



Invited paper

## Considerations in HIV Prevention for Women Affected by the Criminal Justice System

 Katie Kramer, MSW, MPH<sup>a,\*</sup>, Megan Comfort, PhD<sup>b</sup>
<sup>a</sup>The Bridging Group, Oakland, California<sup>b</sup>RTI International and University of California, San Francisco, San Francisco, California

Article history: Received 10 March 2011; Received in revised form 26 May 2011; Accepted 31 May 2011

### A B S T R A C T

Within the national dialogue of HIV prevention strategies, relatively little consideration is given to the millions of women and girls affected by the criminal justice system, either through their own incarceration or that of their partners. Statistics indicate that these women and girls are disproportionately infected or at risk for HIV and other sexually transmitted infections and much of this risk is directly related to the dynamics and circumstances that led to their incarceration or relationships with incarcerated men. As we look for the link between public health and correctional health within our National HIV/AIDS Strategy, it is imperative that the risks, obstacles, and opportunities facing women and girls affected by incarceration are brought into the discussion. Gender-responsive HIV prevention policies and practices must be developed to address the unique risks and opportunities for these women and girls. This paper presents data on HIV risk and other health issues specific to this community of women and girls, discusses key factors for consideration when developing gender-responsive HIV strategies for these communities, and makes recommendations for inclusion in the National HIV/AIDS Strategy and other state and local HIV prevention efforts.

Published by Elsevier Inc.

### Introduction and Background

Although increasing emphasis is placed on HIV prevention programs for incarcerated men, women who are affected by the criminal justice system, either through their own incarceration or that of their partners, are often overlooked. The United States is the number one incarcerator in the world, currently housing 2.3 million adults in correctional facilities. Of this population, 1,150,000 are women. Including the number of women under any form of correctional supervision (prison, jail, parole, or probation,) this number grows to over 1 million women, a rate that has tripled over the past decade (West, 2010).

In addition, an estimated 20% of men in prison are married (Mumola, 2000); studies have found that approximately 50% of incarcerated men consider themselves to have a primary female partner with whom they plan to reunite upon release from

custody (Carlson and Cervera, 1991; Grinstead, Zack, Faigeles, Grossman, & Blea, 1999; Jorgensen, Hernandez, & Warren, 1986). Furthermore, the multisite evaluation of the Serious and Violent Offender Reentry Initiative reported that 75% of incarcerated fathers were either married or in an intimate relationship (Lattimore, Visser, Steffey, Osborne, & Brumbaugh, 2008), and a study of low-income African-American women found that 22% had a current male partner who previously had been incarcerated (Battle, Cummings, Barker, & Krasnovsky, 1995). These findings indicate that, at any given time, millions of women are either separated from a partner who is behind bars or are reuniting with a partner who is returning home from a correctional facility. As we continue to make the link between public health and correctional health, it is critical to talk about best practices and policies that serve all women impacted by the criminal justice system.

### *Incarcerated Women, HIV, and Other Health Issues*

Women affected by incarceration are disproportionately women of color. The majority come from a background of poverty and many experience homelessness. Incarcerated women are

Funded by DHHS Contract #: HHSP233201000701P, R01MH078743 and R01MH094090.

\* Correspondence to: Katie Kramer, MSW, MPH, CEO, Corrections, Communities and Families, The Bridging Group, 4096 Piedmont Ave, Suite 710, Oakland, CA 94611. Phone: (510) 499-6730; fax: (510) 923-0429.

E-mail address: [katie@thebridginggroup.com](mailto:katie@thebridginggroup.com) (K. Kramer).

likely to have been convicted of a drug-related offense. They are often survivors of physical and/or sexual abuse, and have other family members involved in criminal justice system. In addition, the majority (61%) of incarcerated women are parents, compared with their incarcerated male counterparts, 53% of whom are fathers (Baldwin & Jones, 2000; Chesney-Lind, 2002; Lichtenstein & Malow, 2010; Maruschak, Glaze, & Mumola, 2010; Owen, 1998; Richie, 1996).

It has been well documented that incarcerated populations in general are disproportionately impacted by multiple health conditions. Rates of HIV/AIDS in U.S. prisons are 2.5 times the national rate, and rates of hepatitis C are estimated to be as high as 31% to 49% (Baillargeon et al., 2003; Maruschak, 2009; Tan, Joseph, & Saab, 2008). The data on health disparities specifically for incarcerated women, however, are even more alarming. Incarcerated women have greater health care needs than men and fewer resources are typically allocated for correctional facilities housing women. Health issues faced by incarcerated women include HIV, pregnancy, tuberculosis, hepatitis, hypertension, asthma, obesity, and diabetes.

Although women comprise only 7.2% of the U.S. prison population, they are more than twice as likely as imprisoned men to be living with HIV and 15 times more likely to be HIV positive than are nonincarcerated women (Havens et al., 2009; De Groot & Cu Uvin, 2005). In New York state prisons, which estimates the number of HIV and confirmed AIDS cases using data from blind seroprevalence studies conducted biannually, nearly 12% of incarcerated women (compared with 5.6% of incarcerated men) were found to be HIV positive (Maruschak, 2005). The majority of HIV-infected women were most likely infected before their incarceration and had experienced factors that are associated with high risk for both HIV and incarceration (Zack, 2007). Among these risk factors are relationships with high risk partners (U.S. Centers for Disease Control and Prevention, 2008), involvement in substance abuse (Talvi, 2007), and a history of domestic and sexual abuse (Braithwaite, Treadwell, & Arriola, 2005; Hammett & Drachman-Jones, 2006; Lichtenstein, 2005). In addition, 75% of women in U.S. jails reported mental health issues versus 12% of women in the general population. Over two thirds (69%) of women in U.S. jails report substance dependence or abuse, as compared with only 6% of women in the general population (Glaze & James, 2006). Although most infection risk behaviors occur before incarceration, some incarcerated women engage in risk behaviors inside correctional facilities, including syringe sharing involved with injection drug use and tattooing, and unprotected sex with same-sex relationships (Hammett & Drachman-Jones, 2006).

#### *Prevalence of Physical and Sexual Abuse*

There is a clear pathway from childhood abuse to incarceration. Many abused girls become runaways as they try to escape their abuser, which leads to their arrests as status offenders; that is, committing an act (in this case running away) that would not be considered a crime if it were committed by an adult. Many runaway girls become young women who are forced to live and work on the streets with no legal means of survival. These young women often become addicted to substances as they struggle to endure sex work, desperation, and depression. Eventually, these women find themselves involved in the criminal justice system; arrested for economic crimes when trying to make ends meet, for drug-related crimes stemming from their addiction, and/or

for crimes committed against their abusers in an effort to protect themselves and their children (Gilfus, 2002).

Official reports estimate that 43% to 57% of incarcerated women have been victims of physical or sexual abuse before incarceration (American Correctional Association, 1990). Smaller, more in-depth studies indicate rates of physical and sexual abuse as high as 66% to 94% (Browne, Miller, & Maguin, 1999). Nearly three quarters (71%) of incarcerated women have been exposed to domestic violence (Green, Miranda, Daroowalla, & Siddique, 2010).

The progression continues as incarceration further compounds women's trauma. Body searches, handcuffing, shackles and other restraints, and seclusion or solitary confinement can retraumatize women with histories of sexual or physical abuse (Green et al., 2010). Sexual abuse can also occur behind bars. In an effort to address sexual abuse in correctional facilities, the U.S. legislature passed the Prison Rape Elimination Act in 2003. This law aimed to address prison rape through a "zero-tolerance" policy by developing national standards to prevent and detect incidents of sexual violence in prison, making data on prison rape more available to prison administrators and requiring corrections facilities to be more accountable for incidents of prison rape. Yet, as recently as 2010, a Bureau of Justice Statistics survey found that women incarcerated in prisons and jails were more than twice as likely as incarcerated men to report sexual victimization by another incarcerated individual during their confinement (Beck, Harrison, Berzofsky, Caspar, & Krebs, 2010). Furthermore, incarcerated women have been found to be at risk of sexual assault by—or coercive sexual relationships with—male correctional officers (LeBlanc, 2003; The Members of the ACE Program of the Bedford Hills Correctional Facility 1998). Sexual abuse of women by correctional staff during routine medical examinations has also been documented (Braithwaite et al., 2005).

#### *HIV Risk for Women Partners of Incarcerated Men*

The relationship dynamics within heterosexual couples in which the male partner is incarcerated can also affect women's HIV risk. For example, open communication about sex and HIV exposure is associated with higher levels of condom use and lower levels of unprotected sex (Ahlemeyer & Ludwig, 1997; Van Campenhoudt & Cohen, 1997; Bruhin, 2003; Klein, Elifson, & Sterk, 2004). Correctional rules and a lack of privacy can impede a couple's willingness or ability to address sexual-health issues when communicating with each other during the incarceration period. In addition, strict regulations of physical contact between incarcerated individuals and visitors disrupt women's feelings of closeness to their partner and dissuade them from discussing personal topics such as HIV testing or condom use during their visits (Comfort, Grinstead, McCartney, Bourgois, & Knight, 2005).

Communication difficulties also do not immediately abate when a man is released from jail or prison. Stress over finding employment, contributing to the household, and avoiding trouble can cause men to withdraw emotionally and become depressed (Braman 2004; Hagan & Coleman, 2001; Travis & Waul, 2003). As a result, difficult issues such as sexual health and HIV risk that were not discussed during the incarceration period are left unaddressed post-release. In the meantime, the wives and girlfriends of formerly incarcerated men often do not regard correctional settings as being particularly risky in terms of acquiring illness. As a result, they may not see the need to

avoid unprotected sex with a partner who has recently rejoined society (Comfort, Grinstead, Faigeles, & Zack, 2000; Grinstead et al., 2005).

Furthermore, the incarceration of a partner may aggravate preexisting risk factors in women's lives or push women into risk behaviors they had previously managed to avoid, particularly if their male partners had acted as a protector, advocate, or financial provider in the relationship before his arrest. A partner's imprisonment can cause or heighten women's feelings of loneliness, depression, anxiety, and powerlessness (Girshick, 1996)—emotions that may weaken women's bonds to societal support structures and precipitate "entrapment" in situations of severely limited options (Richie, 1996).

A partner's imprisonment may also result in a drop in women's income because of the loss of contributions he previously made to the household, including child care, food, or gifts. This loss is often compounded by the considerable financial cost of prison visiting and phone calls (Grinstead, Faigeles, Bancroft, & Zack, 2001). As a result, some women engage in sex work to combat financial problems during a partner's prison term, whereas others become involved with secondary or multiple partners during a primary partner's incarceration to obtain financial, physical, or practical support. Indeed, one's own incarceration and the incarceration of one's partner have been repeatedly associated with greater prevalence of concurrent sexual partnerships owing to the disruption of primary relationships (Adimora et al., 2003a, 2003b; Gorbach, Stoner, Aral, H Whittington, & Holmes, 2002; Manhart, Aral, Holmes, & Foxman, 2002; Thomas and Sampson 2005).

#### *The Revolving Door of Incarceration*

Couples' relationships often span multiple periods of incarceration, with men or women serving several months in jail or years in prison, then spending a few weeks or months living with their partners, then going back to jail or prison for another sentence, only to return to the same partner once again (Braman, 2004; Comfort, 2008; Nurse, 2004). Unprotected sexual intercourse has emotional and practical importance within a larger context of romantic connectedness and societal reintegration for couples coping with these cycles of freedom and confinement, as does the conception of children (Comfort et al., 2005). In this context, where demonstrations of attachment become crucial, the suggestion by either partner of using condoms upon an individual's release can be seen as disrespectful to the relationship or as negating a new level of commitment, trust, and intimacy (Sobo, 1995; Stevens, 1995).

#### *Facing Life (and HIV Risk) after Incarceration*

When women leave correctional facilities, they may return to homes filled with violence. They may have lost custody of their children during their absence. They may also face stigma and negative societal expectations based on their previous behaviors that resulted in their incarceration. All of these stressors can trigger risky behaviors including substance use, unprotected sex, and/or sex with multiple partners.

Upon release, women also frequently face structural issues, such as lack of work opportunity, lack of childcare, uncertain or inadequate housing, and other repercussions of racism, poverty, and sexism that increase the vulnerability of women to HIV infection. Any and all of these can increase women's HIV risk through lack of health care, illegal or hazardous work, violence,

domestic abuse, and exposure to street drug and sex trade cultures.

## **Discussion**

### *It's All about Relationships*

Risk factors for women are very much "gendered." The U.S. Centers for Disease Control and Prevention surveillance data indicate that 80% of women with HIV were infected by a sexual partner (Quinn & Overbaugh, 2005). Fewer women than men acquire HIV through injection drug use, and even this risk factor is likely to occur in the context of a sexual relationship where drug paraphernalia are being shared. Women are more likely than men to be relationship centered, seek and maintain bonds with others, and avoid conflict in personal relationships (Lichtenstein & Malow, 2010). Most women are arrested because "they couldn't or wouldn't snitch on boyfriends, husbands, friends, or causal relationships" (Talvi, 2007, 7). Even when faced with lengthy sentences, incarcerated women tend to build communities and social networks with other incarcerated women in an effort to survive their incarceration. Yet, many times these women feel isolated and concerned for their relationships with their children and families at home. This isolation is exacerbated if their children are not able to visit these women during their incarceration because prisons are located far away from home or because the children are placed in foster homes and there is limited communication with social workers. Women whose male partners are incarcerated also often feel isolated in their struggles to maintain relationships with their incarcerated male partners, and simultaneously expend a great deal of their limited financial and emotional resources on maintaining this relationship.

Although it is clear that women naturally put a great emphasis on relationships, most HIV prevention interventions are designed for men and focus on risk reduction in individual, rather than relational, terms. Thus, there is great need to develop, evaluate, and disseminate more relationship-based interventions designed to strengthen the positive social support networks for women affected by the criminal justice system.

One such intervention is the Health Options Mean Empowerment (HOME) Project that was developed for women visiting their male partners at San Quentin State Prison (Grinstead, Comfort, McCarthney, Koester, & Neilands, 2008; Reznick, Comfort, McCarthney, & Neilands, 2011). The HOME Project placed HIV risk reduction in the context of women's relationships with incarcerated men. As part of the intervention, HOME trained women visitors to be peer health educators, both for other women visiting men at San Quentin and for women in the peer educators' home communities. The program demonstrated that peer education is a feasible means of providing HIV education to women with incarcerated partners and that flexibility and inclusiveness are important factors in designing interventions for this population. Based on the success of the HOME Project, in 2009 the U.S. Department of Health and Human Services, Office on Women's Health, awarded cooperative agreements to eight community-based organizations across the county to design and implement innovative and gender-responsive HIV prevention programs to meet the unique risks and needs of women within their communities who have currently incarcerated or recently released male partners.

### *Recognize the Difficulties of Women's Lives*

Women and girls affected by incarceration are often juggling many of the hardships of being poor women and women of color. In addition, they face the unique stressors of balancing the emotional and financial toll of their own incarceration themselves and/or that of their male partner both during incarceration and after release. The reality of these burdens greatly hinders their ability to prioritize HIV prevention until other life issues have been addressed.

The fact that women from high-risk communities (including incarcerated women and women partners of incarcerated men) have experienced elevated rates of sexual and physical abuse also greatly impacts their ability to successfully engage in standard HIV prevention practices such as risk negotiation and condom use. Interventions designed to meet their needs must understand and prioritize the other unique life stressors that they are experiencing.

One such intervention is Project START, the first corrections-based intervention to be accepted by the Centers for Disease Control and Prevention as part of its Diffusion of Effective Behavioral Interventions Program (Kramer & Zack, 2009). Project START is an HIV/sexually transmitted infection (STI)/hepatitis risk reduction program for people returning to the community after incarceration. Like other HIV prevention programs, Project START has a focus on reducing HIV/STI/hepatitis risk, yet it has been designed specifically for incarcerated populations. Thus, the program recognizes that there are most often more pressing life needs for an individual returning to the community after incarceration (such as housing, employment, childcare, mental health, and substance abuse) and incorporates linkages to community providers for these life needs in addition to traditional HIV/STI/hepatitis risk reduction strategies (such as encouraging safer sex practices and referrals to syringe exchange). In doing so, Project START recognizes that participants will be more likely to follow-up on their HIV/STI/hepatitis risk reduction goals when other life needs have been addressed. Project START is designed to be flexible and easily adapted to individual needs. In the case of women and girls affected by incarceration, Project START can include service linkages for issues such as child custody, support for survivors of domestic violence, or couples counseling and mental health services.

### *Incarceration Interrupts Family Planning*

Another reality for women affected by the criminal justice system is that many want to conceive children, either after their own release from a correctional facility or after the release of their male partner. They share the common, human desire to have children with the men they love and with whom they are in committed relationships. Incarceration for women and/or their male partners can complicate and delay this goal. After incarceration there may be a "rush" to conceive and have children without prioritizing preconception health (including HIV screening), prenatal health, or HIV prevention.

Typical HIV prevention interventions focus on individual behavioral change without regard for the gender and cultural context in which the behaviors occur. HIV prevention programs designed for women and girls affected by incarceration, by contrast, must take into consideration the other priorities and stressors that feature more prominently in the lives of their target audience. These programs must take into account, and

explicitly address, some women's immediate goal of having children after they and/or their partner have been released from a correctional facility and, thus, include additional risk reduction strategies other than condom usage.

### *Girls on the Side*

Although very little attention has been given to women affected by incarceration, there has been even less focus on girls within the juvenile justice systems. However, it is clear that the pathway that many women take to incarceration includes time within the juvenile justice systems. In addition, many girls have intimate partners who are incarcerated in juvenile or adult correctional systems. Not enough attention has been given to developing and evaluating programs specifically for girls affected by the criminal justice system.

An effort to address this gap is the Girls Study Group (GSG), convened in 2004 by the Office of Juvenile Justice and Delinquency Prevention and led by RTI International. The GSG conducted a comprehensive review of the literature on, and programs targeting, girls' delinquency, a review of risk-assessment and treatment-focused instruments, analysis of secondary data, and dissemination of GSG project findings to the public. The GSG has made significant progress in understanding girls' delinquency, including patterns of offending among adolescent girls, the protective factors associated with girls' delinquency, and the importance of considering these issues when developing effective prevention and intervention programs for these girls (Hawkins, 2010).

One HIV prevention program serving girls within the juvenile justice system that showed positive impact on risk reduction is Girl Talk-2. Girl Talk-2 is a 6-hour, peer-led group intervention serving girls within the county juvenile justice system. An evaluation of the program demonstrated that participants in the Girl Talk-2 intervention group had significantly higher use of condoms and communication skills to defuse potentially violent situations than girls in the comparison group at 6 months follow-up (Kelly, Owen, Peralez-Dieckmann, & Martinez, 2007).

### **Recommendations**

The program and policy recommendations specifically address the unique risks, obstacles, and opportunities facing women and girls affected by the criminal justice system. These recommendations should be considered for implementation within the National HIV/AIDS Strategy as well as by program implementers and policy makers at the state and local level.

- Establish a cross-agency U.S. Department of Health and Human Services community advisory board focused on encouraging and reviewing all related programming initiatives and policies for women and girls affected by incarceration.
- Ensure that all women and girls affected by incarceration (both those who are incarcerated and those partnered with incarcerated men) are counted and considered when decisions are made around the intersection between HIV and the criminal justice system.
- Ensure that all criminal justice and corrections health programs view women and girls in the context of their relationships (partners, children, family, and community).
- Develop and enforce program standards that respect the individuality and autonomy of women and girls, including sexual safety while incarcerated.

- Expand correctional health programming (including in-custody and reentry programs) to include HIV prevention and sexual health education that cover both sexual risk and drug- and syringe-related risks.
- Prioritize the sexual health needs of girls and women under correctional supervision.
- Deliver integrated HIV/substance treatment/mental health programs for women and girls in correctional facilities, and routinely screen for childhood sexual abuse and trauma in connection with these services.
- All HIV prevention programs serving incarcerated women and girls and the women partners of incarcerated men must incorporate issues of gender-based violence prevention and treatment.
- Develop programs and outreach strategies that promote condom distribution and HIV counseling and testing for women planning for their male partners' return home after incarceration.
- Include condoms (male and female), hygiene items, and current information about community resources in release packets for all individuals being released from a correctional facility.

## References

- Adimora, A. A., Schoenbach, V. J., Martinson, F. E. A., Donaldson, K. H., Stancil, T. R., & Fullilove, R. E. (2003a). Concurrent partnerships among rural African Americans with recently reported heterosexually transmitted HIV infection. *Journal of Acquired Immune Deficiency Syndromes*, 34, 423-429.
- Adimora, A. A., Schoenbach, V. J., Martinson, F. E. A., Donaldson, K. H., Stancil, T. R., & Fullilove, R. E. (2003b). Concurrent sexual partnerships among African Americans in the rural south. *AIDS Education and Prevention*, 14, 155-160.
- Ahlemeyer, H. W., & Ludwig, D. (1997). Norms of communication and communication as a norm in the intimate social system. In L. Van Campenhoudt, M. Cohen, G. Guizzardi, & D. Hausser (Eds.), *Sexual Interactions and HIV Risk*. (pp. 22-43). Bristol, PA: Taylor and Francis.
- American Correctional Association. (1990). *The female offender: What does the future hold?* Washington, DC: St. Mary's Press.
- Baillargeon, J., Wu, H., Kelley, M. J., Grady, J., Linthicum, L., & Dunn, K. (2003). Hepatitis C seroprevalence among newly incarcerated inmates in the Texas correctional system. *American Journal of Public Health*, 117, 43-48.
- Baldwin, K. M., & Jones, J. (2000). Health issues specific to incarcerated women: Information for state Maternal and Child Health Programs. *Women's and Children's Health Policy Center, Johns Hopkins University, School of Public Health*. Available: [jhsph.edu/bin/oe/prison.pdf](http://jhsph.edu/bin/oe/prison.pdf). Accessed March 22, 2011.
- Battle, R. S., Cummings, G. L., Barker, J. C., & Krasnovsky, F. M. (1995). Accessing an understudied population in behavioral HIV/AIDS research: Low income African American women. *Journal of Health & Social Policy*, 7, 1-17.
- Beck, A. J., Harrison, P. M., Berzofsky, M., Caspar, R., & Krebs, C. (2010). Sexual victimization in prisons and jails reported by inmates, 2008-09. *NCJ 231169*.
- Braithwaite, R. L., Treadwell, H. M., & Arriola, K. P. (2005). Health disparities and incarcerated women: A population ignored. *American Journal of Public Health*, 95, 1679-1681.
- Braman, D. (2004). *Doing time on the outside: incarceration and family life in urban America*. Ann Arbor: University of Michigan Press.
- Browne, A., Miller, B., & Maguin, E. (1999). Prevalence and severity of lifetime physical and sexual victimization among incarcerated women. *International Journal of Law and Psychiatry*, 22, 301-322.
- Bruhlin, E. (2003). Power, communication and condom use: Patterns of HIV-relevant sexual risk-management in heterosexual relationships. *AIDS Care*, 15, 389-401.
- Carlson, B. E., & Cervera, N. (1991). Inmates and their families: Conjugal visits, family contact, and family functioning. *Criminal Justice and Behavior*, 18, 318-331.
- Chesney-Lind, M. (2002). Imprisoning women: The unintended victims of mass imprisonment. In M. Mauer, & M. Chesney-Lind (Eds.), *Invisible punishment: The collateral consequences of mass imprisonment*. (pp. 79-94). New York: New Press.
- Comfort, M. (2008). *Doing time together: Love and family in the shadow of the prison*. Chicago: University of Chicago Press.
- Comfort, M., Grinstead, O., Faigeles, B., & Zack, B. (2000). Reducing HIV risk among women visiting their incarcerated male partners. *Criminal Justice and Behavior*, 27, 57-71.
- Comfort, M., Grinstead, O., McCartney, K., Bourgois, P., & Knight, K. (2005). "You can't do nothing in this damn place!" Sex and intimacy among couples with an incarcerated male partner. *Journal of Sex Research (special issue on Sexuality and Place)*, 42, 3-12.
- De Groot, A. S., & Cu Uvin, S. (2005). HIV infection among women in prison: Considerations for care. *Infectious Diseases in Corrections Report*. Available: [idronline.org/archives/mayjune05/article.html](http://idronline.org/archives/mayjune05/article.html). Accessed March 21, 2011.
- Gilfus, M. (2002). *Women's experience of abuse as a risk factor for incarceration*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Available: [vawnet.org](http://vawnet.org). Accessed March 20, 2011.
- Girshick, L. B. (1996). *Soledad women: Wives of prisoners speak out*. Westport, CT: Praeger Publishers.
- Glaze, L. E., & James, D. J. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: Bureau of Justice Statistics, NCJ 213600.
- Gorbach, P. M., Stoner, B. P., Aral, S. O., H Whittington, W. L., & Holmes, K. K. (2002). 'It takes a village': Understanding concurrent sexual partnerships in Seattle, Washington. *Sexually Transmitted Diseases*, 29, 453-462.
- Green, B. L., Miranda, J., Daroowalla, A., & Siddique, J. (2010). Traumatic histories and stressful life events of incarcerated parents II: Gender and ethnic differences in substance abuse and service needs. *The Prison Journal*, 90, 494-515.
- Grinstead, O., Faigeles, B., Bancroft, C., & Zack, B. (2001). The financial cost of maintaining relationships with incarcerated African American men: A survey of women prison visitors. *Journal of African-American Men*, 6, 59-70.
- Grinstead, O., Comfort, M., McCarthy, K., Koester, K., & Neilands, T. (2008). Bringing it home: Design and implementation of an HIV/STD intervention for women visiting incarcerated men. *AIDS Education and Prevention*, 20, 285-300.
- Grinstead, O., Faigeles, B., Comfort, M., Seal, D., Nealey-Moore, J., Belcher, L., et al. (2005). HIV, STD, and hepatitis risk to primary female partners of men being released from prison. *Women and Health*, 41, 63-80.
- Grinstead, O., Zack, B., Faigeles, B., Grossman, N., & Blea, L. (1999). Reducing postrelease HIV risk among male prison inmates: A peer-led intervention. *Criminal Justice and Behavior*, 26, 468-480.
- Hagan, J., & Coleman, J. C. (2001). Returning captives of the American war on drugs: Issues of community and family reentry. *Crime & Delinquency*, 47, 352-367.
- Hammett, T. M., & Drachman-Jones, A. (2006). HIV/AIDS, sexually transmitted diseases, and incarceration among women: National and southern perspectives. *Sexually Transmitted Diseases*, 33(7 Suppl), S17-S22.
- Havens, J. R., Leukefeld, C. G., Oser, C. B., Staton-Tindell, M., Knudsen, H. K., Mooney, J., et al. (2009). Examination of an interventionist-led HIV intervention among criminal justice-involved female prisoners. *Journal of Experimental Criminology*, 5, 245-272.
- Hawkins, S. (2010). *The Girls Study Group*. Research Triangle Park, NC: RTI International. Available: [rti.org/brochures/girlsstudygroup.pdf](http://rti.org/brochures/girlsstudygroup.pdf). Accessed March 23, 2011.
- Jorgensen, J. D., Hernandez, S. H., & Warren, R. C. (1986). Addressing the social needs of families of prisoners: A tool for inmate rehabilitation. *Federal Probation*, 50, 47-52.
- Kelly, P. K., Owen, S. V., Peralez-Dieckmann, & Martinez, E. (2007). Health interventions with girls in the juvenile justice system. *Women's Health Issues*, 17, 227-236.
- Klein, H., Elifson, K. W., & Sterk, C. E. (2004). Partner communication and HIV risk behaviors among 'at risk' women. *Soz.-Präventivmed*, 49, 363-374.
- Kramer, K., & Zack, B. (2009). *Project START: An HIV/STI/hepatitis risk reduction program for people returning to the community after incarceration (2nd ed.)*. Implementation Manual and Training of Facilitators Curriculum. Bethesda, MD: Centers for Disease Control and Prevention, cooperative agreement #1-U65-PS-000231-01.
- Lattimore, P.K., Visher, C., Steffey, D., Osborne, J., Brumbaugh, S. (2008). Pre-release characteristics and service receipt among adult male participants in the SVORI multi-site evaluation. Prepared for the National Institute of Justice.
- LeBlanc, A. N. (2003). *Random family: Love, drugs, trouble, and coming of Age in the Bronx*. New York: Scribner.
- Lichtenstein, B. (2005). Domestic violence, sexual ownership, and HIV risk in women in the American Deep South. *Social Science & Medicine*, 60, 701-714.
- Lichtenstein, B., & Malow, R. (2010). A critical review of HIV-related interventions for women prisoners in the United States. *Journal of the Association of Nurses in AIDS Care*, 21, 380-394.
- Manhart, L. E., Aral, S. O., Holmes, K. K., & Foxman, B. (2002). Sex partner concurrency: Measurement, prevalence, and correlates among urban 18-39-year-olds. *Sexually Transmitted Diseases*, 29, 133-143.
- Maruschak, L. M. (2005). *HIV in prisons, 2003*. Washington, DC: Bureau of Justice Statistics.
- Maruschak, L. M. (2009). *HIV in prisons, 2007-8*. Washington, DC: Bureau of Justice Statistics.
- Maruschak, L. M., Glaze, L. E., & Mumola, C. J. (2010). Incarcerated parents and their children: Findings from the Bureau of Justice Statistics. In

- M. Eddy, & J. Poehlmann (Eds.), *Children of incarcerated parents*. Washington, DC: The Urban Institute Press.
- Mumola, C. J. (2000). *Incarcerated parents and their children*. Washington, DC: Bureau of Justice Statistics. National Institute of Justice, NIJ's Response to the Prison Rape Elimination Act, Corrections Today, February 2006. Available: [ncjrs.gov/pdffiles1/nij/213137.pdf](http://ncjrs.gov/pdffiles1/nij/213137.pdf). Accessed May 20, 2011.
- Nurse, A. (2004). Returning to strangers: Newly paroled young fathers and their children. In M. Pattillo, D. Weiman, & B. Western (Eds.), *Imprisoning America: The social effects of mass incarceration*. (pp. 76–96). New York: The Russell Sage Foundation.
- Owen, B. (1998). *"In the mix": Struggle and survival in a women's prison*. Albany: State University of New York Press.
- Quinn, T. C., & Overbaugh, J. (2005). HIV/AIDS in women: An expanding epidemic. *Science*, 308, 1582–1583.
- Reznick, O. G., Comfort, M., McCartney, K., & Neilands, T. B. (2011). Effectiveness of an HIV prevention program for women visiting their incarcerated partners: The HOME Project. *AIDS & Behavior*, 15, 365–375.
- Richie, B. E. (1996). *Compelled to crime: The gender entrapment of battered black women*. New York: Routledge.
- Sobo, E. J. (1995). *Choosing unsafe sex: AIDS-risk denial among disadvantaged Women*. Philadelphia: University of Pennsylvania Press.
- Stevens, P. E. (1995). Impact of HIV/AIDS on women in the United States: Challenges of primary and secondary prevention. *Health Care of Women International*, 16, 577–595.
- Talvi, S. (2007). *Women behind bars: The crisis of women in the U.S. prison system*. Emeryville, CA: Seal Press.
- Tan, J. A., Joseph, T. A., & Saab, S. (2008). Treating hepatitis C in the prison population is cost-saving. *Hepatology*, 48, 1387–1395.
- The Members of the ACE Program of the Bedford Hills Correctional Facility. (1998). *Breaking the walls of silence: AIDS & women in a New York state maximum-security prison*. Woodstock & New York: The Overlook Press.
- Thomas, J. C., & Sampson, L. A. (2005). High rates of incarceration as a social force associated with community rates of sexually transmitted infection. *Journal of Infectious Diseases*, 191, S55–S60.
- Travis, J., & Waul, M. (Eds.). (2003). *Prisoners once removed: The impact of incarceration and reentry on children, families, and communities*. Washington, DC: The Urban Institute Press.
- U.S. Centers for Disease Control and Prevention. (2008). *HIV/AIDS among women*. Atlanta, GA: U.S. Department of Health and Human Resources, Division of HIV/AIDS Prevention. Available: [www.cdc.gov](http://www.cdc.gov).
- Van Campenhoudt, L., & Cohen, M. (1997). Interaction and risk-related behavior: Theoretical and heuristic landmarks. In L. Van Campenhoudt, M. Cohen, G. Guizzardi, & D. Hausser (Eds.), *Sexual interactions and HIV risk*. (pp. 59–74). Bristol, PA: Taylor and Francis.
- West, H. (2010). *Prison inmates at midyear 2009—Statistical tables (Report No. NCJ 230113)*. Washington, DC: Bureau of Justice Statistics.
- Zack, B. (2007). HIV prevention in corrections. In R. B. Greifinger (Ed.), *Public health behind bars: From prisons to communities*. New York: Springer.

---

### Author Descriptions

Katie Kramer is the CEO of Corrections, Communities & Families for The Bridging Group. For the past 20 years, she has focused on the development, implementation, and evaluation of social service and health programs serving individuals, families and communities impacted by incarceration.

Megan Comfort is a Senior Research Sociologist in the Urban Health Program at RTI International and an Adjunct Assistant Professor of Medicine at the University of California, San Francisco. Her work focuses on incarceration, family, intimacy, and public health. She is the author of *Doing Time Together: Love and Family in the Shadow of the Prison* (University of Chicago Press, 2008).