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# BRINGING IT HOME: DESIGN AND IMPLEMENTATION OF AN HIV/STD INTERVENTION FOR WOMEN VISITING INCARCERATED MEN

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Incarceration has been identified as a key variable to be addressed in halting the HIV epidemic among African Americans. Our research team has been conducting and evaluating HIV prevention interventions for prisoners and their families since the early 1990s, including interventions specifically tailored to the needs of women with incarcerated partners. This article describes the development and implementation of a multicomponent HIV prevention intervention for women with incarcerated partners, and presents qualitative data from women who participated as peer educators in this intervention. Women with incarcerated partners reported low rates of condom use and HIV testing combined with a lack of information about prison–related HIV risks. We found that peer education is a feasible intervention to reach women with incarcerated partners and that flexibility and inclusiveness are important factors in designing intervention programs for this population.

The United States has the world's highest per capita incarceration rate. In 2005 the national incarceration rate reached 738 inmates per 100,000 United States residents, which is 5 to 12 times higher than the incarceration rate in European countries (Bureau of Justice Statistics, 2003; Harrison & Beck, 2006; International Centre for Prison Studies, 2006). The nation's 2.2 million jail and prison inmates are not a static population. Each year 7.5 million people leave U.S. correctional facilities to return to their home neighborhoods (Hammett, 2000; National Commission on Correctional Health Care, 2002; Travis, 2000), primarily low–income neighborhoods of color (Braman, 2004; Cadora, Swartz, & Gordon, 2003; Clear, 2002; Lynch & Sabol, 2004).

The scale of incarceration in the United States and its concentration among vulnerable populations have led researchers to examine the public health impact of cor-

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rectional confinement. A 2006 report from the National Minority AIDS Council identified incarceration as a key factor to be addressed in halting the HIV epidemic among African Americans (Fullilove, 2006). Other studies similarly have posited that ethnic/racial disparities in incarceration can be linked to health disparities, including disparities in HIV/AIDS (Blankenship, Smoyer, Bray, & Mattocks, 2005; Iguchi, Bell, Ramchand, & Fain, 2005; Johnson & Raphael, 2006). At year end 2004, the prevalence of confirmed AIDS cases among the nation's prisoners was nearly 3.5 times that of the general population (0.5% vs. 0.15%) (Maruschak, 2006). Ninety–three percent of all U.S. state prisoners are male (Harrison & Beck, 2006), and at year end 2004, 1.9% of male state prisoners were known to be HIV positive (Maruschak, 2006). However, because HIV–testing policies in prisons vary by jurisdiction and not all prisoners are required to test for HIV, the actual prevalence of infection is likely to be higher than reported (Lanier & Paoline, 2005).

Our research team has been conducting and evaluating HIV prevention interventions since the early 1990s in California state prisons. Our first project with those affected by incarceration involved evaluating a peer–led HIV education orientation for arriving prisoners at a medium–sized northern California state prison for men ($N$ = 2,295) (Grinstead, Faigeles, & Zack, 1997). Shortly thereafter, we began to target our intervention efforts toward prisoners who were preparing for their release from custody. This work included the development and evaluation of a peer–led prerelease intervention ($N$ = 414) (Grinstead, Zack, & Faigeles, 1999; Grinstead, Zack, Faigeles, Grossman, & Blea, 1999); development and evaluation of a health promotion intervention for HIV–seropositive prisoners preparing for release ($N$ = 147) (Grinstead, Zack, & Faigeles, 2001; Zack, Grinstead, & Faigeles, 2004); and a multisite study to develop and test an HIV, sexually transmitted disease (STD), and hepatitis intervention for young men preparing for release from prison ($N$ = 515) (Grinstead et al., 2005; Wolitski & the Project START Writing Group, 2006).

Early in the course of these studies, men expressed a need for HIV prevention interventions specifically tailored to the needs of women with incarcerated partners. This insight on their part has proven to be highly relevant to the course of the HIV epidemic in the United States. Like prisoners, women of color and low–income women have disproportionately high rates of HIV infection and AIDS diagnosis (Centers for Disease Control and Prevention [CDC], 2004; Dawson, 2005; Whitmore, Satcher, & Hu, 2005; Zierler & Krieger, 1997). Unprotected sexual intercourse (UPI) with an HIV–positive man accounted for approximately 80% of infections for women in the United States in 2003 (CDC, 2004). Recent research has suggested that having a partner who was incarcerated is associated with higher risk of HIV and STD infection (Johnson & Raphael, 2006; Auerswald, Muth, Brown, Padian, & Ellen, 2006). An estimated 20% of male state prisoners are married (Mumola, 2000), and various studies have found that approximately 50% of male prisoners consider themselves to have a primary female partner with whom they plan to reunite upon release from custody (Carlson & Cervera, 1991; Grinstead, Zack, Faigeles, et al., 1999; Jorgensen, Hernandez, & Warren, 1986). A study of low–income African American women that was not focusing on issues of imprisonment found that 22% of participants had a current male partner who had previously been incarcerated (Battle, Cummings, Barker, & Krasnovsky, 1995). Although important strides have been made in HIV prevention for low–income women and women of color (Lyles et al., 2007; Wingood & DiClemente, 2006), existing interventions do not focus on the distinct issues of having a partner who is or has been incarcerated.

In response to prisoners' requests for services for their partners, we conducted formative research with women visiting imprisoned men and we piloted a single–session intervention designed for this population that was taught by a peer educator (Comfort, Grinstead, Faigeles, & Zack, 2000). This work indicated that it was feasible to engage this population in intervention and evaluation activities. However, this single–session intervention did not have a measurable effect on HIV risk behavior among study participants. We decided to conduct further formative research with the aim of developing a multicomponent intervention targeting the specific needs of women with incarcerated male partners.

The first part of this article describes the process of developing and implementing this multicomponent intervention, the Health Options Mean Empowerment (HOME) Project. The second part presents qualitative interview data from women who participated as peer educators in the intervention. By including these data, we demonstrate the peer educators' role as both service delivery agents and intervention recipients. From this unique point of view, the peer educators provide valuable information about the intervention's feasibility and sensitivity to the needs of its target population, as well as the impact of participation in the intervention on high–involvement individuals. Details of this project's evaluation design and procedures, the descriptive survey data, evaluation outcomes of the intervention, and postrelease issues for couples affected by incarceration will be reported in separate manuscripts.

## FORMATIVE RESEARCH AND INTERVENTION DEVELOPMENT

In the course of our previous studies, we broadened our understanding about the individual–level, couple–level, and structural–level factors that converge to create a context of HIV risk for women visiting incarcerated men (Grinstead, Zack, & Faigeles, 1999; Comfort et al., 2000; Grinstead, Faigeles, Bancroft, & Zack, 2001). For example, we learned that prison policies prohibiting sexual contact during the incarceration period can affect women's risk of HIV infection by increasing depression and encouraging UPI upon a man's return to the home as a means of reestablishing closeness and intimacy. Following from this information, we designed a model of HIV risk and risk reduction for women with an incarcerated male partner (see Figure 1). In this model, we postulated five domains that contribute to HIV risk for women upon their partner's release from custody: isolation, misinformation, risk minimization, relationship pressures, and institutional policies. In 2003 we conducted qualitative interviews with twenty women visiting their incarcerated partners to further investigate these domains and to probe for other areas of potential importance for intervention development (Comfort, Grinstead, McCartney, Bourgois, & Knight, 2005).

At the completion of our formative phase, we assembled an intervention development team consisting of the principal investigator, project director, project assistant, qualitative analyst, the two staff members who had conducted the formative interviews, and representatives from our community–based organization (CBO) partner, which focused specifically on providing education and support for individuals and families affected by incarceration. We had previously collaborated with this CBO on numerous projects and found this partnership to be an invaluable component in efforts to provide services to prisoners and their families. In particular, this CBO had cultivated a mutually respectful working relationship with the prison administration, which enabled us to obtain permission to recruit program participants as they waited on state property to enter the prison.

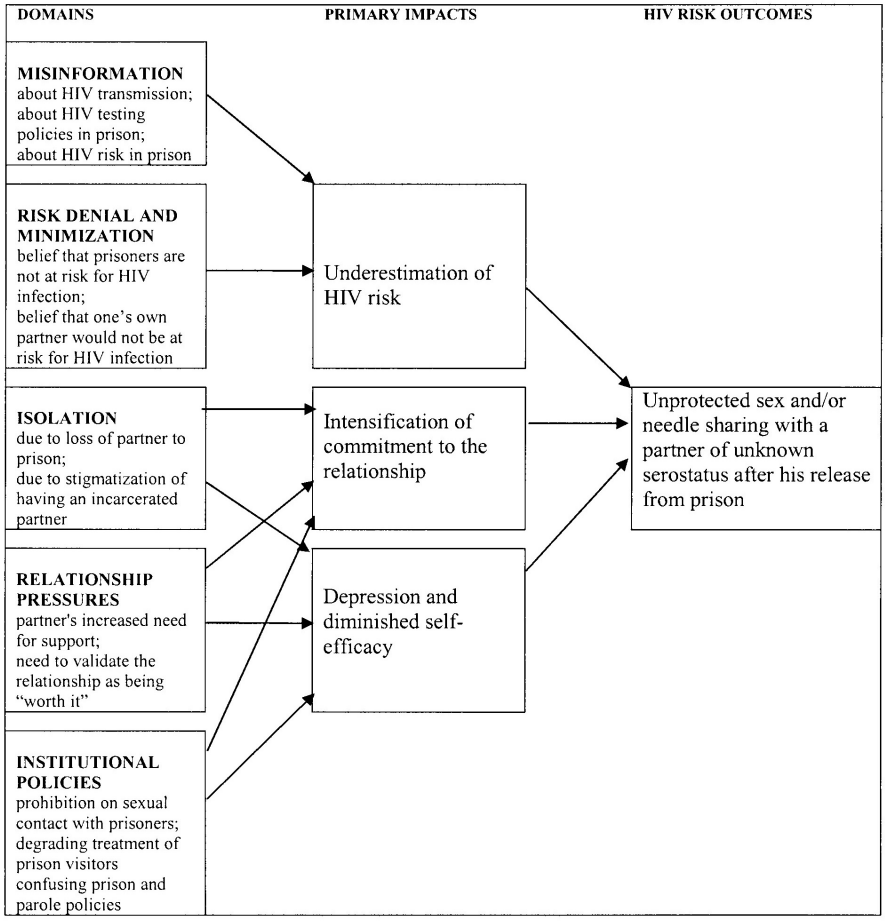


**FIGURE 1. Model of HIV risk and risk reduction for women with incarcerated partners.**

Several considerations guided our intervention development. Findings from the literature on HIV prevention interventions for women show that effective interventions address gender–related influences on behavior, utilize peer educators, and include multiple intervention sessions (Lyles et al., 2007; Wingood & DiClemente, 2006; Wingood & DiClemente, 1996). In addition, we needed to create an intervention that would be acceptable to and feasible for our study population. From our formative research, we knew that logistical considerations were important: women visiting incarcerated men had significant constraints on their time and availability, often were not able or inclined to linger after their visits, and were frequently parenting young children. We also knew that issues of trust and confidentiality were paramount. Women were fearful that anything they disclosed to staff or other visitors might then be repeated to prisoners or correctional officers, and they therefore tended to protect their privacy while at the prison and were suspicious of people who wanted to "get into their business." Finally, our formative research had taught us that HIV was not the top priority of women visiting incarcerated men. Although some women said they

would consider attending a session on HIV, the majority of women we talked with were more interested in receiving information on children's health issues, incarceration and parole policies, and how to access resources for food, housing, and child care. In designing the intervention, we aimed to be responsive to the articulated needs of our population while clearly focusing on sexual health information and behavior change that could prevent the transmission of HIV and other STDs.

## OVERVIEW OF THE HOME INTERVENTION

Our formative research and intervention development work led us to design an intervention that was intentionally flexible, multipronged, and attentive to the stated needs of the visiting community. We named our intervention the Health Options Mean Empowerment (HOME) Project in an effort to appeal to women's interest in health issues beyond HIV and to focus on women's lives away from the prison in their homes and home communities, with an allusion to their incarcerated loved one eventually being "back home." Throughout the intervention we attempted to maintain a neutral stance regarding the women's relationships with incarcerated men. This approach enabled women to participate fully in the intervention even when they were feeling ambivalent about their relationships. In addition, although the HOME project was designed specifically for the needs of women in romantic or sexual partnerships with incarcerated men, all women visitors were encouraged to participate in the intervention activities described in this article. We decided to include mothers, sisters, friends, and other nonpartner visitors in project activities because women visiting prisoners experience exclusion in many areas of their lives, and we did not want to add to these experiences by prohibiting their participation in what at the time was the only program in operation for visitors at this prison. We also anticipated that women visiting their incarcerated partners would benefit from the social support provided by nonpartner visitors (and vice versa).

We fielded our intervention for 12 months (from February 2005 through January 2006). The HOME project took place at a center for prison visitors that is just outside the gates of a northern California prison. The HOME field staff consisted of four women, two who focused on intervention activities and two who focused on program evaluation. In hiring our intervention and evaluation staff members, we assembled a team that reflected the racial/ethnic diversity of the visiting population and that offered a variety of outreach styles (with the hope that visitors would encounter at least one person whose manner would draw them into the program), yet who were united in the program's core principles of making women feel welcome, protecting their confidentiality, and responding to their needs. Training of the HOME staff emphasized the difficulties faced by people visiting incarcerated men and the importance of maintaining participants' confidentiality, as well as HIV and STD risk among prisoners and their partners and other health issues for people affected by incarceration. HOME staff members were present, either in the center for visitors or in the area where visitors wait to enter the prison, during all hours that the prison was open for visiting (all day Thursday through Sunday). HOME staff members would approach women visitors, engage them in conversation, offer refreshments and information about visiting the prison if needed, and tell them about the HOME project.

Of the two intervention staff members for the project, one was primarily responsible for scheduling, coordinating, and facilitating HOME intervention activities. We created an initial list of activities during the intervention development, with the goal of having each activity address one or more of the domains in our model of HIV risk and

**TABLE 1. Sample List of HOME Project Activities**

| Name | Type | Description | Model Domains Addressed |
|---|---|---|---|
| Health fair | Community | Ten service providers from local CBOs and agencies were invited to distribute informational materials and talk with women at tables set up in the prison visitors' parking lot. | Misinformation<br>Risk denial and minimization<br>Isolation |
| Condom demonstration | One–on–one or small group | HOME staff members and/or peer educators demonstrated the correct use of male and female condoms and encouraged discussion and hands–on practice using models. | Misinformation<br>Risk denial and minimization |
| Friday lunch | Community (with opportunity for One–on–one) | Lunch and a guest speaker every Friday during a period when women waited to enter the prison. Guest speakers included nutritionists; nurses; a pediatrician; a former prisoner who successfully completed parole; a parole officer; and service providers working in the areas of employment, substance abuse, family legal services, and educational assistance for former prisoners | Misinformation<br>Risk denial and minimization<br>Isolation<br>Relationship pressures<br>Institutional policies |
| Bulletin boards | Small group (construction) Community (viewing) | Peer educators worked with HOME staff to decorate and routinely update a bulletin board in the area of the prison where visitors wait to enter the prison. Peer educators posted information about prison visiting policies and general and sexual health issues, as well as motivational messages, cartoons, and humor writings. | Misinformation<br>Risk denial and minimization<br>Isolation<br>Institutional policies |
| Letter writing | One–on–one | HOME staff members and/or peer educators provided coaching on writing to politicians and prison officials to advocate for prisoners' rights. Stationery, stamps, and addresses were provided. | Isolation<br>Institutional policies |
| Video: Inside/Out* | One–on–one or small group | The video Inside/Out was developed by members of our research team specifically to address HIV and hepatitis C risk among prisoners and their partners. HOME staff members and peer educators watched the video with an individual woman or a small group and facilitate discussion of the issues raised. | Misinformation<br>Risk denial and minimization<br>Relationship pressures<br>Institutional policies |
| Health van | One–on–one | The HOME project facilitated regular visits of a local county's health van, which had been given permission to park in the prison visitors' parking lot. HOME staff members and peer educators conducted outreach with women visitors and referred them to the van for services, including blood pressure, blood sugar, and HIV testing. | Misinformation<br>Risk denial and minimization |
| Stress reduction | One–on–one or small group | Visitors were offered the opportunity to learn about various forms of stress reduction, such as yoga and acupuncture, from local practitioners. | Isolation<br>Relationship pressures<br>Institutional policies |
| Sexual health chat groups | Small group | A facilitator from a local county Department of Health regularly conducted small–group discussions about HIV, hepatitis C, and other sexually transmitted diseases. These discussions focused on understanding transmission risks and skills–building for talking about sexual risk with a partner. | Misinformation<br>Risk denial and minimization<br>Isolation<br>Relationship pressures |

*Note.* Copies of the Inside/Out video or DVD and an accompanying discussion guide can be obtained by contacting Centerforce, 2955 Kerner Blvd., 2nd floor, San Rafael, CA 94901; www.centerforce.org

risk reduction (Table 1). More activities were added and particularly popular activities were repeated throughout the intervention period. Because one of our intervention goals was to link women to resources in their residential neighborhoods, many of our activities involved inviting a speaker or outreach worker from a CBO or a local service provider to give a presentation, talk one–on–one with visitors, and distribute information materials. These activities happened on average once a week. When an outside speaker was not present, the HOME intervention staff conducted small–group activities such as demonstrations of male and female condoms, discussions of women's health concerns, or coaching on how to write letters to politicians or prison officials to advocate for incarcerated loved ones. Such activities happened on a daily basis, with the intervention staff members choosing the activity in response to the needs or interests of the visitors who were present at a given time. The intervention staff members also were continually available for one–on–one discussions with women who wanted to talk in private; these conversations typically resulted in the HOME staff member making facilitated referrals to pertinent services in women's communities. Women who participated in HOME activities were not remunerated.

The other intervention staff member was primarily responsible for coordinating the HOME peer educator program. Our previous work (Grinstead et al., 1997; Comfort et al., 2000) indicated that prisoners and their female partners react positively to receiving information from peers, and that peer educators themselves gained knowledge and self esteem. Our formative research with women visiting incarcerated men also made clear that constraints on women's time greatly restricted their ability to attend prescheduled, multicomponent group trainings. The peer–educator training for HOME was designed to encourage maximum participation by adapting training and supervision to each woman's schedule. Women who showed interest in the HOME project were informed about the peer educator program and met with the peer educator coordinator, who explained that participation in the program was open to any woman visiting a prisoner who wanted to be involved, was willing to sign a confidentiality agreement protecting information about other visitors, and agreed to meet in person or talk on the phone with the peer educator coordinator on a regular basis for training and supervision. Women who accepted these conditions were scheduled for a peer educator orientation session (which could occur immediately if the woman and the peer educator coordinator were available). Upon completion of this session, the woman was considered to be a HOME peer educator and began receiving a bimonthly remuneration of $50.

During the 1-year intervention period, 14 women completed the orientation session to be peer educators. Thirteen of these women remained in contact with the program and participated as HOME peer educators, and one was lost to follow–up after completing the orientation session. The peer educator coordinator held an individual supervision session with each peer educator in person or on the phone approximately once a week from the time the woman attended the orientation until the HOME intervention was concluded (ranging from 2 to 11 months). Peer educators were invited to continue their participation in the program after the man they were visiting was released from prison; of the 6 women in this situation, all 6 maintained occasional phone contact with the peer educator coordinator and returned at least once to participate in a HOME activity.

Peer educators received training sessions either one–on–one or in small groups as their time permitted. Peer educators who finished six training activities (Table 2) were presented with a certificate of completion. During the intervention period, two

women received this certificate. The remaining 11 peer educators participated in multiple training activities but did not finish all 6 and therefore did not receive the certificate of completion. However, we held two special luncheons honoring all of the peer educators for their efforts on behalf of HOME. These luncheons were open to all prison visitors and included a guest speaker, speeches by the peer educators, and small gifts and certificates of appreciation.

## INTERVENTION FEASIBILITY, ACCEPTABILITY, AND IMPACT: PEER EDUCATOR INTERVIEWS

We conducted in–depth, semi–structured qualitative interviews to obtain in–depth information about the feasibility, acceptability, and impact of the HOME project on women who participated as peer educators and to enrich our understanding of their experiences in the program. All women who completed the orientation session and subsequently attended at least one supervision session with the peer educator coordinator were invited to participate in a qualitative interview. Eleven women agreed to this interview, one declined, and one was unable to be contacted. Between 3 and 6 months after their first interview, the peer educators were invited for a follow–up interview. Nine women agreed to the second interview, 1 declined, and 1 was lost to follow–up. Among the 11 women who participated in the first interview, 2 were Latina and 9 were African American. They ranged in age from early 20s to late 50s. One woman was visiting her son and 10 women were visiting incarcerated partners; half of the women had been in a romantic relationship with this partner for at least 2 years.

The interviews were conducted by a highly experienced qualitative interviewer who was not a member of the HOME project staff. All initial interviews were conducted face–to–face in private rooms at either the visiting center or at our offices at the Center for AIDS Prevention Studies (CAPS). Follow–up interviews were conducted either face–to–face or over the telephone, whichever was more convenient for the peer educator. All interviews were audio recorded and transcribed verbatim. Transcribed interviews were entered into Atlas.ti, a qualitative software product used to facilitate the organization of data. Analysis of the data began with an a priori list of key domains of interest based on the structure of the interview guides. Analysts then engaged in a collaborative open coding process of five randomly selected transcripts. We refined our a priori domains of interest collectively and devised a set of codes that allowed us to identify general themes in the data. The research team met regularly to compare coding experiences and to continue refinement of the codebook. Each interview was coded and verified by a second reviewer to ensure validity. The major thematic areas of concern were summarized and entered into matrixes to allow cross–classification and to visually display the data analysis.

The peer educator interviews provide a unique perspective on the HOME intervention. Peer educators were high–involvement participants in the intervention, receiving extensive one–on–one training and supervision and regularly attending the HOME project activities. Yet they were also service–delivery agents who approached other women visitors to disseminate information, assisted in facilitating HOME activities, and worked side by side with the intervention staff members to create posters, distribute brochures, and conduct other forms of outreach. The qualitative interview data presented in the following sections of this article highlight this dual role of the peer educators, who comment on their experiences being both program participants and service providers. These data thereby provide information from the peer educators' point of view on the feasibility and acceptability of the intervention, as well as the

**TABLE 2. Training Activities for Peer Educators**

| Activity | Description |
|---|---|
| Orientation | Meet with the peer educator coordinator for an overview of the HOME project, the role of peer educators in the HOME project, the importance of maintaining confidentiality (sign confidentiality agreement), and to set personal goals for supervision and training. |
| Inside/Out video | Watch the Inside/Out video with the peer educator coordinator and other available peer educators. Discuss the issues raised, and how peer educators could facilitate a discussion of the video with other women visitors. |
| HIV/AIDS and HCV information session | Learn basic information about HIV/AIDS and HCV in a one–on–one or small group session with the peer educator coordinator. Talk about the special circumstances affecting HIV and HCV risk for women with incarcerated partners, including prison policies about HIV testing and medical treatment. |
| Building resource awareness | Meet with the intervention activities coordinator to review the informational brochures distributed by the HOME project and to learn about local community–based organizations and service providers who participated in HOME activities. |
| Community–building skills | Participate in the designing and decorating of the HOME project bulletin board. Contribute ideas about the information that is important for women visitors. |
| Outreach skills | Meet with the peer educator coordinator to discuss effective outreach skills and how to develop these skills. Set personal goals for conducting outreach with women visitors at the prison and/or with women in the community who have incarcerated partners. |

personal impact they experienced due to their involvement with HOME. This article presents common themes that emerged from the qualitative data; although not all educators spoke to each theme, there was a general level of consensus and no interview participant articulated directly dissenting points of view.

## FEASIBILITY: FACILITATING PROJECT PARTICIPATION

Our aims were for prison visitors to perceive that participation in the HOME project was feasible given the many constraints on their time, that the HOME staff members were sensitive to the issues affecting visitors, and that the project was responsive to the various needs women expressed regarding the health and well–being of their partners, their children, and themselves. Information provided in the qualitative interviews indicated that, from the peer educators' perspective, we were largely successful in achieving these goals. For example, when asked how they became involved in the HOME project, several women indicated that the flexible structure of the program was especially attractive to them because it adjusted to the fluctuating demands they already faced from work, child rearing, and maintaining their relationship with a prisoner. One woman with an 11–year–old child who did not visit her partner regularly owing to her full schedule and the difficulty of obtaining an appointment at the prison explained that she would not have agreed to participate if the program requirements had been more rigid:

> When I met [the peer educator coordinator] she was nice. And she was just over there doing her regular research work and she was just saying, "Would you be interested in—whatever." And I was like, "I don't come a lot." I didn't want to commit myself to something that wasn't—because visiting [my incarcerated partner] wasn't my life, so when I made it [to the prison] I made it, when I couldn't, I couldn't. I had no control over whether I would get a visit [appointment] or not. And I sure wasn't going to get up [in the morning] to come just to the HOME project for like a couple of hours to peer educate when I already had a full time job. So I explained to her that and she was like, "Oh no, whenever you come. No pressure. You just check in. Here's the agenda that we follow and different things that I want you to do. When we finish you'll get a certificate." So I said "Okay." Then [when I was a peer educator] I would come in early or stay a little bit after the visits, maybe thirty minutes to an hour, and we would do different workshops

> and watch movies and meet with the other peer educators. And it was cool . . . It was a convenient program. No pressure . . . [The peer educator coordinator] even made it so that I can do the peer education stuff in my community, meaning I can talk to women who go to prisons, not necessarily the prison where I was doing the peer education at, but just in general, so that was cool.

A common theme across interviews was that the program provided a way to engage in "something positive" that could counterbalance the largely negative feelings inspired by the prison environment. As with the woman cited above, some were lukewarm when first recruited but agreed to the peer educator orientation because it was "something to do" while waiting for their visits:

> It's a good program for people who don't know [about resources they need]. You gotta want to do it though. You can't just do it just to be killing time. At first that's what I thought, "I could do this [to kill time]." But then I got into it and that's when I started recruiting a lot of people [to participate in HOME activities] . . . And whatever they got out for you, as far as helping you with parenting and health and even like a job resource thing, I think they have something like that up there . . . It ain't much, but it's something different, and helpful. Something you can use for when he do come home [from prison]. It's needed, to make a long story short. It's very much so needed.

## ACCEPTABILITY: PROVIDING SUPPORT FOR INCARCERATION ISSUES AND SEXUAL HEALTH

In designing our intervention, we were mindful of the challenges of broaching sensitive and stigmatized topics such as HIV in a correctional setting, which itself evokes feelings of stigmatization and vulnerability. For this reason, we trained our team extensively on the issues affecting prisoners and women visiting incarcerated men, aiming to increase staff members' appreciation of the complex emotions and difficult situations that might affect our participants. One peer educator spoke of her feelings of being accepted and supported by the HOME staff, which contrasted with the reactions she experienced in her family and social relations as a result of her relationship with a prisoner:

> Sometimes I feel like the HOME project is my little source of comfort. I felt like I got close to them, and like I said I feel like they are people that you can talk to and they're not there to judge you, they're there to help you and to educate you and to guide you the best they can in the direction that you may need to go, whatever was going on or what you need questions on or whatever. And I like that because I feel like a lot of times where I went, or just talking with people, I was judged right away as soon as I said the word "prison"—it's a bad thing.

A few minutes later, this peer educator went on to relate how the nonjudgmental tone of the HOME project staff regarding maintaining ties with prisoners reflected a lack of stigma surrounding women's access to information on HIV and her personal comfort level discussing sexual health:

> And I think that it's good that they talk to the women [about HIV] or at least have the information available to them if they want to learn about it. I think that that's good. A lot of people don't go because they're embarrassed or whatever, but I think that is good they give you the option that you can either take it or not . . . So I don't feel as uncomfortable talking about it or picking up and maybe reading about something that I didn't know what it meant as far as a sexual disease or how it could be contracted or whatever. I feel more comfortable sitting and actually reading something like that here [at the program site] than I would anywhere else. I've never picked up anything like that anywhere. I didn't even talk to a doctor about it. I just don't.

Comments such as these emphasize the importance of the training and approach of frontline staff in an intervention project. The peer educators' assessment of the HOME staff was unanimously positive (which, of course, could be at least partly due to the artificial situation of a research interview) with several women spontaneously identifying someone with whom they felt they "clicked." Many women expressed that they found both the intervention and evaluation staff members to be trustworthy and sensitive, qualities we held to be crucial to the success of the project given that we were operating in close proximity to the prison, conducting research on sensitive topics, and trying to get women to participate in activities involving discussions of sexual and other health–related behaviors. In the course of discussing what skills are needed by a peer educator, one woman described herself as modeling the approach of a HOME staff member:

> [The staff member] was sitting outside and I was like, "Man it gets so stressful with these kids explaining to them about sex and menstruation." I told her, "My daughter's starting to get breasts and hair on her private and menstruation and I don't really know how to talk to her about that." That's just like corny, but [the staff member] was like, 'It's better to make it a comfortable experience and talk to her like mommy than wait and let her experience that on her own." So we got into a conversation that lasted for probably 5 or 10 minutes and she was just telling me different ways that I can approach the situation. And I was like, "Okay, yeah that would be better." And I went home and I tried it and it wasn't that big of a deal . . . So [in conducting peer education] I think it's about opening up but it's also about feeling comfortable with the person who you're with as far as the people at the HOME project, like yourself and other people. If they're approachable and they appear to be honest and just like somebody who genuinely cares you can get the person to open up more and want to talk. And that's how the [HOME staff] seem up there to me—and they're not nosey. That is such a big deal to me. Because you've got people that's prying and digging in your business and then you got people that's just doing their own thing and you're kind of like bothering them. Like with [the staff member], she wasn't like dabblin'. I brought it up to her.

## PERSONAL IMPACT: BENEFITS OF A DUAL ROLE

As noted earlier, the decision to include a peer education component in the HOME project stemmed from both our previous research indicating that prisoners and their visitors prefer to receive sexual health information from a peer and from our understanding that women who are trained as peer educators and who participate in outreach activities benefit from the information and skills they acquire. When speaking about the impact of their involvement with HOME, many women described the synergistic benefits of both receiving and delivering intervention services. In one woman's words, "Even though we're peer educating, we're really seein' *ourselves* in the women that we talk to." Another woman responded to a question about how to best communicate information about HIV to visitors by insightfully describing the motives behind the HOME project's peer education program:

> Because it's like having someone learn to be a peer educator, but at the same time they're learning for their selves also. And it was a warm environment . . . So it's like they're learning for their self but not really realizing it because they're learning for someone else. And then a lot of people really enjoyed the fact that there were a lot social events, a lot of things that were going on there. So that played a big part in it too . . . You're learning but you're really not just realizing that you're really learning. It's . . . a subtle kind of thing.

Peer educators indicated that this "subtle" approach of providing sexual health educator training with the intent that the peer educators then provide outreach to other

women made them more receptive to topics they had previously avoided or felt were irrelevant to them:

> Learning about HIV and hepatitis C and sexually transmitted diseases . . . Information is the key. I used to listen to that and I used to think, people make you sick. Every time you turn around they're talking about [official–sounding voice] "You have to be educated on this, and educated on that." Now I know it is very important. But I used to be the one that said, "I ain't going to no classes and take up nothing. I don't want to hear all of that."

A recurrent theme in the interviews was that being a peer educator provided women with a natural opening to initiate conversations about HIV and STD risk not only with women visitors but also with their families and friends. Seeing themselves as "raising awareness" among their kin and community members, peer educators revealed their own increased sexual health consciousness as well:

> [HOME has] opened me up a little bit more. It's allowed me to open up more to my son . . . I'm open up more with my sisters, my brothers, I say "Hey any of you know the statistics, the high numbers?" Because everybody that goes to jail is not there to stay—they're coming out. And who they are in there may not be who they decide to be when they come out. So you have to be aware. So it's helped me out to just open the shade of awareness to more people and if they decide to take it they do, if they decide not to they don't. But I decided to share more.

In another woman's words:

> And the HOME Project gave me more than just trying to be friends and stuff. They was also teaching me and telling me to be safe. It ain't no joke out there, and messing with these men that's in prison . . . I mean, shoot, I helped [HOME] a whole lot too, they be so proud of me and stuff. Because I do go out there and mention about everything that I got taught here . . . I like to go back home and I tell everybody about this. I'm not afraid to tell people that I'm going to prison to see my man, but also when I'm there I go to [HOME] . . . It's help to me. It's given me knowledge to help others . . . I'm 27 years old. I've been doing a whole lot of stuff through my years. And as I get older I get wiser too and being a peer educator and knowing about certain stuff it just really puts something to mind and it helps me out a whole lot.

For many women, their role as peer educators also provided a way of opening a conversation with their incarcerated partner about HIV and STDs, and particularly the taboo subject of risk in prison. Peer educators demonstrated strong interest in the details of life behind bars but frequently mentioned that they had not felt able to ask their partners about sexual behavior and drug use in prison despite the men's repeated incarcerations. Because women met with HOME staff immediately before or after their visits, telling their partners about the day's program and training activities facilitated more personalized discussions of risk and prevention:

> [HOME] made me be curious about what goes on in the prison. I always was curious and I come from the program, and I go in and go visit and I sitting there and tell my husband "So what—?" So I get to talkin' to him and see what he see and see what he know, cause he in there so he could tell me. So he told me a lot of things that cleared my mind.

Another woman explained how she was able to provide information and outreach to her partner:

> When I go see my man too in prison I tell him about [information learned in HOME]. "Did you take your HIV test?" Sometimes I joke about it, but it's serious. So it's basically I talk about it all the time . . . Basically he wants to get a tattoo and I told him about the hep-

> atitis. I was like, "Okay get the hepatitis if you want to." I told him joking like "You gonna get the hepatitis!" . . . He said because I don't have the HIV virus that means that he's okay. But I'm like, "No that doesn't mean that. Did you take the HIV test?" . . . I always talk about it with him. That's been our main conversation in prison because we don't really have nothing to talk about.

As this woman's comments illustrate, many discussions with partners focused on HIV testing in prison and after men's release from custody as prevention behavior. Another peer educator described how she informed her partner that she wanted them to test together when he left the prison, a first in their relationship:

> I told [my partner] about what I learned. And I was telling him about it and I was asking questions about when was his last HIV test. And [saying] we should take one . . . "Here's the list of clinics for you to go to if you need to go to a clinic." And so the information I got from the HOME project I basically gave it to him. And he take heed. Even though we ain't together like that [meaning they were not sexual during his incarceration] I be like, "Don't be bringing me no HIV!" . . . We're a couple, we're together, [testing is] something we should do together . . . Another thing too, me and him wasn't practicing safe sex before he left. I mean when we first got together we was, but two years had gone by so we just got comfortable. So that's another reason why I want to be tested with him.

At her follow–up interview, this peer educator reported that her partner took an HIV test in prison shortly before his release and provided her with the paperwork when he came home, while she tested with her health care provider. Her experience raising this issue with her partner and following through with HIV testing for the first time in their relationship resonates with the comments of another peer educator, who described her efforts to help women open dialogues about risk: "Some people just don't know how to say, 'Babe, let's take a AIDS test' . . . Women are scared to even, like, 'I don't want my husband to think I think like that about *him*.' Or 'It couldn't be my husband.' But, you learn how to say it." In their dual roles as intervention recipients and service providers, women learned to communicate sexual health information to their peers, a skill that helped them "learn how to say it" in their own relationships.

## CONCLUSION

Overall, we found peer education to be a feasible means of reaching women with incarcerated partners, who can experience isolation as a result of stigma, poverty, and other factors and who are generally stressed by the demands on their time. Participants in the HOME peer education program reacted positively to their interactions with project staff, who had been extensively trained to recognize and engage issues affecting prisoners' loved ones. They voiced appreciation for the nonjudgmental approach of the staff, and attributed their comfort in discussing sensitive topics to the project's ethos of acceptance, support, and respect for participants' privacy. We also found that involving participants in the dual role of intervention recipient and service provider can be effective in respectfully imparting sexual health information, enabling women to tailor this information to their own needs, and empowering women to be agents of change not only in their own lives but also in their family networks and communities.

Two factors contributed to the feasibility of the HOME intervention. First, by using peer educators to conduct outreach and assist with activities, we were able to streamline the number of full–time intervention staff members. Second, inviting speakers from community organizations simultaneously allowed us to connect women visitors to services in their home neighborhoods while keeping costs low, be-

cause the services provided by the community speakers fell under the purview of their job responsibilities and therefore they did not charge a fee. Both of these factors also facilitated the daily operations of the intervention, since there was a relatively large pool of peer educators and community service providers who could conduct or assist with outreach and activities.

In addition to program feasibility, our interviews indicated that women with incarcerated partners are at risk for HIV infection. Risk factors described by the HOME peer educators included low rates of condom use and HIV testing with their primary partners, combined with a lack of information about prison–specific HIV risk and difficulty communicating with their partners about sexual health. We also learned that women did not prioritize sexual health issues and were sensitive about raising these issues in the prison context.

The finding that women visiting incarcerated men desire flexibility and inclusiveness in program design may be applicable to other similar situations beyond this study. Although an adaptable, multicomponent design requires additional staff effort, our experience with the HOME intervention demonstrates that such a design allowed women to participate in the intervention who otherwise would not have been inclined or able to do so. This low–threshold approach could be an important consideration in the development of interventions with other groups of at–risk women.

As a result of what we learned in the HOME intervention, we have embarked upon "next steps" in both our programmatic and research development. Our CBO partner recently received funding to continue the intervention as part of its services provided to children and families of prisoners. This intervention will include many of the same components as the HOME project, including the use of peer educators and the flexible, convenient design of their supervision and training. Meanwhile, women's descriptions of their experiences after men's release from prison informed the development of the next step in our program of research, which will be a study of male–female couples after the man leaves prison. We hope that, like the HOME project, this new study will contribute to our understanding of the context of HIV risk and risk reduction among people affected by incarceration. Finally, in addition to journal publications, findings on the intervention feasibility and outcome will also be offered at conferences focused on service providers and specifically to agencies providing services to this population.

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