Women's Prisons: The Need for Quality Preventive Reproductive Care Programs

Approved Cheryl Barachowski-Fuller Date May 9, 2009

Advisor

Women's Prisons: The Need for Quality Preventive Reproductive Care Programs

A Seminar Paper

Presented to the Graduate Faculty

University of Wisconsin-Platteville

In Partial Fulfillment of the

Requirements for the Degree

Master of Science in Criminal Justice

Lois E. Kramer

2009

Abstract

Women's Prisons: The Need for Quality Preventive Reproductive Care Programs

Lois E. Kramer

Under the Supervision of Dr. Cheryl Banachowski-Fuller

Statement of the Problem

Women have a distinct set of gender-specific health concerns that require regular preventive healthcare and prompt medical attention when a problem develops. Women in prison have the same needs, only complicated by their incarceration and a prison system that is struggling to keep pace with modern medicinal practices and attitudes. Many female inmates arrive with untreated diseases, pregnancies, a history of inadequate if any healthcare, and ignorance of basic information about their own reproductive healthcare and protection from sexually transmitted diseases. Many are drug users who indulge in risky sexual behavior, predisposing them to a swarm of communicable diseases.

Historically, politically, and culturally speaking, women have been second class citizens, even in prison, until relatively recent times. Incarcerated women are often from society's poorest economic stratum.

With the rapid increase in the rate of imprisonment of females over the last two decades and the advances made in preventive healthcare and treatment of reproductive disorders, it has become necessary to seriously address the issue of preventive reproductive healthcare for women prisoners. As it is also a matter of constitutional entitlement, it is unlawful to deny appropriate healthcare to anyone who is incarcerated.

Method of Approach

An extensive literature search was performed, including pertinent websites, journal articles, and books. Particular attention was paid to the most current writings available, including literature released in 2009. The National Criminal Justice Resource Service (NCJRS) web site was accessed to find relevant sources of further information. The Center for Disease Control and Prevention (CDC) web site was accessed for additional publications and secondary data relevant to women's health issues. The American Public Health Association (APHA) Standards, the National Commission on Correctional Health Care (NCCHC) Standards, and the Federal Bureau of Prisons (BOP) Clinical Practice Guidelines were all examined to determine existing guidelines and standards. Feminist theory was reviewed to obtain perspective on underlying causes for inferior healthcare offered to incarcerated women. A critical analysis of the data collected was used to develop a list of recommendations for an ideal program for preventive reproductive healthcare of incarcerated women.

Results of the Study

Thorough investigation into the relevant literature revealed that incarcerated women have been largely ignored until recent history and their special reproductive health needs have often been neglected or mishandled. Programs and services for women have traditionally been an afterthought, if considered at all, as the prison system concentrated on the majority male population.

Despite the less than ideal conditions and services often afforded incarcerated women, there is a surprising body of professionally authored guidelines and standards already published and in circulation. The BOP has its own set of preventive healthcare guidelines in place, and, theoretically, they must be followed in all federal prisons. The NCCHC published its updated correctional healthcare standards in October of 2008, and they are distributed to all accredited jails and prisons. The APHA has published its comprehensive set of correctional healthcare standards since 1976.

What's the problem then, if standards are already in place? Reasonable standards exist on paper. The primary focus now needs to be on keeping them current and consistent with community standards, making them universally applicable to all prisons, educating the public about the necessity of doing so, and enforcing the standards once they are in place.

Table of Contents

	Page
APPROVAL PAGE	i
TITLE PAGE	ii
ABSTRACT	iii
TABLE OF CONTENTS	vi
SECTION	
I. INTRODUCTION-DISCUSSION OF THE PROBLEM	1
II. LITERATURE REVIEW	5
A. Reproductive Health Issues	5
B. Definition of Preventive Reproductive Care Program	13
C. Cases of Inadequate Care	15
D. Effectiveness of Current Prison Procedures	17
III. THEORETICAL FRAMEWORK-FEMINIST THEORY	20
A. Liberal Feminism	21
B. Radical Feminism	23
C. Marxist Feminism	23
D. Socialist Feminism	24
E. Application to Women's Health Care	25
IV. EXAMINING EFFECTIVE PROGRAMS	29
A. American Public Health Association Standards	30
B. National Commission on Correctional Health Care Standard	34
C. Federal Bureau of Prisons Guidelines	37

V. RECOMMENDATIONS FOR IDEAL PROGRAM 40

A. Description of Ideal Program 41

B. Importance of Universal Application 48

C. Suggested Future Research and Need for Action 50

VI. SUMMARY AND CONCLUSIONS 52

REFERENCES 55

I. INTRODUCTION: WOMEN'S PRISONS: THE NEED FOR QUALITY PREVENTIVE REPRODUCTIVE CARE PROGRAMS

Women have unique and complex anatomies, a fact that presents a distinct set of reproductive health issues. In general, women present higher rates of illness, including infectious disease, than men do (Talvi, 2007). This is just as true for women in correctional institutions. These gender-specific needs must be adequately addressed in women's prisons in order to prevent more serious health issues from occurring. Unfortunately, there is no universal standard for women's healthcare in prisons throughout the United States.

Gynecological problems occur frequently in prison. However, most prisons do not employ full-time doctors, let alone gynecologists. Women often have to wait weeks to see a doctor, and by the time they are seen their problem may have progressed to a dangerous stage. Only about half of the prisons in the U.S. provide important screening tests, such as Pap smears and mammograms for women, and even when they do, prisoners often cannot afford the required co-payment for such medical treatment. Abnormal pap smears are rarely given proper attention and follow-up care (Grana, 2002; Talvi, 2007). To ensure the health of the mother and child, pregnant inmates need quality prenatal care, which many do not receive while incarcerated. The labor process itself can be particularly dangerous if women are kept in restraints, as is often the case (Grana, 2002).

According to the Wisconsin Women's Network, inmates in Wisconsin's women's prisons are not getting the health services they need. Amnesty International has spoken out about this issue and suggests that all women's prisons provide on-site reproductive care (Ketcham, 2001). Efforts have been made to consolidate Wisconsin's four women's correctional facilities under one system to better serve the specific health care needs of women (Wisconsin Department of Corrections, 2005). Incidentally, a lawsuit filed by the American Civil Liberties Union charged Wisconsin's prison system with dispensing inferior health care to women prisoners compared to men. According to one complaint, a female inmate had reported chronic symptoms of endometriosis for seven years without proper medical attention. The delay in treatment resulted in her needing a hysterectomy, which might have been unnecessary if the problem had been addressed in a timely manner (American Civil Liberties Union, 2006).

The number of female prisoners in Wisconsin increased by 863% between 1977 and 2004 (Women's Prison Association, 2004). Thus, a reassessment of women's healthcare is necessary as the female inmate population continues to grow. While incarcerated, inmates are entitled to reasonable healthcare, comparable to what they could obtain outside the prison setting. The purpose of this study was to determine, through examination of multiple sources of data, including internet sites, journal articles, and books on the topic, if current reproductive programs for women prisoners are effective. Much of the readily available research on

women's reproductive health care in prison is more than a decade old. However, some recently published books on the topic provide a more comprehensive look at women's health care in prison. This paper is a compilation of the most effective and promising ideas pertaining to women's preventive reproductive care and will describe an ideal program based on examination of the past and most up-to-date research. This program will ensure that women in prison receive the quality preventive care they need to avoid more serious conditions.

As more and more women enter the prison system, the need for this specialized care grows. It needs to be recognized that the prison sentence itself is the punishment assigned by the court – not the neglect of important health issues. Women in all institutions should have access to the recommended routine health care they deserve and correctional institutions should be aware of the benefits of providing timely health care interventions to women. It is important to understand that this timely intervention is more cost-effective than neglect and emergency care, and that the health of prisoners will be drastically improved.

This paper provides a recommendation for an ideal preventive reproductive healthcare program for women incarcerated in prisons in the United States. My specific recommendations will include more doctors being hired, initial STD testing for all women, and screening for cervical cancer (Pap smear) and breast cancer (mammogram). Recommendations are based upon elements of current health care programs that are

effective and functioning well, in addition to elements that are deemed to be lacking in current programs.

The general plan of organization for this study will include a thorough review of pertinent literature that will reveal the reproductive issues women in prison face, define what is meant by preventive reproductive care programs, and cite cases of inadequate care. A theoretical framework section will describe the feminist theory and its application to women's healthcare in prison. Several programs with effective standards for reproductive care will be explored with emphasis on elements that are preventive in nature. Recommendations for an ideal women's reproductive health care program will be made based on this review. A summary and conclusion section will recapitulate why quality reproductive programs are necessary in all correctional institutions housing females and highlight the benefits of implementing such programs. The need for immediate action to remedy this issue will be stressed in addition to the suggestion that future research address the topic of women in prison more thoroughly.

II. LITERATURE REVIEW

This section is composed of three parts. The first part will present and explain reproductive health issues faced by women in prison. The second part will define what a preventive reproductive health care program is and what it is designed to do. The third part will cite cases of inadequate care for the purpose of revealing its consequences and establishing the need for such programs. The final part will analyze the apparent effectiveness of current prison policy regarding women's reproductive health care needs and restate the purpose and need for this research.

A. Reproductive health issues

There have always been significantly more men than women in the prison system and its design clearly disproportionally reflects the needs of men. As a result, women have a history of receiving inferior care, and their problems have commonly been neglected (Braithwaite, Arriola, & Newkirk, 2006). There are currently more than 200,000 women in prison (10% of the prison population), making women's unique reproductive health problems an essential issue to address (Roth, 2007). In fact, the number of female prisoners has increased by six times in the last 20 years and this population is now growing at a faster rate than male prisoners (Braithwaite et al., 2006). It is far more difficult for a woman behind bars to obtain or fight for her reproductive rights than for a man. In fact, the 1996 Prison Litigation Reform Act (PLRA) makes it even more difficult for women to

question the quality of care they are receiving and the conditions they endure while in prison (Roth, 2004).

STDs

STDs are a common problem among women entering the prison system for a number of reasons, including sexual abuse, prostitution, and lack of education or proper health care. The numerous inmates admitted on a daily basis, along with limited qualified medical staff and exam facilities in most women's prisons, present a difficult burden for prison staff to complete appropriate STD screenings (Morbidity and Mortality Weekly Report, 1999). This is particularly problematic in state prisons, whereas federal prisons have a distinct set of guidelines to be followed. Frequent occurrences of syphilis, gonorrhea, and Chlamydia suggest the prudence of screening for these diseases upon intake to the prison. Fortunately, in the last ten years, a reliable urine test has been developed so that screening for gonorrhea and Chlamydia can be accomplished in the absence of elaborate medical facilities and technicians. Nevertheless, the tests are not being administered on a universal basis (National Council on Crime and Delinquency, 2006).

Female inmates may also acquire these infectious diseases while incarcerated, commonly as a result of sexual abuse. However, many of these diseases are asymptomatic and women may not realize they are infected. Those who do request STD tests are frequently subject to long delays or worse, complete denial and neglect. Most prisons do not have a

specific protocol for obtaining such tests, making it difficult for women to initiate the request. Chlamydia infection is a persistent problem among inmates, and when not treated it can lead to serious reproductive issues, such as pelvic inflammatory disease (PID) and infertility (National Council on Crime and Delinquency, 2006). This is true for any disease that affects the reproductive organs.

Pap smears

Pap smears are essential screening devices in the early detection of cervical cancer. An abnormal pap smear may indicate infection with human papillomavirus (HPV), which is the leading cause of cervical cancer and may also cause symptoms such as genital warts. When a pap test is found to be abnormal, the woman should be closely monitored for changes in cervical cells and examined in more frequent intervals than someone receiving a normal Pap test result. Unfortunately, in prison, they are often performed irregularly, long after they are requested, or not at all, and attempting to get a follow-up appointment after an abnormal pap smear is extremely difficult. Women in prison are already at greater risk than the general population due to their high rate of substance abuse, contributing to high-risk sexual behaviors. In addition, very few entered the prison with any prior adequate medical care. Despite the reports of less than ideal care in this area, the prison setting offers an ideal situation for monitoring, treating, and follow-up care. The patients are readily available for screening and treatment at the appropriate times and because it is

such a high-risk population for cervical cancer and other reproductive health issues, this setting also provides a unique opportunity to educate inmates about proper health care (Magee, Hult, Turalba, & McMillan, 2005). Still, women are often denied screening for cancerous cells, and procedures that should follow abnormal test results, such as colposcopies that provide a closer look at the cervix, the surgical removal of high-risk parts of the cervix, and of course repeat testing to monitor changes in cells (Braithwaite et al., 2006). This would ultimately benefit the communities into which they are eventually released by helping to control the spread of diseases such as human papillomavirus (HPV), but this is not a priority of the current system. Until a 2005 study of California prisons, there had not been any studies about cervical cancer in the U.S. prison population in 20 years. The California Department of Corrections (CDOC) runs the world's largest women's prisons, so its studies cover a significant portion of incarcerated women (Magee, Hult, Turalba, & McMillan, 2005).

Breast exams

Women entering prison often have severe health problems and have never received proper medical care because of debilitating factors such as low income, living in poor underdeveloped neighborhoods, and lack of sufficient (or any) insurance. It is a well-known fact that there is a disproportionate number of women of color in the nation's prisons. These women present a higher rate of undetected breast cancer than the rest of the population. Breast exams and routine mammograms (when age-

appropriate) are crucial in the early detection of breast cancer. Women requesting breast exams in prison often have to wait long periods of time before they are seen, even if a lump or any other potential risk factor is already present. In addition, many are not aware of how to properly perform a self breast examination. This can have devastating results and may result in much more dire consequences than if the issue had been investigated earlier. Some of these consequences include enduring avoidable mastectomies, allowing the cancer to progress to a later, more serious stage and metastasize throughout the body, and possibly death (Barry, 2001). If detected earlier, women may have options in treatment of their breast cancer, some of which are not as surgically invasive, more cost-effective, and lead to a quicker recovery.

Pregnancy

Of the women entering prison (or jail) 5-6% are pregnant, and the majority of female inmates are already mothers and generally the primary caretakers of minor children (Roth, 2007). When a mother is incarcerated, the responsibility of caring for these children is commonly taken on by a grandmother, rather than the father of the child (Roth, 2004). Of the pregnant prison inmates in the nation, 20% said that they did not receive any prenatal care, and 50% of those in jail also reported this (Roth, 2007). As a consequence of being sent to prison, pregnant women often give up their choice to elect an abortion due to the obstacles and delays put in place by the system (Roth, 2006). These women are forced into

childbearing, which is not an accepted or lawful punishment in this country (Roth, 2004). Of those who do eventually receive desired abortions, some have to get more complicated and costly procedures as a result of the delay. Women are also faced with the difficult task of deciding whether or not to have an abortion, while not knowing what their future holds as far as the actual length of time they will spend in prison (Roth, 2005).

The law "protects" inmates against sexual assault, but unfortunately this does not prevent it from occurring, and sometimes pregnancy results. Guards are given a great amount of power over prisoners and have access to them at all hours of the day and during every activity. This makes female inmates extremely vulnerable to sexual abuse and it also makes it difficult to report (Summer, 2007). In the past, men's duties in women's prisons were limited, but Title VII of the Civil Rights Act of 1964 allowed women equal rights for employment and they were able to work in all-male prisons. As a result, the restrictions on men's duties in women's prisons were lifted, and now the correctional staff in women's prisons is predominantly male. However, in *Torres v. Wisconsin*, one women's prison was allowed to restrict men from working closely with female inmates, as it was found not conducive to the rehabilitation of the women, many of whom had been abused by males in the past (Braithwaite et al., 2006).

Women are often put in isolation if they attempt to report a guard for sexual abuse. Unfortunately, many of these women are already

accustomed to such abuse, as 80% of them have been physically or sexually abused before entering the prison system. According to Stannow, executive director of Stop Prison Rape, an organization that seeks to stop the sexual abuse of those confined, one in four women is sexually abused in the worst of prisons. The psychological trauma caused to the prisoner as a result of the sexual assault is almost always ignored. Prisons are not set up for talk therapy and nothing is truly confidential as it would be outside the prison (Summer, 2007).

It is difficult for inmates impregnated while in prison to get emergency contraception in time for it to be effective, and just as difficult to get an abortion (Summer, 2007). Women in prison still possess their right to get an abortion, and the prison is obligated to make this procedure possible. They are required to take prisoners to a hospital outside of the prison setting or provide on-site abortions. However, Wisconsin and Minnesota are the only two states that have specific policies regarding abortion when pregnancy occurs after a sexual assault (often by a prison guard). Both of these states will pay for the abortion if this situation is encountered. The Federal Bureau of Prisons also has this policy (Summer, 2007). Other prisons may avoid this by refusing to offer transportation or funds, for example. Intentional delays may also prevent women from making the cut- off date for a safe abortion (Roth, 2004). If prisoners decide not to terminate their pregnancies, they will often lose

their parental rights and their child will be assigned to foster care if there is no relative to care for it (Summer, 2007).

The birthing process is not without complications either. Women in prison are in a very stressful environment, which is definitely a contributing factor to the high rates of stillbirths and miscarriages among inmates (Roth, 2005). Women are often not transported to a hospital until they have already gone into labor, and sometimes even end up giving birth in their prison cells. They are handcuffed and chained during transportation and then are usually chained to their hospital beds for the birth and recovery. This makes it very difficult and uncomfortable for a woman to change positions or go to the bathroom, both of which they would have to be unchained for. In fact, as of 2000, Illinois was the first and only state that prohibited the confining of women in chains during labor and the rest of the birthing process. It was the Chicago Legal Advocacy for Incarcerated Mothers (CLAIM), an organization aimed at uncovering the truths and hardships suffered by pregnant inmates that helped this law get passed. Most inmates are separated from their babies and sent back to prison immediately after the birth. Some prisons do have nurseries where the mother may remain with the child anywhere from a month to a year. The nurseries are hardly ever full however, because women have to qualify for this privilege. In ideal situations some women may be given the opportunity to spend their last trimester at their own residence and even care for their child during its first few months there (Roth, 2004).

Federal prisons are obligated by their own guidelines to implement a program that educates inmates on parenting and allows for some sort of visitation with their children. This has been the case since 1995, but these prisons are located in only 12 states and Puerto Rico, often creating an insurmountable distance between the inmates and their families. This makes it almost impossible for many women to see their children, let alone form relationships with them. This can further hurt their cases for parental custody later on (Roth, 2004).

The Prison Rape Elimination Act (PREA) was passed by Congress in 2003 to prevent sexual assault in prisons. It finds sexual assault in prison completely unacceptable and seeks to increase knowledge of such events and devise national standards for detecting and preventing them. Although this law is extremely significant, in reality, it does not guarantee that sexual assault will no longer occur. Further efforts are still needed to bring this problem to the nation's attention (Summer, 2007).

B. Definition of preventive reproductive health care program

A preventive reproductive health care program is defined as a comprehensive program that explicitly states gender-specific health procedures that will be routinely carried out in order to prevent serious problems with the female reproductive system, including the uterus, ovaries, fallopian tubes, cervix, vagina, and breasts (The New York Times Company, 2009). This includes care for reproductive problems that women already have upon entering the prison system, and problems that

arise while they are incarcerated. Such programs provide STD testing for inmates upon arrival, or by later request, pap smears at appropriate intervals, depending upon the state of the cervix and age of the woman, breast exams and mammograms as indicated for one's age, and quality prenatal and postnatal care to ensure the health of the mother and child. These programs are concerned with the early detection and treatment of cervical and breast cancer as well as the rapid diagnosis and treatment of spreadable diseases such as Chlamydia and gonorrhea. Prevention is key in the avoidance of unnecessary and possibly life-threatening reproductive conditions.

Another important element of the program is education. The prison setting provides a captive audience of women who are at risk for reproductive health problems and have a serious need to be informed about proper feminine hygiene and healthcare (Magee et al., 2005). Preventive reproductive health care programs provide women with the information they need to become better aware of their bodies, including being able to identify signs and symptoms that something is awry, gaining knowledge of necessary routine care and an understanding of how disease is spread, and important tips for avoiding risky behavior. The program also provides the prison with acceptable standards of care and explains the benefits of following them, as well as the consequences for ignorance and neglect. Detailed guidelines outlining appropriate care for incarcerated women have been published by the Federal Bureau of

Prisons (FBOP, 2007), and the American Public Health Association (APHA, 2003).

C. Cases of Inadequate Care

In a 2005 study of a California prison, most of the women in the study reported unpleasant experiences with pelvic exams (which include pap smears). Complaints were that doctors were usually male, handled them roughly, and used improper-sized speculums. They also complained of a lack of privacy and cleanliness in exam rooms. The doctors were said to behave unprofessionally and be quite disrespectful of the women, while offering very little communication (Magee et al., 2005). It is important to keep in mind that 80% of women prisoners have been sexually or physically abused before entering the prison system, so there is a special need for a sensitive, well-trained medical staff (Summer, 2007).

The lack of continuity in healthcare resulted in delays in test results and the cancellation or modification of previously prescribed treatment. Also, no standard procedure for obtaining a pap smear existed (Magee et al., 2005). In many cases, women had to exaggerate symptoms in order to be seen by a doctor, and had trouble getting appropriate follow-up care after an abnormal pap smear (Magee et al., 2005). These problems are typical in women's prisons across the nation. In June, 2004, Governor Arnold Schwarzenegger appointed a panel to review the CDOC. They cited numerous deficiencies that resulted in inadequate care. As a result of this review, the CDOC healthcare system has been given high priority

for reformation (Magee et al., 2005). Incidentally, in a recent survey of a Washington D.C. prison, female inmates in need of care requested medical attention 10-15 times before receiving it (Roth, 2006).

A woman in a California prison attempted to get an examination of an obvious lump in her right breast and was ignored for three years. When she was finally seen by a doctor, she was diagnosed with breast cancer and had a mastectomy. A year later the cancer returned on the other breast and that also had to be removed. The same woman later reported severe vaginal bleeding and this problem was not treated for years. She underwent a hysterectomy, which would likely not have been necessary if she was examined years before. Furthermore, a lump found on her neck was not biopsied for six months, eventually proving to be cancerous and also requiring removal. Radiation therapy was administered, but as a result of all the delays in diagnosis and treatment, the cancer has metastasized and she continues to be plagued with suffering as a result of the prison's neglect (Barry, 2001).

A 1998 case of negligent care in a Milwaukee, Wisconsin prison resulted in the dismissal of two nurses on staff. It was the female prisoner's due date when she reported to the guards that she was in labor and experiencing pain. The guards relayed the information to the nurses on duty, but they failed to take any action or even go to check on the inmate. She gave birth in her cell by herself in the middle of the night. The

fact that the nurses were held responsible for their neglect is unusual (Roth, 2004).

A California inmate was diagnosed with possible pre-eclampsia before she was transferred from jail to prison. She entered the Central California Women's Facility (CCWF) in her fifth month of pregnancy, had repeated high blood pressure readings (an indicator of pre-eclampsia), but her condition was ignored until her eighth month of pregnancy. At that time she was put on a week's bed rest and then returned to the prison yard, though her blood pressure readings remained high. The baby died in utero at nine months. In another unusual settlement, the woman was awarded substantial financial compensation from the state (Barry, 2001)

There are many more horror stories of criminal neglect and abuse in the treatment, or lack of treatment, of female inmates and their prison birthing experiences. Ranging from simple insensitivity toward inmates to stillbirths and inadequate postnatal care resulting in infant death, they are all negative outcomes that could have been avoided with a minimum of standard care.

D. Effectiveness of Current Prison Procedures

The cases above provide lucid testimony to the fact that most prisons today do not have effective preventive reproductive care programs (Barry, 2001; Magee et al., 2005; Roth, 2004; Roth, 2006). Even though we claim to be an incredibly advanced and just society, the majority of women are still suffering from unnecessary neglect and abuse when it

comes to their reproductive health care needs in prison. This is particularly paradoxical because prisoners are the only group of people in the U.S. that are actually guaranteed medical care by the constitution. The 8th Amendment provides individuals with protection from cruel and unusual punishment, but more often than not, no authority figure or organization is enforcing this. Although medical care is guaranteed, in reality, it is not necessarily received because prison authorities are the sole providers of prisoners' medical needs (Roth, 2007). When their power is not carefully monitored by an unbiased authority figure (rather than a fellow officer), cases of sexual abuse and neglect of female prisoners will inevitably arise. Current research on women's health in prison and published case studies demonstrate that this is a common occurrence in prisons around the nation. Such cases are so shocking and barbaric that they resemble the quality of treatment a prisoner of war would receive in an unindustrialized nation. Thus, it is necessary to universally implement an ideal preventive reproductive program in women's prisons. It is also crucial that the operation of such programs be closely monitored to ensure prisoners are actually getting the rights granted to them and not suffering from any abuse of any kind at the hand of prison staff, such as guards, nurses and physicians. Regular evaluations of each prison should be conducted and the resulting reports turned into a central agency for review. Prisons found guilty of providing women with inadequate reproductive health care must

then be forced to make immediate reformations, with the firing of staff members as a consequence of any disregard for the order.

To reiterate, the research problem is that there is a large population of women in prison, and this population is growing at a faster rate than that of male prisoners. Prisons are not historically designed to accommodate women, and therefore women's specific reproductive needs are often neglected, harming the prisoners, surrounding communities, and quite possibly the prison budget. The research will make an argument that preventive reproductive programs in all women's prisons are essential to uphold the rights of the inmates and circumvent more catastrophic health disasters. A recommendation will be made regarding the ideal preventive reproductive care program and the precise details will be provided.

III. THEORETICAL FRAMEWORK: DISCUSSION AND APPLICATION OF FEMINIST THEORY TO WOMEN'S HEALTH CARE IN PRISON

Early theorists had their own ideas about women who commit crimes. Lombroso, in his 1895 *The Female Offender*, theorized that women are less evolved than men, and thus prone to deviant behavior. In the early 1900's W. I. Thomas attributed women's crime to their desire for excitement and adventure. Freud hypothesized that women's crime is biological in origin and due to "penis envy", or their dissatisfaction with their inferior anatomy. Thus, he postulated, women are prone to immoral behavior (Grana, 2002).

More recently Otto Pollak, in his book *Criminality of Women* (1950), presented his *chivalry hypothesis*, in which he claims that women fare better than men in their treatment by the criminal justice system because women are not supposed to commit crimes (in society's view). At the same time he asserts that women are devious creatures whose crime is often motivated by sex. In 1975 Adler suggested that women were committing more traditional male crimes due to the feminist movement toward gender equality. It has even been postulated that women's crime will eventually catch up to that of men because of the greater opportunity now afforded to female criminals. The current liberal feminist philosophy as it relates to women and crime is that as education, employment, and political opportunities increase for women, their level of crime will decrease (Grana, 2002).

According to Grana (2002), there are four different types of feminist theory, including liberal feminism, radical feminism, Marxist feminism, and socialist feminism. They all focus on the oppression of women in a world dominated by men. These various theories are commonly used to explain why women commit crimes. After a comprehensive understanding of these theories has been achieved, they can also be used to explain why women receive subordinate health care while incarcerated.

A. Liberal feminism

Liberal or mainstream feminism theorizes that women are not afforded the opportunities that men are, which is why some are forced to commit crimes to obtain basic necessities, that is to support themselves and their children (Grana, 2002). Liberal feminists are not concerned with gaining special privileges, but rather seek equal status with men in society, including access to equal pay and position (York University, 2006).

The liberal feminist movement has its roots in the 18th century, when Mary Wollstonecraft, an influential Irish/English feminist, published *Vindication on the Rights of Woman* (1792). In this pioneering treatise, she purported that women are not emotionally fragile by nature, but are molded that way by the society in which they live. She was convinced that education was the impetus that would lift women from their position of servitude to one of respect, from mere “adornments” to useful human beings. Her radical beliefs, particularly about women’s sexuality, posed a

threat to conventional society, and another hundred years passed before her ideas began to be considered (Kreis, 2004).

Early waves of the liberal feminist movement began with efforts to seek education for women and the right to vote, an entitlement not to be acknowledged until 1920. Once this milestone had been achieved, there was little activity in the feminist movement until the 1960's, when women began demanding equality in the social, political, and economic world. Feminist leaders like Betty Friedan and Gloria Steinem confronted traditional conservative society with their radical views on women's liberation and the quest for equality of the sexes (Cornell College, 2000).

Liberal feminists seek to remove barriers to equality, not to battle patriarchy or capitalism (Welch, 2001). Barriers to gender equality can be removed through the process of ridding the legal system of laws that discriminate on the basis of gender. As a branch of this philosophy, feminist legal theory asserts that the law treats men and women unequally. Clare Dalton, a Harvard Law School graduate and professor at Northeastern University, is a leading proponent of this theory. She has dedicated many years of her life to the problem of domestic violence, and is a frequent speaker on the topic (Robert Reich, 2002).

Some adherents of liberal feminism believe that monetary amends should be made to women who are the victims of past discriminatory practices (Cornell College, 2000). Indeed, Lilly Ledbetter was granted such an award and lent her name to the Lilly Ledbetter Fair Pay

Restoration Act, signed into law on March 11, 2009 as one of President Obama's first official acts. It established the White House Council on Women and Girls, led by Valerie Jarrett, and according to Obama will "ensure that American women and girls are treated fairly in all matters of public policy" (Boston Globe, 2009).

B. Radical feminism

Radical feminism theorizes that women are victims of a patriarchal society, in which men have all the power and women are forced into positions of subservience. The oppression of women is viewed as such a long-standing, deeply engrained problem that followers of radical feminist theory feel compelled to reject much of documented science, as it was conducted within the framework of male-centered culture (York University, 2006). This theory emphasizes the societal condition of women being viewed as sexual objects and used for free labor within marriage. In this view, women's lowered status makes them vulnerable to crimes of sexual harassment, rape, and domestic violence (Grana, 2002). In the criminology field radical feminists examine the legal system's role in the oppression of women (Drislane & Parkinson, 2002).

C. Marxist feminism

Marxist feminism blames capitalism for the oppression of women, and theorizes that when capitalism is replaced (with socialism) then women will enjoy freedom from oppression (Grana, 2002). It emphasizes

equal pay for equal work and the concept of “comparable worth” (Cornell College, 2000).

Many poor families are headed by single women who work for substandard wages, thus forcing them into the predicament of having to accept welfare from the government to support their children. Alternatively, they must depend on a man for support. Marxist feminist theory proposes equal pay for equal work, thus eliminating the need for government assistance in many cases (Cornell College, 2000). This equality of pay would ensure that women are afforded the same opportunity as men to earn enough money to care for their families. The effect of this outcome on the women’s prison population is an obvious one: the need for many of the crimes committed by women in need of money would be eliminated and fewer women would be committing crimes to support their families.

D. Socialist feminism

Socialist feminism attributes women’s oppression to both patriarchy and capitalism, either together or with one overshadowing the other (Grana, 2002). In socialist feminist theory, it is this oppressive combination that drives women to commit crime. Juliet Mitchell espoused this theory in her 1971 writing of *Woman’s Estate*, in which she describes the following four variable components of women’s condition:

- *Socialization* refers to the biological “destiny” of women to become mothers, and the raising of daughters in a patriarchal society.

- *Production* refers to any work that women do, whether it is for monetary profit or free labor, as in the home.
- *Reproduction* defines women's roles as mothers and the social, emotional, and professional cost associated with bearing and raising children.
- *Sexuality* is defined by the society in which we live, in this case (the United States) patriarchal and capitalist. The standards and cost of being sexually attractive are determined by society in general, and males in particular.

Grana gives the name q*uadraplexation* to the interaction of these four variables (Grana, 2002).

Technology can be credited with more recent trends in social feminism, as traditional jobs requiring male brute strength have been gradually replaced by automation, allowing women to perform many of the same jobs formerly exclusive to men. As our once agriculturally based economy evolved into industry-driven capitalism, patriarchy was disrupted, allowing a window for social feminism to take hold (Ehrenreich, 1976). Followers of socialist feminist theory advocate a classless society (Drislane & Parkinson, 2002), rejecting the individual in favor of the common good (York University, 2006).

E. Application to women's health care

Imprisoned women face all of the discrimination and oppression conferred upon women in the general population, only greatly magnified.

The poorest and most marginalized women in our society are the most susceptible to substandard health care, and where could there be a better place to find such a population than in our women's penal institutions, locked away from the public eye and immersed in the ultimate den of degradation and oppression? They are literally imprisoned in a "system that is fundamentally gendered male" (Crooms & Gardiner, 2004, p. 264).

In her book *No Longer Patient: Feminist Ethics & Health Care* (1992) Susan Sherwin cites significant discrepancies between male and female health care in terms of diagnosis, treatment, and research. Medical research has concentrated on men, particularly in the field of cardiovascular disease, even though heart disease is also the leading cause of death among women. Women receive an abundance of medical treatment, she says, but it is too often inappropriate or unnecessary. They are at times not offered the best treatment because of the medical community's perception that women are not capable of understanding medical jargon or following their instructions. In keeping with the concept that the most oppressed and least privileged receive the poorest healthcare (and have the most health problems), incarcerated women, particularly those of color, are deemed undeserving of quality health care (Sherwin, 1992).

The California Coalition of Women's Prisoners (CCWP), established in 1995, advocates on behalf of incarcerated women for the exposure and reformation of deplorable living conditions in prison,

including substandard and negligent health care. At the forefront of their advocacy is the need for adequate funding of women's health care, which has traditionally been underfunded relative to that of the male prison population. Members cite unnecessary and botched surgeries (especially mastectomies) by unqualified medical staff, lack of availability of needed medical provisions, and distribution of inappropriate and expired medications (Whitehead, 2007). Incarcerated women have endured long, agonizing deaths for ailments that could have been simply treated if addressed in a timely, thoughtful, and competent manner (Talvi, 2007). CCWP stresses the need for feminist activist groups, theorists, and scholars to stay focused on this too often overlooked element of society (Whitehead, 2007). Indeed, Talvi acknowledges that the focus of her writing had been primarily male prisoners until her most recent book, *Women Behind Bars*. Her realization that imprisoned women are still often viewed through stereotypical eyes of age-old sexism and the "overt medical neglect of women's chronic health needs" spurred her to do more research and writing on the topic of women's struggles in prison (Talvi, 2007, Why a Book About Women in Prison section, para. 4).

All of the strands of feminist theory discussed above claim that women are forced into crime by societal oppression, whether by patriarchy, capitalism, or any other barriers to equality. As women are relative newcomers to the prison system, they have been fitted in to a system that was designed for and by men. Although efforts have been

made over the years to provide appropriate facilities and care for female inmates, there is still significant work to be done in this area. The following statement was made more than ten years ago, but it still holds true in today's correctional environment: "reproductive health care notwithstanding, the systematic denial to women of parity of services readily and routinely available to incarcerated men is the most widespread and invidious impediment to adequate health care for women offenders" (Ross & Lawrence, 1998, p.122).

IV. EXAMINING EFFECTIVE PROGRAMS

Currently there are no universal standards for women's healthcare in our nation's correctional institutions. However, several organizations have developed a specific set of standards that they strongly suggest women's prisons implement in order to properly care for the inmates' reproductive needs. The Federal Bureau of Prisons does have specific guidelines that federal prisons must follow, but no other institutions are required to abide by them. These guidelines assure that women receive quality preventive care, as well as adequate treatment of existing health problems. Clearly, such a program would be invaluable to prisons across the country, not just federal institutions.

The fact that effective programs do exist and organizations have developed guidelines deemed appropriate for women's health care in prison is encouraging. The next step is to stress the importance of addressing this issue to the public. It is important to explain not only how the inmates will benefit from such a program, but also how the communities in which these women will eventually reside will benefit.

The three programs that will be discussed are: the American Public Health Association Standards, the National Commission on Correctional Health Care Standards, and the Federal Bureau of Prisons Clinical Practice Guidelines. Each program details specific guidelines to be followed in order for women in prison to receive adequate reproductive health care. The value and importance of these guidelines will be

explained in the following sections. Not only is it essential to provide quality care for the health of the prison population and the general population to which they will be released, but it is mandated by the U.S. constitution that we provide adequate care for those we have incarcerated. Inmates have no means of securing health care for themselves while imprisoned, so we are obligated to provide it to them.

A. American Public Health Association Standards

The American Public Health Association (APHA) was the first organization to publish standards for healthcare for those who are incarcerated. Since its first set of standards was published in 1976, they have been revised two more times to accommodate problems associated with growing prison populations. The current third edition (2003) is unique in that it covers sexual activity and gender issues extensively, including specific guidelines for the care of women in prison. The standards promote providing inmates with quality and timely care to improve the health of inmates and ultimately the community (APHA, 2003).

It is essential that all new inmates are told how to request medical intervention when necessary, and such requests must be reviewed on a daily basis. Sick call must be available at least 5 days out of the week to see inmates with non-emergency problems. It is also necessary for such healthcare standards to be evaluated and updated by the systems that employ them. Any problems in inmate care should be resolved promptly as well as improvements made when necessary to meet the national

standards of care. The medical staff must be licensed and properly trained to address health needs in a correctional setting and there must be an adequate number of employed professionals to ensure quality care. In order to have ample resources to care for inmates, programs must have sufficient funding (APHA, 2003).

As part of intake procedure, all inmates must receive a full medical examination and screening sometime within the first week of incarceration. They must be asked about their medical and sexual history. Women should be tested for pregnancy, syphilis, Chlamydia, gonorrhea, and given a Pap test to detect any irregular cervical conditions. Follow-up care should be planned and recorded at the initial visit. Follow-up care must be swiftly provided for all health problems detected and any abnormal test results must be monitored, evaluated, and treated if possible. If patients are in need of a more specialized service that standard health care providers cannot provide, the institution must make access to such services available. In cases where emergency or urgent care is necessary, it must be given and it must be up to national standards. Often urgent care can eliminate the need for later emergency care, so these requests must be listened to. All inmates must be given health evaluations on a regular scheduled basis. For women, this includes breast exams, Pap tests, and mammograms when appropriate according to age and risk factors. When inmates are released from the institution, the medical staff needs to be notified in advance so they have time to gather the inmates'

records and make plans for receiving medications and follow-care (APHA, 2003).

Standards for handling STDs are particularly important because of the large number of inmates who are considered to be at high risk for STDs. If prisons handle these diseases properly, the rate of transmission will be lower, there will be fewer incidents requiring emergency care, and fewer deaths. Inmates should be taught STD prevention to reduce the spread of disease in the prison and in the community into which they are released. Due to the risk for cervical cancer, women should be taught about human papillomavirus (HPV) and the need for Pap tests. The subject of birth control should also be addressed, with a regimen beginning one month before the inmate's projected release date. STDs must be treated following the CDC guidelines, and medications should be administered in the fewest number of doses possible so that prisoners are not released before their treatment is complete. Each STD should have its own treatment protocol and special housing should be provided when needed. Despite rules prohibiting sexual activity in the prison setting, it does occur and health service providers must acknowledge this fact (APHA, 2003).

Because the majority of women in prison are of reproductive age and are at high risk for many related health issues, an extensive list of special health service provisions that should be available to female inmates is provided in the APHA standards.

- Initial screening should include gathering of patient history (including pregnancies, children, any physical abuse or drug use, known diseases of the reproductive system, contraception, and safe sex practice), a breast exam, instructions for self breast exam, and a mammogram if age appropriate. A pelvic exam should include cytology to test for cervical cancer and samples to test for vaginal disease including Chlamydia, syphilis, gonorrhea, and any other infections.
- Periodic exams of the reproductive system (including the above) should be given and documented in keeping with community standards.
- Onsite gynecological services including ultrasound and colposcopy should be available along with prompt attention and follow-up.
- Appropriate prenatal care must be provided as soon as a pregnancy is confirmed. This must include any special dietary requirements, tests and screening, and care required for high risk pregnancies according to the standards of the American College of Obstetrics and Gynecology.
- Pre-scheduled arrangements must be made with a hospital to accommodate the pregnant inmate for delivery of her baby, allowing extra in-hospital time for mother-infant bonding. No restraints are to be used during labor or delivery.

- Following delivery, a mother must either be placed in a facility that allows her to be with her infant or be allowed regular visiting privileges to a nursery.
- Prison health staff must be trained to safely deliver a baby in case of emergency.
- Family planning services, including contraception and abortion, must be made available to incarcerated women. Sterilization must take place only with informed consent.
- Hormone replacement therapy (HRT) should be made available when appropriate.
- Abusive relationships need to be recognized and discussed. The safety of female inmates must be ensured and services provided to deal with the physical and emotional effects of abuse.
- All sexual contact between male and female prisoners and/or staff is considered nonconsensual and will not be tolerated. Care must be taken to ensure that male guards are not assigned to duties that involve inappropriate exposure of female inmates.
- Community social service programs must be involved with female inmates who have minor children. They should facilitate reasonable visits with the children and provide necessary help and counseling.

(APHA, 2003)

B. National Commission on Correctional Health Care Standards

The National Commission on Correctional Health Care (NCCHC) was established in 1983, as an outgrowth of the American Medical Association's (AMA) involvement in the 1970's effort to improve health care in correctional institutions. An investigation by the AMA revealed insufficient and poorly managed health care for inmates in the jails and prisons of the United States, and found a lack of national standards. The NCCHC evolved into a major non-profit organization that acts as a sentinel to the nation's correctional health care standards, abiding by the constitution as well as currently accepted medical practice. The standards published by the NCCHC are acknowledged by the medical and corrections professions as well as courts as the benchmark of health care in correctional institutions. The group has expert input from hundreds of health care and administrative professionals, and provides an array of services and publications to aid correctional health care professionals in their endeavor to offer quality care to the nation's incarcerated population. Its *Standards for Health Care in Jails* and *Standards for Health Care in Prisons* (published in two separate volumes) are distributed free of charge to all accredited correctional institutions in the United States. The positive effects of improved health services in prisons and jails carry over into the general population when inmates are released (NCCHC, 2009).

The NCCHC's latest revisions to its *Health Care Standards* were introduced in October of 2008 at the National Conference on Correctional Health Care, held in Nashville, Tennessee. They have since been

published and distributed to all accredited correctional facilities. Updates reflect current community standards in the medical and corrections fields, and offer a new level of efficiency and flexibility to corrections health care workers. Field observations as well as recommendations from task force members were used in the three-year long revision process. New standards require a more thorough initial screening, but offer the option to forego the initial health assessment if it is not indicated (i.e. if the patient is in good health). If the assessment is indicated, it must be completed within a week in prisons and within two weeks in jails. The standards stress the importance of prompt (within a few days) diagnosis and treatment for incoming inmates who are already sick. The revised standards also provide for more efficient and cost-effective administrative procedures, with an attempt to minimize paperwork and concentrate on actual medical care (NCCNC, 2009).

Specific changes that directly affect reproductive health care for female inmates are the following:

- Pelvic/Pap exams are required for females in prisons and recommended for females in jails.
- Essential care of pregnant inmates is clarified, including care of opioid-dependent pregnant inmates.
- Continuity of care instructions are detailed.
- Attention to patient safety and improved clinical practice.

(NCCHC, 2009)

C. Federal Bureau of Prisons

The Federal Bureau of Prisons (BOP) guidelines have been established for preventive health care for inmates in federal institutions. The guidelines, based on recommendations from the U.S. Preventive Services Task Force (USPSTF), do not include standards for diagnostic or medical treatments. They specify that new inmates be screened for communicable and/or chronic diseases, any current drug abuse, and mental illness (BOP, 2007).

Inmates and health care providers together are responsible for the efficient delivery of preventive health care. Inmates are to be given written directions detailing the proper procedure to obtain services. Intake screening pertaining to female reproductive care includes the following:

- Syphilis screening for females
- Chlamydia testing for females under age 25, those with HIV, or a history of prior STD infection. This test may be performed by cervical swab or from urinalysis by nucleic acid amplification test (NAAT).
- A Pap smear will be administered to look for cervical cancer. Specific instructions are given for examination of all areas of the cervix.
- A measles-mumps-rubella (MMR) vaccine is to be administered to women of child-bearing age who have not previously received it as an adult.

(BOP, 2007)

Preventive health care visits should be scheduled within six months of intake. At this time, any risk factors and the frequency of recommended preventive visits will be assessed. After this, periodic visits are recommended every 3 years for inmates under age 50 and every year for inmates 50 and older. This frequency, however, should be patient-specific. Reproductive health services offered to inmates based upon risk factors include the following:

- Breast cancer screening to be done by mammogram every 2 years beginning at age 40 and every year for high-risk inmates.
- Cervical cancer screening by Pap smear to be done annually for females age 30 and younger and every 3 years for females age 31-65.

(BOP, 2007)

All three of the above programs guidelines offer reasonable standards of care for women's reproductive health needs, along with general healthcare recommendations. The BOP standards focus on preventive care, which is a good policy in or out of the prison setting. The APHA standards offer a complete set of guidelines, including preventive care, with the focus on public health. The NCCHC standards are very complete in their scope of health care, while satisfying constitutional requirements, and have been revised the most recently (2008) to reflect current standards. All of the programs outlined here suggest preventive care and

treatment intervals that are equal to community standards, and do not suggest inferior care for those who are incarcerated. All three programs have been carefully compiled by highly qualified professionals in the field of medicine and health care administration.

V. RECOMMENDATIONS FOR IDEAL PROGRAM

As illustrated in the previous section, there are several organizations that have developed detailed standards for women's health care in prison which they deem necessary in order to provide quality preventive care. Prisons cannot blame their administration of inadequate care on a lack of reputable guidelines. The standards listed above are published and/or offered free to all prisons and are compiled using reliable medical and government sources. It is quite apparent that many of the published standards would greatly improve the care women are currently receiving in prison if combined in one unified document to be universally implemented in prisons all across the country.

Medical professionals concur that women require unique care in order to evade potentially serious medical problems. This is especially true of women in prison since they are at a higher risk for disease than the general population. If not given adequate reproductive health care, women may develop damaging, even deadly conditions that will plague both the prison system and the community. Of course, men's health care is important too, but women are susceptible to a plethora of problems relating to their reproductive system and generally receive care inferior to their male counterparts.

All of the standards recommended for women in prison are also recommended for women outside of the prison community, with the exception of some unique suggestions for those incarcerated in close

quarters with one another. This implies that all women are entitled to receive the national standard of health care whether they are behind bars or not. Based on this principle and thorough examination of the reputable programs discussed in the previous section of this paper, recommendations for an ideal preventive program will be discussed below. A discussion on the importance of the universal application of this program will follow.

A. Description of ideal program

An ideal preventive reproductive health care program must consist of the following recommendations, most of which can be found in previously discussed programs, with some additional recommendations added following review and analysis of the literature:

Intake procedure

During the first week of incarceration all women must be given a complete medical examination with a breast exam, pregnancy test and a Pap test to detect the presence of cervical cancer or precancerous cells. This must also include screening for Chlamydia, gonorrhea, syphilis, and HIV. At this initial meeting, a full medical history must be gathered, which includes information about past sexual partners, preexisting conditions, substance abuse, pregnancies, family history, and prior STD infection.

Follow-up care

If it is found that follow-care is necessary because of an abnormal Pap-test, positive STD test, or pregnancy, it should be planned

immediately and the upcoming procedures and treatment described in detail to the patient. The inmate must know the date of her follow-up appointment before she leaves the initial intake visit. Of course this care will be administered in a timely manner to avoid any serious complications that can arise with neglect. If a procedure is needed that cannot be provided by the medical staff within the prison, plans for obtaining it an outside facility will be made.

Knowledge of procedure for requesting care

New and existing inmates must be properly informed on the procedure for requesting care. This procedure should be explained upon intake along with all the potential reproductive problems that could occur if prompt care is not requested. Inmates must be provided with a list of services available as well as the reason for such procedures. Because of poverty and lack of education, some inmates may not be aware what the national standard of health care for women involves and may be behind on necessary screenings.

Swift response to inmate requests

The medical staff must review requests for care on a daily basis to ensure that no serious problem is overlooked or postponed for a dangerous amount of time. Inmates must have access to health care at least five days of the week to deal with problems that are not emergencies, but may become more severe if left unattended.

Treatment of STDs

A standard protocol for treating various STDs is necessary. The CDC guidelines for treatment should be followed. Since inmates are continually released from prison, it is wise to prescribe the treatment with the minimal amount of doses needed to remedy the problem so they are not released in mid-treatment. This will also be more efficient for prison staff administering medications. Usually those infected with STDs do not need to be separated from other prisoners, but if the disease is extremely infectious, even without close sexual contact, the inmate(s) will be isolated until the treatment has worked to avoid an outbreak of any disease within in the prison.

Inmate education

Educating female inmates about their reproductive systems, including the spreading of STDs, pregnancy, and the purpose of routine exams (including self breast exams) is imperative. The prison setting offers a unique opportunity to educate a portion of the population at particularly high risk for disease and pregnancy. Taking advantage of this opportunity will improve the reproductive health of female prisoners and the community into which they will be released by reducing the spread of STDs, unwanted pregnancies, and preventable cases of cancer. Young women in particular should be informed about birth control options and told where they can receive free or inexpensive birth control at a local Planned Parenthood (or similar organization) when released. Prisons may also wish to take this opportunity to vaccinate women against certain

strains of the human papillomavirus that are known to cause cervical cancer. The relatively new Gardasil vaccine is effective but expensive, so this should be optional and only for those at the greatest risk.

Routine evaluations

All female inmates must receive routine medical evaluations as they would outside the prison to maintain a healthy reproductive system. Women will receive Pap tests, breast exams, and mammograms as recommended by medical professionals according to age and possible risk-factors. The initial evaluation should be done about six months after intake, and the spacing of future evaluations will be planned at this time, again, according to age and need.

Pregnancy, prenatal care and delivery

If any inmate enters the prison pregnant or becomes pregnant while incarcerated, she has the right to have an abortion. Pregnant inmates must be given an especially nutritious diet and appropriate screenings and check-ups, comparable to what would be received outside of the prison facility. The hospital in which the inmate will deliver must be planned ahead of time for efficiency and ease. Women must be free of shackles and may not be chained to the bed during delivery for obvious safety reasons. After the birth of the child, the woman will be allowed to visit her baby up until the time when another party assumes care for the baby. There should always be one member of the prison staff on duty who is trained to deliver babies in case emergency delivery is necessary.

Inmates with children

Within in the first couple weeks of incarceration, arrangements must be made for female inmates with children to have scheduled visitations. This would obviously have to be conducted in a special room in the prison, preferably one that does not resemble the rest of the prison. Instead of sitting across a table or behind glass, inmates will be allowed to sit in a child-friendly room with their family for the visit. Any chains should be removed from the mother before she enters the room and put back on after the child has left.

Urgent and emergency care

No inmate shall be denied necessary urgent or emergency care. If special attention is paid to requests for urgent care, the need for expensive emergency care will be reduced and fewer inmates will suffer permanent reproductive damages. Their must be a designated procedure for notifying guards that care is needed immediately. This should also be explained upon intake.

Sexual abuse

Any instance of sexual abuse, whether it be between inmates or inmate and guard, should be promptly reported. Any guards guilty of sexual contact with an inmate will be permanently removed and punished by law. To help prevent the occurrence of such acts, there should be predominantly female employees in women's prisons. When males are employed, they must not have contact with female inmates unless in the

presence of other employees (just as a nurse would sit in on an appointment with a male gynecologist). They should never be allowed to view the women when showering, dressing or using the bathroom.

Release procedure

The medical staff must have a detailed procedure for handling the release of female inmates. Inmates will need documentation of the care they received while in prison so that health professionals outside the prison system will be able to examine and treat them properly. Some inmates may be released before a treatment is finished, in which case they should be provided with medication to take with them, or directed where to get affordable follow-up care in the community. Women intending to resume birth control after release should be given pills (or equivalent method) to start a month before their release to avoid unwanted pregnancy.

Licensed professionals

The medical staff in women's prisons must consist of licensed professionals, specifically trained and qualified to deal with women's reproductive issues with knowledge and sensitivity. An ample number of professionals should be hired to assure that all of the women's reproductive health care needs can be addressed efficiently. Specific numbers will depend on the number of women the institution houses at one time.

Hire more specialized physicians

Women have complicated reproductive systems and they often require specialized care. Prisons must hire more physicians that possess expertise on conditions of the female reproductive system. Having physicians within the prison system that can perform all of the necessary exams, screenings, and treatments will save the prison money, make providing care more convenient and secure, and improve the timeliness of the care that is received, ultimately resulting in the prevention of more serious and costly medical conditions. Having unqualified or inexperienced physicians and/or too few physicians will jeopardize the health of the inmates and the community in the long run. Proper initial care is far more cost-effective than paying for mistakes and neglect resulting from inadequate care.

Increase funding

Sufficient funding must be available in order to provide women with quality reproductive health care. Women have a long history of receiving inferior care compared to men. The budget must allow for women to receive care equal to that they could obtain outside the prison and in accordance with national standards. If a prison evaluation finds a prison is not up to par with its women's health care program, it must increase funding in that area and promptly correct the problem. An appropriate portion of local taxes should go for funding proper health care, in addition to a portion of federal taxes. Health and safety of the prisoners should be the number one priority and they need to be treated accordingly. If extra

programs need to be temporarily cut to ensure the health of the prisoners, this must be done to increase funding for proper medical care. Of course, ideally, nothing will be cut and medical care will be enhanced.

Evaluation of programs

It is essential that each prison's health care program be routinely evaluated by a nonpartisan official to make sure it is running in accordance with the standards set by the universal preventive health care program. When appropriate, updates and improvements to the program should be made in a timely manner.

B. Importance of universal application

Consistent care throughout the nation's correctional healthcare systems would make transfers smoother and releases back into the community safer. When inmates are transferred from one prison to another, which is common practice, the method of treatments for various conditions may vary, as well as the routine evaluations and services offered. Transferred inmates who were currently undergoing treatment may be forced to switch treatments, thus delaying recovery, and in some instances resulting in inferior treatment plans, or worse, no treatment at all. With national standardized care, inmates being transferred would be able to easily resume ongoing treatments and receive the same level of care. Inmates can be sure that serious health problems addressed in their current prison will also be addressed upon transfer. With everyone receiving the same standard of care, we can be sure that no transferred

inmate will be susceptible to diseases in the new prison that were treated and under control at their former prison. Likewise, no transferred inmate will introduce any new disease carried over from the former prison into the new prison.

When considering issues of importance, public safety must be kept in the forefront. With the implementation of a universal quality preventive healthcare program, the public can take comfort in the fact that all female inmates released into their respective communities will have been thoroughly evaluated and treated for any possible diseases. They will also be thoroughly educated on the spread of diseases and preventing unwanted pregnancies. Because this high-risk group of individuals is effectively targeted while in prison, this is sure to decrease the spread of infectious STDs in the community and reduce the number of unplanned pregnancies.

National guidelines adhered to by both federal and state prisons would facilitate efficient operation of a quality preventive reproductive healthcare system, and would prevent discrepancies in care from one part of the country to another that could result due to politics or local community prejudices. Regional variances in healthcare services and attitudes must become a thing of the past. The nation has come a long way since its division and segregation of select groups of the population, but we have not completed the journey until we are all treated as equals, regardless of race, sex, religion, etc. By universally implementing a set of

national guidelines for all women's prisons, we are one step closer to ensuring that our constitutional rights are being upheld.

C. Suggested future research and need for action

Publications devoted to women's healthcare in our nation's prisons are a relatively new development. Because women in our correctional system have historically been ignored and have taken a back seat for so many years to men and programs designed for them, it is imperative that we now devote some significant resources, both human and financial, to resolution of this oversight. Consequences of operating with blinders on are sure to prove costly, both in terms of lives, quality of life, and cost. By combining the best features of preexisting healthcare guidelines and utilizing the thousands of hours of expert input already in place, the time and cost of further study and research can be kept to a reasonable level.

Studies showing the positive outcomes of implementing a comprehensive reproductive health care program for women prisoners are necessary in order to prove its cost effectiveness as well as its health benefit to the public. Much of the groundwork work has already been accomplished by highly qualified professionals and now needs only to be examined and evaluated to make the case for universal application of such a program. The focus must be on proving the value of a universal comprehensive healthcare program for correctional institutions, both in terms of cost efficiency and public safety.

Existing records can be examined to show the high price paid for inadequate or even harmful healthcare, including lawsuits for delayed or denied treatment of needed reproductive healthcare, sexual abuse by prison staff, and even death and disability suffered from neglect or poorly administered medical care. Obviously, comparing costs over the long term can and will require considerable time. Thus, it would be efficient to further examine current and past records pertinent to medical practice in correctional institutions, and to incorporate the expertise of those who have already invested hundreds of hours in evaluating health care standards.

Acknowledging the fact that, according to constitutional law and regardless of cost, adequate healthcare must be provided, this paper recommended implementing a new universally applied comprehensive healthcare program in our nation's women's correctional institutions as soon as possible. From that point forward, researchers can track the effectiveness of the new system compared to historical records.

VI. SUMMARY AND CONCLUSIONS

Since the first women were imprisoned they were relegated to the attics and closets of men's prisons and forgotten. History has shown little concern for female prisoners, having concentrated its efforts on programs for male inmates. Obviously, males make up a much larger percentage of inmates than do females (90% male vs.10 % female) and thus have been the focus of most of the attention (Roth, 2007). It has taken many years to progress to the point where women are housed in their own dedicated prisons and federal guidelines recognize the need for specialized reproductive health services for women. Now, after carefully considered input from hundreds of professionals in the fields of medicine, correctional medicine, public health and administration, we are in position to hone the present systems into an ideal health care system - particularly preventive reproductive health care for female inmates.

Undeniably the most difficult obstacle to overcome will be convincing the public of not only the necessity but the requirement to provide quality reproductive health care to the nation's incarcerated women. Already in society's lowest possible social stratum, this group has little in the way of support and few advocates to help them gain it. Most of them have already been neglected, abused, and discarded. It will be necessary to explain to the public that, because we have chosen to lock these members of society away, we are obligated by our constitution to

provide them with adequate health care. That is care that is equal to what can reasonably be obtained outside the prison walls.

Constitutional obligation aside, it is also necessary to educate the public about the intellectual good sense of providing quality healthcare to those who are incarcerated. The reaction of many might be, “Why should they have access to better health care than I have, and why should my tax dollars pay for it?” It is true that many people who are not in prison have little or no health care, and those who do may pay a hefty price for it. Nevertheless, nearly all of the women who are incarcerated will eventually be released back into society, and it is a public health concern that they not be released with communicable diseases.

Once the public and its elected representatives have been persuaded that there is a need for improvement in the area of healthcare for incarcerated women, it is their obligation to exert the pressure necessary (on prisons and government officials) to drive the reform of our current standards, establish a universal program, and demand its implementation and oversight. In some cases, that may mean simply abiding by the federal standards already in place, and enforcing any infractions of the requirements. In other cases, getting on board with a unified set of standards would be in order. In all cases, adherence to the universal guidelines would be mandatory, to include program evaluation and oversight.

With an ever increasing female prison population, due largely to tougher drug laws and their enforcement, it is time to re-evaluate our obligations to the women we incarcerate. By locking up increasing numbers of single parents (usually female) who have minor children, we have disrupted families and created societal dysfunction. By incarcerating pregnant inmates we now incur the responsibility for prenatal care, birthing, and aftercare. Women come equipped with a whole set of reproductive health issues unique to their gender. It is imperative that we take responsibility for these side effects of justice by providing appropriate preventive reproductive healthcare to women in prison. They should not be further punished by negligent or inferior healthcare.

REFERENCES

American Civil Liberties Union. (2006). *Women at Wisconsin's Taycheedha prison suffer medical neglect and receive worse mental health care than men.* Retrieved October 14, 2008, from http://www.aclu.org/prison/women/25405prs20060502.html

American Public Health Association. (2003). *Standards for health services in correctional institutions.* Washington, D.C. American Public Health Association.

Barry, E.M. (2001). Bad medicine: Health care inadequacies in women's prisons. *Criminal Justice Magazine, (16)*1. Retrieved February 2, 2009, from http://www.abanet.org/crimjust/cjmag/16-1/barry.html

Boston Globe. (2009). *Obama creates women's council*. Retrieved March 19, 2009, from http://www.boston.com/news/politics/politicalintelligence/2009/03/obama_creates_w.html

Braithwaite, R.L., Arriola, K. J., & Newkirk, C. (2006). *Health issues among incarcerated women.* New Jersey. Rutgers University Press.

Center for Disease Control and Prevention. (1999). Chlamydial and gonococcal infection in women entering jails and juvenile detention centers. *Morbidity and Mortality Weekly Report, 48*(36), 793.

Cornell College. (2000). *Feminist theory*. Retrieved March 22, 2009, from http://www.cornellcollege.edu/womens_studies/resources/theory. FEMINISM

Crooms, L. & Gardiner, J. K. (2004). *Preface to the prison issue*. Retrieved April 4, 2009, from http://www.feministstudies.org/issues/vol-30-39/30-2.html

Drislane, R. & Parkinson, G. (2002). Online dictionary of the social sciences. Retrieved March 24, 2009 from http://bitbucket.icaap.org/dict.pl?term

Ehrenreich, B. (1976). *What is socialist feminism?* Retrieved March 19, 2009, from http://www.cwluherstory.org/CWLUArchive/socialfem.html

Federal Bureau of Prisons. (2007). *Preventive health care.* Retrieved November 25, 2008, from http://www.bop.gov/news/PDFs/phc.pdf

Grana, S.J. (2002). *Women and (in)justice: The criminal and civil effects of the common law on women's lives.* Boston, MA: Allyn and Bacon.

The Institute for Criminal Justice Healthcare. (n.d.) *Our mission.* Retrieved November 21, 2008, from http://www.icjh.org/flashintro.html

Ketcham, L. (2001). *Women in the criminal justice system*. Retrieved October 14, 2008, from http://www.wiwomensnetwork.org/womenandcriminaljustice.html

Kreis, S. (2004). *Mary Wollstonecraft.* Retrieved March 19, 2009, from http://www.historyguide.org/intellect/wollstonecraft.html

Magee, C.G., Hult, J. R., Turalba, R., & McMillan, S. (2005). *Preventive care for women in prison: A qualitative community health assessment of the Papanicolaou test and follow-up treatment at a*

California state women's prison. Retrieved February 2, 2009, from http://www.ajph.org/cgi/reprint/95/10/1712

National Commission on Correctional Health Care. (2009). *About NCCHC.* Retrieved April 14, 2009, from http://www.ncchc.org/

National Council on Crime and Delinquency. (2006). *The spiral of risk: Health care provision to incarcerated women*. Retrieved February 2, 2009, from http://www.nccd-crc.org/nccd/pubs/2006_spiral_of_risk.pdf

Reich, R. (2002). *Meet Clare.* Retrieved March 22, 2009, from http://www.robertreich.org/gov/clare.asp

Ross, P.J., & Lawrence, J.E. (1998). *Health care for women offenders: Specialized services, needs will challenge correctional administration into the next century*. Retrieved April 6, 2009, from http://ncjrs.gov/App/publications/abstract.aspx?ID=176013

Roth, R. (2004). *Justice denied: Violations of women's reproductive rights in the United States prison system.* Retrieved February 5, 2009, from http://www.rhrealitycheck.org/print/5598

Roth, R. (2005). *Women's rights don't stop at jailhouse door.* Retrieved February 5, 2009, from http://www.rhrealitycheck.org/print/5598

Roth, R. (2006). *Reproductive rights in theory and practice: The meaning of Roe v. Wade for women in prison.* Retrieved February 5, 2009, from http://www.rhrealitycheck.org/print/5598

Roth, R. (2007). *What do prisons have to do with reproductive rights?*

Retrieved February 5, 2009, from http://www.rhrealitycheck.org/print/5598

Sherwin, S. (1992). *No longer patient: Feminist ethics & health care*. Philadelphia, PA: Temple University Press.

Summer, N. (2007). *Powerless in prison: Sexual abuse against incarcerated women*. Retrieved February 5, 2009, from http://www.rhrealitycheck.org/print/5597

Talvi, S.J. (2007). *Women behind bars: The crisis of women in the U.S. prison system.* Emeryville, CA: Seal Press.

Welch, P. (2001). *Strands of feminist theory*. Retrieved March 22, 2009, from http://pers-www.wlv.ac.uk/~le1810/femin.htm

Whitehead, J.C. (2007). *Feminist prison activism: An assessment of empowerment*. Retrieved April 4, 2009, from http://fty.sagepub.com/cgi/content/abstract/8/3/299

Wisconsin Department of Corrections. (2005). *Reorganized system in DOC to improve management of female inmates.* Retrieved October 14, 2008, from http:// wi-doc.com/Female_reorg.htm

Women's Prison Association. (2004). *Imprisonment in Wisconsin.* Retrieved October, 14, 2008, from http://www.wpaonline.org/institute/hardhit/states/wi/wi.htm

York University. (2006). *Theories used in IS research: Feminism theory*. Retrieved March 22, 2009, from http://www.istheory.yorku.ca/Feminism.htm