



## POSITION STATEMENT

### Women's Health Care in Correctional Settings

#### Introduction

In 2017, women represented 15% of adults in jails and 7% of adults in prisons in the United States (Bronson & Carson, 2019; Zeng, 2019). While the number of incarcerated males has steadily declined, the number of incarcerated females continues to rise. Women have gender-specific health needs that correctional facilities must address. Rates of substance use disorder, prior trauma and abuse, mental illness, and sexually transmitted infections (STIs) are high among incarcerated women, and higher than those of incarcerated men, and these factors intersect with various adverse social determinants of health that characterize their preincarceration lives (Sufirin et al., 2015). Moreover, the majority of incarcerated women are younger than 45 (Bronson & Carson, 2019) and therefore have specific reproductive health needs. Research on the provision of gynecologic and other women's health care services for incarcerated females is limited, but what does exist has identified neglect of their gender-specific health care needs (Sufirin et al., 2015). This position statement addresses some of the unique health care needs of women in correctional settings.

#### Background

##### *Gynecological*

Research has documented that incarcerated women tend to have higher rates of gynecological conditions, such as irregular menstrual bleeding and vaginal discharge, than nonincarcerated women, and may have had limited access to gynecologic care prior to incarceration. For instance, the chronic stress that characterizes the lives of many incarcerated women, including factors such as unstable housing, poverty, exposure to trauma and violence, addiction, and mental illness, may influence menstrual bleeding. In one study, up to 40% of incarcerated women had abnormal menstrual bleeding (Allsworth et al., 2007). Although the majority of incarcerated women are young and therefore menstruating, their access to menstrual hygiene products is inconsistent and often inadequate (Kravitz, 2019).

To optimize care, a thorough gynecologic history should be collected at intake; standard elements should include menstrual history, sexual activity, prior STIs, prior diagnoses of pelvic pain or fibroids, prior breast and cervical cancer screening, and contraception history. It should also inquire about current symptoms such as vaginal discharge, bleeding, and pelvic pain, and whether the woman has had unprotected sex with a man within the last 5 days (to assess the need for emergency contraception). The U.S. Preventive Services Task Force (USPSTF; 2017) has determined that evidence is insufficient to recommend routine pelvic examinations on asymptomatic, nonpregnant women. Therefore, pelvic exams must be done only when indicated, such as when a woman has symptoms of pain, abnormal bleeding, or discharge, or when cervical cancer screening is due. If a pelvic exam is indicated, health care providers should incorporate a trauma-informed approach (see, for instance, the Reproductive Health Access Project, 2015).

##### *Trauma, Substance Use, and Mental Illness*

Incarcerated women have high rates of mental illness and substance use disorders, which are often inadequately treated in the community. In prisons, 66% of females had a history of a mental health



diagnosis compared to 35% of males (Bronson & Berzofsky, 2017). Similarly in jails, 68% of females had a history of a mental health diagnosis compared to 41% of males (Bronson & Berzofsky, 2017). In state prisons, 69% of females met criteria for drug dependence or abuse (using DSM-IV criteria; Bronson, Stroop, et al., 2017).

The prevalence of histories of sexual, physical, and emotional trauma, including intimate partner violence, among incarcerated women is also astoundingly high, as high as 90% in one study (Lynch et al., 2012). Trauma and victimization may relate to women's involvement in the criminal justice system, and incarceration itself may retraumatize some of these individuals. Such histories can lead to lifelong mental health issues, such as depressive disorders, stress disorders, anxiety disorders, learning problems, substance use disorders (with their attendant physical health problems), and behavioral problems. Screening for traumatic histories can help identify women who need treatment and other resources, and should be done for all women entering correctional facilities. Correctional health staff should be trained in trauma-informed care and be aware of appropriate referrals for those with a positive screen. Importantly, pelvic and breast exams can be retraumatizing for people with a history of sexual trauma and should be done only when clinically indicated.

### ***Breast and Cervical Cancer***

Rates of cervical and breast cancer are higher among incarcerated women, likely related to under-screening both before incarceration and while in custody (Brousseau et al., 2019; Pickett et al., 2018). Most cervical cancers are preventable with appropriate screening via Pap smears and HPV testing. The American College of Obstetricians and Gynecologists (ACOG; 2018) recommends screening all females ages 21 to 29 every 3 years, and those ages 30 to 65 every 3 to 5 years. Immunocompromised women and those with history of cervical dysplasia should have more frequent screening, per national guidelines. Importantly, abnormal Pap smear results must be followed up appropriately, which often means colposcopy. Correctional facilities should not routinely perform Pap smears upon intake, unless the woman is due for one based on previous screening, nor annual Pap smears for women serving long sentences. The Centers for Disease Control and Prevention (CDC; n.d.) recommends HPV vaccination through age 26 to reduce cervical cancer risk, and this can be implemented in correctional settings.

National guidelines for screening mammograms for women of average risk should be followed in correctional settings. ACOG (2017a), USPSTF (2016), and the American Cancer Society (ACS; 2019) all have evidence-based guidelines that differ based on the age of initiation of mammograms, screening intervals, and the role of shared decision making. Correctional facilities should decide on one set of guidelines to follow. Recommendations on screening clinical breast exams also vary, with USPSTF and ACS recommending against it and ACOG recommending annual exams beginning at age 40. As with avoiding unindicated pelvic exams due to lack of benefit and potential to retraumatize women, breast exams for asymptomatic women should not be part of routine intake/exam procedures. Women with known personal or familial risk for breast cancer who are serving long sentences should also undergo screening and diagnostic imaging according to national guidelines (Society of Gynecologic Oncology, 2017).

Follow-up of abnormal pap smear or mammogram results may present challenges in short-stay facilities as women may be released before results are returned. Tracking systems and contact with community health providers may facilitate postrelease cancer prevention and diagnosis.



### ***Sexually Transmitted Infections (STI)***

A common reported symptom among women in custody is vaginal discharge, which may be related to higher rates of STIs, nonsexually transmitted bacterial vaginosis, or physiologic discharge that women may not be aware can be normal. To distinguish among these diagnoses, women with symptoms should undergo appropriate testing. Women entering correctional facilities have high rates of STIs: A Rhode Island study found that 33% of women tested positive for an STI at admission, including 26% with trichomoniasis (Willers et al., 2008). Rates of gonorrhea as high as 3% (Javanbakht et al., 2014) and chlamydia as high as 14% (Willers et al., 2008) have been reported. The prevalence of HIV among incarcerated women was 1.3% in 2015 (Maruschak & Bronson, 2017).

Based on this high prevalence, the CDC recommends that all females age 35 or younger receive screening for gonorrhea and chlamydia at intake to a correctional facility (Workowski & Bolan, 2015). Vaginal NAAT testing has the highest accuracy and women can collect this as a self-swab. Urine testing, while less accurate, is easier to collect and may be appropriate when vaginal swabs cannot be feasibly collected. Given the trauma that pelvic exams can cause, pelvic exams for the sole purpose of GC/CT testing should be avoided. Women in custody should also be screened for HIV and other STDs in accordance with CDC guidelines (Workowski & Bolan, 2015).

### ***Family Planning***

Incarcerated women generally have had limited access to contraceptive services in the community and have high rates of prior unintended pregnancy (Clarke, Herbert, et al., 2006; LaRochelle et al., 2012). A study in Rhode Island showed that only 28% of sexually active women had consistently used birth control in the 3 months prior to incarceration; 85% of these women planned to be sexually active upon release, yet only 9% reported wanting to be pregnant (Clarke, Herbert, et al., 2006). In this same setting, nearly half of the pregnant inmates had become pregnant in between incarcerations (Clarke et al., 2010). Moreover, 60% of incarcerated women who could become pregnant upon release wanted to start a method of contraception while in jail (LaRochelle et al., 2012). Despite this need for contraception among incarcerated women, in a national study of correctional health providers only 38% reported that contraceptive methods were available on-site and 55% said that women could not continue using their current method of contraception (Sufrin et al., 2009). In another study, nearly one-third of women entering jail had had unprotected sex within the last 5 days and could therefore be candidates for emergency contraception (Sufrin et al., 2010).

Research has documented the feasibility in a variety of correctional settings of offering the full range of reversible contraceptive methods, including pills, injectable contraception, intrauterine devices, and implants (Sufrin et al., 2017). However, given the potential for women to experience diminished autonomy and coercion in correctional settings, care should be taken when providing long-acting reversible contraceptive methods, which require a provider to insert and remove the device. Likewise, especially given documented recent abuses in prisons, and in accordance with ACOG guidelines, sterilization should generally not be performed on incarcerated people (ACOG, 2017b). Incarceration is also a time to help women who want to become pregnant after release. These women should receive preconception counseling that focuses on the risks of substance use, improving nutritional status such as folate supplementation, and optimizing physical and mental health (ACOG, 2012).



### ***Aging and Chronic Disease***

Many prisons may be failing to recognize and prepare for the special physical, preventive health, social, and psychological needs of older females (Reviere & Young, 2004), such as menopausal hot flashes, which can be challenging for women to manage in the correctional environment. Incarceration also has been linked to greater prevalence of hypertension, hepatitis, and cancer in women when compared to men, which indicates a need for better health care resources for older females (Binswanger et al., 2009).

### ***Nutrition and Diet***

Correctional institutions should ensure that women across all life stages receive a healthy diet consistent with federal dietary and nutrient guidelines (U.S. Department of Agriculture [USDA], 2020). Obesity is more common among incarcerated women (37%-43%) compared to incarcerated men (20%-27%; Maruschak et al., 2015). While the USPSTF has concluded that evidence is insufficient to recommend routine calcium and vitamin D supplementation to prevent fractures in community-dwelling women, they do not make recommendations for women in institutional settings; diets for women in correctional settings should have adequate calcium and vitamin D, following recommendations from the USDA and the National Academies (n.d.).

### ***Pregnancy, Postpartum, and Parenting***

Some women enter correctional settings pregnant. Sexually active women remain at risk for pregnancy until they go through menopause or have a hysterectomy. Correctional facilities should screen all women for pregnancy with a history, and offer urine testing to all females under age 50 within 48 hours of arrival. There is a dearth of data on pregnancy frequency and outcomes for people in custody, but a 2019 study reported that a total of 4% of women admitted to 22 state and all federal prisons were pregnant, and that 753 women gave birth in custody (Sufrin, 2019). Additionally, most incarcerated women are mothers and the primary caregivers to young children, ranging from 56% in federal prisons to 70% in local jails (Glaze & Maruschak, 2010). Facilities should support efforts for women to provide breast milk for their infants and to maintain contact with their children, and should recognize the psychological difficulties that separation may cause to incarcerated mothers and their families.

Correctional facilities must provide pregnancy and postpartum care in accordance with community standards of care and national guidelines. More information about pregnancy and postpartum care and nutrition in corrections, the nonuse of restraints in pregnancy, and promoting breastfeeding is available from NCCHC through the following resources:

- Pregnancy and Postpartum Care (white paper)
- Restraint of Pregnant Inmates (position statement)
- Breastfeeding in Correctional Settings (position statement)

### **Standards**

NCCHC recognizes that incarcerated women have gender-specific health care needs that correctional facilities must address. In the *Standards for Health Services* (the basis of NCCHC's accreditation program for jails, prisons, and juvenile detention and confinement facilities), standards that impact women's health care include the following:

- Receiving Screening (E-02) requires inquiry into current and past illnesses, health conditions, and special health requirements; this would encompass current gynecological problems and pregnancy status for women and female adolescents.



- Initial Health Assessment (E-04) recommends that clinical practice guidelines be followed for pelvic examinations and Pap smears.
- Medically Supervised Withdrawal and Treatment (F-04 for adults) and Intoxication and Withdrawal (G-07 for juveniles) acknowledge the special management of pregnant patients with opioid use disorders.
- Contraception (B-06 for adults) and Contraception and Family Planning Services (G-08 for juveniles) recommend providing nondirective contraception counseling and methods, access to emergency contraception, and, along with Medication Services (D-02 for adults), continuation of current contraceptive method while incarcerated.
- Counseling and Care of the Pregnant Inmate (F-05 for adults) and Counseling and Care of the Pregnant and Postpartum Juvenile (G-09) specify that comprehensive counseling and assistance are given to pregnant individuals in keeping with their express desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child. It also addresses prenatal care and the nonuse of restraints during childbirth.
- Response to Sexual Abuse (F-06 for adults) recommends that emergency contraception is available.

### **Position Statement**

NCCHC recognizes that the number of incarcerated females is large and growing annually, presenting unique issues for health services. Therefore, NCCHC recommends the following:

1. Correctional institutions must meet recognized community standards for women's services as promoted by standards set by NCCHC.
2. Correctional health services, community clinicians, and advocacy groups can collaborate to provide leadership for the development of policies and procedures that optimize women's gender-specific health care needs in corrections, and to do so in trauma-informed ways.
3. Correctional institutions should provide comprehensive services for women's unique health issues:
  - a. Follow age-appropriate screening guidelines established by national organizations for STD screening, breast and cervical cancer screening, and HPV vaccination.
  - b. Implement intake procedures that include histories on menstrual cycle, prior pregnancies, gynecologic problems, STI risk factors, HPV vaccine history, current and prior contraception use, current breastfeeding, and history of sexual and physical abuse.
  - c. Offer a pregnancy test within 48 hours of admission to all females who could be pregnant—i.e., those who are sexually active (until they go through menopause or have a hysterectomy).
  - d. Screen all women at entry for sexual and physical trauma histories and refer for services as indicated; do not perform routine pelvic and breast exams on asymptomatic women as this is medically unnecessary and may be traumatizing.



- e. Make trauma-informed, gender-appropriate counseling and treatment available for all women, especially those with mental health issues.
  - f. Make counseling and treatment available for women with alcohol and other substance use disorders.
  - g. Recommendations for contraception and pregnancy planning:
    - i. Allow women to continue contraceptive methods they are already on pre-incarceration, especially if their incarceration is short term or if the method is for noncontraceptive reasons.
    - ii. Offer contraception counseling and access to initiating reversible methods of contraception methods in a noncoercive manner, especially in preparation for release.
    - iii. Screen for eligibility for emergency contraception at intake and make such contraception available in a timely fashion.
    - iv. Defer sterilization until release.
  - h. Address the unique health care needs of older women, including symptom management and treatment of menopausal hot flashes.
  - i. Provide individuals with access to an appropriate, no-cost supply of menstrual hygiene products.
4. Correctional institutions should provide comprehensive sexual and reproductive health education to females that includes education about topics such as STIs, normal and abnormal vaginal discharge, and family planning.

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