"You're in a World of Chaos": Experiences Accessing HIV Care and Adhering to Medications After Incarceration

Alexis C. Dennis, MPH*
Clare Barrington, PhD, MPH
Sayaka Hino, MPH
Michele Gould, MPH
David Wohl, MD
Carol E. Golin, MD

*Most HIV-infected inmates leave prison with a suppressed viral load; many, however, become disconnected from care and nonadherent to medications during reentry to community life. In this secondary data analysis of focus groups (*n = 6*) and in-depth interviews (*n = 9*) with 46 formerly incarcerated HIV-infected people during reentry, we used an inductive analytic approach to explore the interplay between individual, interpersonal, community, and structural factors and HIV management. Participants described barriers and facilitators to care engagement and adherence at each of these four levels, as well as a milieu of HIV and incarceration-related stigma and discrimination. The constellation of barriers and facilitators created competing demands and a sense of chaos in participants' lives, which led them to address reentry-related basic needs (e.g., housing, food) before health care needs. Interventions that simultaneously address multiple levels, including augmenting employment and housing opportunities, enhancing social support, and reducing stigma, are needed.*

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In the United States, HIV prevalence among incarcerated persons is three to five times higher than that of the general population (Baillargeon et al., 2010; Westergaard, Spaulding, & Flanigan, 2013). Seventy-five percent of HIV-infected inmates begin treatment while incarcerated, and approximately 55% to 59% have suppressed viral loads upon release (Baillargeon et al., 2009; Stephenson et al., 2005). However, many HIV-infected inmates have difficulty sustaining adequate disease management during reentry. For example, in Texas only 5.4% of HIV-infected inmates filled prescriptions for antiretroviral therapy (ART)

*Alexis C. Dennis, MPH, is an Associate in Research, Duke Global Health Institute, Duke University, Durham, North Carolina, USA. (*Correspondence to: alexis.dennis@duke.edu). Clare Barrington, PhD, MPH, is an Assistant Professor, Gillings School of Global Public Health, University of North Carolina, Chapel Hill, North Carolina, USA. Sayaka Hino, MPH, is a Project Coordinator, Institute for Global Health and Infectious Diseases, University of North Carolina, Chapel Hill, North Carolina, USA. Michele Gould, MPH, is a Project Manager, Institute of Behavioral Research, Texas Christian University, Ft. Worth, Texas, USA. David Wohl, MD, is an Associate Professor of Medicine, School of Medicine, University of North Carolina, Chapel Hill, North Carolina, USA. Carol E. Golin, MD, is an Associate Professor, Gillings School of Global Public Health and School of Medicine University of North Carolina, Chapel Hill, North Carolina, USA.*

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within 10 days of release, 17.7% within 30 days, and 30% within 60 days (Baillargeon et al., 2009). In other studies, only 20% to 54% of inmates enrolled in an HIV clinic within 1 month of release (Baillargeon et al., 2010; Wohl et al., 2011). Disruptions in care and poor adherence lead to higher HIV-related mortality, poorer HIV-related outcomes, and resistance to HIV medications in recently released individuals (Rosen, Schoenbach, & Wohl, 2008; Springer, Friedland, Doros, Pesanti, & Altice, 2007). Release from prison has been associated with an increase in viral load (Stephenson et al., 2005), which can result in ongoing HIV transmission if individuals engage in HIV-related risk behaviors (Rosen et al., 2008; Springer et al., 2007). Understanding facilitators and barriers to linkage to HIV care and adherence to treatment post release is critical for reducing HIV-related morbidity and mortality and preventing transmission within the communities to which these individuals return (Spaulding et al., 2009; Stephenson et al., 2005).

Several barriers and facilitators influencing access to care and medication adherence by formerly incarcerated HIV-infected individuals during reentry have been identified in the literature. Barriers identified in studies of former prisoners include strained interpersonal relationships (Baillargeon et al., 2009), return to impoverished neighborhoods (MacGowan et al., 2003), dual stigma of incarceration and HIV (Alexander, 2012), and inaccessibility of housing (Alexander, 2012; Baillargeon et al., 2009; Katzen, 2011; Stephenson et al., 2005), transportation (Katzen, 2011; Stephenson et al., 2005), insurance and employment (Alexander, 2012; Baillargeon et al., 2009; Katzen, 2011), as well as issues with mental illness and substance abuse (Springer, Azar, & Altice, 2011). Social support from case managers and personal motivation have been identified as facilitators that promote HIV management by improving ART adherence (Alexander, 2012; Katzen, 2011; Springer et al., 2011; Woods, Lanza, Dyson, & Gordon, 2013). Although researchers have identified these barriers and facilitators, it remains poorly understood how these factors interact and influence each other and, ultimately, affect an individual's success in adhering to HIV care. We examined the interplay of factors across these multiple levels and their impacts on engagement with care and adherence to ART among formerly incarcerated persons during reentry.

Methods

Study Design

We conducted a secondary analysis of formative, qualitative data, including in-depth interviews (IDI) and focus groups (FG) with formerly incarcerated men and women with HIV, collected to inform development of imPACT (Individuals Motivated to Participate and Adhere to Care and Treatment), a comprehensive intervention to help incarcerated people with HIV engage in HIV care and adhere to ART after release (Golin et al., 2013). The institutional review boards at both The University of North Carolina at Chapel Hill and Texas Christian University approved all study procedures before study initiation.

Recruitment and Study Population

Recruitment fliers were displayed in HIV clinics, HIV outreach centers, and substance abuse treatment centers in order to passively recruit participants. Researchers also used database systems in HIV clinics to identify individuals who had previously provided consent to be contacted for participation in research studies. Our secondary data analysis included data from 12 female and 34 male, formerly incarcerated persons with HIV, residing in two states in the southern United States. At the time of the interviews, all participants were accessing HIV care. We summarized demographic features of all study participants in Table 1. Table 2 lists demographic information for each IDI participant to illustrate the diversity of life experiences of the individuals in this study. FG participants shared demographic profiles similar to those participating in IDIs.

Data Collection

Two interviewers conducted six FGs ($n = 37$ participants across groups) and nine IDIs with individuals who were eligible but unable to attend an FG due to transportation challenges. Both IDI and FG guides focused on participant initiation of and

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