Female Offenders and HIV/AIDS
Prevention and Managing the Continuum of Care
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>05</td>
</tr>
<tr>
<td>Demographics and Trends</td>
<td>07</td>
</tr>
<tr>
<td>Key Perspectives</td>
<td>11</td>
</tr>
<tr>
<td>Recommendations for Prevention and Treatment</td>
<td>15</td>
</tr>
<tr>
<td>Designing Prevention and Treatment Interventions</td>
<td>21</td>
</tr>
<tr>
<td>Evaluation and Continuous Improvement of Programs and Services</td>
<td>23</td>
</tr>
<tr>
<td>Other Management Considerations</td>
<td>24</td>
</tr>
<tr>
<td>Conclusion</td>
<td>27</td>
</tr>
<tr>
<td>Resources</td>
<td>28</td>
</tr>
<tr>
<td>References</td>
<td>30</td>
</tr>
</tbody>
</table>
The Centers for Disease Control and Prevention (CDC) estimates the rate of HIV/AIDS cases in the United States (U.S.) per 100,000 African American female adults and adolescents (60.6) was nearly four times higher than the for Hispanic female adults and adolescents (16.0), and nearly 20 times higher than the rate for Caucasian female adults and adolescents (3.3). Furthermore, African American women have an HIV-related mortality rate 13.8 and 15.7 times higher than Caucasians for the 25 to 44 and 45 to 64 age groups respectively.\(^1\) In fact, AIDS was the leading cause of death for African American women aged 25 to 34 years from 2001 to 2006.\(^2\)

Incarcerated adult women are also more likely to be African American. Their rate of incarceration is 3.8 times higher than for Caucasian women, and 2.4 times higher than for Hispanic women.\(^3\) Individuals at risk for incarceration are also more likely than others to be at high risk for HIV infection. As elaborated in this booklet, this is particularly true for females, as prisons are the only known setting in the U.S. where HIV prevalence is higher in females than in males, with about 2.6% of female and 1.8% of male state prison inmates known to be HIV-infected.\(^3,13\)

Because female offenders often return from detention, jails or prisons to highly concentrated and economically depressed communities with little access to health and HIV/AIDS services,\(^4\) time spent in correctional institutions can provide an important opportunity for them to learn about their HIV infection, cope with their diagnosis, understand their medical options, and develop skills to avoid passing on the virus to anyone else. Additionally, discharge planning, transitional HIV/AIDS services, and the prevention and treatment services provided by local faith- and community-based organizations (F/CBOs) can be a stabilizing force for HIV-positive female offenders. These services can ease their transition back into their communities and provide the needed support to decrease the likelihood that they will revert to the maladaptive behaviors that led to their institutionalization (see also the NMAC booklet *Hitting the Bricks: Working with Ex-Offenders Living with HIV/AIDS* for more information). This booklet presents HIV/AIDS prevention and treatment interventions premised on the need for these interventions to be gender-based and part of a seamless, system-wide approach designed to improve measurable outcomes over the long-term for female offenders.
**Target Audiences:** This booklet is meant to serve as a guide for corrections practitioners and F/CBOs who work with female offenders when they are institutionalized and when they return to the community. It will also be useful for policy and funding decision-makers and social advocacy groups.

**Organization of the Booklet:** The booklet will first provide the reader with statistics and trends related to women and HIV/AIDS in the U.S. general population, the characteristics of the female offender population within the criminal justice system, and the extent of additional challenges associated with HIV/AIDS. This is followed by an overview of two key theoretical perspectives for successfully designing and implementing prevention and treatment interventions with the female offender population—the Pathways Perspective and the Systems Perspective. A person-centered case planning and tracking approach for addressing female offenders’ high-risk behaviors and managing the complexities of abuse, physical and mental health, substance abuse and other issues is described. This discussion emphasizes applying both the Pathways Perspective and the Systems Perspective to developing and implementing a comprehensive long-term prevention and treatment response to address not only HIV/AIDS, but the multifaceted problems underlying female offenders’ high-risk behaviors. The booklet then presents ways that F/CBOs can more effectively address female offenders’ needs including how to evaluate and improve or replace those programs that are not achieving measurable outcomes and build the internal and external capacity of F/CBOs to better meet the needs of the clients they serve. This discussion is followed by conclusions and additional resources.

**Use of Terms:** For the purposes of this booklet, the term “female offender” refers to both women and girls. Most of the research on statistics and trends, including the discussion related to prevention and treatment interventions presented target adult female offenders—those women aged 18 or older, who are institutionalized. The term “female ex-offender” refers to a woman who has been released from a correctional institution. The term “communities of color” refers to African Americans, Hispanics, Asian and Pacific Islanders, and American Indians/Alaska Natives.
Demographics and Trends

Women and HIV/AIDS: The General Population

Women make up a growing proportion of people living with HIV/AIDS in the U.S. In 1992, women accounted for 14% of all adult and adolescent HIV/AIDS cases. By 1997, their percentage rose to 22%, and in 2007, they accounted for about 26% of the estimated 42,495 diagnosed adults and adolescents. African American women in the 16 to 21 age group were seven times as likely as Caucasian women to be HIV-positive.

From 2003 through 2007, an estimated 48,104 AIDS cases diagnosed among female adults and adolescents were attributed to either high-risk heterosexual contact or injection drug use. Among female adults and adolescents diagnosed with HIV/AIDS in 2007, 83% of the cases were attributed to high-risk heterosexual contact while 16% were attributed to injection drug use. Figure 1 further breaks out causes of HIV transmission by race and ethnicity.

Case Study: Felicia

Felicia is a 22 year-old African American female. She has been given an 18-month sentence on a drug-related charge, and has never before been institutionalized. Felicia was advised at her medical intake that she should consider an HIV test. Felicia refused testing, but asked if she could get the test later if she changed her mind: “I never thought about my risk for AIDS before, but I had sex with my boyfriend without protection. I know he doesn’t have HIV, but I wonder if I should get tested just to be safe. I don’t know if I want to get tested in jail because I don’t want everyone else here knowing my personal business.”
According to the CDC research, the rate of HIV among females aged 16 to 21 is 50% higher than among males in that age group. Young women are at a greater risk of contracting HIV for several reasons, including:

- Biological reasons (e.g., having untreated sexually transmitted diseases)
- Lack of awareness
- Not knowing their partners' risk factors (e.g., a history of unprotected sex or injection drug use)
- Feeling less power in relationships
- Having sex with older men who are infected

While HIV transmission does occur in custody, most HIV-infected inmates are likely infected prior to entering jail or prison.

**Women and HIV/AIDS: The Criminal Justice System**

As stated, institutionalization in the criminal justice system represents an important opportunity for reaching HIV-positive women, and women who are at the highest risk for HIV/AIDS. In 2007, women comprised about 7.1% of the population in U.S. correctional institutions, and their numbers are rising fast. From 1990 to 2000, the number of women in correctional institutions doubled. Then from 2000 to 2007, it increased an additional 23%. Figure 2 shows the different rates at which African
American, Caucasian, and Hispanic women face institutionalization in the U.S.

Institutionalized women are almost 35 times as likely as women in general to be living with HIV/AIDS in the U.S., with rates in some states more than four times higher than that. For example, by year end 2006, in the New York (12%), Florida (7.6%), and the New Jersey (7.2%) correctional systems, the rate of HIV positive females were 160, 100 and 96 times that of the general population, respectively.

The rate of infection for institutionalized women is 53% higher than the rate of infection for institutionalized males. Racial disparities also exist in HIV incidence among female offenders. Among female offenders, as stated, African American non-Hispanics (3.4%) and Hispanics (2.7%) were about six times as likely as Caucasian non-Hispanics (0.5%) to be HIV positive.

**Women and HIV/AIDS: The Effects of Behavioral Interventions**

Successful prevention efforts require an understanding of the behavioral factors that contribute to HIV transmission. Condoms are highly effective in preventing sexual transmission of the HIV virus, but often are not used. HIV counseling and testing has been shown to reduce high-risk behavior by about 68% among individuals who learn they are infected.
Most behavioral interventions reduce risk by between 20% and more than 40%. While such intervention programs have been found effective where implemented, it is the F/CBOs that are in the best position to increase their reach and accelerate progress in prevention efforts.

Related to designing prevention efforts, it is important for F/CBOs to understand that behavioral factors that account for HIV infection vary by age. According to the CDC research, injection drug use was responsible for 25% of AIDS cases in women age 35 to 44 years and 28% among females age 35 years and older—far more than the 8% of cases in females age 13 to 19 years, and 12% in women age 20 to 24 years. Among females age 13–19 years, 43% of HIV/AIDS cases were caused by HIV transmission around the time of her birth. Although everyone is potentially at risk for HIV/AIDS, these statistics show that the HIV/AIDS epidemic has not affected all population groups equally and prevention efforts should be targeted accordingly.

**Case Study: Tamara**

Tamara, a 23 year-old Caucasian female, has just been given a release date after serving six years for a violent crime. She tested positive for HIV while institutionalized, and has taken part in a peer support group for HIV+ offenders. She is taking HIV medications that are keeping her viral load undetectable, but she has a difficult time with some of the side effects. At her first meeting with the HIV discharge planning case manager, Tamara said that she was both excited and scared to be released. She hasn’t told her teenage daughter, who has been living with Tamara’s mother, that she is HIV-positive. “I want to be a good mother to my child, and to show her that she shouldn’t be ashamed of me. But I don’t want her to be discriminated against or teased because her mother has HIV. I don’t know how I can take all those pills.”
Key Perspectives

Pathways Perspective

Successful HIV/AIDS prevention and treatment interventions require a deep understanding of female offender behavior. The research on female crime and delinquency finds that gender matters significantly in shaping the behavioral patterns of criminal offending. Specifically, the most common pathways to crime for women include the following issues:

- **Histories of Personal Abuse**: Female offenders have histories of sexual and/or physical abuse that appear to be major roots of subsequent delinquency, addiction and criminality. Abusive families and battering relationships are also strong themes in the lives of female offenders that may lead to juvenile runaways, prostitution, property crime, and drug use.

- **Mental Illness and Substance Abuse**: Emotional disconnections contribute to criminal pathways. Many women suffer from some form of mental illness or co-occurring disorder, with nearly 8 in 10 mentally-ill female offenders reporting having experienced prior physical or sexual abuse. The link between female criminality and drug use has been found to be very strong as well.
**Economic and Social Marginality:** Economic difficulties, often shaped by disconnections from school, work and families, further increase the likelihood of criminal behavior.

**Homelessness:** A result of severed social relations, economic vulnerability, addiction and abuse, homelessness is a frequent complication in the lives of female offenders.

**Relationships:** Criminal involvement was often found to have come about through relationships with family members and significant others.

Research using the Pathways Perspective continues to add to the portrait of female offending. For many young girls from poor families, the Pathways Perspective provides a portrait of law breaking as a resistance to victimization. Dislocated from family, education, and legitimate occupations, these girls may experience sustained criminal involvement as a rational coping strategy. These issues are exacerbated for African American women, who in addition to the cumulative effects of poverty and under-education, are also impacted by the war on drugs, disparate sentencing laws, and the like.

**Systems Perspective**

In addition to understanding the Pathways Perspective, it is important for F/CBOs and HIV/AIDS service providers to understand and apply the Systems Perspective “lens” when designing and implementing prevention and treatment interventions for female offenders. This will better enable F/CBOs to understand not only the complex system of interactions, interventions and influences that contributed to female involvement in the criminal justice system and lead to HIV risk behaviors, but also how to create a seamless, system-wide approach to improving outcomes for them. This perspective includes focusing not only on the symptoms of female offenders’ drug problems or health care needs, but also viewing prevention and treatment interventions as opportunities to uncover and assess the root causes of those problems that may have the greatest impact on:

- Reducing the female offender population
- Reducing HIV infection rates
- Reducing mortality among those already infected
- Doing all of the above in a resource efficient way
In summary, to break the cycles of female offenders’ high-risk behaviors—both criminal and in terms of health risks—F/CBOs must, from both a gender and systems perspective, develop, evaluate and refine their prevention and treatment interventions to better predict the future—they need to look at how the system is functioning and where it is leading for each individual. Related to HIV/AIDS prevention and treatment, these perspectives include asking:

- What are the best types of HIV/AIDS short- and long-term prevention and treatment interventions for women when they are institutionalized and when they return to the community?
- How do these prevention and treatment interventions avoid treating individual risk factors in isolation, and instead recognize the complexity of female offenders’ situations, many of whom have histories of trauma, substance abuse, and mental health problems prior to their institutionalization?

Applying the Pathways Perspective and the Systems Perspective to developing and implementing prevention and treatment interventions will increase the likelihood of their success. Applying these perspectives also requires the F/CBO, corrections practitioners, and/or other case workers to assemble multi-disciplinary staff to regularly discuss and develop rehabilitative services to treat female offenders’ long-term
prevention and treatment needs. Coordination between the correctional system and the array of public, private, F/CBOs increases the likelihood of effective service delivery by limiting operational gaps in the continuity of care. Gender responsive case management seeks to reduce the high-risk behaviors that lead to female offenders’ involvement with the criminal justice system and increase the health and well-being of women, their families, and their community. It is inclusive of the person-centered case management model described further below.

According to the Reentry Policy Council, effectively coordinating treatment inside the correctional institution with that in the community requires cooperation between nearby F/CBOs, substance abuse treatment providers, corrections, and other community providers. Such efforts ideally enable female offenders to continue seeing the same primary care providers or substance abuse professionals after reentry to the community as they saw during institutionalization. If that is not possible, corrections personnel, at a minimum, can provide opportunities for female offenders to develop relationships with community providers during the months before release.

An example of this principle in action is Project Bridge in Rhode Island, which provides a variety of services for HIV-infected male and female offenders. As described by the Reentry Policy Council, “First, Brown University or Miriam Hospital-based infectious disease specialists treat HIV-infected inmates within the correctional system. In addition, approximately 60 days prior to a person’s release, a two-person team from Project Bridge (an outreach worker and a social worker) approaches potential participants to develop a treatment plan. Upon release, project participants usually see the same medical providers they saw while they were in prison. Moreover, the team members provide reminders and transportation assistance for medical appointments, facilitate communication with hospital staff, and help participants obtain other social services, including substance abuse treatment.”
Recommendations for Prevention and Treatment

Applying the Pathways Perspective and the Systems Perspective also involves identifying and addressing family planning and prenatal care services, substance abuse treatment, HIV/AIDS education, medical testing and care for coinfections or other conditions, literacy, language and basic skills assessment, mental health, housing, food, transportation, clothing, employment, or benefits as needed for each female offender. Specifically, HIV/AIDS-related recommendations for prevention include developing a strategy for comprehensive HIV/AIDS prevention, addressing HIV risk factors and providing education and care for HIV prevention during pregnancy. Recommendations for treatment include providing person-centered case planning and tracking inclusive of addressing depression and other mental health disorders, drug and alcohol use, coinfections, self-esteem issues and parenting issues.

Prevention

The National Institute on Drug Abuse states that, “Comprehensive HIV/AIDS prevention, which includes the strategies and components of community-based outreach, drug abuse treatment, and sterile syringe access programs—all in combination with testing and counseling for HIV and other infections—currently is the most effective approach for preventing the spread of HIV, other blood-borne infections, and STDs in drug-using populations.”

Offender-led prevention intervention has been found effective as it fosters greater mutual trust and cooperation. As many correctional systems do not have the expertise or means to adequately deal with the health need of inmates, collaboration with public health programs and departments is recommended.
**Address HIV Risk Factors**

To identify women’s risk factors for HIV/AIDS and other infectious diseases, medical evaluations in correctional institutions (and intake procedures with social service workers) should include questions about a number of social factors. A woman's history of physical abuse, sexual abuse, sexual assault, domestic violence, commercial sex work, and drug use all may have a direct impact on her risk for HIV/AIDS, as well as the appropriate course of HIV/AIDS counseling, education, testing, treatment, and case management.

Because institutionalized women may have multiple sources of HIV risk in their lives, and because they may have limited access to HIV testing and counseling services outside of correctional institutions, there should be multiple opportunities for women to agree to HIV counseling and education while they are institutionalized. Education and testing services should be offered on multiple occasions, especially to women who:

- Are pregnant
- Have a current or prior STD diagnosis
- Have abnormal Pap smear test results
- Have Hepatitis B or C
- Have a history of sex work
- Have a history of sexual abuse
- Have a history of drug use

**Provide Care for HIV Prevention During Pregnancy**

The following precautions, taken both inside correctional institutions and in the community, will help the female offender’s unborn baby have a very low chance of getting HIV—less than 2 in 100:

- Providing medical care that treats both the pregnancy as well as HIV infection.
- When going into labor, possibly administering additional drugs to prevent passing HIV to the baby during childbirth.
- Avoiding breastfeeding—the HIV virus is in breast milk—so the mother will need breast care training while lactating.
- Arranging for the newborn to receive their medications to prevent HIV soon after birth and check-ups and tests over the first several months to determine if HIV has been transmitted.
Female Offenders and HIV/AIDS

HIV and STDs

Institutionalized women tend to have high rates of sexually transmitted diseases (STDs), vaginal infections, and abnormal Pap smears. In one study, more than three-quarters of newly institutionalized women had abnormal Pap smears; more than half had vaginal infections or STDs.26

High rates of STDs are associated with high risk for HIV for three main reasons:

1. Unprotected sex that results in the transmission of an STD could also result in HIV transmission.

2. STDs can cause genital lesions that can increase a man's or a woman's susceptibility to HIV infection. In addition, STDs increase the number of CD4 cells in a woman's cervical secretions. CD4 cells are target cells for HIV, and thus can increase a woman's susceptibility to HIV infection.

3. If a person is coinfected with HIV and an STD, which can result in more “shedding” of HIV, the coinfected person is more likely to infect another person if they engage in high risk behavior, such as unprotected sex or sharing needles.27

Testing

Early testing is a priority for effective treatment of HIV/AIDS and prevention of its transmission to others. As of 2006, only 21 states reported testing all inmates for HIV at admission or sometime while in custody. Most states, and the federal system, only test upon request by the inmate, if there was potential exposure to HIV or for members of high-risk groups.28,13

In 2009, the CDC published guidelines on HIV testing in correctional settings that advocate testing all inmates with an opt-out approach, where the inmate is informed that an HIV test will be performed unless they decline. This approach is intended to reduce the stigma associated with
testing, and improve early diagnosis and access to care and prevention.\textsuperscript{28} Efforts to improve HIV detection and treatment in correctional institutions may be paying off as evidenced by a positive trend in AIDS-related deaths. Between 2001 and 2005, the rate of AIDS-related deaths as a percent of all deaths in the prison population was nearly cut in half from 10.3\% to 5.3\%, while the rate in the general population remained stable at about 4\% over that time period.\textsuperscript{13}

**Addressing Depression and Other Mental Health Disorders**

Depression and other mental health disorders are prevalent among people living with HIV/AIDS and those in correctional facilities\textsuperscript{29} and may also be one of the most important variables affecting the success of HIV/AIDS-related prevention, treatment and social services. A study assessing HIV risk behaviors among female offenders found that PTSD was associated with and may contribute to high rates of risky sexual behavior, including prostitution. Therefore, targeted HIV risk reduction efforts among female offenders should include evaluation for PTSD; and those with a diagnosis of PTSD should be evaluated for prior HIV sexual risk behaviors.\textsuperscript{30}

**Addressing Drug and Alcohol Use**

In addition to mental health issues that individuals at high risk for HIV/AIDS, female offenders also have a high rate of involvement with drugs and alcohol. Female offenders are 5 to 8 times more likely to abuse alcohol than other women, ten times more likely to abuse drugs, and 27 times more likely to use cocaine.\textsuperscript{30} More female than male offenders report that they were under the influence of drugs when they committed the offense for which they were institutionalized, and more female than male offenders report regular drug use (though men report more alcohol use).\textsuperscript{11} These sex
and drug-related risk behaviors, coupled with the shared racial disparities among HIV-positive and institutionalized women, help explain the high rates of HIV/AIDS among them. They also help define the gender-specific aspects of quality HIV/AIDS services for institutionalized women.

**Addressing Coinfections**

Hepatitis C virus (HCV) is the most common chronic blood-transmitted infectious disease in the U.S. today, and institutionalized individuals have a nine times greater rate of infection than the general population. Studies indicate that among those in the general population with the virus, one-third or more pass through a correctional facility within a year’s period.\(^{31}\) Data from several states indicates that female offenders have even higher rates of chronic HCV than male offenders, so the HIV/HCV coinfection rate may also be very high among women.\(^{32,33}\) It has been estimated that up to 80% of HIV-positive male offenders are coinfectected with HCV.\(^{34}\)

HCV has a complex interaction with HIV infection in that HCV leads to liver damage more quickly and may also affect the treatment of HIV infection. Therefore, it is important for HIV-infected persons to know whether they are also infected with HCV and, if they are not, to take steps to prevent infection. Many people with HCV do not have any symptoms of the disease.\(^{35}\) Even if female offenders are not able to obtain testing and treatment for hepatitis within correctional institutions, case managers should be aware of this important health issue, and should be able to link clients with hepatitis resources in the community after release.\(^{36}\)

**Treating Self-Esteem Issues**

In institutional settings, female offenders have very little opportunity to exercise personal decision-making. It follows that the more time they have spent in an institutional setting, the more likely they will have self-esteem issues which, in turn, impact the effectiveness of prevention and treatment efforts. For this reason, F/CBOs should, as part of their case management, offer female offenders a “debriefing” period in which the focus is on empowering the female offender to help her develop a strong sense of self and personal responsibility in addition to addressing health and other rehabilitative needs.\(^{37}\)
Addressing Parenting Issues
Sixty-two percent of women in state correctional facilities and 56% in federal facilities are reported to be mothers, and family responsibilities are often the top priority for parents being released. HIV/AIDS services for female offenders and ex-offenders should address family issues such as foster care, family reunification, parenting education, child care, guardianship planning, domestic violence prevention, and victim services.

Despite women comprising a small percentage of institutionalized parents, they are significantly more likely to have been primary caretakers of children prior to entering the institution and are more likely to plan to return to that role upon release. This means that these mothers are concerned with their children’s day-to-day welfare, since incarceration may have disrupted their family and may have caused children to move. While 90% of children of male offenders live with their mother during their father’s institutionalization, only 28% of children of female offenders live with their other parent. Rather, 52.9% live with grandparents, 25.7% live with other relatives, and 10.4% live with friends/others, while 9.6% live in non-relative foster homes. An additional complication for maintaining family connections is that the limited number of facilities for female offenders makes visitation especially difficult, since children and caregivers may not be able to travel the long distances required.

Female offenders who are mothers, therefore, face all of the challenges of other female offenders, including higher likelihood of overcoming physical, sexual and emotional trauma, and health-related issues, but also confront the stress of a threatened mother-child relationship (whether through action like a Termination of Parental Rights petition or through lack of contact). Those female offenders also face the need to care for chronic health conditions like HIV/AIDS, and the risk of infecting their children, or the care for children already infected. These women can greatly benefit from a focus on HIV/AIDS prevention education as well as parenting skills classes, e.g., anger management, how to interpret children’s behavior, and how to administer positive discipline. For mothers who are institutionalized, parenting skills classes may also include how to “parent” from a distance, e.g., understanding the role of a parent, the effects of incarceration on the family and child, how to answer children’s questions about incarceration, and how to communicate with their children through letters, pictures, and telephone calls.

F/CBOs that help women address parenting challenges can increase the likelihood that her children will not follow in her footsteps.
Designing Prevention and Treatment Interventions

Build HIV/AIDS Programs Specifically for Women That Address Their Multi-Faceted Needs

The most effective HIV/AIDS services for female offenders are often designed from the ground up with women in mind. The National Institute of Corrections,11 the National Institute of Justice,43 and other researchers44 and model programs45 have studied prison-based programs for women, and describe the characteristics of quality services designed specifically for women:

- Programs provided in a physically and psychologically safe space
- Women-only programs
- Skilled staff who are able to respond to expressions of emotion, and are willing and able to communicate openly with female offenders
- Women staff and peers who provide strong role models and mentors for program participants, including ex-offenders and ex-addicts
- Programs that address self-sufficiency, self-esteem, and empowerment
- Programs that use a non-aggressive management style, i.e., less authoritarian than traditional male-oriented prison programs, and
- Programs that affirm supportive relationships among program participants.

Use Peer-Based Formats

Since the beginning of the HIV/AIDS epidemic, peer-based HIV/AIDS programs have been a particularly effective service delivery strategy for institutionalized women. Some model programs were designed and founded by female offenders with eventual support from prison staff and administrators.46 Community peer-based programs such as AA and NA have also achieved extraordinary success.
Peer-based programs, by design, have many of the important program characteristics found to be effective for women, particularly increasing self-esteem, building supportive relationships among participants, providing role models to whom participants can relate, and using a nonaggressive program style. The fact that female offenders living with HIV/AIDS take it upon themselves to design peer-based programs speaks to the perceived power of such programs to help women cope with the impact of the virus behind prison walls as well as when they return to the community.

Case Study: Liz

Liz is 32 year-old Hispanic female who was released from jail three weeks ago, after serving three months. She tested HIV-positive when she was 28 years old, and she has never been on treatment. Liz has a history of heroin use, and says she has had trouble staying clean since she was released. Her case manager sees a home pregnancy test in Liz's purse when they meet. She asks Liz about it, and Liz becomes upset. She says she thinks she may be pregnant, and she wants to talk about getting clean and learning about what else she can do to not hurt the baby. Liz has a 14 year-old son and 6 year-old daughter who are in foster care.
Evaluation and Continuous Improvement of Programs and Services

Truly effective programs need two qualities: (1) the willingness to throw out old ways of doing business when the data shows they are not effective, and (2) the tools and ability to gather and analyze the right data to notice.\(^48\)

In an environment of multiple F/CBOs working with multiple correctional jurisdictions and public service agencies, it is common for incomplete information about each offender to be found in numerous unconnected database systems and paper records. The concept of a unified Health Summary report and an integrated Transition Accountability Plan (see also the NMAC booklet, *Hitting the Bricks: Successful Reentry of Offenders Living with HIV/AIDS*, for more information) are manual attempts at bringing important data together in a useful way. An investment in coordinating data gathering and tracking results over the long-term (even following up years later) could have a substantial payback in terms of program changes to help the F/CBOs be more effective for years to come.\(^49\) While an integrated and automated data sharing system across correctional jurisdictions, F/CBOs, and treatment facilities in the community is the ideal, all practical steps in that direction can have paybacks in terms of understanding the most appropriate services for female offenders and learning which programs are most effective.
Other Management Considerations

Environment

Female offenders face a world that is often hostile to “ex-cons,” and being made to feel unwanted or feared can drive them away from seeking badly needed services. While they might be reluctant to admit it, even trained staff in the helping professions can harbor stereotypes and preconceptions about female offenders.

An F/CBO can work with staff to replace prejudice with facts:

- Many F/CBOs provide specialized training for staff on issues of multiculturalism and diversity—similar training can also be used to help staff learn to work effectively with female offenders.
- Other agencies experienced in working with female offenders will often be willing to share their experiences with other F/CBOs if approached.
- If no other F/CBO in the area has this type of experience, then other organizations working in the criminal justice field, such as parole offices, county sheriff’s departments or other law enforcement-oriented groups can be approached.
- Before committing to any training, be sure to review the proposed curriculum or presentation to ensure that the training will inform and encourage staff in their work.

Placing staff with significant experience (either professional or life experience) in some key service areas can help create a prevention and treatment friendly environment. For example, many F/CBOs run a wide range of support groups catering to a variety of populations and needs. Some F/CBOs have added support groups specifically targeted to female offenders with HIV/AIDS and have altered existing groups to ensure that female offenders feel comfortable and receive attention to their needs. Such groups might be led by ex-offenders or by facilitators experienced in dealing with the issues of female offenders.

Expertise

Often, taking a gendered and systems perspective will lead an F/CBO to reexamine its internal capacity. An F/CBO needs to be willing to adjust guidelines when new evidence about effectiveness (for individuals or populations) comes to light through ongoing data analysis. By focusing
on intended outcomes rather than simply outputs (the direct result of its actions), it may discover that the necessary skills do not presently exist in its own organization or external partners. An F/CBO must then be willing to develop skills in-house through technical assistance, bring in additional personnel, or take a more creative look at partnership opportunities.

Most F/CBOs use front-line case managers to help their clients obtain necessary prevention and treatment interventions. To work with female offenders, an F/CBO should take care to develop staff expertise in key areas including abuse, women’s health, mental health, housing, benefits, and parole, among other topics described in this booklet.

**Diversity**

It is well-documented that patterns of disparity affect prevention and treatment services for communities of color. To deal with these disparities requires corrections practitioners as well as F/CBOs to engage in ongoing collaboration with the diverse racial and ethnic communities they serve. This is a prerequisite especially if their organizational mission and goals include outreach and education. Further, an institution or F/CBO with a diverse workforce is likely to be better able to understand and address the prevention and treatment needs of the female offenders it serves as well as achieve greater validity, relevance and receptivity of these services. It also empowers diverse communities with the knowledge and skills to understand their particular prevention and treatment issues.

Finally, the effective and responsible F/CBO must also be designed so that it can learn from its own experience, which will enable it to continuously improve the quality of the services it delivers. An agency with these capabilities has the highest probability of delivering services that will ultimately integrate the female offender into society as a contributing member. Agencies that are oriented in this way are organized as systems of racially and ethnically diverse individuals, rather than as systems of racially and ethnically homogeneous individuals so common in hierarchically structured management organizations.

**Institute a Collaborative Approach**

The need for improved capacity may go beyond informal linkages to establishing formal agreements to ensure joint planning and coordination among programs and agencies, sometimes including the female offender herself. Useful working relationships can take many forms—from the
one-on-one personal relationships that a case manager develops with a contact at the Department of Social Services to the collaboration of two executive directors seeking a government grant. Good relationships can be forged when staff from one F/CBO visits the facilities of another. When staff have seen a site for themselves, they are often much more willing to make referrals to that site. Face-to-face meetings with other agencies’ staff can lead to confidence that the agencies will do what is best for referred clients and will report any difficulties.

Most non-medical F/CBOs already have agreements with one or more hospitals or clinics serving people living with HIV/AIDS, including those with mutual referral arrangements. In an effort to better serve recently released female offenders, such a relationship can be improved by establishing more personal connections. According to the Reentry Policy Council, the main barriers to F/CBOs forming effective partnerships with state and local governments “stem not from church/state issues, but rather from practical matters—ranging from government officials’ insufficient familiarity with small neighborhood-based organizations and those organizations’ inexperience navigating government bureaucracies.” A practical matter may be as simple as a case manager calling the clinic manager to notify her that she is sending a newly released woman in order to assure that the woman receives the attention she needs to get medical documentation for benefits.
Conclusion

Correctional institutions are home to the highest concentrations of HIV-positive women in the U.S. and these are predominantly women of color. Yet, because women are a minority of those living with HIV/AIDS, and a minority among the U.S. offender population, it is often easy to overlook their needs or to simply try to fit them into interventions designed for men. But women require programs that recognize the life circumstances that brought them in contact with the criminal justice system and that put them at risk for HIV/AIDS. Model programs and research have shown that effective programs for women are not overly complicated or expensive, but they tend to take a more preventive, gender specific and holistic approach to HIV/AIDS rather than “tweaking” traditional programs designed for men. Building interventions that view each participant as individuals with particular behaviors, life experiences and personal learning styles enables F/CBOs to increase the likelihood that the revolving door for the female offender will end—not only for her, but for her children. NMAC encourages those who work with female offenders directly and others interested in improving the long-term behavioral outcomes for female offenders to take advantage of the excellent written resources that have been developed in this field.
Resources

Systems Perspective


Gender-Responsive Perspective


General HIV/AIDS Resources, Including Communities of Color

- National Minority AIDS Council website: [www.nmac.org](http://www.nmac.org); phone:
• AIDS.gov website (see subpopulation pages for women, prisoners and minority communities): www.aids.gov

Reentry and Case Management Resources
• National Institute of Corrections TPC Handbook: http://www.nicic.org/Library/022669
• CDC HIV Prevention Case Management Guidance: http://www.cdc.gov/hiv/topics/prev_prog/CRCS/resources/PCMG/index.htm

Housing Resources
• Federally Funded Housing Choice Vouchers (“Section 8 Housing”) website: http://www.hud.gov/offices/pih/programs/hcv/
• HUD/Office of Public and Indian Housing Customer Service Center phone: 1-800-955-2232; Housing Authority Contact Information website: www.hud.gov/offices/pih/systems/pic/haprofiles
• Housing Opportunities for People with AIDS (HOPWA) Web site: www.hud.gov/offices/cpd/aidshousing/programs; HOPWA Administrative Offices phone: (202) 708-1934
• Reentry Policy Council interactive housing option comparison Web site: http://tools.reentrypolicy.org/housing

HIV/AIDS and Mental Health Resources
• The Body’s Mental Health Web site for those with HIV/AIDS: www.thebody.com/mental.html

HIV/AIDS and Substance Abuse Resources
• For referrals to treatment programs, call the National Institute of Drug Abuse at: 1-800-662-HELP
• The Body’s Substance Abuse Web site: www.thebody.com/whatis/druguse.html
References


33. Maryland Department of Health and Mental Hygiene and Maryland Division of Correction. (2003). Examination of HIV, Syphilis, Hepatitis B and Hepatitis C in Maryland Correctional Facilities.


