“You love who you love. You don’t turn it on and off like a light switch.”

A Cross-site Evaluation of HIV/AIDS Prevention and Support Programs for Women Partners of Incarcerated or Recently Released Men

Prepared for DHHS, Office on Women’s Health

Prepared by The Bridging Group
August 2015
Official Citation


Women Partners Evaluation Study Team & Contributing Authors

Katie Kramer, MSW, MPH¹
Barry Zack, MPH¹
Sharon McDonnell, MPH¹
Megan Comfort, PhD²
Mary Bowers (ret), MSW³

Acknowledgements

The Bridging Group would like to thank all of the dedicated staff from the Women Partners grantee sites for their dedication, collaboration, and hard work on this multisite evaluation and in particular, the women participants from these sites who shared their stories through participation in evaluation surveys and focus groups.

---

¹The Bridging Group
²RTI International and University of California, San Francisco
³DHHS, Office on Women’s Health
# TABLE OF CONTENTS

- **Executive Summary** .................................................................................................................. 5
- **Introduction** ................................................................................................................................. 7
  - HIV Prevention with Women Partners of Incarcerated & Recently Released Men .................. 7
  - Office on Women’s Health Response ......................................................................................... 9
- **Table 1: Women Partners Grantee Sites** .................................................................................... 9
- **Table 2: Core HIV Prevention Curriculum** ................................................................................. 10
- **Grantee Agency Overviews** ........................................................................................................ 12
  - AIDS Action Coalition ................................................................................................................. 12
  - Calvary Healthcare ....................................................................................................................... 12
  - Center for Health Justice .............................................................................................................. 13
  - Metropolitan Charities ................................................................................................................ 13
  - The Osborne Association .............................................................................................................. 14
  - Recovery Resource Council ......................................................................................................... 14
  - San Ysidro Health Center ............................................................................................................ 15
  - South Side Help Center ............................................................................................................. 15
- **Evaluation Study Overview** ......................................................................................................... 16
  - Table 3: Measurable Outcomes of the Evaluation Study ............................................................ 16
- **Evaluation Study Methodology** ................................................................................................. 17
  - Collaborative Evaluation Approach ............................................................................................ 17
  - Evaluation Study Methodology Overview .................................................................................... 17
  - IRB Process ................................................................................................................................... 18
    - Figure 1: Study Timeline ........................................................................................................... 18
  - Quantitative Methodology ........................................................................................................... 19
    - Figure 2: Quantitative Methodology Procedures ....................................................................... 20
  - Quantitative Analysis .................................................................................................................... 21
  - Qualitative Methodology ............................................................................................................. 22
  - Focus Groups with Program Participants .................................................................................... 22
Table 4: Topics for Participant Focus Group Questions 22
Qualitative Analysis 23

Evaluation Study Findings 24
Participant Demographic - Surveys 24
Table 5: Participant Demographic Data at Baseline 24
Table 6: Relationship Data 25
Participant Demographics and General Description – Focus Groups 26
Table 7: Demographic Data for Focus Group Participants 26

Outcome 1: Number of Women Partners Receiving Gender-Based Prevention Education 28
Table 8: Participation Rates and Program Dosage by Program Type 28

Outcome 2: Knowledge about HIV Prevention, Transmission, and Personal Risk 32
Table 9: HIV/STI Knowledge Areas and Survey Questions 32

Outcome 3: Acquisition of New Communication and Risk Negotiation Skills 36
Table 10: Sample Questions on Communication Skills Areas 36

Outcome 4: Intention to Make Safer Behavioral Choices 40

Outcome 5: Sense of Social Support Network 42
Table 11: Social Support Areas and Survey Questions 42

Outcome 6: Community Linkages to Care and Social Services for Women & Their Children 45

Outcome 7: Number of Women Voluntarily Testing for HIV and Other STIs 47

Recommendations 49
Program Development 49
Policy and Research Development 50

About the Evaluators: The Bridging Group 51

Appendices 52

Appendix A: Study Enrollment Form
Appendix B: Baseline Survey
Appendix C: Post Intervention Survey
Appendix D: 30-Day Follow-up Survey
Appendix E: Participant Focus Group Guide
While increasing focus is placed on HIV prevention programs for incarcerated men, women in relationships with these men are often overlooked. Research indicates that these women, who are primarily low-income women of color, are at increased risk of HIV and STI infection since the couple’s separation increases her likelihood of 1) concurrent partners and 2) financial and psychological stresses which then increase her risk for sexual and drug using behaviors. Post incarceration, couples may engage in unprotected sex to demonstrate loyalty, reestablish intimacy, and to conceive children.

To address this issue, in 2011, the U.S. Department of Health and Human Services, Office on Women’s Health funded eight agencies across the country to provide HIV/AIDS Prevention and Support Service Programs for Women Partners of Incarcerated/Recently Released Men. These sites are a combination of urban and rural areas with large communities of women of color, particularly African American women. The Women Partners program sites integrated a core of common characteristics into their programs, including: 1) recruit women with currently incarcerated or recently released male partners; 2) utilize a similar core HIV/STI prevention education curriculum; 3) provide both male and female condoms; 4) facilitate onsite HIV testing or testing referral; and 5) integrate optional gender-responsive program content such as domestic violence, nutrition, parenting, or other women’s health issues.

In 2012, The Bridging Group (TBG) was contracted by all eight Women Partner grantees (with support from OWH) to conduct a collaborative cross-site evaluation study. This study was conducted to improve our understanding of HIV and other health risks unique to women partners of incarcerated men and examine the effectiveness of implementing a gender-specific intervention. Quantitative and qualitative data were collected around seven main outcome measurements of the evaluation study.

Main Outcome Measurements
1) Number of women partners receiving gender-based prevention education;
2) Knowledge about HIV prevention, transmission, and personal risk among women partners;
3) Acquisition of new communication and risk negotiation skills among women partners;
4) Intention to make safer behavioral choices related to HIV and other sexually transmitted infections among women partners;

---

5) Sense of social support network among women partners;
6) Community linkages and networks for ensuring both care and social services for women partners and their children; and
7) Number of women partners voluntarily testing for HIV and other STIs.

The eight program agencies were provided three years of OWH funding to implement their programs from 2011-2014. TBG was awarded two years of funding from the eight agencies to carry out the cross-site evaluation from 2012-2014. From February 2013 through December 2013, 388 women across all eight program sites completed questionnaires at baseline, post intervention, and at 30 days post intervention. Qualitative data was also collected from 39 women who participated in focus groups at all sites.

Results

- Significant increase in knowledge of HIV transmission, testing, and prevention (p<0.0001);
- Significant increase in gender-specific knowledge regarding condom use (p<0.0001);
- Significant increase in participants who reported having ever used a female condom between baseline and follow-up surveys (p<0.0001);
- Significant increase in sense of social support networks (p<0.0001)
- 81% of the participants reported that they had never been tested for HIV were tested for the first time during or after the program; and
- While partner testing was not a primary outcome measure, women reported that 29% of their partners tested during the program and 28% of partners tested after the program.

Implications of Results

Prior to the OWH initiative, there was a major gap in information addressing the unique context of HIV and other health risks for women with incarcerated partners and in understanding the usefulness and effectiveness of interventions that address this population. This evaluation demonstrated that developing programs to meet the specific health risks and needs of women partners is feasible. The Women Partners Program is a gender-responsive, high-impact prevention intervention that significantly increases testing rates, perception of personal risk, female condom use, and positive social support networks. These results help provide a context for policy considerations, information to federal and state agencies or local organizations looking to replicate and/or sustain similar programs, and add greatly needed information to fill the void in knowledge about the health disparities of this community of vulnerable and underserved women.
HIV Prevention with Women Partners of Incarcerated & Recently Released Men

While more focus is being placed on the need for HIV screening and prevention programs for incarcerated men, an often overlooked component of the intersect between HIV and incarceration are the millions of women who are involved in sexual relationships with incarcerated male partners. The United States is the number one jailer in the world, currently housing 2.2 million adults in correctional facilities with 15 million people processed through the US correctional system each year. An estimated 20% of incarcerated men are married and additional studies have found that approximately 50% of incarcerated men identify a primary female partner who they plan to reunite with once released.

It is well documented that incarcerated men are disproportionately affected by multiple health conditions and illnesses. Rates of HIV/AIDS in US prisons are 2 ½ times the national rate while rates of Hepatitis C (HCV) are estimated to be as high as 49%. Many of these men engaged in behaviors prior to incarceration including multiple sex partners and/or injection drug use that put them at increased risk for acquiring HIV, HCV, and other STIs. Thus, the far majority of incarcerated men living with HIV are infected before they enter prison. But HIV risk behaviors can often continue inside the correctional facility including injection drug use, tattooing, body piercing, and consensual, nonconsensual, and survival sexual activities. Scarcity of sterile drug paraphernalia may lead to needle sharing in prison and distributing condoms or sterile injection equipment is, except in rare circumstances, prohibited. In addition, incarceration disproportionately affects men of color — males constitute 93% of individuals incarcerated in US prisons; 41% of incarcerated men are African American and 20%

---

are Latino for a total of 61%. Yet, African Americans and Latinos only make up approximately 25% of the overall US population.\textsuperscript{16}

Data has also indicated that having a partner with a history of incarceration is associated with higher rates of HIV and STIs.\textsuperscript{17,18} Women with current or recently incarcerated male partners are primarily low-income women of color for whom racism, poverty, and sexism contribute to an increased risk for HIV and whose life stressors are exacerbated by their partner’s imprisonment.\textsuperscript{19,20} More specifically, during her partner’s incarceration, a woman is likely at increased risk for HIV infection since the couple’s separation increases her likelihood of concurrent partners and financial and psychological stresses increase her risk for unprotected penetrative sexual intercourse (UPI) and needle sharing.\textsuperscript{21,22,23,24} Post incarceration, couples may be motivated to engage in UPI in order to demonstrate loyalty, reestablish intimacy, and to conceive children.\textsuperscript{25,26}

In response to the increasing burden of new HIV infections among low-income women of color, HIV prevention interventions have been developed to address the unique risks that women face.\textsuperscript{27,28} However, there continue to be contexts of risk that have not been addressed by interventions to date which may be key to targeting HIV prevention interventions to the most

vulnerable women. One such context is having an incarcerated male partner. Research conducted by the University of California, San Francisco (UCSF), Center for AIDS Prevention Studies in collaboration with Centerforce (a community-based organization providing services for incarcerated individuals and their families since 1975) with women visiting their male partners at San Quentin State Prison indicated that it is feasible to engage women in HIV-related interventions and research evaluation activities, and that an intervention tailored to meet the specific needs of women with incarcerated male partners can affect these women’s efforts to communicate with others regarding HIV prevention.\(^{29,30,31}\)

**Office on Women’s Health Response**

Based on the success of the research conducted by UCSF and Centerforce and on its goal to provide gender responsive programs to meet a wide range of women throughout the United States, in 2008, the Office on Women’s Health (OWH) implemented the initiative “HIV/AIDS Prevention and Support Service Programs for Women Partners of Incarcerated/Recently Released Men” (hereafter referred to as the Women Partners Program). Through a competitive grant process, OWH funded eight sites around the country to provide HIV Prevention and Supportive Services for Women Partners. These sites are a combination of urban and rural areas with large communities of women of color who are affected by the criminal justice system. Funded agencies include a variety of agency types: health clinic, substance use treatment provider, multi-service community-based organization (CBO), faith-based organization (FBO), and criminal justice focused CBOs. Table 1 provides an overview of each of these organizations.

### Table 1: Women Partner Grantee Sites

<table>
<thead>
<tr>
<th>Agency</th>
<th>Women Partners Project</th>
<th>Location</th>
<th>Agency Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Action Coalition</td>
<td>Healthy Connections Project</td>
<td>Huntsville, AL</td>
<td>Multi-service CBO</td>
</tr>
<tr>
<td>Calvary Healthcare</td>
<td>SISTA Connection Project</td>
<td>Washington, DC</td>
<td>FBO, CBO</td>
</tr>
<tr>
<td>Center for Health Justice</td>
<td>Project Home Los Angeles (PHLA)</td>
<td>Los Angeles, CA</td>
<td>Criminal justice focused CBO</td>
</tr>
</tbody>
</table>


The eight program sites were funded to develop HIV prevention programs specific for women partners. They utilize a variety of intervention activities and curricula to implement their programs and meet the expectations of OWH grantees. All sites integrated a core of key characteristics into their programs. The following are the core cross-site characteristics.

**Core Cross-site Program Similarities**

- Recruit women with currently incarcerated or recently released (within 1-2 years) male partners
- Utilize a similar core HIV/STI prevention education base*
- Provide male and female condoms during and after the program
- Offer or provide referrals for HIV testing

*Table 2 provides an overview of the core HIV prevention education components that were integrated into each of the eight programs.

**Table 2: Core HIV/STI Prevention Education Components**

| HIV Prevention & Transmission | Female Anatomy | HIV and STI Testing | Correct Condom Usage (male and female) | Communication and Negotiation Skills | Risk Reduction and Decision Making Skills |
Many agencies also created or collaborated with other service providers to incorporate additional gender responsive strategies into their programs such as: 1) nutrition & cooking classes, 2) parenting skills groups, 3) onsite childcare, 4) scrapbooking and other opportunities for women to “tell their story,” 5) incorporating the voices of men into their programs, 6) presenting sexual health in context of a history of abuse, 7) addressing family planning and conception post release from prison or jail, and/or 8) financial planning that specifically addresses the costs and burden of having an incarcerated partner.

Sites also had the freedom to develop site specific topic areas to meet the unique needs of the women in their communities that best fit into the infrastructure and missions of their organizations. To this end, the following are a list of program variances across sites.

**Cross-site Program Variances**

- Sites utilized a variety of curricula including an adapted SISTA intervention,\(^\text{32}\) original HOME Project,\(^\text{33}\) or locally developed curricula
- Some sites included additional program content including domestic violence, nutrition, parenting, financial planning, other women’s health issues, and anger management.
- Sites provided a variety of intervention types from overnight weekend retreats, 1-2 day retreats, or weekly/bi-weekly multi-session classes
- Sites varied in program length (5-20 hours)
- Sites varied in program site location such as onsite at agency, in shelters, in drug treatment centers, etc.

---


\(^{33}\) [http://caps.ucsf.edu/centerforce/home-prevention-for-women-with-incarcerated-partners](http://caps.ucsf.edu/centerforce/home-prevention-for-women-with-incarcerated-partners)
AIDS ACTION COALITION

Location: Huntsville, AL

Agency Overview: AIDS Action Coalition (AAC) is a nonprofit that provides medical care and support services to anyone living with HIV & AIDS in the 12 counties across North Alabama. The clinic is partially funded through the Ryan White Care Act and state supported grants. Service areas include HIV testing, Supportive Care, Prevention Education, and Substance Abuse Treatment.

Healthy Connections Project: Healthy Connections is a program specifically designed for women in a relationship with a man who is either incarcerated or has been recently released from prison. Program participants are eligible to receive case management services and attend a free weekend retreat with workshops that teach ways to enjoy better sexual, emotional, and physical health.

CALVARY HEALTHCARE

Location: Washington, DC

Agency Overview: Calvary Healthcare is a nonprofit faith-based community organization that serves the greater Washington DC community through Health/HIV awareness, substance abuse recovery, and ex-offender re-integration services that revive and restore individuals, families, and community.

SISTA Connection Project: A group-level, gender and culturally relevant intervention, designed to increase condom use with African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power.
CENTER FOR HEALTH JUSTICE

Location: Los Angeles, CA

Agency Overview: Center for Health Justice (CHJ) is a nonprofit organization whose mission is to empower people affected by incarceration to make healthier choices and advocate for the elimination of disparities between prisoner health and public health. CHJ strives to reach its mission by providing education, post release incarcerated services, and policy and advocacy services.

Project Home LA (PHLA): An empowerment program for women who have incarcerated or previously incarcerated male partners, based on the UCSF/Centerforce HOME Project. PHLA encourages women to talk about the risk of acquiring HIV/STDs in their social networks.

METROPOLITAN CHARITIES

Location: Tampa, FL

Agency Overview: Metropolitan (Metro) Charities is a nonprofit organization that has provided services for individuals living with HIV/AIDS since 1993. Metro Wellness and Community Centers are committed to provide premier HIV services, support, and health and wellness programs that enhance quality of life. Service areas include HIV/AIDS services, HIV/AIDS Minority Programs, Prevention, Mental Health and Substance Abuse Treatment Services, and LGBTQ and Transgender Support, Education, and Activities.

Women Empowered & Standing Tall (WEST): WEST is a 5-week workshop series specifically for women who have a boyfriend, fiancé, husband, or “baby daddy” who is currently in jail or prison or has been released within the past year. WEST is a skills building workshop that focuses on risk refusal and negotiation skills as well as enhancing knowledge of a woman’s own reproductive health.
THE OSBORNE ASSOCIATION

Location: New York, NY

Agency Overview: The Osborne Association offers opportunities for individuals who have been in conflict with the law to transform their lives through innovative, effective, and replicable programs that serve the community by reducing crime and its human and economic costs. The Osborne Association offers opportunities for reform and rehabilitation through public education, advocacy, and alternatives to incarceration that respect the dignity of people and honor their capacity to change.

Loving Out Loud (LOL): LOL is a gender responsive program for women who are intimate partners of a man or woman who is incarcerated or has been recently released for no more than one year, helping them to improve communication, build healthier relationships with their partners, and reduce the risk of sexually transmitted infections and HIV through a framework of empowerment and understanding of healthy relationships.

RECOVERY RESOURCE COUNCIL

Location: Fort Worth, TX

Agency Overview: Recovery Resource Council (RRC) is a nonprofit organization with over a 50 year history of providing an essential link for behavioral health issues including substance abuse services as well as mental health issues for adults, youth, and families who are in need. The Council provides individual and family counseling, substance abuse counseling, Department of Transportation (DOT) assessments, case management for special populations, HUD and Shelter Plus Care housing services for the homeless, and court ordered substance abuse education classes.

Women Partners Program: The Women Partners Program at RRC provides in-depth HIV prevention education through a 4 course curriculum tailored to women and their variety of needs, experiences, and concerns.
SAN YSIDRO HEALTH CENTER

Location: San Diego, CA

Agency Overview: Since 1969, San Ysidro Health Center (SYHC) has been dedicated to improving the health and well-being of the community’s traditionally underserved and culturally diverse people. SYHC has a legacy of service in meeting this mission by providing high quality, accessible, and affordable medical, dental, behavioral health, and special support services via 10 community health centers throughout the greater San Diego area.

Women Partners Program: The Women Partners Program at SYHC provides group and individual sessions for women who have a partner currently in prison or who has been in prison. The program is open to Latina and African American women who are willing to discuss and explore the meaning of being a woman and how to stay healthy. Topics discussed include ethnic and gender pride, HIV/AIDS education, assertiveness skills, behavioral self-management and condom use, and coping skills. The program has been culturally adapted to meet the wide range of Spanish speaking Latina women throughout the greater San Diego area.

SOUTH SIDE HELP CENTER

Location: Chicago, IL

Agency Overview: Founded in June 1987, South Side Help Center (SSHC) is purposed to help people of all ages embrace a lifestyle of prevention against mental, physical, and social ills by providing positive, healthy alternatives so that community residents can lead productive lives.

Women Empowered to Live Life (Well Project): The Well Project provides culturally appropriate, gender-specific prevention and risk reduction messages for women with currently incarcerated or recently released male partners. The project provides women with HIV/AIDS education and risk reduction information with an emphasis on promoting and reinforcing safer behavior through enhanced decision making skills. Participants receive interpersonal skills training in negotiating and sustaining appropriate behavior changes.
In 2012, The Bridging Group was contracted by all eight Women Partner (WP) grantees (with support from OWH) to conduct a collaborative cross-site evaluation study. This evaluation study was intended to improve our understanding of HIV and other health risks unique to women partners of incarcerated men and examine the effectiveness of implementing a gender-specific intervention. The information presented in this evaluation study is needed to examine the overarching outcomes of these programs with particular sensitivity to meeting the specific needs of women partners of incarcerated and recently released men.

Information from this study will be used to provide a context for policy considerations, to provide information to federal and state agencies or local organizations who may look to replicate and/or sustain similar programs, and to add greatly needed information to fill the void of information about this community of women through dissemination of findings to key stakeholders including federal agencies, community service providers, policy makers, and study participants.

Measurable outcomes for this collaborative evaluation study were determined through: (a) direction from OWH staff, as guided by the National HIV/AIDS Prevention Strategy; (b) development of logic models for each of the eight Women Partner grantee sites that identified at least 4 common cross-site domains; and (c) input from staff at each of the eight Woman Partner grantee sites during the evaluation design phase of this project. Table 3 presents the seven measurable outcomes for this study.

<table>
<thead>
<tr>
<th>Table 3: Measurable Outcomes of the Evaluation Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Number of women partners receiving gender-based prevention education</td>
</tr>
<tr>
<td>▶ Knowledge about HIV prevention, transmission, and personal risk among women partners</td>
</tr>
<tr>
<td>▶ Acquisition of new communication and risk negotiation skills among women partners</td>
</tr>
<tr>
<td>▶ Intention to make safer behavior choices related to HIV and other sexually transmitted infections among women partners</td>
</tr>
<tr>
<td>▶ Sense of social support network among women partners</td>
</tr>
<tr>
<td>▶ Community linkages and networks for ensuring both care and social services for women partners and their children</td>
</tr>
<tr>
<td>▶ Number of women partners voluntarily testing for HIV and other sexually transmitted infections</td>
</tr>
</tbody>
</table>
Collaborative Evaluation Approach

The study team from TBG took a collaborative approach toward designing, implementing and analyzing the outcomes of this evaluation study. This collaborative approach included engaging key staff from OWH and the eight Women Partner grantee sites at every step of the process. Staff from TBG began meeting with OWH and staff from the Women Partner grantee sites in 2012 to gather input for the evaluation design and evaluation tools. Input was integrated into the overall evaluation design and final survey instruments. TBG staff continued to host monthly cross-site conference calls as well as site specific calls with staff from the grantee sites throughout the duration of data collection in order to discuss data collection efforts, address quality assurance issues, answer questions, encourage on-time data submission, and trouble shoot data collection issues. Grantee staff were also engaged in data analysis through one face-to-face data input meeting and a series of individual and group conference calls dedicated to examining the outcomes and interpreting the results. Finally, OWH staff and staff from four of the eight grantee sites worked with TBG staff to develop and present an oral presentation of the evaluation study results at the 2014 United States Conference on AIDS.34

Evaluation Study Methodology Overview

To evaluate the Women Partners Programs, the TBG study team conducted the following study activities:

- **Developed Eligibility Check-list, Study Consent, and Enrollment Protocols** for all women eligible for the Women Partners Program at program sites and who also voluntarily signed up to participate in the cross-site evaluation;

- **Created and Implemented Baseline, Post Intervention, and 30–Day Follow-up Protocols and Surveys** for the women enrolled in the evaluation study of Women Partners Programs at the grantee sites;

- **Conducted Focus Groups** at each of the eight grantee sites with women enrolled in the evaluation study who had successfully completed the Women Partners Program;

- **Facilitated Staff Debrief Sessions** at each of the eight grantee sites with key staff involved in the implementation or supervision of evaluation activities at their site.

---

34 Kramer, K., Bowers, M., Williams, T., Pitts, K. O’Shaughnessy, O., Huerta, B.  *Beyond the Bars: The Importance of Focusing on Women Partners of Incarcerated or Recently Released Men in High Impact HIV Prevention Programs.* United States Conference on AIDS, October 2014.
**IRB Process**

All study protocols and data collection tools (qualitative and quantitative) went through an independent Institutional Review Board (IRB) for review, approval, and monitoring throughout the duration of the study. TBG utilizes the consulting services of Ethical & Independent Review Services (E &I) for all of its IRB and human subjects review (eandireview.com).

Figure 1 presents an overall timeline for the study.

**Figure 1: Study Timeline**
Quantitative Methodology

Quantitative data was collected on-site at all of the eight Women Partner grantee sites through enrollment three participant surveys: Baseline, Post Intervention, and 30-Day Follow-up. All surveys were completed in person; no surveys were mailed or emailed to participants (see Appendices A-D for Enrollment Form and Baseline, Post Intervention, and 30-Day Follow-up Surveys).

- **Study Consent and Enrollment** was conducted independently after program recruitment and enrollment was completed and before any program activity was initiated.

- **The Baseline Survey** was administered after consent was obtained and study enrollment was completed and before any program activity was initiated.

- **The Post Intervention Survey** was administered with participants up to 7 days post program completion.

- **The 30-Day Follow-up Survey** was completed with participants from 21-37 days post program completion.

After program enrollment was completed, a Women Partners grantee site staff not associated with program enrollment introduced the evaluation study to the program participant. If the participant expressed interest in the study, the evaluation study recruiter then assessed eligibility and if eligible, completed the study consent and enrollment procedures. When necessary, onsite bilingual staff met with the participants to explain the study and obtained consent in the participant’s native language. To confirm comprehension, each participant was asked to paraphrase the consent form. There were no negative consequences if anyone choose not to join the study; the individual was still able to participate in the HIV Prevention Program for Women Partners.

During the study enrollment process, participants were asked to provide personal contact information and contact information for up to two additional family members or friends for study follow-up. Demographic data was also collected and documented on the Study Enrollment Form. This data included information on age, gender, race and ethnicity, current living situation, number and age of children, education level, and relationship status.

Each survey took 15-20 minutes to complete. All surveys were identified through a personal identification number (PIN) and thus no participant names or identifiable information were attached to any survey. After data were collected, program site staff entered the data into an online cross-site password-protected encrypted database using SurveyMonkey. Each site
maintained a list of participant names and personal identification numbers that were secured in a password protected computer file and was kept separate from study data. Participants were reimbursed $10 for their time in participating in each the Baseline and Post Intervention Surveys and $20 for the 30-Day Follow-up Survey.

Figure 2 presents the overall quantitative methodology for the evaluation study.

**Figure 2: Quantitative Methodology Procedures**

1. **Enroll Participant in Program (confirm eligibility)**
2. **Study Recruitment, Enrollment, and Consent**
   - Informed Consent
   - Assign Study PIN/Link
   - Locator Form
   - Participant’s Bill of Rights
   - Study Enrollment Form
3. **Complete Baseline Survey**
   - (after enrollment and before any program activities)
   - Participant completes survey (provide support as needed)
   - Participant receives a $10 gift card
4. **Facilitate Program**
5. **Complete Post Intervention Survey**
   - (within 7 days of program completion)
   - Participant completes survey (provide support as needed)
   - Participant receives a $10 gift card
6. **Complete 30-Day Follow-up Survey**
   - (within 21-35 days of program completion)
   - Participant completes survey/provide support as needed
   - Participant receives a $20 gift card
Quantitative Analysis
Of the 388 participants that consented and enrolled in the evaluation study, 371 were included in the analysis. 17 participants were administratively dropped due to ineligibility for the program (3) or because they did not attend the program (14). Of those included in the analysis, 83% completed the baseline and post surveys and 60% completed the baseline, post and follow-up surveys.

Participant demographic characteristics were summarized with frequencies and averages. Analysis was conducted on an aggregate level with data from all sites combined for seven outcome measures. To assess program impact, trend analyses were conducted with a repeated measures approach and effect sizes and significance levels were calculated. Additionally, the following demographic and program characteristics were tested in univariate subgroup analyses, adjusted for site, to assess their impact on the outcome measure: age, education, relationship status at enrollment, and partner incarceration status at enrollment. Multivariate analyses were conducted with all significant covariates in univariate analyses to identify independently significant covariates.
Qualitative Methodology

Qualitative methods were used to complement the quantitative data by building an in-depth understanding of participants’ experiences of the WP programs as well as the perspectives and processes of the staff members responsible for program development and implementation. All qualitative data collection was conducted by TBG study staff on-site at the eight agency locations between August and November 2013.

Focus Groups with Program Participants

In addition to the three surveys, a convenience sample of 6-10 program participants at each program site participated in a focus group. Agency staff were requested by TBG to recruit 6-10 women who had completed the WP program to participate in a focus group held at each agency location. Women who agreed to participate underwent a separate consent process and were provided with a $20 gift card for their participation; a group meal was also provided just prior the focus group. On the day of the focus group, agency staff welcomed participants, introduced them to TBG staff and then left the room. A total of 39 women participated in focus groups; focus groups lasted from 45 minutes to 2 hours. Two TBG staff members conducted each focus group; one person facilitated while the other took hand-written notes and assisted as needed with facilitation. All focus groups were also audio-recorded.

TBG staff developed a guide used to facilitate all focus groups. Table 4 presents an overview of the topics covered in the Focus Group Guide (see Appendix E for the Focus Group Guide):

<table>
<thead>
<tr>
<th>Table 4: Topics for Participant Focus Group Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Recruitment &amp; Expectations</strong></td>
</tr>
<tr>
<td>▪ How participants learned about the WP program</td>
</tr>
<tr>
<td>▪ Why they decided to participate</td>
</tr>
<tr>
<td>▪ What they expected from the program</td>
</tr>
<tr>
<td><strong>Program Strengths</strong></td>
</tr>
<tr>
<td>▪ What parts of the WP program participants particularly enjoyed</td>
</tr>
<tr>
<td>▪ What parts of the WP program participants thought were important and why</td>
</tr>
<tr>
<td><strong>Program Staff</strong></td>
</tr>
<tr>
<td>▪ Reflections on program staff</td>
</tr>
<tr>
<td>▪ The impact of the staff on the program</td>
</tr>
<tr>
<td><strong>Areas for Improvement</strong></td>
</tr>
<tr>
<td>▪ What parts of the WP program participants did not enjoy</td>
</tr>
<tr>
<td>▪ What parts of the WP program participants felt could be improved or added to the curriculum</td>
</tr>
<tr>
<td><strong>Program Referrals &amp; Dissemination</strong></td>
</tr>
<tr>
<td>▪ Experiences talking or not talking to others (family, friends, partners) about participating in the WP program</td>
</tr>
<tr>
<td>▪ Experiences referring other women to the program</td>
</tr>
<tr>
<td><strong>Comparison to other HIV Prevention Programs</strong></td>
</tr>
<tr>
<td>▪ How the WP program compared to other programs the participants had attended</td>
</tr>
<tr>
<td><strong>Referrals to Other Programs &amp; Services</strong></td>
</tr>
<tr>
<td>▪ What referrals to other programs or services participants received through the WP program</td>
</tr>
</tbody>
</table>
Qualitative Analysis

Focus group data were analyzed in an iterative process by the full TBG team. We used a “Framework Analysis” approach to qualitative data analysis, which was developed for studies in which “the research is required to gather specific information and has the potential to create actionable outcomes.” Framework analysis follows a series of steps, including familiarizing oneself with the data, indexing and charting data, identifying thematic frameworks, and mapping and interpreting data themes. The two TBG research team members who had not been present at the focus group initially listened to the recordings for each group. Using a template that corresponded to the focus group guide domains, they wrote extensive notes and analytical memos for each recording. Next, the TBG research team members that had been present, reviewed the recordings, notes, and memos for each group, adding their reflections and impressions to the notes and observation logs for that group. Once this process was completed, each member of the team had either been present at or had listened to each focus group and therefore the full team was familiar with the entire data set, and all members had indexed and charted data from the eight focus groups through the analytical memos and notes. All study team members, in preparation for a 3-day in-person data analysis meeting, reviewed the eight files.

At this meeting, the study team identified common themes and quotations illustrating those themes, noting when those themes arose across all eight sites, when themes appeared linked to program commonalities among certain sites (e.g., weekend retreats), and when themes were site-specific and potentially represented regional differences or agency staff influences. Themes were then mapped onto the evaluation outcomes of interest as a means of elucidating how the qualitative data could inform the understanding of the quantitative outcomes and analyses.

EVALUATION STUDY FINDINGS

Participant Demographics - Surveys

Participant demographic information was collected for all participants on the study enrollment form. Table 5 provides a summary of this data.

Table 5: Participant Demographic Data at Baseline (N=371)

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>37 years</td>
<td>18-62 years</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Latina</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Mixed/Other</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some high school or less</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>High school degree or GED</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Some college or degree</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td><strong>Parent Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79% Mothers</td>
<td>74% of Mothers Have Minor Age Children</td>
<td></td>
</tr>
<tr>
<td><strong>Incarceration Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58% had histories of incarceration</td>
<td>63 days</td>
<td></td>
</tr>
<tr>
<td><strong>Housing Situation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lived in house/apt they paid for</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Lived in house/apt someone else paid for</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Car, street, shelter</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Sober living/drug treatment</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Domestic Violence Shelter</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Other (half-way house, motel, etc.)</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Participants’ ages ranged from 18 to 62, with a mean of 37 years. A majority identified as African American (72%) followed by Caucasian (13%), Latina (8%), and mixed or other race (7%). 27% reported that their highest education level was some high school or less, 35% reported having a high school degree or GED, and 37% reported that they had at least some college education (some college, college degree or postgraduate degree).

A majority of the participants (79%) have children, with the mean number of children being 3 (range: 1 to 13). The mean age of the children was 15 years. Of those with children, 74% have
minor children and of those with minors, 75% have minor children living with them. More than half of the participants (58%) had been previously incarcerated with the median number of days in jail or prison being 63 days. Half of the participants (50%) reported having previously participated in a program about HIV/STD prevention.

29% of women currently resided in a relatively unstable or temporary living environment such as a car, motel, shelter, drug treatment facility or domestic violence shelter.

Nearly half (47%) lived in a house or apartment they pay for, 24% lived in a house or apartment that someone else pays for, and 29% of participants currently resided in a relatively unstable or temporary living environment (including car/street/homeless shelter, sober living/drug treatment facility, motel/hotel, halfway/transitional house, domestic violence shelter, etc.).

Given the fluidity of intimate relationships among many of the women in the Women Partners Programs, relationship status data was collected at multiple times during the study including at enrollment and on the post and follow-up surveys. Table 6 summarizes participant relationship data.

<table>
<thead>
<tr>
<th>Table 6: Relationship Data (N=371)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationships Status at Baseline</strong></td>
</tr>
<tr>
<td>In committed relationship/domestic partnership</td>
</tr>
<tr>
<td>Single/never married</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Divorced, separated, widowed</td>
</tr>
<tr>
<td>Other or not sure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Change in Relationship Status (since last survey)</strong></th>
<th><strong>Post Survey (%)</strong></th>
<th><strong>Follow-up Survey (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>In relationship with same partner</td>
<td>73%</td>
<td>69%</td>
</tr>
<tr>
<td>New partner</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>No partner</td>
<td>24%</td>
<td>23%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Partner Incarceration Status (at enrollment)</strong></th>
<th><strong>Percent (%)</strong></th>
<th><strong>Range (Median)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently incarcerated</td>
<td>48%</td>
<td>Range of Incarceration 7 days – 30 years (418 days)</td>
</tr>
<tr>
<td>Recently released from jail/prison</td>
<td>49%</td>
<td>Median time since release (203 days)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
<td></td>
</tr>
</tbody>
</table>

36 All participants identified as having an incarcerated or released partner at enrollment.
At enrollment, almost half (45%) of the participants reported being in a committed relationship or domestic partnership, 25% reported being single and never married, 17% reported being married, 11% reported being divorced, separated or widowed, and 3% reported being in an ‘other’ relationship or not sure about the status of their relationship. On the post survey, 73% of participants reported being in a relationship with the same main partner, 3% reported having a new partner, and 24% reported having no main partner. At follow-up, 69% or participants reported being in a relationship with the same main partner, 8% reported having a new partner, and 23% reported having no main partner.

Approximately half of the participant’s had incarcerated partners (48%) and half had released partners (49%); 3% did not know their partner’s incarceration status. Among incarcerated partners, the length of incarceration ranged from 7 days to 30 years, with the median being 418 days (approximately 14 months). Among released partners, the median number of days since being released was 203 days (approximately 7 months).

Among those who completed the post survey, 12% reported being HIV positive (HIV status was not assessed on the baseline survey). This percentage of women living with HIV may be over representative for the larger female partner population in the communities served by this program. Three of the program sites actively recruited known women living with HIV, from HIV positive partner programs, or through peer networks or in communities with a higher risk of HIV. As well, based on input from program staff at some of the sites, the evaluation team ascertained that some participants may have misinterpreted the question “Have you tested HIV positive on an earlier test?” where the word ‘positive’ is interpreted as good results (i.e. HIV sero-negative). Regardless of the accuracy of this HIV+ rate, it highlights the need to prioritize prevention education efforts to this population.

**Participant Demographics and General Description- Focus Groups**

Of the 39 focus group participants, seven were between ages 20-29, four between 30-39, twelve between 40-49, fifteen between 50-59, and one was 62. Twenty-seven participants identified as African American, four as Caucasian, three as Latina, one as Black-Hispanic, and four did not identify their race/ethnicity. Twenty-eight participants said that they had children, ranging from 0 to 40 years of age. Table 7 summarizes focus participant demographic data.

<table>
<thead>
<tr>
<th>Table 7: Demographic Data for Focus Group Participants (N = 39)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>20-29 years</td>
</tr>
<tr>
<td>30-39 years</td>
</tr>
<tr>
<td>40-49 years</td>
</tr>
<tr>
<td>50-59 years</td>
</tr>
<tr>
<td>60+ years</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
<td>African-American</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>Latina</td>
</tr>
<tr>
<td>Black-Hispanic</td>
</tr>
<tr>
<td>Did not specify</td>
</tr>
<tr>
<td><strong>Parent Status</strong></td>
</tr>
</tbody>
</table>

Child age range = 0-40 years old

The focus group participants, mirroring the overall group of women who participated in the WP programs, came from many walks of life. Corresponding to the recruitment strategies employed by each agency site, some women were homeless and struggling with active addiction or recovery from substance use; some subsisted on a very low income through low-wage work, government entitlements, or both; and some assumed the role of the “stable matriarch” in their family networks and were relied upon for financial and emotional support by siblings, children, and grandchildren. In many focus groups at least one woman spoke about having been incarcerated herself, and numerous women had multiple loved ones who are or have been incarcerated. **Overall, having an incarcerated or recently released partner was almost always just one unique challenge out of several with which women were coping.**

As numerous women across sites remarked, women with incarcerated partners face significant hardships “on the outside” and yet, “we’re in there [jail/prison] too.”

---

*Women with incarcerated partners face significant hardships “on the outside” and yet, “it’s like we’re in there [jail/prison] too.”*  
- WP Program Participant
**Outcome 1: Number of Women Partners Receiving Gender-Based Prevention Education**

**Theme: Women Partner Programs are needed and desired.**

Participants were very engaged in programs at all of the eight program sites though there was some variance in program attendance based on program type (weekly/bi-weekly sessions, daily retreats, or overnight retreats). A majority of the participants (80%) completed the entire program, regardless of program type. An additional 14% of participants completed more than half of the program and 7% of participants completed less than half of the program. Half of the participants attended biweekly or weekly sessions (51%), 26% attended overnight retreats, and 23% attended non-overnight retreats. Almost all of the participants attending overnight or non-overnight retreats completed the program (99% for overnight and 100% for non-overnight) and 60% of those attending biweekly or weekly sessions completed the program. The program lengths ranged from 5 to 20 hours, with a mean of 11 hours completed. The mean hours completed for the overnight retreats was 18 hours, for non-overnight retreats was 9 hours, and for biweekly or weekly sessions was 7 hours. Table 8 provides an overview of participation rates by program type and program dosage.

**Table 8: Participation Rates and Program Dosage By Program Type (N=371)**

<table>
<thead>
<tr>
<th>Program Dosage</th>
<th>All Participants (N=371, 100%)</th>
<th>Overnight Retreat (N=98, 26%)</th>
<th>Non-Overnight Retreat (N=84, 23%)</th>
<th>Bi / Weekly Sessions (N=189, 51%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>completed 100% of program</td>
<td>80%</td>
<td>99%</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>completed 50-99% of program</td>
<td>14%</td>
<td>1%</td>
<td>0%</td>
<td>26%</td>
</tr>
<tr>
<td>completed &lt;50% of program</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Program Hours</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program length (hours)</td>
<td>5-20</td>
<td>12-20</td>
<td>5-12</td>
<td>5-12</td>
</tr>
<tr>
<td># program hours completed (mean)</td>
<td>11</td>
<td>18</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>
**Theme: Women overwhelming indicated that they enjoy the program.**

Women participating in both the surveys and the focus groups strongly expressed appreciation for the Women Partners Programs. Almost all of the participants (96%) reported being satisfied with the program. 94% of participants recommended the program to other women, 92% talked to friends about what they learned in the program, and 87% talked to family members about what they learned.

Across sites, women initially identified attending a program session for reasons such as curiosity, a desire to learn more about sexual health and/or HIV, being required to do so by probation, to fulfill a requirement for a drug treatment program, and because of the incentives (including, where applicable, the prospect of having an overnight retreat). Women expressed that they had not previously heard of programs specifically for women with incarcerated or recently released partners, and in some cases this drew them to the program: “You don’t see that kind of stuff [programs for WP]... with [other] women who are also going through this kind of thing.”

\*You don’t see that kind of stuff [programs for Women Partners]... with [other] women who are also going through this kind of thing.\*  
- WP Program Participant

Women overwhelmingly articulated that once the program began, “It’s more than the Wal-Mart card” that kept them coming back: “I had perfect attendance, it was something I looked forward to every week.” “I was so motivated... [the content was so interesting that] I didn’t want to leave.” Many women expressed that once they attended the first session, they experienced a realization that they and other women they knew were in need both of HIV education services as well as supportive forums for coping with a partner’s incarceration and/or recent release: “The retreat really opened my eyes to a whole lot of really important things that we experience on a daily basis.” “[I learned so many new things that] I was like a child being born.” “I’ll never forget [the WP program] – I’ll take it with me.” “This has been a life changing experience.”

The most frequent responses to what participants liked best about the program include the information and education that was learned, the ability to express one’s self openly, support from other women, and the staff. The things participants most frequently mentioned as being helpful were HIV/STD information, connecting with other women, learning how to use condoms correctly, and communication skills. The things participants most often identified as areas of improvement include wanting longer and/or more sessions, better and more advertising for the program, more role playing and hands-on activities, more information about what goes on in
jail/prison and preparing for their partner’s release, information on parenting children whose fathers are in prison, and opening the program to male partners, other women, and youth. Two interesting ideas mentioned were having an anonymous Q&A time and having the women sign a commitment to get tested for HIV at a certain frequency.

**Theme: Gender-responsiveness of WP programs enabled women to participate and heightened their enjoyment of the programs.**

Women participating in the focus groups identified multiple gender-responsive elements of the WP programs that facilitated their participation. On a practical level, women were highly appreciative of agencies that were able to provide on-site childcare. Agencies were also sensitive to various issues that affect women such as domestic violence, homelessness, poverty, drug use, and mental health challenges. In addition to addressing these topics in the program content, many agencies were able to provide specific support and services in order to include women living under these circumstances (e.g., supplying private transportation to and from the program for women living in shelters). Many agencies also set the days and times of their program sessions to accommodate the need to pick up children from school or attend Sunday church services. By taking the realities of women’s lives into account when developing program logistics, agencies permitted a wide range of women to participate: “I wanted to come anyways, but they made it easy, they were easy to talk to.”

Gender-responsiveness was also strongly felt on an emotional level. The dynamics of the focus groups themselves often replicated the sense of bonding with other women that women described as occurring during the WP programs: in their notes, TBG staff observed that focus groups were often full of laughter, warmth, and moments of personal sharing. Women identified that they relished the opportunity to talk openly with other women in the

<table>
<thead>
<tr>
<th>GENDER-RESPONSIVE ELEMENTS TO WOMEN PARTNER PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>✤ On-site childcare</td>
</tr>
<tr>
<td>✤ Inclusion of information on and support for issues of domestic violence, drug use, homelessness, mental health</td>
</tr>
<tr>
<td>✤ Program schedules based on children friendly times</td>
</tr>
<tr>
<td>✤ Warm and supportive program environments</td>
</tr>
<tr>
<td>✤ Compassionate female staff members</td>
</tr>
<tr>
<td>✤ Gender-specific HIV and STI education</td>
</tr>
</tbody>
</table>
WP programs about sex, love, relationships, and specific gender challenges: “We’re a sister group, let’s get together and talk.” Women indicated that these discussions resonated with them in that they were raw, sensitive, and honest: “This is more intimate, you relax. You keep coming, you’re comfortable with the women you’re there with.”

Likewise, many focus group participants spoke warmly and effusively about agency staff members (all of whom were female), often identifying these women as role models, inspiring leaders, and compassionate providers who deeply understood the trials and travails of being a woman in today’s world: “The happiness that you feel when you’re around a person that’s like that, that’s very happy and joyful. We never had a dull moment around her.” Strong staff facilitation had an impact on program retention: “I really liked the ladies that came, they are really up front. And they make it fun, so it makes me really pay attention.” “[Staff member] is just such a hoot to be around, she brings the class alive. And so after the first time, I was ready to go back again, and again, and again, just to see her presentation.”

Finally, women rousingly endorsed receiving gender-specific HIV and STI education. Topics such as female anatomy, reproductive health, and symptoms of common STIs were identified as pertinent, helpful, and quite often as information that was new to women. Across sites, program content emphasized positive messaging about being a woman and highlighted women’s strengths: “[I learned] How to stand up for myself, I used to be shy…learning about my body.” “I learned that I’m a phenomenal, beautiful, more educated woman that can still be who I am and have a voice with the highest respect for yourself and others.” In addition, women reflected on how their participation in the WP program inspired them to think about talking to their children, particularly girls, about relationships and sexual health: “[The program] makes me more aware of how I’m going to parent my daughter about relationships.” “[I] have a 13 yr. old granddaughter, she’s out here just wanting to ‘experiment with the life’ so the condoms that I got…female condoms that I got…I gave to her…and explained to her how to use it.”
Theme: Women-specific HIV prevention education is still needed.

Though we are several decades into the epidemic, and almost 50% of women in the study reported having previously participated in a program about HIV/STD prevention, women at numerous sites still reported having had a lack of information or misinformation about HIV prior to their program participation. Women with family members or friends who have died of AIDS gave examples of their own fears (e.g., believing that HIV could be transmitted via sweat or through skin-to-skin touching) and phobias (e.g., not allowing HIV-positive people into their homes). A desire to learn more motivated some women’s program participation: “I wanted to take the terror out of the diseases, both of the diseases [HIV and HCV].” Women greatly valued the education they received: “Since I know more now [about HIV], I’m not close minded.” “[Sharing the information learned] helps me to enlighten other females.” “Back in my day it would have been shameful to talk about stuff like that, and you didn’t talk about stuff like that. So we grew up not knowing. And I think it’s very important for our children to know what’s going on and how they can protect theirselves.” “The program educated me on sex, drugs, and a lot of areas that I thought I knew a lot of things about, but I realized there were a lot of things I didn’t know.”

HIV knowledge was assessed by creating a score based on true/false items for three knowledge areas: basic HIV/STD prevention knowledge, gender-specific condom knowledge about condoms, and prison-specific HIV/STD knowledge. Those who did not provide an answer to all communication items for each group were excluded from scoring. Table 9 provides an overview of questions asked in each of the three knowledge areas.

Table 9: HIV/STD Knowledge Areas and Survey Questions

<table>
<thead>
<tr>
<th>A. Basic HIV/STD Prevention Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I know how hepatitis C (HCV) is spread from person to person</td>
</tr>
<tr>
<td>2. I can look at someone and tell if they have HIV</td>
</tr>
<tr>
<td>3. I can look at someone and tell if they have a sexually transmitted disease (STD)</td>
</tr>
<tr>
<td>4. HIV can be spread through sharing tattoo equipment</td>
</tr>
<tr>
<td>5. Hepatitis C (HCV) can be spread through sharing tattoo equipment</td>
</tr>
</tbody>
</table>
6. You have to take a test to know if you have HIV
7. If someone takes an HIV antibody test the day after becoming infected with HIV, they will test HIV positive right away
8. Using male condoms can help protect you from becoming infected with HIV

B. Gender-specific Condom Knowledge
1. I am confident that I could put a male condom on my partner correctly
2. I know what a female condom is
3. I am confident that I could insert a female condom correctly
4. Using female condoms can help protect you from becoming infected with HIV

C. Prison-specific HIV/STD Knowledge
1. Condoms are given to men in our state prisons
2. Bleach for cleaning needles is given to men in our state prisons
3. Men who have HIV are always separated from men who do not have HIV in jail/prison
4. Only men who consider themselves gay men have sex with men in jail or prison

Participants demonstrated a significant increase in knowledge in all three knowledge areas. More specifically, for basic HIV/STD knowledge regarding transmission, testing, and prevention, there was a significant increase in knowledge between the baseline (79% correct) and post (90% correct) surveys. In further analysis of basic HIV/STD knowledge, younger participants (ages 18-29 and ages 30-44) had significantly higher overall scores compared to older participants (age 45+). Additionally, participants with at least some college education had significantly higher overall scores compared to those with less education.

For gender-specific knowledge regarding male and female condoms, there was a significant increase in knowledge between the baseline (65% correct) and post (90% correct) surveys. Further analyses demonstrated that younger participants (ages 18-29) had significantly higher overall scores compared to older participants (ages 45+). In addition, participants who are not married or in a committed relationship had a significantly larger increase in their scores.

---

37 t: -8.43, df: 188, p<0.0001.
38 F=3.90, p=0.021.
39 F=4.91, p=0.027.
40 t: -11.86, df: 213, p<0.0001.
41 F=4.34, p=0.014.
compared to those in a married/committed relationship.\textsuperscript{42}

For prison-specific HIV/STD knowledge regarding prevention practices in jail and prison, there was a significant increase in knowledge between the baseline (55\% correct) and post (76\% correct) surveys.\textsuperscript{43} The average percent correct on the follow-up survey was 80\%, which was also significantly higher than the post score demonstrating that women continued to retain and increase their knowledge about prison-specific HIV/STD issues 30 days after completing the program.\textsuperscript{44}

These findings indicate that overall knowledge about HIV/STD increased after participation in the Women Partners Program. Also, knowledge retention was high for all three knowledge areas with follow-up scores equal to or above post scores. The average knowledge about basic HIV/STD prevention was high at entry into the program (79\% correct). On average, participants answered approximately two-thirds of the gender-specific condom knowledge questions correctly and about half of the prison-specific HIV/STD knowledge questions at program entry. After the program, the average basic HIV/STD prevention knowledge and gender-specific condom knowledge was high (90\% for both categories) and prison-specific HIV/STD knowledge was at 76\% correct.

Finally, the differences in results between younger and older participants are important given that older women need HIV/STD education but are often overlooked because many programs target younger women. As well, it is important to consider why prison-specific HIV/STD knowledge was not as high at the end of the program as other HIV/STD knowledge areas. This distinction may be a result of the many different policies and practices regarding HIV/STD prevention among different prisons and jails (both systems and institutions) that may be confusing for individuals to learn and retain knowledge about over time.

\textit{\textquotedblleft The program educated me on sex, drugs, and a lot of areas that I thought I knew a lot of things about, but I realized there were a lot of things I didn\textquotesingle;t know.\textquotedblright}  

- WP Program Participant

\textsuperscript{42} F=4.29, p=0.039.  
\textsuperscript{43} t=-10.08, df: 206, p<0.0001.  
\textsuperscript{44} t=-2.38, df: 206, p=0.02.
Theme: Making the connection between men’s incarceration and women’s sexual health risk

Women commonly expressed that prior to attending the WP program they had not thought specifically about how their partner’s incarceration could have an influence on sexual health and sexual risk. At agency sites where the “Inside/Out” video was used as instruction material, women frequently mentioned the video as having made them think about the possibility of men having sexual relationships with men while incarcerated. Reactions to this idea varied across sites: in some locations, women reflected on supportive discussions with staff members and other women that had allowed them to consider this possibility within their own relationships and to think through what this would mean to them in terms of communication they wanted to have with their partners as well as HIV testing: “Ain’t no man gonna tell you if they had sex with another man.... It will start an argument if you ask them...let’s be real... To kill all of that [suspicion and wondering], we’re going to take the HIV test.” In other locations, women made comments that indicated they had received fear-based messaging that made them feel anxious about this possibility and perhaps angry at incarcerated and formerly incarcerated men for potentially engaging in this sexual behavior: “They say a lot of women contract HIV from their male partners who’s been incarcerated because they – I want to say this right – imitate homosexuality in prison and they never tell you, so when they come out, you dealing with them without condoms and anything, and that’s how you become infected.” Women also noted learning new information about HIV and HCV transmission risk associated with in-prison tattoos.

“Ain’t no man gonna tell you if they had sex with another man.... It will start an argument if you ask them...let’s be real... To kill all of that [suspicion and wondering], we’re going to take the HIV test.”

- WP Program Participant

http://thebridginggroup.com/Video.html
Theme: Communication and risk negotiation skills in a trauma informed context.

Communication and risk negotiation were identified by all eight program sites as skill areas necessary to help women partners reduce their risk of HIV and other STI transmission. These skills were assessed by creating a mean scale score for two groups: 1) communication with main/other sex partners and 2) communication with others. Participants were provided with a series of situations and asked to indicate their ability to communicate or negotiate with others. Those who did not provide an answer to all communication items for each group were excluded from scoring. Communication with main and other sex partners was combined due to relationship fluidity throughout the evaluation period. Table 10 provides a sample of questions asked in each of the two communication areas.

Table 10: Sample Survey Questions on Communication Skills Areas

<table>
<thead>
<tr>
<th>A. Communication with Main/Other Sex Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Would you be able to ask your spouse/main partner about HIV risk behaviors (like having sex without a condom, sharing needles, etc.) he may have been involved in while he is/was in jail or prison?</td>
</tr>
<tr>
<td>2. Would you be able to talk with your spouse/main partner about him getting an HIV test after he is/was released from jail or prison?</td>
</tr>
<tr>
<td>3. Would you be able to insist that you use a female condom with your spouse/main partner anytime you wanted to use one?</td>
</tr>
<tr>
<td>4. If you wanted to refuse unprotected sex with your spouse/main partner the first time you have sex after he is/was released from jail or prison, would you be able to?</td>
</tr>
<tr>
<td>5. If you wanted to ask your spouse/main partner if he has other sexual partners in the community after he was/is released from jail or prison, would you be able to?</td>
</tr>
<tr>
<td>6. Would you be able to ask your spouse/main partner if he has injected drugs?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Communication with Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am afraid there will be bad consequences if I try to set boundaries with other people to protect myself from harm</td>
</tr>
<tr>
<td>2. I feel comfortable asking for what I need from other people</td>
</tr>
<tr>
<td>3. I am scared to ask for what I need from other people</td>
</tr>
<tr>
<td>4. I can express feeling angry without becoming aggressive</td>
</tr>
</tbody>
</table>

Participants demonstrated a significant increase in communication and risk negotiation skills with both their main/other sex partners regarding risk behaviors and HIV/STD prevention and with others regarding boundaries, needs and feelings. The findings indicate that communication and risk negotiation skills increased after participation in the Women Partners Program.
Specifically, related to communication and risk negotiation with main / other sex partners regarding risk behaviors and HIV/STD prevention, there was a significant increase in communication and risk negotiation skills between the baseline and post surveys.\textsuperscript{46} Interestingly, further analysis demonstrated that women with currently incarcerated partners reported significantly higher overall scores related to communication and risk negotiation skills compared to those with recently released partners.\textsuperscript{47}

For communication with others regarding boundaries, needs and feelings, there was a significant increase in communication and risk negotiation skills between the baseline and post surveys.\textsuperscript{48} Further analysis indicated that participants, aged 30-44 years, had significantly higher overall scores compared to those aged 45 years or older.\textsuperscript{49} Also, participants with currently released partners had a significantly larger increase in their scores compared to those with incarcerated partners who had a slight decrease in scores.\textsuperscript{50}

It is interesting to note the differences in perceived communication skills between participants who had a currently incarcerated partner and those who had released partners. This difference may be explained by the notion that for women who had a currently incarcerated partner, the skills may be considered hypothetical because they may not have had a chance to implement them. Thus women may have an increased perception of their communication skills.

\textsuperscript{46} t: -3.65, df: 135, p<0.0001.  
\textsuperscript{47} F=6.59, p=0.011.  
\textsuperscript{48} t: -2.55, df: 187, p=0.01.  
\textsuperscript{49} F=3.35, p=0.037.  
\textsuperscript{50} F=5.23, p=0.023.
**Theme: Recognizing self-worth and assertively communicating needs and boundaries**

Women identified learning communication skills and an understanding between the differences in “aggression” vs. “assertiveness” as highlights of the WP programs. Some women identified this as the primary purpose of the program: “You learn how to talk to your man.” For many, understanding their own emotional needs and responses, often within a trauma informed and gender responsive framework of women being socialized to take care of others, was important: “In our nature, as women...we’re nurturers... [and this] carries over to our partner... you have to deal with that codependency so you can be more assertive.”

Numerous women characterized themselves and other women with incarcerated partners as having an attraction to “the lifestyle of having a ‘bad boy’ in the penal system.” Women recognized that these men often tried to dominate relationships, but also saw possibilities for themselves to establish new communication patterns: “It’s not about him being disrespected, but about me and my children.” “Do you have enough in you to ask him to go get tested without feeling bad or worried about what he’s going to say to you?”

**Theme: Defining relationships in the context of incarceration is challenging**

Across sites, rich discussions arose in the focus groups around how partner incarceration alters the dynamics, terms, and definitions of relationships. Women spoke movingly of how men are at once part of their lives and absent when they are incarcerated, as well as the challenges of reuniting after men’s release from custody. Women openly shared stories of beginning new relationships when a partner was incarcerated, having relationships with multiple people that shifted according to when each person was locked up or in the community, and having sexual relationships with men and with women: “Yes I have a husband, and yes I sleep with someone else, ‘cause we’re separated.” In staff debriefs, agency staff echoed having observed much complexity and fluidity in women’s relationships and how incarceration influenced women’s definitions of romantic, sexual, main, and other partners. For example, one staff member noted that a woman who was married to an incarcerated man did not

“**Yes I have a husband, and yes I sleep with someone else, ‘cause we’re separated [while he is in prison].**”

- WP Program Participant
consider him a “partner” because they were not able to have sexual relations. Staff at sites that conducted overnight retreats also noted a number of participants who entered the retreat defining their relationships as being with a “main partner” and left the retreat questioning the terms of their relationship and the label they wanted to assign it.

“\textit{It is sometimes very difficult for women to determine if they are with their partner while he is incarcerated, even if they are married. It’s like ‘I don’t consider myself with him, but I am with him’.}”

- WP Staff Member
**Outcome 4: Intention to Make Safer Behavioral Choices Related To HIV and Other STDs**

**Theme: Sexual risk reduction skills are still important and valuable to learn.**

Consistently across sites, women clearly recalled male and female condom demonstrations as an important part of the WP program. Learning about and trying female condoms was especially popular, and was spontaneously mentioned as a program highlight in nearly every focus group: “I finally, I never knew at first, how to put on those women condoms.” “I thought I knew how [to use a male condom]. And I started out okay [in the practice session]. But I didn’t end up taking it off properly. So that was very interesting. And the women’s condom – I heard about them, but that was it, I just heard about them. I’d never actually seen one.”

There was a significant increase in intention to use condoms more often with main/other partners between baseline (82%) and post (91%) among those not trying to get pregnant. \(^5^1\) At entry into the program, 44% reported always or mostly using condoms with their main or other partners and between post and follow-up, 56% reported always/mostly using condoms (among those who reported having sex and not trying to get pregnant). There was a significant increase of 23% to 32% of participants who reported having ever used a female condom between the baseline and follow-up surveys. \(^5^2\)

\(^{51}\) \(p=0.027\)

\(^{52}\) \(p<0.0001\)
In addition to voicing appreciation for the opportunity to learn more about condom use, numerous women expressed being motivated to undertake the sexual risk reduction strategy of having fewer sexual partners. Women also lauded the WP programs for providing skills to select sexual partners within a context of protecting one’s health and well-being: “[The program] shows you how to choose a mate more wisely.” Women specifically identified that learning how to identify warning signs of physical abuse in the context of sexual relationships was helpful to them.

Women identified in particular that learning how to identify warning signs of physical abuse in the context of sexual relationships was helpful to them.

At entry into the program, 41% of women reported having sex with other partners (that were not their main partner). Between the post intervention survey and follow-up, 16% of those with a main partner reported sex with other partners and 19% of those who no longer had a main partner reported having sex with other/non main partners. 35% of those with incarcerated partners and 39% of those with released partners reported sex with other partners at baseline (among those with a main partner throughout the program). Between post and follow-up, 24% of those with incarcerated partners and 8% of those with released partners reported sex with other partners. In the context of condom use and the reality of women’s lives, it is important to note that at baseline, 19% of participants reported that they are trying to get pregnant within the next year.
Outcome 5: Sense of Social Support Network

Theme: It’s all about relationships.

Women identified developing a social support network as one of the most valuable strengths of the program. Social support was assessed by creating a mean scale score for two groups: 1) social support regarding HIV/STDs and 2) social support regarding incarcerated partners. Participants were provided with a series of situations and asked to indicate their sense of social support. Those who did not provide an answer to all communication items for each group were excluded from scoring. Table 11 provides an overview of questions asked in each of the two social support areas.

Table 11: Social Support Areas and Survey Questions

<table>
<thead>
<tr>
<th>A. Social Support Regarding HIV/STDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I’m worried about HIV or STDs and need to talk to someone openly, I have a friend, family member, or mentor I can talk to</td>
</tr>
<tr>
<td>2. If I have a good friend whom I think might get HIV or other STDs, I feel like I could talk to him or her about how to protect themselves</td>
</tr>
<tr>
<td>3. If people have questions about HIV or other STDs, they ask me for information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Social Support Regarding Incarcerated Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have a friend, family member, service provider, or mentor I can talk to about my spouse/main partner going to jail or prison</td>
</tr>
<tr>
<td>2. If I need help with something related to my spouse/main partner being incarcerated, there is someone who will be there for me</td>
</tr>
<tr>
<td>3. If people need help with something related to their spouse/main partner being incarcerated, they ask me for support and information</td>
</tr>
</tbody>
</table>

The findings indicate that the sense of social support increased after participation in the Women Partners Program. There was significant increase of reported social support between baseline and post surveys, both in terms of HIV/STDs\(^{53}\) and regarding incarcerated partners.\(^{54}\)

\(^{53}\) t: -6.65, df: 208, p<0.0001.

\(^{54}\) t: -6.65, df: 208, p<0.0001.

“All we need is someone able to relate, understand and not judge us.”

- WP Program Participant
Theme: “All we need is somebody able to relate, understand, and not judge us.”

In staff debriefings, agency staff expressed a range of thoughts regarding the need for HIV prevention programs that focus specifically on women with incarcerated and recently released partners. While some staff believed that WP were at no higher risk for HIV infection than women in general, other staff strongly considered WP to have specific needs that were best addressed in groups of peers undergoing similar challenges. In support of the latter perspective, women participants often articulated a sense of relief and comfort about being able to speak openly and share experiences with other women who understood the context of incarceration. As one woman stated, she was reassured to learn that “I’m not the only person in the world going through this crisis.” Women identified feeling “a bond” with other women who had an incarcerated or recently released partner, saying the ties they formed were “Basically like family.” Being able to discuss incarceration-related stresses and strains with peers in the same situation was helpful:

“A lot of time your girlfriends don’t understand. ‘Girl, why you sending him money?’ or ‘Girl, why you want to be with him?’...It’s hard to be around someone who just don’t have a clue as to why you do the things you do, whether it’s why you date somebody that’s locked up or why you do drugs, or why you are depressed. You know, it’s always good when you can have a person that gets you, it’s like you’re not alone. It’s like, ‘Oh somebody gets it too, I’m not the only crazy one, right?’

Numerous women also talked about developing friendships with women from their WP program group and socializing with each other away from the agency site. Sometimes the ties formed were long-lasting:

“Being able to talk to women that knows the feeling of their husband, fiancé, or boyfriend being locked up... It was like I could confide in them, and we can talk... We still communicate
now [after the WP program is over] and our kids play together and some of their boyfriends and fiancés are still locked up, but because we met on that meeting, we still talk and we're able to coach each other through.”

Finally, a sense of support and community also grew among women whose partners broke up with them upon release from incarceration. In several focus groups, women who had had these experiences leveraged their experiences and perspectives with “cautionary tales” to encourage women who were still in relationships to draw boundaries with men and assert their own needs and desires (e.g., regarding sending money or visiting).

“A lot of time your girlfriends don’t understand. ‘Girl, why you sending him money?’ or ‘Girl, why you want to be with him?’... You know, it’s always good when you can have a person that gets you, it’s like you’re not alone. It’s like, ‘Oh somebody gets it too.’”

- WP Program Participant
Theme: Before I participated in Women Partners, I did not realize how many services there are in the area that can help me.

Women participants identified a range of challenges in their lives. Common issues were lack of adequate income to cover basic needs for themselves and their children and/or grandchildren. Several women spoke about struggling with mental health issues, especially depression. Some women also identified substance use and recovery from addiction as ongoing difficulties in their lives. Domestic violence arose in multiple conversations, typically in the context of women having left an abusive relationship or worrying about violence resuming after an incarcerated partner returned to the home. In these conversations, women provided each other with supportive listening, encouragement, and occasionally advice. Sometimes women noted that the agency staff had provided them with referrals during the WP program, particularly if the agency itself had other services to address their particular needs. Given the many competing demands on women’s time and energy, women were not always able to follow-up with a referral.

95% of women reported that before participating in the Women Partners Program they did not realize how many services are available to them in their community.

A majority of the participants (95%) reported that before participating in the Women Partners Program they did not realize how many services were available to them in their community. The service that was learned about the most was HIV testing services with 80% of women reported having learned about or were referred to this service. This was followed by healthcare services (52%), counseling or therapy (51%), substance abuse treatment (43%), and anger management (40%). About a third of the participants reported learning about parenting assistance (33%), financial planning (32%), housing assistance (29%), and food assistance (28%).
Approximately a quarter of participants (23%) contacted a program they learned about or were referred to. The most contacted program was HIV testing services (47%) followed by mental health counseling (34%), substance abuse treatment (30%), and healthcare services (27%). 23% contacted a program for food assistance, 22% contacted a housing assistance program, 20% contacted an anger management program, 18% contacted a financial planning program, and 17% contacted a parenting assistance program. Of those who contacted a program, 93% reported receiving help from all or some of the programs they contacted and 95% were satisfied with the contacted programs.
**Outcome 7: Number of Women Voluntarily Testing For HIV and Other STIs**

*Theme: WP programs provide many opportunities for HIV testing.*

Providing or referring to HIV and other STI testing was a required component of the WP program. Five of the sites provide on-site HIV testing during the program and three sites offer referrals to testing services. Among those who attended a program with on-site testing during the program, 74% reported being tested compared to 42% at sites without onsite testing (excluding known HIV positive participants).\(^5\)

81% of women participants who have never been tested for HIV in the past, were tested for the first time during or after the WP program.

Most of the participants (92%) reported that they have been tested for HIV at least once prior to participating in the WP program. Of those tested, 56% reported being tested within the previous six months, 20% reported being tested six months to one year prior, and 24% reported being tested more than a year prior. Over half (63%) of the participants reported being tested during or after the program with 59% tested during the program and 50% tested within 30 days after the program.

This data excludes women who self-reported living with HIV. **Of those that had never been tested for HIV, 81% were tested for the first time during or after the program.** Almost all of the participants plan to test in the future as well.

Further analysis demonstrated that for all participants tested in the program, participants aged 18-29 years were significantly more likely to have been tested during or after the program compared to those aged 45 years and older.\(^6\) In addition, women with minor aged children (18 years old or younger) were significantly more likely to test than those with only non-minor children\(^7\).

Many women spoke of getting tested for HIV with their partner as a result of the WP program. Receptivity to HIV testing was high, with women expressing that they welcomed the availability of HIV testing as part of the program when that was the case. Some women seemed unaware of the possibility of rapid test results, and were particularly pleased to be able to learn their status right away: “That was amazing for me.” Programs that also offered HIV testing for partners through their regular agency services were greatly appreciated. **While partner testing was not a required program component, over a third of participants (37%) reported that their main partner was tested during or after the program with 29% tested during the program and 28% tested within 30 days after the program.** These numbers indicate that programs focused

---

\(^5\) p<0.0001
\(^6\) OR: 2.57, p=0.038
\(^7\) OR=2.41, p=0.041
on women in the context of their intimate relationships, present an opportunity to provide couples and/or partner testing services as well.

In further analyses, participants aged 45 years or older were significantly more likely to have a partner who tested during or after the program compared to those aged 30-44 years.\textsuperscript{58} Participants who are in a married or committed relationship were also significantly more likely to have a partner who tested than those who are not in a married/committed relationship.\textsuperscript{59} Women spoke of asking or “requiring” their partners to test; a pregnant woman who expressed concerns about her partner’s monogamy because he did not “come straight home” after his incarceration had him test for “all sorts of STDs and HIV. I wasn’t going to put me or my baby at risk.” In many focus groups, women recommended that programs similar to the WP program be available to men, which was perhaps an indirect indication of further desire for testing and services to support couples.

\textsuperscript{58} \textit{OR: 2.39, p=0.026}

\textsuperscript{59} \textit{OR: 2.51, p=0.013}
Findings from this evaluation study of the Women Partners for Currently Incarcerated or Recently Released Men Program suggest several recommendations to be considered by OWH, Women Partners grantees and other stakeholders interested in HIV prevention among women affected by the criminal justice system. The following is a set of recommendations categorized by recommendation type.

**Program Development**

- Incorporate realistic pre-release planning regarding healthy relationships with women both before and after their partners are released;
- Develop programs for children and adolescents affected by the criminal justice system;
- Retreat style programs, while resource intensive, provide a valuable and innovative program platform to provide gender-responsiveness, build community, and offer more program time and much needed respite for women;
- It is important to incorporate some level of understanding for men on the inside and make “non judged space” for women who choose to remain in their relationships with their incarcerated male partner;
- Due to the prevalence of domestic violence and abuse in many of the participants lives, programs should include trauma informed elements that are provided by trained and supported staff;
- Local mental health providers should be screened and/or trained to ensure that they provide trauma informed and gender responsive treatment services before referrals are made;
- Incorporating and/or staffing programs with individuals with lived experiences related to HIV and incarceration brings a deeper level of authenticity and reality to the program;
- Due to the complexities of their lives, women need more ongoing services and support after WP programs to sustain the level of support developed during the program;
- Include men in some components of programs for women and/or develop programs for justice involved men;
• Programs need to develop environments that are non-judgmental, non-stigmatizing, sex positive and include harm reduction messaging. Scare tactics and fear-based messages should not be included;

• Women partners in many of these programs were in intimate relationships with both other women and men. Thus there is a need to include and/or create programs for lesbian, bi-sexual and women who have sex with women as well as women in heterosexual relationships with men;

• These programs draw women from a wide range of ages – thus it is important to develop and/or adapt programs to meet the age specific needs and safer sex messaging for women of different ages or stages in their lives such as early childbearing years and/or pregnancy prevention; raising children + pregnancy planning; perimenopause and/or menopause.

Policy and Research Development

• Giving women gender responsive tools that they can adapt to the circumstances of their own lives should focus on relationships and process rather than outcomes;

• Defining relationships and partnerships is complex and fluid. Thus population-sensitive policies and programming must be responsive to the realities of how men’s incarceration and re-entry influence women’s perceptions of relationship status, particularly what one could term the “concurrent monogamy” of having multiple steady partners in one’s life, only one of whom is available for a sexual relationship at any given time;

• For future policy and research directives, strong efforts must be made to provide more nuanced indicators of relationship status than “married” and “unmarried” or “steady” and “casual.” Potentially important measures include how long someone has been involved with a specific partner, how a woman defines main or primary partner, whether she intends to continue a relationship with him, whether they have had children together or intend to have children together, and whether their relationship has weathered one or more incarceration cycles.
ABOUT THE EVALUATORS, THE BRIDING GROUP

Founded in 2008, The Bridging Group (TBG) is a consulting firm focusing on the effect of incarceration on the public’s health, families, and community re-entry. The company’s expertise includes: 1) Capacity Building Assistance & Technical Assistance; 2) Evaluation & Research; 3) Fund & Program Development; and 4) Training, Education & Dissemination. Together, the principal consultants have over 50 years of experience working on the development, implementation, and evaluation of programs serving individuals and families affected by the criminal justice system. In addition to the principal consultants, The Bridging Group works with a team of affiliated consultants who represent some of the country’s leading experts in criminal justice-based program development, training, evaluation, and dissemination. TBG staff has extensive experience working with government agencies, academic, and research institutions, as well as non-governmental community organizations at the U.S. local, state and federal levels and has worked with government agencies and NGOs all over the world. TBG also has a strong community/ academic partnership with the University of California, San Francisco.

For more information about The Bridging Group, please visit www.thebridginggroup.com or contact them at info@thebridginggroup.com.
APPENDICES

Appendix A: Study Enrollment Form
Appendix B: Baseline Survey
Appendix C: Post Intervention Survey
Appendix D: 30-Day Follow-up Survey
Appendix E: Participant Focus Group Guide