HIV Vulnerabilities and Risk Perception of Justice-Involved Women

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Abstract

Women with histories of justice involvement are not only more likely to enter prison with a diagnosis of HIV infection, but also are up to 15 times more likely to be HIV positive than women in the general U.S. population. Given the growing prevalence of both women affected by HIV and women in the criminal justice system, an urgent need exists for prevention interventions tailored for justice-involved women. This formative qualitative study uses semi-structured interviews to examine formerly incarcerated women’s perspectives on their HIV risks and behaviors. Findings inform future HIV-risk reduction interventions for justice-involved women.

Keywords: HIV/AIDS risk, HIV prevention, incarceration, women, criminal justice, ex-offenders, sexually transmitted infections
The confluence of social, health, and economic burdens of women involved in the criminal justice system disproportionately affects their vulnerability to HIV/AIDS. The synergistic interaction of these factors has been described as the SAVA syndemic (Substance Abuse, Violence and AIDS), with the term syndemic describing a set of linked health problems that create a complex set of interrelated endemic and epidemic conditions influenced by broad political-economic and social factors (Romero-Daza, Weeks, & Singer, 2003; Singer, 1994). The current explosion in criminalization and incarceration, particularly for communities of color has been described as “unprecedented in size, scope, and negative consequences”—both in direct and collateral impact (Brewer & Heitzeg, 2008, p. 625). The SAVA syndemic is increasingly important to social work given the gender and racial/ethnic disparities of the U.S. prison system. Therefore, the overall purpose of this paper is better understand HIV risks for justice-involved women in order to tailor HIV prevention efforts for this vulnerable population. In order to do this, an overview of the multiple social and health factors that contributes to the SAVA syndemic are explored and analyzed using semi-structured interviews using the ecological systems theory paramount to social work.

Over the last 30 years, the number of women incarcerated in state and federal prisons has risen 800%, with women of color three times more likely to face incarceration than their White counterparts (Sabol & Couture, 2008; Women’s Prison Association [WPA], 2009) and disproportionately represented among new cases of HIV infection (Centers for Disease Control and Prevention [CDC], 2010). Although African American women and Latinas represent 12% and 15% of the U.S. population respectively, these groups account for more than 80% of all female HIV/AIDS cases in the United States (Weiss et al., 2011). For more than a decade, rates of HIV among incarcerated women have exceeded those of incarcerated men (Epperson, Khan, Miller, Perron, & El-Bassel, 2010; Maruschak, 2005). The higher HIV rate among women is paradoxical given that in the overall U.S. population, men account for more than three times the number of HIV/AIDS cases compared to women (Centers for Disease Control and Prevention, 2011). However, research on incarcerated populations has shown that women had higher rates of HIV/AIDS than men (Hammett, 2006; McClelland, Teplin, Abram, & Jacobs, 2002). As compared with women in the general U.S. population, incarcerated women are up to 15 times more likely to be HIV positive (de Groot & Cu Uvin, 2005; Havens et al., 2009). In addition, women are more likely than men to be HIV positive when they begin their first episode of incarceration (Kramer & Comfort, 2011).

To explain women’s heightened risk of HIV/AIDS both before and after imprisonment, researchers have described several pathways, with substance abuse being the most persistent (Epperson et al., 2010; Meyer, Chen, & Springer, 2011; Zhang, 2004). Incarcerated women are more likely than incarcerated men to have been convicted of a drug-related offense (Havens et al., 2009; Kramer & Comfort, 2011). Between 2003 and 2007, the number of inmates incarcerated for drug-related crimes rose 15% for men as compared with 29% for women (WPA, 2009). In addition, several studies have shown an association of being female with increased rates of sharing injection drug equipment and sharing needles for tattooing (Evans et al., 2003; Johnson, Yep, Brems, Theno, & Fisher, 2002). Unger et al. (2006) explained that such gender differences in injection drug-use behaviors are possible consequences of unequal partner dynamics. Specifically, these researchers identified risk behaviors, such as sharing needles as strongly linked to women’s intimate partner relationships and reported, the refusal to share
needles might be interpreted as a lack of trust or intimacy. This association can particularly impact women with male partners because the woman is often “un-empowered to insist on clean needles if they are dependent on the partner to provide them with instrumental support such as money, a place to stay, or protection on the streets” (Unger et al., 2006, p. 1609).

Women represent one of the fastest growing HIV/AIDS populations worldwide according to the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) (UNAIDS/WHO, 2007). Estimates suggest that 70% of newly diagnosed HIV infections among women have been transmitted through heterosexual contact (Ravi, Blankenship, & Altice, 2007). Sexual behaviors that increase risk of HIV infection, including unprotected sexual encounters, concurrent sexual partners, sex with injection drug users, and exchanging sex for money or drugs, contribute to the heightened HIV risk of justice-involved women (de Groot & Maddow, 2006; Hammet, Harmon, & Rhodes, 2002; Khan et al., 2008). Women who become involved in justice system often report histories of various forms of violence, which results in these women being more likely than others to experience sexual, physical, and emotional abuse (Huebner, DeJong, & Cobbina, 2010).

Gendered pathways, or gendered inequalities have been used to describe the disparity among women involved in the justice system. According to Huebner and colleagues (2010), “one of the most salient tenets of feminist criminology is the association, or blurred boundaries, between women’s victimization and offending” (p. 227). Intimate partner violence, victimization, and associated trauma further exacerbate unsafe sexual practices (Blenko, Lin, O’Conner, Sung, & Lynch, 2005) and has been directly associated with an increase in substance dependence (Millay, Satyanarayana, O’Leary, Crecelius, & Cottler, 2009).

Further, a multitude of social, economic, health, and mental health conditions contribute to the intensified HIV vulnerability of justice-involved women. The majority of incarcerated women have low levels of education and employment as well as low socioeconomic status (Covington & Bloom, 2007; Huebner et al., 2010). In addition, two-third of incarcerated women are mothers of minor children and these women are more likely than incarcerated fathers to continue to contend with parenting obligations during their periods of incarceration (Braithwaite, Treadwell, & Arriola, 2005; Glaze & Maruschak, 2008.). Justice-involved women are more likely than others to report histories of homelessness (Covington & Bloom, 2007; Hanlon et al., 2005; Kramer & Comfort, 2011) and multiple health conditions, including hepatitis C, substance abuse, sexually transmitted infections (STIs), food insecurity, and pregnancy (Williams et al., 2013). Hanlon et al. (2005) found that incarcerated mothers, as compared with other incarcerated women report higher rates of homelessness, family violence, physical or sexual abuse, physical health problems, and mental health disorders—the collateral damage connected to mass criminalization and incarceration (Brewer & Heitzeg, 2008). Furthermore, recidivism rates exacerbate these negative social, health and economic consequences (Huebner et al., 2010).

The prevalence of psychiatric disorders among incarcerated populations is also higher among women (Binswanger et al., 2010; Meyer, Chen, & Springer, 2011), with some research suggesting that approximately 75% of incarcerated women meet criteria for a mental illness (James & Glaze, 2006). The rates of mental health problems among justice-involved women has
been shown to be significantly and directly associated with both incarceration and HIV risk (Binswanger et al., 2010; Meyer et al., 2011).

As this background documents, there is an intersecting relationship between gender, race and oppression, something that has been addressed in the literature. Windsor, Benoit, and Dunlap (2010) categorize various forms of oppression as “classism, sexism, familism, racism and drugism” (p. 36) among disadvantaged African American women, which overlap with the lives of the study sample and justice-involved women generally. The multiple dimensions of oppression highlight the multiple forms of micro and macro systems that contribute to a set of synergistic or intertwined health and social problems that comprise the SAVA syndemic for justice-involved women. Given the high HIV risk of women involved in the justice system, it is crucial to tailor HIV prevention interventions to better meet the needs of this population.

Incarceration provides an opportunity to deliver gender-specific HIV risk-reduction programs. Using a social ecological framework based on Bronfenbrenner’s (1979) early work, this study defined risk as a variety of negative outcomes that accumulate over time (Fraser, Richman, & Galinsky, 1999). Risk can be conceptualized as factors that compound over time and snowball into greater vulnerability.

However, given the complex web of interrelated factors that increase the HIV vulnerability of justice-involved women, a vital first step in designing appropriate, gender-specific interventions is developing a better understanding of the ways in which these women perceive risk. This article describes an exploratory qualitative study of the perceptions of HIV risk factors in women, as reported by women who were formerly incarcerated. The findings reported here represent a first step in developing HIV prevention interventions for justice-involved women.

Methods

The purpose of this study was to develop a grounded theory about HIV vulnerability and risk perception from previously incarcerated women (N=28). Qualitative semi-structured interviews were conducted with 28 women who had been incarcerated in North Carolina state prison facilities. The interviews were designed to explore the women’s viewpoints of risk and risk behaviors across three domains: (a) their perceptions of their own risk of contracting HIV as well as other women’s risk of contracting HIV; (b) their perceptions of why women engage in HIV risk behaviors; and (c) their perceptions of the ways (how and when) women protect themselves from contracting HIV.

Sample

Study inclusion criteria included being female, 18 years or older, English speaking, self-identified as engaging in heterosexual activity, and having an awareness of their current HIV status. Study participants ranged from 21-54 years, and were recruited through a variety of means including referral by a prison social worker and participation in other studies. In addition, we also recruited by asking participants if they could recommend names of potential participants, who were then contacted by the recruitment staff. Participants were given $30 gift cards and a make-up case of toiletries following their interview.
While the study addresses qualitatively the HIV vulnerabilities of justice-involved women and the complex web of factors that result in high risk behaviors, it is important to note a study limitation is that the sample consisted specifically of women who were located and incarcerated in North Carolina; thus, limiting generalizability due to specific regional and demographic differences of the sample and the related U.S. context described.

**Data Collection**

This study used qualitative semi-structured interviews with women who were formerly incarcerated in North Carolina state prison facilities (N=28). Interviews lasted from 60 to 120 minutes and were designed to explore women’s viewpoints of risk and risk behaviors across three domains: (a) their perceptions of their own risk of contracting HIV as well as other women’s risk of contracting HIV; (b) their perceptions of why women engage in HIV risk behaviors; and (c) their perceptions of the ways (how and when) women protect themselves from contracting HIV. Interviews took place in participants’ homes or another location of the woman’s choice. Each interview was conducted by a trained research assistant, who audiotaped the interview and transcribed the audiotapes as soon as possible after the interview.

**Coding and Analysis**

Transcriptions of the interviews were reviewed for accuracy before data analysis began. The interview transcripts were independently coded by two investigators using Nvivo7 analysis software and by focusing on the general question: “What puts women at risk of HIV/STI?” Transcripts were coded using open coding, and the codes were organized into categories and themes by the investigators using Glaser & Strauss’s (1967) comparative method. Initial inter-rater agreement between the two coders was 87%; field notes, data review, and discussion were used to build consensus (Padgett, 1998).

**Results**

The mean age of participants was 36.6 years (SD 8.28 years); 60% of the women identified as White, 36% identified as Black, and 4% identified as Latina. Nearly all participants had children (96%), with an average of 2.3 children (SD 1.49). Four (14%) participants reported they were currently living with a husband or boyfriend. On average, participants had completed 11.2 (SD 3.0) years of education. All participants lived in North Carolina, with 64% living in urban areas and 36% living in rural settings.

In their responses to interview questions, the study participants identified many of the same risk factors for HIV as those outlined in the literature. This study organized women’s risk factors into three thematic areas consistent with the micro, mezzo, and macro foci of the ecological systems perspective: (a) intrapersonal factors, specifically women’s basic needs; (b) interpersonal factors, such as harms and betrayals caused by the men with whom the women were involved; and (c) community factors, including dangerous and chaotic neighborhoods.
Intrapersonal Factors: Women’s Needs

Every woman interviewed identified addiction and the need for substances as a risk factor for HIV in women. Substances were seen as dangerous for two reasons. First, participants noted that substance use can cloud a woman’s judgment relative to protecting herself from HIV exposure. The comment of one woman aptly summarized this link as experienced by many of the women: “I know if I wasn’t intoxicated and high I would’ve thought better and not been caught up in the moment, y’know…His words wouldn’t have been so swiftly in my ears, I would’ve still been cautious.” Another woman stated plainly, “When you’re drinking you just don’t think about it…you just don’t think about protecting yourself. You really don’t.”

Substance abuse was also seen as a risk factor for women because their addictions often forced the women to trade sex for drugs. One woman recalled that at the height of her addiction, she would have done anything to secure her drug of choice:

[I would do] whatever it took to get some more [drugs]. I’d do it even when I didn’t want to have sex with this man without a condom…I would stay right there and get the money and do whatever it was he’d ask me to do...[I] wanted to feed the addiction, yeah, it’s just the addiction.

Another participant reported that her addiction led to her exploitation by men when she traded sex for drugs:

I can remember the first time I had sex with a guy for some crack. And I remember cryin’ and sayin’, “I’ve never done this, don’t let me do this.” And he was sayin’, “I’m not making you. You want it, it’s right there, but you know.” And I did it and then he left and then I cried. And I smoked it and I cried.

In addition to trading sex for drugs, some participants mentioned trading sex for other basic needs, such as food and rent, and noted that some women engaged in high-risk sexual behaviors as a means to meet their basic needs. A participant commented, “You’re having sex for whatever reason [with someone] other than your partner…you’re having sex for money or food or whatever, y’know.” For many ex-offenders with few skills, the stigma of a prison record makes finding employment extremely difficult; some participants noted that engaging in sex work was sometimes the only option for ex-offenders. One woman stated,

You can’t get that money doing something else with your education and your criminal background, you know what I’m saying? If you have a criminal background, you’ve been to prison, and you’re a prostitute and you have a drug problem then the only thing you know to do is what you know…

Finally, a number of participants identified their emotional needs, and specifically their need to feel loved, as a primary factor that put them at risk for HIV. The women viewed the need to feel loved as something that could easily cloud a woman’s judgment and cause her to enter unhealthy relationships that cause harm and risk. A participant ruefully explained,
Because I’ve made the same [bad] choice time after time after time. They’ll tell me “Oh, I love you. I want to be with you. I’m looking for a relationship.” You know I crave love. I wanna be with someone. I want someone to love me. So, as soon as they tell me that, then I’m all in…And then the drinking and the crack comes in.

One participant stated that although she was aware that her current relationship put her at risk for HIV infection, she was unable to leave the relationship because of her need for love, which she described as being “ignorant.” Overall, participants saw women as being at greater risk for HIV because of they were easily exploited due to high needs, limited resources, and few options. For example, one woman described her intense need for a relationship as compelling her to stay in a negative relationship that was placing her at high risk for HIV:

I probably should be more cautious ‘cause he’s not faithful and I know that. I don’t know, I guess ignorance is bliss…I’m not ready to leave him yet…I love him or I would have left him years ago. Just ignorance I guess. I think that’s just his nature. You either accept that or you don’t and I’m just not ready to leave him…I wish I was. Just trying to hang on to an illusion of hope I guess that he’ll change.

Interpersonal Factors: Relationships with Men Are Dangerous

Throughout the interviews women portrayed men as dangerous, callous, and often intentionally betraying and brutal. A number of women described relationships with men who refused to wear condoms even though the men had multiple partners and the men transmitted STIs to the woman. One participant described her husband’s pattern of having multiple partners that resulted in the wife contracting an STI several times: “He kept giving me, going between me and his girlfriends, and I would contract what was it? Trick? Trichomoniasis? Something like that. I was devastated.”

Several women described a dynamic wherein their partners would act insulted if requested to wear a condom even though the man had multiple relationships and concurrent sex partners. A woman described her experience with a partner who refused to use a condom:

And he was like, “What? You don’t trust me?” So to prove to him that I trusted him, I said, “Alright, okay, you’re right….” And I caught Chlamydia from him—and at that very moment I found out, I wished that I would’ve thought wiser.

Most participants identified men’s behavior — specifically violence and overt forms of betrayal—as another reason for women engaging in behaviors that put them at high risk of HIV infection. This behavior included sexual abuse of girls and the consequences of that abuse that manifested in adult women, domestic violence by a partner, and rape in adulthood. Several women noted that victims of childhood abuse faced increased risk of HIV as adult women because these women tended to self-medicate their emotional pain with substances or with sex. The following comment of one participant was typical of the participant descriptions of the abuse dynamic.
If you were molested as a child, something that you can [do is] self-medicate any type of pain you’ve gone through. That you can self-medicate yourself with, then you do it. And a lot of times sex is one of them [form of self-medication].

A second participant described the impact that being sexually abused as a child had on her behavior throughout her life:

I grew up knowing nothing but basically that people would not love me not unless I had sex with them…So, I went through life feeling with what happened to me, [molested], that as I met someone, as soon as I got with them, the first time they asked me to have sex with them, I did.

These participants’ quotes highlight the connection between sexual oppression and violence as a result of gender inequity around power and control. As women feel vulnerable and taken advantage of by the men in their lives, this severely limits their ability to take control of their sexual risk behaviors and ability to prevent HIV and related health outcomes.

In addition, participants identified abusive relationships in adulthood as increasing women’s risk of HIV. Women in relationships marked by domestic violence, including physical, verbal, or emotional violence, were considered as being at increased risk of HIV infection because of the violence inherent in their relationship made it impossible for the women to ask their partner to use a condom. Indeed, women reported that the threat of violence was a constant presence, and therefore engaging in safer sex practices was not an option. The comment of one participant echoed the viewpoint expressed by many.

I think if someone is being domestically violent, violated, or however you say that, I think most likely the person wouldn’t use a condom because that would be the least thing they could worry about… [S]he wouldn’t want to make him mad.”

Violence was also linked to rape, which is the most overt risk of HIV for women, and something discussed by many of the participants. Rape was reported as part of violent relationships and sometimes as a result of a partner’s drug-related activity. One participant recounted a horrific situation in which a woman’s rape was arranged to pay a drug debt.

My friend, well my cousin, got raped by her friend’s friend… her boyfriend signed it up [conspired] for the whole thing to happen. Her ex-boyfriend like signed her up to get raped by his friend. Cause they was all in drugs and I guess my cousin owed him some money and stuff.

Overall, study participants often perceived interpersonal relationships as dangerous. The women described betrayal by men that ranged from callous infidelity (e.g., refusal to use a condom) to intentional violence and sexual exploitation. Relationship violence and betrayals were seen as increasing women’s risk for HIV both in the short-term (i.e., infection) and in the long-term through a life trajectory of self-medication with substances or sex.
Community Contexts: Crime and Chaos

Over two-thirds of women in our study mentioned growing up in unsafe neighborhoods as an additional risk factor for contracting HIV. These women described environments characterized by drugs and prostitution, creating situations in which youth observed many high-risk behaviors and repeated those behaviors as they became adults. These quotes highlight the collateral damage described by the literature—the unintended impacts of incarceration on communities. One participant described the impact of growing up in a chaotic environment, saying:

“You have others more so who end up selling drugs and prostituting and that kind of thing because that’s what they grew up around, that’s what they were used to, that’s what they saw. I mean if you’ve grown up in the hood and all you know is the hood and you’ve never seen anything beyond the hood, then what are you going to be? In the hood. You know what I’m saying?”

In addition to environments marked by exposure to high-risk behaviors, dangerous communities put women at risk by simply being areas with high rates of criminal activity. Living in areas with high rates of drug abuse and drug trafficking places women at heightened risk for connecting with intimate partners who are HIV-positive as well as partners who are likely to exploit the women sexually. These environments also place women at higher risk for violent victimization.

Discussion

The themes identified by study participants were similar to the risk factors reported in the literature. However, three additional themes related to HIV/STI risk perception emerged in our interviews with women who were ex-offenders. The first theme was a risk we conceptualized as (a) risk denial and ambivalence, and the second theme was (b) a fatalistic attitude that we articulate as loss of hope. A third theme (c) offering hope and alluding to participants’ resiliency will be further illuminated.

Risk Denial and Ambivalence

Overall, women expressed concern for HIV-infection risk among their family/friends. However, few of the women expressed any level of concern for their personal risk of HIV infection. Many of the women who distanced themselves from ideas of risk said they protected themselves from HIV. However, later in their interviews, these women reported engaging in ongoing risky sexual activities. Nearly universal among the sample, most of the women expressed a desire to trust their partner but did so with the frank understanding that their trust might be broken. Of the 28 women in the study, 20 reported having a steady partner. However, only 6 of the 20 women reported using condoms at least some of the time with their partners. When interviewers asked, “Do you feel like you’re at risk for catching HIV?” the women’s responses exemplified the theme of risk denial and ambivalence. A typical response was, “…you know I trust him [but] there’s still that little bit of you know, people make mistakes”.

Critical Social Work, 2014 Vol. 15, No. 1
Many women expressed frustration with their relationships with male partners, describing condom refusal and the man’s concurrent sexual partners; nevertheless, these women stated they did not use condoms because they were in a long-term relationship. Interestingly, many of these women qualified their confidence in their partner's fidelity with laughter and tentative statements such as “at least I hope so,” which exemplified their relationship ambivalence. This ambivalence was also illustrated by a participant who said: “I mean, any man can stray, you know what I’m saying, but I don’t think so…no…I’m pretty positive”; or another who said, “No, he’s my only partner and, as far as I know, I’m his only partner”.

Loss of Hope

The most striking theme that emerged regarding why these women engaged in HIV-risk behaviors involved a fatalistic sense of not caring about themselves or having lost hope that life could be different. Women described a number of reasons for their sense of fatalism including addiction, abuse and trauma, low self-esteem, and difficulty with post-release community reentry that included difficulty finding work and housing. These elements were woven into a larger picture in which the women reported feeling that they had few options and expressed a sense of resignation (e.g., “given up”), which placed them at risk for HIV/AIDS. One woman described her fatalistic state of mind as a result of corrosive experiences that degraded and shamed women:

And when you start, uh trading your body, you know, I mean, it eats at your very soul. And uh you can't, and then you feel so bad about yourself and what you've done … that um, doing it again gets you away from it. And …then before long, you've got a habit and you really can't stand to think about what you've been doin’ and you don’t care.

Given the attitude of many women was one of “I just don't care anymore,” many participants expressed this loss of hope as a reason why they did not bother with steps to protect themselves from HIV/AIDS. Table 1 summarizes some of the most poignant quotes given by the study participants.

Table 1
Quotes of Fatalistic Theme or “I just don’t care”

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<thead>
<tr>
<th>Quotes Summarizing Fatalistic Theme or “I just don’t care”</th>
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<tbody>
<tr>
<td>❖ “Well, I just didn’t care. I did a lot of drug use and running. Not, just not caring. And sleep with whoever you can sleep with.”</td>
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<tr>
<td>❖ “I didn’t care if I caught something. I didn’t care if I died.”</td>
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<tr>
<td>❖ “What caused me not to care? I thought there was no hope. What was my reason for being here? Is this what God put me here for? To get high and to not care?”</td>
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The loss of hope theme was most frequently alluded to when respondents reflected on their past drug use and sex work as typified in the following quotes from two participants: “You’re really not caring that much about yourself and what’s really going on…when I started using drugs” and “I was high. I was drunk. I just didn’t care…I wanted to do it [unprotected sex].”
Interestingly, when study participants (average age 36.6 years) spoke of younger inmates they interacted with during incarceration, participants stated the younger generation of women did not care and were at increased risk of HIV infection. Comments from two participants were typical of most responses:

“They ain’t caring about it [condoms] no more…they just too tired to go get ‘em, they might have been out on the streets all night or something like that. They just don’t care. I can take that [condom] tomorrow, put it off, put it off, they’re too busy getting their groove on and chasing their ghosts.”

A Cause for Hope

Despite the deleterious themes presented thus far, one optimistic theme that resonated throughout the interviews was the protective factor of children in promoting hope and resiliency among justice-involved women which corresponded to literature on the positive impact children can have on justice-involved women (Enos, 2001; Glaze & Maruschak, 2008). When the sampled women were asked, “What keeps you wanting to live?” children came through as a strong protective factor that motivates at-risk women to change their HIV-risky behaviors. The following examples in Table 2 articulate sentiments around this theme of hope.

Table 2
Quotes Summarizing Theme of Hope and Resilience

<table>
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<tr>
<th>Quotes Summarizing Theme of Hope and Resilience</th>
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<tr>
<td>“My young ‘uns, the love I have for my young ‘uns, they are the world to me.”</td>
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<tr>
<td>“My kids. Gotta do this for them you know. ‘Cause I just made to have myself stable enough and you know have enough support for them that they don’t go down the roads I went down.”</td>
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<tr>
<td>“My kids’ happiness; that’s what gives me hope. That one day I’ll see them graduate from high school and hopefully go on to college and become something successful. That’s what gives me hope.”</td>
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Implications for Social Work Practice, Policy, and Research

Granted, the sample size of 28 and the need for replication of themes among a larger, more diverse group of justice-involved women is warranted, the results from the study help contextualize the complex web of factors that result in HIV risk among justice-involved women, particularly women in the south east U.S.. Study findings suggest, because of their reluctance to admit the possibility of partner infidelity, women often remain in high-risk relationships through a mix of denial and ambivalence, which results in their engaging in risky behaviors. Finally, in this study we heard women describe how the nexus of their life factors resulted in a sense of not caring about themselves or their futures and a loss of hope that kept them from trying to protect themselves from exposure to HIV and other STIs.

The findings suggest that social workers and other providers engaged in prevention interventions for justice-involved women should move beyond education on condom use and safer sex mechanics to a focus on dynamic and contextual issues that shape women's HIV-risk behaviors. To be effective, prevention interventions must address not only basic needs for food,
shelter, and safety but also needs related to substance abuse treatment and need for trauma-informed care. These interventions must also include addressing women’s desire for relationship, denial or ambivalence about risk and relationships, and the need for continued condom use with long-term partners.

Most important in HIV prevention interventions for justice-involved women is the need to address the hopelessness women experience when caught in the net of addiction, abuse, poor self-esteem, and community or policy barriers to employment and safe housing, which result in a sense of failure and loss of motivation for self-care. Addressing this loss of hope through the provision of positive alternatives and trauma-informed services is essential (Covington, 2008; Harris & Fallot, 2001). To effectively design and implement specific interventions for justice-involved women, it is essential that researchers and social workers and other providers collaborate and understand the complex, dynamic relationship among the diverse elements of substance abuse; sex-work; trauma; abuse; betrayal; male disregard; violence; community contexts of crime, chaos, and concurrency; and perceived risks.

Further, a closer look at incarceration patterns and recidivism risk post incarceration would benefit from the lifecourse perspective to further assess risk and resiliency factors associated with women involved in the justice system (Fraser et al., 1999). Additional research is needed to more fully understand these dynamics, and how these changes over time given the cross-sectional nature of the data, in order to develop effective interventions for justice-involved women that mitigate sexual risk behaviors and risk of HIV infection. These interventions should begin while women are in prison and continue as women transition back to their communities. Findings suggest that incorporating mothering concepts and a focus on children into interventions, specifically for justice-involved women, may be an effective way to increase motivation for women with children to engage in services and maintain behaviors to decrease risks of HIV infection.
References


