug AZT may help prevent transmission of the virus from infected mothers to their babies, a finding with potentially important ramifications for the developing world.

The U.S. Centers for Disease Control and Prevention in Atlanta on Wednesday reported results of a study on 400 HIV-infected women in Thailand, which found that those taking low doses of AZT in the weeks before delivery were half as likely to give birth to an HIV-infected baby as those receiving a placebo.

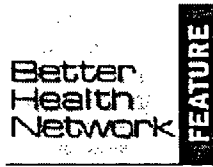
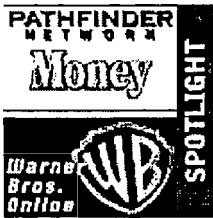
Higher doses of AZT, given over a longer period of time, have become the standard of care for HIV-positive pregnant women in the United States and Europe, cutting transmission to newborns by nearly 70 percent.

Because of the cost and the logistical problems associated with such a long-term regimen, that treatment is considered impractical for the developing world.

However, CDC researchers say the results of the new study show that low-dose therapy, while not as effective as the treatment used in Europe and the United States, does offer improved odds for HIV-positive women in the developing world at one-tenth of the cost.

"Now that this practical and feasible regimen has been proven safe and effective, these findings will help extend perinatal





safe and effective, these findings will help extend perinatal HIV prevention to many developing countries that previously had no realistic therapy options," said Dr. Helene Gayle of the CDC.

CDC defends use of placebo in study

In the Thai study, half of the pregnant HIV-positive women were given AZT and the other half a placebo. Among those who got AZT, 9 percent gave birth to babies infected with HIV. Among those getting the placebo, more than 18 percent had HIV-positive babies.

Some critics of the CDC study charged that it was unethical to give some women a placebo, despite the fact that experience in the industrial world strongly indicated that AZT could help prevent transmission of HIV to babies. But CDC officials defended the study design, saying using a placebo comparison group was the only way to prove that low-dose therapy was safe and effective.

"Without the placebo, the wrong conclusions about efficacy could have been easily drawn," Gayle said. "We would not be able to demonstrate to policy makers in Thailand and other countries that the therapy is safe."

However, with that thesis established by the Thai study, researchers say they will offer AZT to all of the women enrolled in a similar study now under way in Africa.

Senior Medical Correspondent Dan Rutz contributed to this report.

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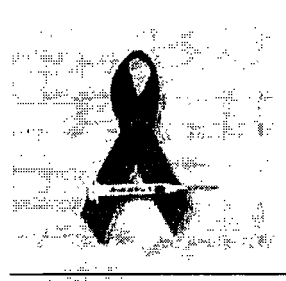
EN ESPAÑOL

AIDS researchers appeal for vaccine help

February 15, 1998

Web posted at: 7:44 p.m. EST (0044 GMT)

PHILADELPHIA (Reuters) - Leading U.S. AIDS researchers appealed for help from across the scientific community on Sunday in finding a vaccine against the HIV virus.



Peter Kim of the Massachusetts Institute of Technology said vaccine research needed all the help it could get. With more than 40 vaccines in trials, none has been shown to work safely in people.

"What's clear is that there are no currently available vaccines produced that are showing efficacy in humans," Kim told a news conference. "We think we need an influx of a broad range of expertise."

Kim made his appeal to the annual meeting of the American Association for the Advancement of Science in Philadelphia.

AIDS researchers have recently complained that science is still very ignorant about how the human immune system works.

Kim said help was needed to learn about the body as a system, right down to the molecules that make up cells. He said HIV was hard to structure and look at -- unlike other viruses, scientists know very little about its physical makeup.

The most promising vaccine developed so far was a live attenuated vaccine. This is made from HIV that has been genetically weakened, and it looks hopeful in monkeys.

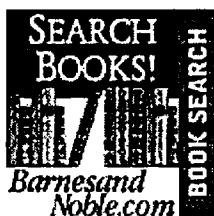
But no one is quite sure how or why it works. "There's a nasty possibility that it's achieved by a mechanism that we don't understand," said Dr. John Moore of the Aaron Diamond AIDS Research Center in New York.





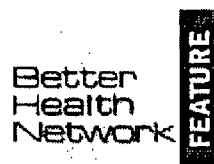
Of course, he added, "It's not necessary to know how a vaccine works to test it."

But there is evidence the live attenuated vaccine can re-constitute itself as virus in the body and might actually infect the vaccinated person.



Doctors who have volunteered to test such a vaccine on themselves are being put on hold by the National Institutes of Health (NIH), which would have to approve any such trials. The NIH says it is too dangerous.

Experts say a vaccine offers the only real hope against HIV. Most people in most countries cannot afford the drugs that can keep the virus suppressed.



Even years of taking strong drugs cannot eradicate the virus. HIV lurks in some of the immune cells it infects when they enter an inactive "resting" phase, and the HIV also becomes inactive.

The drugs only work against actively replicating virus.

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AIDS RESEARCH

Impending AIDS Vaccine Trial Opens Old Wounds

In the early 1980s, virologist Donald Francis, then with the Centers for Disease Control and Prevention in Atlanta, was one of the first to sound the alarm about the AIDS epidemic. Later this year, Francis may score another first: As president of VaxGen, a biotechnology company in South San Francisco, California, Francis hopes this year to launch the first ever full-scale trials of an AIDS vaccine. After years of slow progress in the AIDS vaccine field, that might sound like good news. But VaxGen's plans to begin so-called phase III trials in the United States and Thailand have provoked

strong reactions from AIDS researchers, who remain badly split over what kinds of vaccines are likely to work (*Science*, 23 May 1997, p. 1197). And a report in the February issue of the *Journal of Virology*, which casts doubts on whether vaccines like VaxGen's protect against HIV, has fueled the debate.

VaxGen does not yet have formal approval from U.S. or Thai authorities to proceed with phase III trials, but Francis told *Science* that he expects to get the green light soon. The U.S. Food and Drug Administration (FDA) has approved phase I and II trials—which test for safety and early signs of efficacy—of a modified version of a vaccine that has already gone through toxicity testing, and Thai authorities are expected to give their nod in the coming weeks. Moreover, Francis says, the FDA's vaccine advisory committee has given its blessing to VaxGen's plans to move to phase III once these trials reconfirm the safety of the vaccine, which is made from a genetically engineered version of a protein called gp120 that makes up much of the outer coat of HIV.

The FDA declined to comment on pending clinical trials for confidentiality reasons. But Mary Lou Clements-Mann, a vaccine expert at Johns Hopkins University School of Medicine in Baltimore and a member of the FDA advisory committee, confirmed Francis's account. "The committee felt comfortable with their overall strategy," she says. But this feeling of comfort is not shared by all AIDS researchers. "It is evident that gp120-based vaccines have not yielded antibodies that neutralize most natural strains of HIV,"

says Nobel laureate David Baltimore, head of a special committee that advises the U.S. government on AIDS vaccines. "This raises

serious doubts about the utility of these vaccines." Indeed, disappointing early results from trials of gp120 vaccines led the U.S. National Institute of Allergy and Infectious Diseases (NIAID), which coordinates federally funded AIDS vaccine trials, to decide in June 1994 not to devote its own funds to phase III tests (*Science*, 24 June 1994, p. 1839).

Thus VaxGen, which spun off from the biotechnology giant Genentech in 1995 and in which Genentech still holds a 25% stake, is raising some

\$20 million in private funds to pay for the trials, which—if they are approved—will involve some 5000 volunteers in the United States and 2500 in Thailand. Francis argues that none of the previous trials with gp120 vaccines have been designed to test their actual efficacy in preventing HIV infection. VaxGen's vaccine, Francis adds, has a proven ability to protect chimpanzees against HIV and to produce strong immune responses in humans. "What is the argument against [phase III trials]?" Francis asks. "If you don't follow the process completely, you may make premature conclusions and stop the progress of vaccine development."

But a study in the current issue of the *Journal of Virology*, led by virologist Steven Wolinsky at Northwestern University Medical School in Chicago, has heightened the concerns of many researchers that the gp120 formulation is unlikely to work. The Wolinsky team—which includes David Ho and John Moore at the Aaron Diamond AIDS Research Center in New York City, Bruce Walker at the Massachusetts General Hospital in Charlestown, and others—focused on 18 volunteers who received gp120 vaccines during an earlier trial and later became infected with HIV. A small number of such "breakthrough" infections

should be expected, even with an effective vaccine, but Wolinsky's team could find no significant differences between those who became infected and those who did not. For example, the infected subjects had the same concentrations of anti-HIV antibodies in their blood as uninfected vaccine recipients had, and the amount of virus in their blood was no lower than in unvaccinated HIV-positive patients.

Ronald Desrosiers, a vaccine researcher at the New England Regional Primate Research Center in Southborough, Massachusetts, says that "if a vaccine did have at least partial protective efficacy, one would expect noticeable viral load reductions," even in people who became infected. "The bottom line," Wolinsky says, "is that we had neither beneficial nor adverse effects in any of the individuals we studied." While he cautions that the study does not prove that the vaccine is ineffective, Wolinsky concludes that "the results are very disappointing." Anthony Fauci, director of NIAID, agrees. The study "fortifies the decision I made 3 years ago" not to fund gp120 vaccine trials.

But Francis and some other AIDS researchers hotly dispute the Wolinsky conclusions. They cite a study of seven breakthrough patients published last year in the *Journal of Infectious Diseases* by a team led by immunologist Phillip Berman, VaxGen's vice president of research. The Berman team found that all seven subjects were infected by viruses whose gp120 proteins were structurally different from that used in the vaccines. Berman and Francis argue that these results suggest gp120 vaccines could be effective if they include proteins from more than one HIV strain. Hence, the vaccines VaxGen plans to subject to phase III testing contain two types of gp120s: one from a laboratory strain already used in previous tests, and a second that corresponds to currently circulating natural viruses either in the United States or Thailand, depending on where the vaccine is being tested.

Susan Zolla-Pazner, an immunologist at the New York University School of Medicine, says that because the Wolinsky and Berman papers

were asking different experimental questions, "I don't think anyone can say who is right and who is wrong." And, she and others argue, the issue will never be resolved until some sort of AIDS vaccine is put to the acid test of a phase III trial. Indeed, the frustration over not knowing what will work and what will not, which is shared by all AIDS vaccine researchers, may eventually tip the scales in favor of VaxGen's trials. Says Clements-Mann: "If we don't move forward to phase III, we will never have a vaccine."

—Michael Balter



Pushing ahead. AIDS pioneer Francis plans full-scale trials.



Disappointed. Wolinsky's team found no benefits from vaccine.