

Reproductive Justice, Health Disparities And Incarcerated Women in the United States

The intersection of women's reproductive health and rights with the criminal justice system made headlines throughout 2014. Revelations about the coercive sterilization of women in prison rocked California,¹ and across the country, women spoke about the pain and indignity of being shackled during labor.² Meanwhile, officials in Tennessee and Alabama sanctioned the arrest of pregnant and postpartum women struggling with addiction, claiming that incarcerating them protects their fetuses and newborns from future harm.^{3,4}

But other developments show that incarceration is far from safe for pregnant women and developing fetuses. Also in 2014, a pregnant woman being treated with methadone was sent to a jail in Texas that subjects all people using opiates to immediate detoxification and withdrawal,⁵ despite evidence that this can lead to a miscarriage or stillbirth.⁶ Women in Ohio and New York were forced to give birth inside jail.^{7,8} And another woman in Texas filed a lawsuit against a jail for ignoring her when she went into preterm labor. After 12 hours of pleading for help, she gave birth in a cell to a baby whose umbilical cord was wrapped around its neck; the jail nurse did nothing to revive the baby, who died before paramedics arrived.⁹

These events illustrate the high stakes of incarceration for women and the need for greater attention from reproductive rights advocates and health care professionals. On any given day, more than 213,000 women¹⁰—some of them pregnant, most of them mothers—are navigating the difficult terrain of incarceration. The manner in which the criminal justice system comes to bear on their reproductive lives and health experiences are best understood through the frameworks of reproductive justice and health disparities.

REPRODUCTIVE (IN)JUSTICE AND INCARCERATION

Incarceration presents serious health risks: Prisons expose women to violence, sexual assault, injury, communicable diseases, and poor nutrition and living conditions.^{11,12} Moreover, prisons and jails are highly regimented institutions that control many aspects of women's daily lives, while frequently failing to meet their basic needs.¹³ These daily conditions of imprisonment, along with the broader context of mass incarceration*¹⁴ (especially as it pertains to the experiences of poor communities and communities of color^{15,16}), are also a matter of reproductive justice.

Women of color developed the reproductive justice framework to analyze intersecting forms of oppression

and promote human rights. The pioneering organization Forward Together (previously known as Asian Communities for Reproductive Justice) argues that reproductive justice will be achieved when all people "have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives."¹⁷(p. 2) Advocates distill the policy implications of this aspirational definition into three core components: the right to have children, the right to have an abortion and the right to raise children with dignity and in safety. Imprisonment infringes on women's constitutionally protected reproductive rights by confining them during their reproductive years, denying them access to necessary medical care, subjecting them to substandard medical care and separating them from their children.¹⁸

WOMEN BEHIND BARS

The reproductive health experiences of incarcerated women must be understood in the context of the significant increases that have occurred in the number of incarcerated women in the last three decades. Since the escalation of the "war on drugs" in the 1980s, the United States has seen an exponential rise in the number of people behind bars, from 501,886 at the end of 1980¹⁹ to 2,287,949 at the end of 2013.¹⁰ This expansion has been especially dramatic for women and even more so for women of color: From 2000 to 2013, the number of incarcerated females increased by 30%, whereas the number of incarcerated males grew by 13%.¹⁰ Black women are incarcerated at a rate 2.3 times that of white women, and Hispanic women are incarcerated at a rate 1.5 times that of white women.²⁰ The majority of incarcerated women (70%) have been convicted of nonviolent crimes, most commonly property and drug-related offenses,²⁰ which are often tied to the conditions of disadvantage that characterize the lives of many women enmeshed in the criminal justice system.

Available data illustrate that the prevalence of STDs, histories of trauma and abuse, drug addiction and mental illness is high among women in prisons and jails—much

*The term "mass incarceration" (or "mass imprisonment") has many dimensions. Most commonly, it refers both to the trend in the last 40 years in the United States of an unprecedented and exponential rise in the number of imprisoned people and to the systematic incarceration of certain groups. Specifically, "mass incarceration" refers to policies that have disproportionately led to large-scale imprisonment of people from poor and black communities.^{15,16}

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higher than it is among the general population and among incarcerated men. For instance, one study found a prevalence of chlamydia of 14% among women entering jail²¹—a much higher rate than the nationally reported prevalence of less than 5% among nonincarcerated women.²² HIV affects 2.4% of women in prison,²³ compared with 0.18% of non-incarcerated women²⁴ and 1.8% of incarcerated men.²⁵ In addition, 50% of women in prison and 80% of women in jail report a history of physical or sexual abuse,²⁶ and nearly three-quarters of incarcerated women demonstrate symptoms of a psychiatric illness.²⁷ This reality results from deeply entrenched structural inequalities—poverty, unstable housing, limited access to health care, undereducation, racial discrimination and unemployment—that manifest themselves in unequal rates of disease.²⁸

Given that 74% of imprisoned women are between the ages of 18 and 44,²⁰ parenting and reproductive health issues are important parts of their overall health. The majority of women in prison (56% in federal and 62% in state prisons) are mothers to minor children, and many were primary caregivers before their arrest.²⁹ Once behind prison walls, mothers find it very difficult to remain connected to their families: More than half of women in state prison never see their children for a visit, and collect phone calls can cost as much as a dollar a minute.³⁰ Perhaps most significantly, incarceration starts the clock on the termination of parental rights. If a woman cannot arrange for someone she knows to care for her children, they will be sent to foster care. Under federal law, states are supposed to initiate proceedings to terminate a parent's rights once a child has been in foster care for 15 months, a period shorter than many prison sentences.³⁰

Previous studies have reported that most incarcerated women were sexually active before incarceration (84%) and were not using contraceptives prior to arrest (78–84% of those who were sexually active); incarcerated women also are more likely than those in the general population to have had an unintended pregnancy (84% vs. 50%) or an abortion (55% vs. 33%).^{31–33}

RIGHT TO MEDICAL CARE

Amid the reproductive and general health care disparities that distinguish incarcerated women, there exists a paradox that when women are imprisoned, they gain a constitutional right to health care that does not exist outside prison walls. The 1976 Supreme Court decision *Estelle v. Gamble* established that “deliberate indifference to [an incarcerated person’s] serious medical needs” violates the Eighth Amendment’s prohibition on cruel and unusual

treatment.³⁴ As one court explained in 2008, “Having stripped [incarcerated persons] of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course.”³⁵(p. 517) The Constitution thus prohibits correctional officials and staff from “intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed.”³⁴(pp. 104–105)

Since many people in jails and prisons lacked access to health care before being confined,²⁸ the *Estelle* mandate makes incarceration, theoretically, an opportunity to provide much-needed health care and public health interventions.³⁶ All people entering correctional facilities are supposed to get some form of a medical intake evaluation, which could be an opportunity for assessing their immediate reproductive health issues—for example, screening for emergency contraception eligibility, STDs and pregnancy. However, the idea that incarceration is a window of opportunity must also be seen as problematic, and reflective of the deficiencies of our broader health care system.

Furthermore, the terms “serious medical needs” and “deliberate indifference” leave much to the discretion of individual correctional facilities. Incarcerated women face many barriers to asserting their rights in court, including the difficulty of proving deliberate indifference—a much more stringent standard than medical malpractice.¹⁸ Accordingly, the quality and consistency of health care services provided are variable, certainly when it comes to women’s reproductive health. This inconsistency is evident in surveys that document vast differences in pregnancy care and accommodations,³⁷ contraceptive services³⁸ and abortion access^{39,40} in prisons. Indeed, despite the dramatic increase in the numbers of incarcerated women, their gender-specific health care needs remain largely neglected.

Reflecting a general lack of oversight, no federal government body has established national standards for medical care in prisons. Various nongovernmental organizations—most notably, the American Public Health Association and the National Commission on Correctional Health Care (NCCHC)—publish voluntary standards (Appendix Table 1, Supporting Information), and the NCCHC accredits its jails and prisons.^{41,42} However, following these standards is optional, and many prisons and jails are not accredited.*

RIGHT TO ABORTION

Courts have consistently affirmed that a woman’s constitutional right to abortion, as guaranteed by the 14th Amendment’s right to privacy, survives incarceration, albeit with some limitations.⁴³ While incarceration inevitably leads to some restrictions on the exercise of constitutional rights, these restrictions are permissible only if they further “legitimate penological interests,” such as rehabilitation, deterrence and institutional safety.⁴⁴ Prison and jail officials who deny incarcerated women access to abortion effectively punish women by forcing them to continue their pregnancies.³⁹ In numerous cases, courts have recognized

*The NCCHC does not publish the number of jails and prisons that are accredited. In 1999, Amnesty International estimated that 25% of prisons and 7% of jails were accredited by the NCCHC (source: Amnesty International, “Not Part of My Sentence”: Violations of the Human Rights of Women in Custody, 1999, <<https://www.amnesty.org/en/documents/document/?indexNumber=AMR51%2F001%2F1999&language=en>>, accessed May 31, 2015. No study has evaluated the reasons why many prisons and jails are not accredited.

that categorically restricting abortion access and forcing childbirth do not serve any penological interests.⁴³

Courts have also struck down obstacles to abortion access that stop short of outright prohibition. For example, courts have struck down the requirement that women obtain a court order from a judge authorizing either a temporary release (often called a furlough) or transportation in order to have an abortion.⁴³ Other courts have held that jails and prisons cannot base abortion access on a woman's ability to pay up front for the procedure or transportation.⁴⁵

By and large, these cases were not decided under the standard of the Eighth Amendment's right to medical care, but instead under the 14th Amendment's privacy standard. Thus far, only one appeals court has squarely held that when correctional officials delay or prevent a woman's desired abortion, they not only violate the 14th Amendment, but also display deliberate indifference to a serious medical need: That was the Third Circuit Court of Appeals (covering Delaware, New Jersey and Pennsylvania), ruling in the 1987 case *Monmouth County Correctional Institution Inmates v. Lanzaro*.⁴⁶ This decision distinctly recognized the right to abortion as the right to health care, and it is the only one that has explicitly held that the state must cover the cost of the procedure for an incarcerated woman if she cannot afford it.⁴⁶ In addition, the Third Circuit has rejected the distinction between so-called elective and medically necessary abortions. An elective medical procedure is one that can be delayed indefinitely without significant consequences for the patient's health or life—which is not the case with respect to abortion.^{39,43}

PRACTICAL BARRIERS TO ABORTION CARE

In many cases, the problem is not restrictive policies, but the lack of any clear policy at all: A study of state prison systems found that one-third had no written abortion policy.³⁹ In another study, 68% of correctional health providers in a national survey reported that a woman could obtain an abortion, but providers reported varying degrees of assistance with transportation, payment and arranging the appointment.⁴⁰

Even court decisions are ineffective without policies to implement them. For example, although the *Lanzaro* decision obligated Pennsylvania facilities to provide timely access to abortion services and to cover the cost of the procedure under certain circumstances, a 2012 survey found that 35% of jails in the state had no policy on abortion.⁴⁷ The remainder incorrectly classified abortion as an elective procedure and did not specify the process that a woman would need to follow to request an abortion, and most incorrectly stated that the correctional facility or the county is not financially responsible for elective abortions.

Ultimately, incarcerated women are entirely dependent on their jailers for access to the care they need. Thus, even if there is no policy prohibiting access to certain types of care, in the absence of a clear policy mandating treatment, incarcerated women face many barriers to care. Moreover,

the geographic, financial and regulatory obstacles that women seeking abortion in the United States routinely face are greatly exacerbated for incarcerated women. Many prisons are located in rural areas, making the fact that 89% of U.S. counties lack an abortion provider⁴⁸ all the more limiting. Additionally, more than half the states impose a waiting period on women seeking abortion, which may require at least two trips to a clinic,⁴⁹ a significant burden for women who must rely on their jailers for transportation.

Furthermore, the *Lanzaro* decision requiring states to cover abortion costs for women who cannot afford them reaches only those few states in the Third Circuit.⁴⁶ More commonly, facilities require women to pay not only the cost of the procedure, but also costs related to transportation and correctional staff time. Indeed, while NCCHC standards require that prisons and jails seeking accreditation provide "counseling and assistance" to women who express the desire to have an abortion, they make no mention of payment or other logistics for this health care.⁴¹ The American Public Health Association standard is stronger, stating that "women must have access to abortion counseling and services upon request,"^{42(p. 108)} but no institution is required to follow these standards.

PREGNANCY CARE

Some 5% of women in jail, 4% in state prison and 3% in federal prison report that they are pregnant upon intake;^{25,50} many women first learn they are pregnant in prison or jail. There are no reliable national data on the exact prevalence of pregnancy among incarcerated women or on pregnancy outcomes, including the frequency of miscarriage and abortion. Yet it is clear that the quality and scope of prenatal care that incarcerated women receive vary widely. Unlike abortion care, which is provided for incarcerated women exclusively by qualified professionals in the community, prenatal care may be provided on-site by health care personnel employed either by the jail or prison, by the local health department or by for-profit companies. In a nationally representative survey of women who had experienced a pregnancy while incarcerated, 94% of those in state prisons and 48% of those in jails reported having had at least one obstetric exam during pregnancy; only 54% and 35%, respectively, reported having received "instructions on child care, exercises, special diet, medication, or special testing" while pregnant.^{25,50} Although women have brought class-action lawsuits to improve pregnancy care and have sought redress after suffering medical neglect, the courts have not articulated a clear constitutional standard for the medical care of pregnant women beyond the "deliberate indifference" standard set forth in *Estelle*.⁵¹

Most pregnant incarcerated women are considered at high risk for adverse perinatal outcomes such as preterm labor, having a low-birth-weight infant and stillbirth.⁵² This is not surprising, given that they frequently had poor health status, lived in disadvantaged socioeconomic circumstances and had limited access to health care before

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incarceration. Nonetheless, some studies have found that incarcerated women are less likely than “similarly disadvantaged” women in the community to have preterm births, low-birth-weight infants, stillbirths and other adverse pregnancy outcomes.⁵³ Importantly, the data must be evaluated in light of what we know about grossly inadequate care in prisons and jails and the too frequent incidents of pregnant women’s suffering poor outcomes in their cells without appropriate medical attention. Moreover, the studies should not be taken to mean that pregnant women should be incarcerated in order to improve birth outcomes, since the outcomes reported are narrow and short-term.⁵³ Indeed, the medical and public health consensus is that incarceration “ultimately [undermines] the health of pregnant women and their fetuses.”⁵⁴(p. 8)

Separated from their usual support networks, and unsure of what will happen to their newborns after delivery, incarcerated women may find pregnancy and childbirth isolating and stressful experiences.¹³ Adding to this, pregnant incarcerated women have no control over their environment and the comforts of daily living we might take for granted. For instance, sleeping in a bottom bunk requires medical authorization; mealtimes and food are set, making it hard for women with pregnancy-related nausea.

As with pregnancy prevalence, no national data exist on how many women give birth while in custody. However, a report from 1999—the only year for which an estimate is available—documented that 1,400 women in 43 state prison systems gave birth.⁵⁵ Given the increase in the female incarcerated population since then, this number is now likely greater. Women who give birth while incarcerated are usually taken to a nearby hospital; however, untrained correctional staff may neglect or dismiss their symptoms of labor,¹³ and some women end up giving birth in prison or jail. In an attempt to ameliorate women’s sense of isolation, doulas have started programs such as the Prison Birth Project to support women during labor and delivery in the hospital.^{56,57} These programs are few and far between, however, and typically rely on doulas who donate their services.

After giving birth, most women are separated from their newborn when they return to prison or jail. The infant either is cared for by a designated family member or goes into foster care. Eight states have nursery programs inside prison walls that allow some mothers to keep their infants for varying periods of time.⁵⁸ But prison nurseries are controversial and do not address the root problems underlying women’s incarceration and the family disruption that follows. Few states have enough—or any—community-based alternatives for women in the criminal justice system, a preferable option to incarceration for women’s well-being and family preservation. The goals of such alternatives to incarceration include minimizing harm to children and saving money by allowing women to fulfill family responsibilities while meeting the requirements of their sentence.⁵⁸ The JusticeHome program in New York City combines supervision with inten-

sive home-based services for women who plead guilty to certain felonies; those who complete the program have their charges dismissed.^{59,60} The most robust alternatives provide treatment for substance use, mental illness and other challenges in order to prevent arrest or incarceration in the future.

SHACKLING

Of all the issues affecting pregnant, laboring and postpartum women behind bars, shackling has garnered the most media, political and legal attention.⁶¹ Shackling—the use of handcuffs, leg irons, waist chains or other restraints—at any point in pregnancy can increase the risk of falls, which can lead to placental abruption (separation of the placenta from the uterus), hemorrhage and stillbirth. In addition, restraints interfere with health care professionals’ ability to provide critical interventions when obstetric emergencies, such as seizures or fetal distress, arise during pregnancy or childbirth. Despite these risks to the pregnant woman and her fetus, and despite widespread opposition from health professional organizations,^{42,52,62–64} only 21 states and the District of Columbia have passed laws to ban or limit shackling.^{65,66} Furthermore, evidence shows that some pregnant incarcerated women in states with antishackling laws are still being restrained,^{13,47,60,67} suggesting the need for better monitoring or enforcement.

FAMILY PLANNING

Most incarcerated women are eventually released from prison or jail, and tending to their preventive health care needs while they are in custody can help them prepare for successful reentry to the community. One strategy is to assist them with planning for their reproductive futures.⁶⁸ This includes preconception counseling for women who want to get pregnant, and contraceptive counseling and provision for those who want to avoid pregnancy upon release. Most incarcerated women (85%) plan to be heterosexually active within six months of their release,³¹ and 60% want to start birth control before their release in order to avoid barriers to access in the community.³² However, once women are incarcerated, the majority are not allowed to continue birth control methods they were already using, and very few facilities provide on-site access to contraceptives in preparation for release.³⁸ For example, in one survey of correctional health providers, only 38% reported that birth control was available in the facility; 55% indicated that women were not allowed to continue a method they were already using.³⁸

Disruptions in contraceptive use have significant implications for women in jail, who are often there for short periods of time; a lapse in use of a hormonal method puts women at risk for unintended pregnancy when they get released. While the NCCHC now has a standard addressing contraception, meeting that standard is not required for accreditation, and the standard does not require on-site provision of methods.⁴¹ In addition, we found no court decisions addressing whether contraceptive access is con-

sidered a serious medical need. Despite the limited availability of contraceptives in prisons and jails, research has shown that women are more likely to initiate a method if it is available on-site than if they are just given a referral to a family planning clinic in the community.⁶⁹ Contraceptive programs in Rhode Island⁶⁹ and San Francisco⁷⁰ offer examples of ways to pay for and provide reversible methods to women in preparation for release. New York's prison system contracted with Planned Parenthood to offer contraceptives prerelease from 2009 to 2013, but it has ended the program.¹³

Only a few prison systems allow women to have private visits with their partners, and then only if they are legally married.⁷¹ In general, little is known about how the contraceptive needs of this small group of women are met. In New York, for example, prisons offer only condoms, putting women who do not want to become pregnant at risk for pregnancy.¹³

Providing incarcerated women with access to contraceptives is a critical part of comprehensive reproductive health care, but this must also be balanced with the unique power dynamics, limited autonomy and coercive conditions that are inherent in the prison and jail environment. Although incarcerated people have a right to refuse medical treatment,⁷² they may still fear repercussions if they do not follow a doctor's recommendation. Thus, they might feel coerced into starting to use contraceptives or choosing a particular method, even despite a provider's best intentions to offer nonbiased counseling. Sterilization is a particularly acute example of the potential for coercion, as evidenced by documentation that more than 100 women in California's prison system were unlawfully sterilized from 2006 to 2010.⁷³

In addition, because poor women of color are disproportionately incarcerated, contraceptive provision in prisons and jails must be attuned to the legacy of eugenics, which coercively suppressed reproduction in communities of color.^{73,74} Providing birth control without such a political-historical awareness risks perpetuating a strategy of "stratified reproduction,"⁷⁵ whereby some women's reproduction is valued and others' is not. To mitigate the potential for coercion, contraceptive counseling should be part of a larger discussion about women's reproductive life goals, rather than just about birth control methods. In addition, jails and prisons offering IUDs and implants, methods that are provider-controlled, should have separate visits for counseling and insertion to ensure that incarcerated women, like all women, have adequate time to consider their options.

NEXT STEPS

Viewed within the broader context of racial bias in the criminal justice system, economic inequalities,⁷⁶ gender discrimination and the sheer scale of imprisonment, incarceration in the United States is a reproductive justice issue. Many incarcerated women have tremendous reproductive health care needs, which are often neglected

or not considered serious medical needs. Whether incarcerated women are receiving substandard prenatal care, prevented from having abortions, pressured into using birth control or shackled to the rail of a hospital bed during childbirth, what happens to women behind bars reflects the politics of reproduction in the United States. To ameliorate these injustices, reproductive health care providers and advocates must work not only to improve access to reproductive health services for women while they are incarcerated, but also to promote policy changes that invest in women's lives outside of prison or jail; such efforts will reduce the likelihood of women's being incarcerated and will strengthen the health and well-being of marginalized women, their families and their communities.

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