CONTRACEPTIVE CARE IN JAIL:

REPRODUCTIVE JUSTICE FOR

INCARCERATED WOMEN

by

Kyl Christina Myers

A dissertation submitted to the faculty of
The University of Utah
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Department of Sociology

The University of Utah

May 2018

The University of Utah Graduate School

STATEMENT OF DISSERTATION APPROVAL

The dissertation of **Kyl Christina Myers**

has been approved by the following supervisory committee members:

Claudia Geist	, Chair	**8/18/2017** Date Approved
Elizabeth Clement	, Member	**8/18/2017** Date Approved
Heather Melton	, Member	**8/18/2017** Date Approved
Megan Reynolds	, Member	**8/18/2017** Date Approved
Carolyn Sufrin	, Member	**8/18/2017** Date Approved

and by **Ming Wen** , Chair/Dean of

the Department/College/School of **Sociology**

and by David B. Kieda, Dean of The Graduate School.

ABSTRACT

This dissertation explores women's contraceptive access while incarcerated in jail. In many U.S. jails, women's hormonal contraceptive methods are discontinued and not reinitiated prior to release, and most jails do not provide women in their custody the opportunity to initiate a contraceptive method. Additionally, many women do not have access to postpartum sterilization procedures while in the custody of a jail and giving birth at a local hospital. This dissertation addresses three research questions.

I answer the first research question, "What are the contraceptive needs and method preferences of women incarcerated at the Salt Lake County Jail?" through a quantitative analysis of surveys completed by 194 women incarcerated at the Salt Lake County Jail. I found that just over half of the participants had used contraception in the previous year. Forty-one percent of participants planned to use contraception after release, and 67% reported interest in initiating contraception in jail. Women were most interested in using condoms, IUDs, implants, the birth control shot, and the pill. Providing birth control methods in the Salt Lake County Jail could increase contraceptive use and potentially reduce the number of unintended pregnancies women experience after release.

I answer the second research question, "What attitudes do incarcerated women have toward sterilization occurring while in custody?" through a qualitative analysis of transcripts from three focus groups. The majority of participants believed that sterilization should be available for incarcerated women, and they argued that an organization unaffiliated with the jail should be responsible for sterilization education and consent processes to reduce sterilization abuse. Sterilization of

incarcerated women is a controversial issue and additional efforts should be made to include incarcerated women's voices in the discussion.

I answer the third research question, "What mechanisms and rationales do specific jails utilize to either discontinue or continue and initiate contraceptives for women in their custody?" through a qualitative analysis of transcripts from interviews with jail health care providers working in eight different jails in the United States. Half of the providers described comprehensive contraceptive programs in their facilities, including reproductive life planning, contraceptive counseling, and the availability of a range of methods—including IUDs and implants—for women prior to release. Two providers described limited contraceptive care, and two providers described their facilities having no contraceptive care available for women. Factors associated with comprehensive contraceptive care in a facility included a "champion" who initiated the program and health care provided by a public health department.

This dissertation is dedicated to the women I met inside the jail,

who taught me more about reproductive justice than I ever could have taught them.

TABLE OF CONTENTS

ABSTRACT iii

LIST OF TABLES viii

Chapters

1 INTRODUCTION 1

The Jail and the Women It Houses 3
But Why Would They Need Birth Control in Jail? 5
The Issue of Sterilizing Incarcerated Women 6
A Note About Language in This Dissertation 6
Research Questions and Dissertation Structure 7

2 LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK 10

Introduction 10
Jail, Not Prison 11
Demographic Characteristics of Incarcerated Women 12
Unintended Pregnancies and Births 16
Unintended Pregnancy and Incarceration 18
Contraception and Preventing Unintended Pregnancies 22
Contraceptive Studies in Jail 30
Health Care in Jail 35
Contraceptive Care in Jail 38
Most Jails Do Not Provide Contraceptive Care 39
Key Contributions 42
Using a Reproductive Justice Framework 44
Woman-Centered, Intersectional Research 48
Interrogating Power Dynamics 49
Conclusion 50

3 METHODOLOGY 54

Introduction 54
Chapter 4 Methodology 56
Chapter 5 Methodology 63
Chapter 6 Methodology 73

4 CONTRACEPTIVE NEEDS AND PREFERENCES OF WOMEN AT THE SALT LAKE COUNTY JAIL 83

Introduction 83
Materials and Methods 86
Results 88

Discussion 92
Conclusions 96

5 STERILIZATION ATTITUDES AMONG WOMEN AT THE SALT LAKE COUNTY JAIL . 105

Introduction 105
Methods 111
Results 114
Discussion 132

6 CONTRACEPTIVE CARE IN EIGHT U.S. JAILS 146

Introduction 146
Methods 152
Results 154
Discussion 198

7 CONCLUSIONS 211

Summary of Chapter 4: Contraceptive Needs and Preferences in the Salt Lake County Jail 212
Summary of Chapter 5: Sterilization Attitudes of Women Incarcerated at the Salt Lake County Jail 218
Summary of Chapter 6: Contraceptive Care, or Lack Thereof, in Jails Across the United States 224
Broader Conclusions 230

Appendices

A: CONTRACEPTIVE HISTORY, NEEDS, AND PREFERENCES SURVEY 232

B: GUIDE FOR FOCUS GROUPS 245

C: GUIDE FOR JAIL HEALTH CARE PROVIDER INTERVIEWS 247

REFERENCES 252

LIST OF TABLES

Tables

1. The Contraceptive Studies 52

2. Survey Participants' Responses to Question About Sterilization Opportunity 80

3. Survey Participants' Responses to Question About Sterilization Pressure.....81

4. Survey Participants' Responses to Question About Sterilization Prohibition.....82

5. Demographic Characteristics of all Participants, *N* = 194 97

6. Sexual, Reproductive and Contraceptive Descriptions of all Participants by Percent, *N* = 194.....98

7. Distribution of Participant Interest in Specific Methods by Percent, *N* = 192 99

8. Method Use in Previous 12 Months Compared to Method Interest at Time of Survey 100

9. Chi Square Association Between Methods Used Before Arrest and Method Interest at Time of Survey, by Most Effective Method 101

10. Participant Interest in Methods According to Effectiveness by Percent *N* = 162 102

11. Logistic Regression and Odds Ratios of Factors Associated With Participant Interest in IUDs and Implants 103

12. Three Models of Logistic Regression and Odds Ratios of Factors Associated With Participant Interest in IUDs and Implants 104

13. Descriptions of Survey Participants and Focus Group Participants 140

14. Sexual, Reproductive and Contraceptive Descriptions of Survey Participants and Focus Group Participants 141

15. Focus Group Participants..... 142

16. Survey Participants' and Focus Group Participants' Responses to Question About Sterilization Opportunity..... 143

17. Survey Participants' and Focus Group Participants' Responses to Question About Sterilization Pressure 144

18. Survey Participants' and Focus Group Participants' Responses to Question About Sterilization Prohibition 145

19. Facility and Community Information 207
20. Provider Profiles..... 208
21. Contraceptive Continuation, Counseling and Initiation in Eight Jails..... 209
22. Sterilization Availability in Eight Jails 210

CHAPTER 1

INTRODUCTION

This research project began in 2011 when I started volunteering in Planned Parenthood Association of Utah's (PPAU) education department. There was an established women's health class taught by a PPAU volunteer for women incarcerated in the Salt Lake County Jail. The volunteer teacher was resigning from the position; I was asked if I would be interested in teaching the class. After shadowing the former teacher, I took on the class as the lead instructor.

Four lessons made up the curriculum for the class: (a) anatomy and physiology, (b) contraception, (c) sexually transmitted infections, and (d) body image. Each lesson was taught on a different day, for a total of four classes to complete the women's health course. If women attended all four lessons they were awarded 5 days of "good time," meaning 5 days would be reduced from their sentence. Often, this good time helped women get home for Christmas or a child's birthday.

The class was taught once a week, which meant each course took 1 month to complete. For security reasons, 12 students were allowed into each class. My co-instructors and I noticed there was a high turnover and approximately half of the students would "graduate" while several students would be released from jail before they completed the course. Frequently, women would return to the course, having been released and reincarcerated. As instructors, we decided we could teach more women and more women could attend all four lessons if we taught two classes a week. Our graduation rate increased; while it was good news for the women to get

time off their sentences, as instructors, we were also grateful for the condensed timeframe in which to give the women more information and resources to make decisions about their reproductive health while incarcerated and after release.

It was during my time teaching this class that I became aware that many jails discontinue women's birth control during incarceration. The specific jail where I taught did not allow women to continue their user-dependent methods while in custody, and it was not possible for the women to initiate birth control while in jail. The women in class would share their concerns about getting pregnant after release because they were not allowed to take their pill or get their next Depo shot. They worried that they were pregnant but did not have money to request a pregnancy test and were unsure how to navigate the jail health care system. Women knew their dealer would be on the ramp waiting for them when they were released. They mentioned trading sex for drugs and asked me for condoms, which I was not allowed to give them. Women lost sleep because of fears that their expired IUD would perforate their uterus. They used douching as a method of contraception. Women's misperceptions about fertility and contraception were more deeply rooted and more numerous than four 1-hour classes could undo. However, their desire for knowledge filled the room, and I felt a responsibility to provide them all the information I could.

During my time as an instructor, I entered a sociology PhD program and had a realization. I could continue coming to the jail each week to teach individual women about contraception and how to access it after release, or I could make it my life's work to address the issue on an institutional level and create change in the system so that women could access contraception in jail.

My relationships with PPAU administrators made my research in the jail possible. I spoke with Planned Parenthood's Vice President of Public Policy and told her about my research agenda. She had a relationship with the sheriff's political advisor, which connected me with the county sheriff, the jail commander, the jail

programs staff and the medical director. The administrators understood the importance of the issue, supported my research, and provided assistance that made the entire project possible. The jail commander wrote a letter of support for my institutional review board (IRB) application, PPAU paid for the costs of producing the survey, and one specific captain and two generous sergeants assisted me in coordinating the dates of research and escorting me in the jail, helping me recruit participants, and even bought my research assistants and me lunch in the jail cafeteria between survey administration sessions. I am indebted to the numerous people who generously gave their time to getting this project off the ground.

The Jail and the Women It Houses

The Salt Lake County Jail is a huge concrete complex, with a network of hallways leading to numerous "pods," where the incarcerated population is housed. Each pod has a main sliding door made of steel and glass, which is controlled remotely by the correctional officer in the pod and by the central security office. The pods are large and open with high ceilings. In the center of the pod, there is a small platform with four concrete stairs up to the station for the officer on duty, which has a computer, phone, and control board. The open, communal area of the pods have two or three long tables with connected seats, like a school cafeteria, that are bolted to the cement floor. There are a few pay phones on the walls and a slide-grip apparatus where flyers and papers with resources can be displayed. A television is mounted to the wall and a stack of chairs is available for women to use when watching cable.

The women create a makeshift indoor track, walking laps around the interior of the pod for exercise when outside their small cells. Along three walls there are two levels of cells, stairs on either side, and a narrow catwalk with a metal railing. Two women share each cell, which has a metal bunk bed bolted to the wall and a metal

toilet. On the upper level of the pod, a secure doorway leads into the central visiting area. On the main level of the pod, there are four shower stalls. The women's feet can be seen underneath the door covering two-thirds of the stall.

There is a multipurpose room where classes take place, or where those who are the best behaved earn alone time to watch TV. The room has a glass wall facing the interior of the pod, so the corrections officer can see in, and those in the classroom can see out. In the classroom, one wall holds a whiteboard and the other has a secure door to the maze of jail halls. There is a stack of a dozen plastic chairs.

The women's navy blue uniforms resemble medical scrubs with simple cotton tops and drawstring bottoms. A few women wear red scrubs; the others call them "strawberries." They are new here, and waiting on their navy outfits. They all wear canvas slip-on shoes in bright orange, pilled white socks, and beige bras and underwear, leaving me to wonder if they were white at one point.

The pod's temperature fluctuates and the women employ creative tactics to either cool off or warm up. Women stick their arms inside their short sleeve tops to stay warm, or roll their sleeves up to their shoulders and their long pants up to their knees to cool down. There is a small outdoor court area attached to each pod, but the dark concrete walls extend as high as the entire two-story jail complex so the women find the slivers of sunlight in which to bask, like lizards absorbing warmth from the rays. They stretch, do yoga, and walk laps around the small courtyard in dyads, talking.

The color palette of the entire pod is concrete, cream, and metal that is either an untouched silver or painted a faded light peach color. The women often told me, "We're sensory deprived—we don't see colors or smell smells, or taste things like we do on the outs." They complemented my clothes, my hair, my nail polish. They asked me the name of my perfume and where I got my jeans. They tell me how they cannot wait to get back to their clothes and make-up and hair products and they

share their fascinating tips for jail cosmetics, making eyeliner with pencil lead and coffee grounds, and hair styling product with Jell-O.

My time teaching hundreds of women in the Salt Lake County Jail changed my life. I never felt unsafe in the jail. The women were not a threat to me. The women were not a threat to society. The women in the Salt Lake County Jail struggled with substance abuse issues and were incarcerated, most often for drug-related offenses, without adequate treatment for their drug dependence and abuse. Overwhelmingly, the women came from disadvantaged neighborhoods around the county. They had low levels of education and were poor or low-income. The majority were mothers, who were doing their best with limited resources. One woman told me she was caught stealing Orajel for her teething baby. Whether she was on probation or had an outstanding warrant, she was back in jail, while her teething baby was in the care of someone else. Meeting these women allowed me to have a more reality-based perspective of the jail system—a jail system that warehouses poor women.

But Why Would They Need Birth Control in Jail?

Before I walked into the Salt Lake County Jail, I had never thought about the contraceptive needs of incarcerated women. I have found that most people have not thought about the need for birth control access in jail, even among women's studies scholars and feminist criminologists (hence the dearth of literature on the topic). On more than one occasion over the last few years, as I've been conducting my research and talking about it with others, someone has said, "Maybe this is a stupid question, but why would they need birth control in jail?"

I tell people how jail stays are typically short-term; women are in and out within days or weeks, and disrupting birth control puts them at risk of unintended pregnancy. I tell people how women with an arrest history have high rates of unintended pregnancy and how jail provides an opportunity to meet their

contraceptive needs. I tell people how avoiding an unwanted pregnancy could help women reintegrate into the community. But most importantly, I tell people how women should have access to resources to avoid unintended pregnancies and incarceration does not make them less deserving of that access. Restricting women's access to contraception in jail represents a reproductive injustice.

The Issue of Sterilizing Incarcerated Women

In 2013, an investigative report revealed that 148 incarcerated women had been involuntarily sterilized in California (Johnson, 2013). As a result, California passed legislation banning sterilization of incarcerated women and reproductive justice activists from around the country supported this prohibition. Around that time, I was designing a survey to assess women's contraceptive needs and preferences in the Salt Lake County Jail. A mentor of mine suggested I add questions to examine incarcerated women's attitudes regarding sterilization opportunity, pressure, and prohibition. There was a swell of discussion among politicians, activists, and legal scholars largely in support of sterilization bans, but a limited amount of information regarding how incarcerated women felt about the issue. The situation in California inspired me to take my research beyond reversible contraceptive methods, also exploring women's attitudes toward, and jails' availability of, sterilization for incarcerated women.

A Note About Language in This Dissertation

First, I fully understand and acknowledge that not all people who have the capability to become pregnant identify as women. I also recognize that contraception and reproduction are issues related to gender inequality and part of a long history of efforts to control female bodies, sexuality and reproduction. I do not want to erase the visibility and experiences of people who can become pregnant and do not identify

as women. Throughout this dissertation, I use the words *women* and *woman*, and I also use gender-neutral pronouns. The language may not be fully representative of the range of gender identities and experiences people have in relation to fertility.

Second, I choose not to use the word inmate in my research; instead, I use the term incarcerated woman/women. I believe that words like inmate, convict, and felon contribute to an othering of women who have been in contact with the criminal justice system and I do not want to perpetuate that othering. The women who enter U.S. jails are not defined by incarceration; they are, unfortunately, experiencing incarceration.

Research Questions and Dissertation Structure

In this dissertation, I explore three research questions:

- What are the contraceptive needs and method preferences of women incarcerated at the Salt Lake County Jail?
- What attitudes do incarcerated women have toward sterilization occurring while in custody at the Salt Lake County Jail?"
- What mechanisms and rationales do specific jails across the U.S. utilize to either discontinue or continue and initiate contraceptives for women in their custody?

To answer these questions, I collected data through surveys and focus groups with incarcerated women and interviews with jail health care providers.

This dissertation has seven chapters. In Chapter 2, I provide a literature review with background information regarding women in jail, unintended pregnancy rates, consequences, and disparities; contraception and contraceptive abuses; contraceptive studies in jails; and jail health care arrangements. I conclude the chapter with an overview of reproductive justice as a theoretical framework for researching contraceptive issues in jail.

In Chapter 3, I provide the methodological overview of the empirical studies found in Chapters 4, 5, and 6. I describe the research design and recruitment procedures for each study, as well as data sources, data collection, and data analysis strategies. I also provide an explanation of internal and external validity and limitations of each study.

In Chapter 4 I address the research question, "*What are the contraceptive needs and method preferences of women incarcerated at the Salt Lake County Jail*?" I provide results from surveys completed by 194 women in the Salt Lake County Jail. I present conclusions for how contraceptive care in jail has the potential to improve contraceptive use and reduce the number of unintended pregnancies women experience after release.

In Chapter 5, I address the research question, "*What attitudes do incarcerated women have toward sterilization occurring while in custody?"* I provide results from three focus groups with 20 women at the Salt Lake County Jail. I present conclusions for how sterilization should be available for women in the Salt Lake County Jail, and propose measures that can be taken to protect women from sterilization abuse.

In Chapter 6, I ask the research question, "What mechanisms and rationales do specific jails across the U.S. utilize to either discontinue or continue and initiate contraceptives for women in their custody?" I present results from eight interviews with jail health care providers across the country. I present conclusions regarding specific factors that are associated with likelihood of a jail providing comprehensive contraceptive care.

In Chapter 7, I provide a summary of the findings from each of the empirical chapters, as well as implications for practice and policy to improve

contraceptive care for women in jail. I also describe broader sociological repercussions regarding women's reproductive health in a jail setting.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Introduction

Incarceration may affect a woman's ability to make autonomous decisions about using contraceptive methods. Lack of access to contraception can increase women's risk of unintended pregnancy and is a reproductive justice issue. In this chapter, I summarize a body of literature describing incarcerated women as a medically marginalized population; unintended pregnancy and births as a public health issue; contraceptive methods and abuses; a review of contraceptive studies in jails; and jail as a potential, but often failing, point of contraceptive care. After the review of the literature, I introduce reproductive justice (RJ) as a conceptual framework and describe how an RJ framework is a strong and appropriate model for addressing the issue of contraceptive access for incarcerated women.

In this dissertation, I center incarcerated women as a medically marginalized and underserved population. Many women who enter U.S. jails lacked health insurance prior to arrest and some struggle with co-occurring mental health issues and drug dependence and abuse (Rich, Wakeman, & Dickman, 2011). Incarcerated women experience reproductive health issues at higher rates than women in the general population, including higher rates of sexually transmitted infections, unintended pregnancy, and histories of trauma and abuse (Sufrin, Kolbi-Molinas, & Roth, 2015). Women who experience incarceration often have numerous health care needs that go unaddressed inside and outside of jail.

Jail, Not Prison

It is important to clarify that this dissertation focuses exclusively on adult women with a history of incarceration inside U.S. jails. After their review of the incarceration and health literature, Massoglia and Pridemore stated that greater research on females with incarceration history would advance the field of sociology, as women have been largely excluded from incarceration and health research (Massoglia & Pridemore, 2015). The limited health research that does include incarcerated women has disproportionately been conducted in prison settings, overlooking jails (Sufrin, 2017). Jails and prisons are distinctly different types of correctional facilities serving unique populations; thus, it is important to study them separately.

The biggest difference between jails and prisons is that jails are designed for short-term stays. Women incarcerated in jail are typically in pretrial detention or serving a sentence of less than 1 year for a misdemeanor criminal offense or a low-level felony (Minton & Zeng, 2016). Nearly half of all women who enter jail are released within 72 hours. While jail stays range in length from a few hours to 1 year, the average jail stay is around 23 days (Minton, Ginder, Brumbaugh, Smiley-McDonald, & Rohloff, 2015).

Another difference is that jails are operated on a local level, by a city or county government. Jails are funded by local taxpayers, situated in the communities where incarcerated persons typically live and return to (Henrichson, Rinaldi, & Delaney, 2015). In jails, the health care arrangements vary (The American College of Obstetricians and Gynecologists, 2012). In some jails health care is provided on site by the city or county health department, while other jails have independent contractors providing care or contracts with local clinics and hospitals (The American College of Obstetricians and Gynecologists, 2012). Regardless of the health care arrangement, the jail's health care budget is funded by local taxpayers. In the next

section I describe common demographic characteristics of incarcerated women.

Demographic Characteristics of Incarcerated Women

The United States incarcerates more of its citizens than any other nation in the world; with only 5% of the world's population, the United States has 25% of the world's incarcerated population (Rich et al., 2011). On any given day, approximately 99,100 women are incarcerated in more than 3,000 jails (Minton & Zeng, 2016). Although women make up only 14% of the incarcerated population, women are also the fastest growing segment of the jail population (Minton, 2015; Minton & Zeng, 2016). In 2000, the female jail incarceration rate was 50 per 100,000; in 2014, the rate was 70 per 100,000.

Compared to women who have never been arrested, women with a history of involvement with the criminal justice system experience higher rates of domestic and sexual violence (James, 2004; Raj et al., 2008). In fact, many women who have experienced incarceration describe a history of victimization, causing the behavior that ultimately resulted in their arrest (Belknap, 2014). For example, women who experience sexual abuse may use illegal substances to self-medicate the psychological traumas of victimization and then be arrested and incarcerated for drug possession. The majority of women in jail were arrested for nonviolent crimes, often property or drug-related (Carson & Golinelli, 2013). When it comes to national demographic characteristics of women in jail, most incarcerated women are poor, are disproportionately women of color, struggle with substance abuse and mental health issues, and have high rates of recidivism.

Socioeconomic Status

One of the biggest predictors of arrest is socioeconomic status. The vast majority of women in jail are socioeconomically disadvantaged (Clarke et al., 2006)

as they are minimally educated, with a high school diploma or less, and live below the poverty line (James, 2004; Rich et al., 2011). Incarceration and socioeconomic status are bidirectionally related, as economic stress may lead to criminal behavior and arrest (Kruttschnitt, 2013), incarceration removes women from the labor force, and formerly incarcerated women face stigmatization in the labor market (Wakefield & Uggen, 2010; Western, Kling, & Weiman, 2001).

Education level, insurance status, and stable housing are proxies for socioeconomic status and predictors of health disparities (Phelan, Link, & Tehranifar, 2010). A 2003 report showed that 47% of people in jail did not complete high school, compared to 18% of the general population; 26% of people in jail had a high school diploma, compared to 33% of the general population; and 14% of people in jail had postsecondary education, compared to 48% of the general population (Harlow, 2003). Minimal education and poverty is associated with reduced health literacy and increased risk of adverse health outcomes (Mirowsky, 2003).

Minimal education also affects an individual's ability to find a job and make a living wage, which impacts their ability to obtain insurance coverage through an employer or afford an insurance plan (Barnett & Vornovitsky, 2016). It is estimated that 90% of individuals released from jail each year are uninsured or lack financial resources for medical care (Lee, Vlahov, & Freudenberg, 2005; Wang et al., 2008). Unstable employment also has an impact on a person's ability to afford a rent or mortgage payment each month. People who have a history of incarceration are 7.5–11.3 times more likely to experience homelessness than the general population (Greenberg & Rosenheck, 2008). This all comes full circle, as people with a history of incarceration face difficulties finding stable employment and housing because they cannot pass a criminal background check, and the only way to earn money is through illegal means, such as dealing drugs.

Race

National data published by the Bureau of Justice Statistics report that in 2016, 48% of incarcerated persons were White, 35% were Black, 14% were Hispanic, 1% were American Indian/Alaska Native, 0.8% were Asian/Native Hawaiian/Other Pacific Islander, and 0.2% were two or more races (Minton & Zeng, 2016). The racial distribution of incarcerated people varies by geographic location as well as rural or urban settings. Findings in one jail are unlikely to be generalizable to all jails, which is why more research and facility-specific recommendations are necessary across the country.

Women of color are disproportionately incarcerated in U.S. jails. Black women are more than twice as likely to be incarcerated as White women, and Hispanic women are 25% more likely to be incarcerated than White women (Carson & Golinelli, 2013). Institutional racial bias and discrimination account for the disproportionate arrest and incarceration rates of poor people of color (Alexander, 2012; Solinger, 2005).

Mental Health and Drug Dependence and Abuse Issues

Women incarcerated in jail have higher rates of mental health and drug dependence and abuse issues than women incarcerated in prison, women without a history of arrest, and incarcerated men (Bronson & Berzofsky, 2017; Bronson, Stroop, Zimmer, & Berzofsky, 2017). Mental health issues and drug dependence or abuse are highly correlated among women in jail (Sacks, 2004). Sixty-eight percent of women in jail had a history with mental health problems (Bronson & Berzofsky, 2017). And 72% of women in jail met criteria for drug dependence and abuse (Bronson et al., 2017).

Due to the deinstitutionalization of psychiatric hospitals, jails serve as the largest mental health facilities in the United States, yet few comprehensive, gender-

specific treatment programs exist (Peugh & Belenko, 1999; Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Among incarcerated people (both men and women), 44% of people in jail with a mental health problem had received mental health treatment since admission compared to 63% of people in prison. And among those with a mental health problem, people in prison (39%) were more likely to receive counseling or therapy than people in jail (18%; Bronson & Berzofsky, 2017). Jails house more women with mental health problems than prisons, but women in jail are less likely to receive treatment and counseling.

Since the 1980s launch of the "war on drugs," drug dependence has been criminalized in the United States rather than treated as a public health issue. Approximately 7 in 10 women in jail (72%) met the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria for drug dependence or abuse, which is 10 times the percentage of adults in the general population meeting the criteria for drug dependence (6%; Bronson et al., 2017). Women in jail were also more likely than men in jail to have used drugs in the month before the offense, or at the time of the offense for which they were in jail. But only 22% of people in jail said they received treatment for drug dependence or abuse since entering the correctional facility (Bronson et al., 2017). Jails house more women with drug dependence and abuse than prisons, but women in jail are less likely to receive treatment and counseling.

Women who are jailed in the United States have astronomically high rates of mental health issues and struggle with drug dependence and abuse. Many women may not receive treatment in jail and are released without having addressed these issues. Jails often have "revolving doors," repetitively serving the same people and populations (Warner & Kramer, 2008).

Recidivism

The Bureau of Justice Statistics states there is no single definition of recidivism, but all definitions share three traits: (a) a starting event, such as release from custody of jail; (b) a measure of failure following the starting event, such as a subsequent arrest; and (c) a recidivism window, such as 6 months, or 1 year, or 5 years.

Research has shown that specific factors influence the likelihood of recidivism among women. Women who are drug-dependent, have less education, and who have more extensive criminal histories are more likely to recidivate (Huebner, Dejong, & Cobbina, 2010; Warner & Kramer, 2008). Lack of access to housing and employment postrelease can also increase the likelihood of recidivism (Adams, Leukefeld, & Peden, 2008). A history of trauma and abuse are also associated with increased risk for offending (Hollin & Palmer, 2006).

Many women with a history of involvement in the criminal justice system are arrested and incarcerated multiple times over the course of their lives (Sufrin, 2017). Women may experience incarceration in jail dozens of times, but never serve a prison sentence. Time in jail is a brief interruption, or "blip," in many women's lives, often a predictable and sometimes purposefully sought out blip. Sufrin reported that some women intentionally get arrested so that they can have temporary access to a bed, food, safety, an opportunity to become sober, or access health care in jail (2017). Jail has become a recurring part of many women's lives.

Unintended Pregnancies and Births

In the United States, approximately 45% of pregnancies each year are unintended (Finer & Zolna, 2014). An unintended pregnancy is one that is either mistimed or unwanted. If a woman reported that she wanted to get pregnant at some point in the future, but not when she did become pregnant, that pregnancy

would be considered mistimed, which is approximately 27% of pregnancies. If a woman did not want to get pregnant at any time in the future, that pregnancy would be considered unwanted, which is approximately 18% of pregnancies.

A woman's childbearing years are generally considered to be between the ages of 15 and 44 (Finer & Zolna, 2011). Most women in the United States report they want to have two children, on average, which means they spend approximately 5 years pregnant, or trying to get pregnant, and 25 years trying to avoid pregnancy. To avoid pregnancy, sexually active, fertile women must utilize a method of contraception consistently and correctly, which I will expand upon in a later section.

Unintended Pregnancy Disparities

Some women are more likely to experience an unintended pregnancy than others (Finer & Zolna, 2016). Unintended pregnancy rates are highest among young women between the ages of 18 and 24. Women of color experience higher unintended pregnancy rates than White women. The rate of unintended pregnancy among women with incomes below the federal poverty level are five times the rate among women with incomes of at least 200% of the federal poverty level. Additionally, unintended pregnancy rates are higher among women who did not complete high school compared to women with a high school degree and postsecondary education (Finer & Zolna, 2016).

The same social characteristics and economic disadvantages that contribute to the increased likelihood of experiencing an unintended pregnancy are also factors associated with risk of incarceration. Compared to White and middle-class women with higher education levels, low-income, minimally educated women of color experience higher rates of both incarceration (Clarke et al., 2006) and unplanned pregnancies (Finer & Zolna, 2014). Women in U.S. jails represent the population most at risk of unintended pregnancy.

Unintended Pregnancy and Incarceration

The overwhelming majority of women incarcerated in U.S. jails are between the childbearing ages of 18 and 44, are mothers of dependent children (Asberg & Renk, 2013), and are at risk of unintended pregnancy. One study found that 83.6% of incarcerated participants had experienced an unintended pregnancy (Clarke, Hebert, et al., 2006). In addition to the co-occurring problems of mental illness and drug addiction, many women entering jails have other medical comorbidities, in addition to histories of violence, sexual abuse and trauma (Steadman & Naples, 2005). Drug use and mental illness are associated with riskier sexual behavior such as multiple partners and transactional sex (Khan et al., 2008), less stable partnerships (Joseph, Joshi, Lewin, & Abrams, 1999) and inconsistent contraceptive use (Sufrin, Tulsky, Goldenson, Winter, & Cohan, 2010)—all factors related to increased risk of unintended pregnancy.

Another factor that increases women's risk of unintended pregnancy is incarceration itself. In some U.S. jails, incarcerated women have access to high-quality sexual and reproductive health care, including contraception. However, the majority of U.S. jails do not provide contraceptive counseling and services for women in their custody (Sufrin, Creinin, & Chang, 2009a). Many jail administrators presume contraception is unnecessary in jail due to sex-segregated housing. This line of thinking is misinformed, as women may be at risk of unintended pregnancy if their hormonal methods are discontinued at intake and if emergency contraception is not available for them in jail. Women may be at risk of unintended pregnancy during incarceration if they are sexually victimized by a male correctional officer. Women may be at risk of unintended pregnancy after being released from jail.

Immediately After Arrest/At Time of Intake

Women who have been sexually active in the days prior to incarceration may be at risk for unintended pregnancy. A woman could be at risk of unintended pregnancy if her hormonal birth control pill is discontinued, she is ovulating, and if she had sex in the previous week. While intercourse occurred before incarceration, fertilization could occur during incarceration. Reducing a woman's risk of unintended pregnancy can be accomplished by allowing her to continue using her hormonal birth control method on schedule.

Secondly, women who have been sexually active in the days prior to incarceration may be at risk of an unintended pregnancy if they did not use contraception or had a contraceptive failure (such as a broken condom or missed pill). Reducing this woman's risk of unintended pregnancy can be accomplished by offering emergency contraception at time of intake (Sufrin et al., 2010).

During Incarceration

In jails, females are housed in units separate from males. This sex-segregated housing structure leads many jail decision-makers to believe contraception is unnecessary in jail, applying the rationale that women are not at risk of getting pregnant because they are not having sexual intercourse with men. However, heterosexual intercourse occurs in jail settings, most often in the context of a male correctional officer and a female in custody. In 2011–2012, approximately 1,300 women incarcerated in U.S. jails reported sexual victimization by facility staff (Beck, Berzofsky, Caspar, & Krebs, 2013). That number is larger than the total number of women incarcerated in Utah jails (1,100) on any given day (Minton et al., 2015). There are no reliable data to estimate how many pregnancies occur from these sexual encounters, but I can say with confidence that heterosexual sex and rape happen in jail and unintended pregnancies are possible.

Soon After Release From Jail

As I have described, an unintended pregnancy could occur after intake or during incarceration; however, many women in U.S. jails are also at risk of unintended pregnancy soon after they are released from jail. Most incarcerated women are heterosexually active and plan to have sex with men after they are released. Incarceration can affect women's fertility in a variety of ways and increase a woman's risk of experiencing an unintended pregnancy.

Lifestyle factors such as nutrition, weight, stress, and using drugs and alcohol can affect a woman's fertility (Sharma, Biedenharn, Fedor, & Agarwal, 2013). In jail, women are unable to continue many of their regular behaviors and habits. During incarceration in most jails, women cannot smoke cigarettes and they are not able to drink alcohol or continue using illegal drugs. In jail, women detox off drugs and have three meals available to them each day. These changes may cause women to gain or lose weight, and their fertility may be impacted by becoming healthier than prior to incarceration. Many women leave jail more fertile than when they entered jail and struggle to access contraception.

If women do not have access to contraception prior to their release from jail, they may have a higher risk of unintended pregnancy. Through a chart review, one study found that 52% of women who were pregnant in one facility had a prior incarceration and many women conceived within 3 months of being released from jail (Clarke, Phipps, Tong, Rose, & Gold, 2010). Having to reinstate health insurance coverage or earn money to cover contraceptive costs postrelease can delay women's (re)initiation of effective contraceptive methods. Additionally, hormonal birth control can take hours or days to become effective after initiation, depending on the method, leaving women at risk of unintended pregnancy in the time between release from jail and when they are able to access contraception and await it being fully effective. Facilities that provide effective methods of contraception to women in their

custody may help reduce the number of unintended pregnancies that women experience after release and the number of pregnant women returning to jail.

Negative Consequences of Unintended Births

It is important to note that approximately one in four (24%) unintended pregnancies end in abortion (Finer & Zolna, 2016). The Turnaway Study found that women's reasons for seeking abortion care included financial (40%), pregnancy happening at the wrong time (36%), concern about their partner (31%), and needing to focus on the children they already had (29%; Biggs, Gould, & Foster, 2013). Some women want to have an abortion but are unable to access one because they cannot afford the procedure, or they are turned away if they seek abortion care after 20 gestational weeks. Women who carry unwanted pregnancies to term are more likely to be young (20–24) and living in poverty (Foster & Kimport, 2013).

Approximately 58% of unintended pregnancies result in birth (Finer & Zolna, 2016). It is also important to note that not all unintended births have negative outcomes; however, unintended births are more likely to have negative outcomes compared to those that are intended. Unintended births are associated with adverse outcomes for maternal and child health, including delayed prenatal care, premature birth, and negative physical and mental health outcomes for children (Herd, Higgins, Sicinski, & Merkurieva, 2016; Wendt, Gibbs, Peters, & Hogue, 2012). Reducing the rate of unintended pregnancy is a public health goal in the United States (HealthyPeople.gov). To reduce unintended pregnancy, there must be an expansion of family planning services for those most at risk.

Contraception and Preventing Unintended Pregnancies

Reproductive Life Planning and Comprehensive Counseling

First and foremost, discussing women's reproductive goals is an imperative starting point in family planning services. Respectful communication that is centered around women's family planning intentions is essential for positive patient-provider interactions (Dehlendorf, Krajewski, & Borrero, 2014). If a woman wants to become pregnant, a provider should provide counseling and resources so she may prepare for a healthy pregnancy. If a woman communicates that she does not want to be pregnant, a provider should counsel her on all contraceptive methods that are available to her, explaining risks and side effects of the methods, and help her make an informed contraceptive decision that aligns with her values (Dehlendorf et al., 2014).

Contraceptive Methods

"The development of safe, effective contraception is widely considered to be one of the greatest public health achievements of the 20th century" (American Public Health Association, 2015).

Effective methods of contraception allow women and couples to time, space, and limit their pregnancies, reducing unintended pregnancy and abortion rates (Peipert, Madden, Allsworth, & Secura, 2012). Contraception reduces maternal morbidity and mortality, and also improves birth outcomes (Cleland, Conde-Agudelo, Peterson, Ross, & Tsui, 2012). Contraception helps women attain their educational and career goals, increase their earning power, reduce the pay gap between themselves and childless and male colleagues, and have more enduring marriages (Sonfield, Hasstedt, Kavanaugh, & Anderson, 2013). On a population level, contraception contributes to slowed population growth and decreased poverty (Bailey, Malkova, & Norling, 2014). Consistent and correct use of contraception is the

most effective way of avoiding unintended pregnancy.

The U.S. Food and Drug Association lists 18 approved methods and devices for contraception that fall in to six categories (FDA, 2017).

- Permanent Sterilization: female tubal ligation, tubal closure with clips, clamps, rings or coil; male vasectomy
- Long-Acting Reversible Contraceptives (LARC): intrauterine device or intrauterine system (Copper IUD, IUD with progestin, Implantable Rod)
- Contraceptive Injection: progestin shot/injection
- Short-Acting Hormonal Methods: combination oral contraceptives (pill), oral contraceptives (mini-pill), patch, vaginal contraceptive ring
- Barrier Methods: diaphragm, sponge, cervical cap, male condom, female condom, spermicide
- Emergency Contraception: Levonorgestrel 1.5 MG/.75 MG, Ulipristal Acetate

According to data from the National Survey of Family Growth, 99% of women between the ages of 15 and 44 who have ever had sexual intercourse have used at least one contraceptive method (Jones, Mosher, & Daniels, 2012). However, there are disparities in contraceptive use.

Contraceptive Use

Young women between the ages of 15 and 19 use contraception at a lower rate than women 20 and older, and while 83% of Black women who are at risk of unintended pregnancy currently use a contraceptive method, that is lower than their Hispanic and White peers, 91% of whom currently use contraception (Jones et al., 2012). Additionally, low-income women are less likely to use contraception compared to higher-income women (Jones et al., 2012). There are several factors that influence contraceptive use, including feelings toward pregnancy and perceptions about one's own fertility (Frost, Singh, & Finer, 2007), contraceptive knowledge and

concerns about side effects, and a host of socioeconomic and partnership characteristics (Frost & Darroch, 2008).

Understanding women's attitudes regarding pregnancy and contraception is important for appropriately meeting their family planning desires and needs. Race, ethnicity, culture, class, and social networks influence women's pregnancy and contraception attitudes (Rocca & Harper, 2012; Solinger, 2005) and it is imperative to provide culturally appropriate and patient-centered family planning services.

Contraceptive Coercion and Abuse

A warranted concern among many reproductive justice advocates is regarding contraceptive coercion experienced by medically marginalized women and perpetrated by medical providers and institutions. Research shows that health care providers speak to women of color differently than they speak to White women and that providers are more likely to recommend IUDs to Black and Hispanic women of low socioeconomic status (Dehlendorf et al., 2014; Dehlendorf, Rodriguez, Levy, Borrero, & Steinauer, 2010; Dehlendorf, Ruskin, et al., 2010). In recent years, reproductive justice activists and academics have raised awareness about contraceptive biases imposed upon women by providers. SisterSong, Women of Color Reproductive Justice Collective, and the National Women's Health Network issued a Long-Acting Reversible Contraception Statement of Principles that has been endorsed by over 250 organizations, providers, and individuals. The principles include:

- Acknowledge the complex history of the provision of LARCs and seek to ensure that counseling is provided in a consistent and respectful manner that neither denies access nor coerces anyone into using a specific method.
- Commit to ensuring that people are provided comprehensive, scientifically accurate information about the full range of contraceptive options in a

medically ethical and culturally competent manner to ensure that each person is supported in identifying the method that best meets their needs.

- Advocates and the medical community must balance efforts to emphasize contraception as part of a healthy sex life beyond the fear of unintended pregnancy with appropriate counseling and support for people who seek contraception for other health reasons.
- The decision to obtain a LARC should be made by each person based on quality counseling that helps them identify what will work best for them. No one should be pressured into using a certain method or denied access based on limitations in health insurance for the insertion or removal of LARC devices.
- The decision to cease using a long-acting method should be made by an individual with support from their health professional without judgment or obstacles.
- The current enthusiasm for LARCs should not distract from the ongoing need to support other policies and programs that address the full scope of health sexuality (SisterSong, Women of Color Reproductive Justice Collective, and the National Women's Health Network, 2017).

Reproductive justice advocates are calling on health care providers to navigate contraceptive issues with an understanding of the historical and contemporary injustices that poor and minority women have experienced in regard to their contraception.

America's history is scarred by the pregnancy-for-profit model of slavery, the eugenics movement, and efforts for racial purification of Whites. More recently, strict welfare eligibility requirements, as well as the criminalization of abortion—and at times contraception—are also examples of how lawmakers try to control women's fertility (Solinger, 2005). Efforts by government officials to control and criminalize

women's sexual and reproductive lives have been well documented. Historian Rickie Solinger describes the inconsistent and often contradictory policies and laws created to force or prevent women's fertility. Historically and contemporarily, women of color and poor women have been victims of contraceptive coercion and abuse. These abuses have also been suffered by women involved in the criminal justice system.

Women have been given the "choice" between contraception and incarceration. In the early 1990s, a new contraceptive method hit the market. Norplant®, a hormonal contraceptive, could be implanted in a woman's arm with 6 years of effectiveness (Gu et al., 1995). The American Civil Liberties Union (ACLU) reports that some judges, seeing Norplant as an opportunity to reduce the fertility of a woman who was charged with child abuse, gave women a choice: they could go to jail, or they could have Norplant inserted in their arm. Although never passed, legislators introduced bills that would have forced women convicted of drug use during pregnancy to have Norplant inserted. The ACLU argues that coercing or forcing a woman to use birth control violates her constitutional right to reproductive and bodily autonomy (ACLU, 1993).

Unfortunately, Norplant was not the last contraceptive method used coercively by judges against women facing incarceration. In 2017, a judge in Tennessee issued a standing order offering free vasectomy for men and a free Nexplanon implant for women incarcerated at the White County Jail in exchange for a 30-day reduction of their sentences (Dwyer, 2017). The Judge, Sam Benningfield, told a news source,

> I'm trying to help these folks begin to think about taking responsibility for their life and giving them a leg up—you know, when they get out of jail — to perhaps rehabilitate themselves and not be burdened again with unwanted children and all that comes with that.

The ACLU responded to the judge's offer as "unconstitutional" and provided this statement,

> Offering a so-called "choice" between jail time and coerced contraception or sterilization is unconstitutional. Such a choice violates the fundamental constitutional right to reproductive autonomy and bodily integrity by interfering with the intimate decision of whether and when to have a child, imposing an intrusive medical procedure on individuals who are not in a position to reject it. Judges play an important role in our community — overseeing individuals' childbearing capacity should not be part of that role.

Both in 1990 and nearly 30 years later in 2017 the ACLU responded to judges' attempts to violate women's reproductive autonomy and coerce women into limiting their fertility through contraceptive implants. In addition to abuses surrounding reversible methods of contraception, incarcerated women have also been subjected to sterilization abuse.

Sterilization Abuse

Sterilization of incarcerated women is a controversial issue with a century-long history. Compulsory sterilization—or legal, forced sterilization—in the United States began in 1907 when the first sterilization law was passed in Indiana (Stern, 2007). The laws were created to quell the reproduction of populations that were deemed "undesirable" and the fertility of women deemed as "unfit" to be mothers (Kluchin, 2009). The factors related to defining who was "unfit" to reproduce included poverty, race, ethnicity, intelligence, sexual deviance and promiscuity, illegitimacy, and criminality (Kluchin, 2009). Over 60,000 individuals were involuntarily sterilized between 1907 and 1963 (Carey, 1998). Since 1920, minorities (primarily Black, Native American and Latina women) and poor women were disproportionately sterilized (Schoen, 2005), most of whom were institutionalized for psychiatric disorders or intellectual disabilities and/or had criminal histories. Compulsory sterilization is considered the ultimate violation of reproductive autonomy (Reid, 2014).

Unfortunately, compulsory sterilization was often promoted under the guise of public health, with arguments that sterilization would be a cost-effective method for

the greater good (Stern, 2005). Proponents of sterilization argued sterilizing a woman who had been determined as "unfit" to have children would save the state money by avoiding the costs of supporting her and her children. This issue was magnified for women experiencing incarceration. The children of women in jail were cared for by family members or in custody of the state, circumstances that unethical doctors used as justification for sterilizing women, deciding on behalf of the women that they should not have more children.

Women involved with the criminal justice system have historically and contemporarily been victims of forced and coerced sterilization. In 2013, a report revealed that at least 148 women in California's corrections system were sterilized without their consent between 2006 and 2010 (Johnson, 2013). This report was the catalyst for a law being passed in California prohibiting sterilization of women in correctional custody (Liss-Schultz, 2014). While this law protects women from being subjected to forced or coerced sterilization during incarceration, it simultaneously removes the option of sterilization for women who want the procedure. The pendulum has swung from women undergoing sterilizations they did not want, to not being able to access sterilizations they do want.

Many states and counties do not have official restrictions for sterilization of incarcerated women. For example, in Utah, sterilization of an institutionalized person is legal if a "physician ensures the person is capable of giving informed consent and that no undue influence or coercion to consent has been placed on that person by nature of the fact they are institutionalized" (Utah Code, 1988). The most likely time that an incarcerated woman will interact with a physician who could perform a sterilization procedure is when she is pregnant, whether during a prenatal appointment or at the time she is admitted to the hospital's labor and delivery unit to give birth.

One specific issue of note is that of Medicaid-funded births for women in

custody. In many cases, a woman who is pregnant and gives birth at a local hospital while she is in the custody of a jail will qualify for the labor and delivery costs to be funded by Medicaid. When an incarcerated woman is admitted into a hospital overnight, her health care costs become Medicaid-eligible as opposed to being a cost absorbed by the jail health care budget. For these women who have Medicaid-funded births, they would not be able to have a sterilization procedure immediately postpartum because Medicaid will not cover the costs of a sterilization procedure without a 30-day waiting period following the signing of an informed consent document. Medicaid coverage ceases for women in jail because their health care costs are covered by the jail. Prior to being admitted to the hospital for labor and delivery, pregnant women are not Medicaid patients and may not have an opportunity to sign a consent document and start the 30-day waiting period because they were not on Medicaid or may not have had access to the provider or hospital that would be doing the sterilization procedure. Essentially, many pregnant women walk into the labor and delivery unit, without Medicaid coverage, and have a birth that is attended by a provider they have never met before. If they wanted postpartum sterilization, they would be unable to have the procedure because they did not have the opportunity to discuss sterilization or sign a consent form 30 days prior. A debate regarding the 30-day waiting period for sterilization procedures for Medicaid patients is expanded upon in Chapter 5.

The criminal justice system and sexual and reproductive health issues have long been intertwined. In fact, Flavin argues incarceration, segregating women from their partners, is a way to control the reproduction of a less desirable population (Flavin, 2009). Incarcerated women have been the victims of many reproductive injustices. There is an opportunity to do better. Several scholars, activists, and health care providers are working to make jails a space where reproductive justice is honored.

Contraceptive Studies in Jail

Fortunately, there has been increasing attention paid to the reproductive health inadequacies and violation of rights that many incarcerated women face, such as shackling during pregnancy, labor, and delivery (ACLU, 2012; The National Commission on Correctional Health Care, 2014; New York Civil Liberties Union, 2008; Ocen, 2012; Sussman, 2008); and restricted access to pregnancy care (Maruschak, 2008; Sufrin, 2017); abortion care (Roth, 2004; Sufrin, Creinin, & Chang, 2009b); and forced sterilization (Johnson, 2013; Roth & Ainsworth, 2014). However, there is a lack of public attention, scant investigative journalism and few scholarly articles regarding the absence of contraceptive care in most of America's jails.

The Contraceptive Studies

To my knowledge, there are only 10 published studies specifically focusing on contraception and women incarcerated in a U.S. jail (Bonney, Clarke, Simmons, & Rich, 2008; Clarke, Hebert, et al., 2006; Clarke, Rosengard, et al., 2006; Hale et al., 2009; LaRochelle et al., 2012; Pruitt, von Sternberg, Velasquez, & Mullen, 2010; Ramaswamy, Chen, Cropsey, Clarke, & Kelly, 2015; Ramaswamy & Kelly, 2014; Schonberg, Bennett, Sufrin, Karasz, & Gold, 2015; Sufrin et al., 2010). These 10 studies were conducted in six locations: three in Rhode Island; one in a metropolitan city in the Southeastern United States; two in San Francisco, California; one in Houston, Texas; two in Kansas City, Missouri; and one in New York City. There are more adult detention centers than there are colleges and universities in the United States, yet we only have published information about the contraceptive experiences and needs of women housed in six of the more than 3,000 facilities (see Table 1).

In this section I provide a review of the contraceptive studies. I will describe their study samples, and how they compare to each other and national jail census data. I will summarize their findings related to sexual, reproductive, and

contraceptive experiences of incarcerated women and address the gaps in the literature.

Demographics

The study sample sizes ranged from 32 to 484, with a mean sample size of 273. Most incarcerated women in the United States are of reproductive age. Similarly, the women in these studies have a mean age of 25–41. The racial distribution varies dramatically. The number of racial and ethnic categories measured range from two to seven with most reporting White and Black participant percentages, many including an "Other" category, and few with Asian, Pacific Islander, and Native American categories. The contraceptive studies report 16–62% White participants, 16–77% Black participants, 7–22% Hispanic participants, 1–11% mixed race participants, 4–5% Asian/Pacific Islander participants, 1–3% Native American participants, and 1–47% "Other."

The contraceptive studies report 43–71% of participants had a high school diploma or GED. While these studies include women with higher levels of education than the national jail population, the rate of high school completion is still lower than that of the general population. The participants in the contraceptive studies also had uninsured rates ranging from 31–59% at time of arrest; while only three studies collected data about homelessness, 3–21% of participants were experiencing homelessness or unstable housing at time of arrest. The participants in the contraceptive studies are representative of medically marginalized populations, with minimal education, a lack of insurance, and housing instability, which are all barriers to accessing health care in general, and contraceptive care specifically.

Sexual and Reproductive History

Like women without a history of arrest, the majority of women incarcerated in jail are sexually active prior to arrest and they intend to have sex after release from jail and wish to avoid pregnancy. Women with a history of incarceration tend to have more complex sexual and reproductive health histories than women in the general population. Among the contraceptive studies participants, 25–34% of participants had a history of transactional sex; 44–57% of participants had a history of sexually transmitted infections (STIs) that often go undiagnosed and untreated prior to arrest; 69–91% of participants had experienced a pregnancy, 61–84% of which experienced an unplanned pregnancy; 35–56% had had an abortion; and 63–81% had given birth to an average of two children. Compared to women without a history of incarceration, women in jail experience higher rates of STIs, unplanned pregnancies, and abortions.

Contraceptive History

The contraceptive studies measured birth control histories differently; some collected information on women's entire birth control histories, some on the 3 months prior to arrest, and some either 30 days prior or at the time of arrest—and the results vary. Three studies measured birth control use "ever," one study measured birth control use in the last 12 months, three studies measured birth control use in the last 3 months, one study measured birth control use in the 30 days prior to arrest, and one study measured birth control use at time of arrest. Contraceptive use ranged from 32% at time of arrest to 10% in the 3 months prior, to 100% of participants in one study having ever used a condom. Additionally, there are racial differences in contraceptive use among incarcerated women, with non-Whites reporting less use of birth control than Whites. While a common theme throughout the contraceptive studies is that women in jail use birth control less often

and less consistently than women without a history of incarceration, a validated, standardized tool to assess birth control history is imperative for gaining a better understanding of contraceptive needs among women incarcerated in U.S. jails.

A high rate of inconsistent contraceptive use among women entering jail leads to a high rate of women being arrested who may currently be at risk of unintended pregnancy. Sufrin et al. found that 29% of 18- to 44-year-old women arrested in San Francisco had unprotected sex within the previous 5 days and were eligible for emergency contraception (Sufrin et al., 2010). Among these women, half expressed ambivalent attitudes about pregnancy and 48% indicated they would take emergency contraception if it were offered to them. The authors of this study estimate that emergency contraception counseling and provision could potentially prevent 52,500 unintended pregnancies annually among newly arrested women in the United States.

Seven of the 10 studies collected information about specific contraceptive method use, but again, the findings vary due to different data collection methods. Six collected condom use. Three collected withdrawal use. One collected diaphragm use. Five collected oral contraception use. Two collected patch and ring use. Five collected Depo shot use. Three collected "Tier two" use (pill, patch, ring, shot) and one of those included intrauterine devices (IUD) in the tier two category. Five collected IUD use and only one study differentiated between the hormonal and copper IUDs. Three studies collected contraceptive implant use (one being Norplant which is no longer available). And six studies collected sterilization use.

While it is well established that many women entering U.S. jails either did not use or inconsistently used birth control prior to arrest, approximately 12–32% of women entering jail consistently used a contraceptive method. Among women using hormonal methods, such as the oral contraceptive pill, vaginal ring, transdermal patch, depot medroxyprogesterone acetate (DMPA or Depo-Provera injection),

intrauterine device (IUD), or subdermal implant, their contraceptive schedule is often disrupted in jail, where daily, weekly, and monthly methods are not administered, injections are not given on schedule, and expired IUDs or implants are not replaced. The discontinuation of short-acting hormonal contraceptive methods happens because of the presumption that hormonal contraceptives are unnecessary in a sex-segregated jail and postrelease needs are not considered. Additionally, in many U.S. jails, birth control is not offered or reinitiated before release, which puts sexually active women at risk of experiencing an unintended pregnancy after release.

Second to the male condom, oral contraceptives are the most common method of birth control incarcerated women used prior to arrest and plan to use after release. The studies found that 2–70% of women used oral contraceptives. This complicates in-jail contraceptive discontinuation policies, as the primary basis for discontinuation is the perceived lack of pregnancy risk in a sex-segregated jail, yet oral contraceptives are commonly prescribed for reasons other than pregnancy prevention. It also takes time for oral contraceptives to become effective, depending when a woman initiates the method during her menstrual cycle, which can leave a woman at risk of unintended pregnancy. The provision of other user-dependent hormonal methods such as the transdermal patch, the vaginal ring, and hormonal injections should be considered when determining family planning programming for women in jail.

The contraceptive studies report that 60–77.9% of incarcerated women would accept contraception if offered to them in jail or soon after release. Clarke et al. (2006) found that women were much more likely to initiate birth control if offered methods in jail (39.1%) compared to those who were referred to a community health clinic for contraceptive methods post release (4.4%). There is consensus among the contraceptive studies' authors that there is a need for contraceptive counseling and services in U.S. jails and these needs should be met to reduce the rate of unintended

pregnancy among a medically marginalized group.

The contraceptive studies show how diverse different jails are but they also show a common need for contraceptive continuation, counseling, and initiation for women in their custody. In the next section I focus on why health care in jail is so varied and give a description of why health care in jail is so important. I also describe the circumstances that have made contraceptive care a low priority in many jails and how comprehensive contraceptive care in jail could improve the lives of women, families, communities and the correctional facility.

Estelle v. Gamble

The legal right to health care for incarcerated persons is a result of the 1976 Supreme Court case *Estelle v. Gamble*, in which a prisoner, J.W. Gamble, initiated a lawsuit against the Texas Department of Corrections after he injured his back doing prison labor (Rold, 2008). Gamble did not win the lawsuit, but the court's decision stated that prison officials are obligated to provide prisoners with adequate medical care for serious medical needs. What qualifies as "serious medical needs," however, remains largely undefined. Numerous cases have been brought to court citing violations of the Eighth Amendment, and the person bringing the lawsuit must prove the facility or provider being sued showed "deliberate indifference to serious medical needs."

Health Care in Jail

There are more than 3,000 jail facilities in the United States serving diverse populations (Stephan & Walsh, 2011). Jails vary in size with capacities ranging from fewer than 25 beds to more than 2,500 beds. Jails are incredibly heterogeneous and one must caution against making generalizing statements about jails and what policies may or may not work within them (Potter, 2010). One must take into

consideration the unique characteristics of the communities that jails reside in and how local culture and political climate influences the facility's practices and policies. As Rosenberg said, "If you've seen one jail, you've seen one jail" (Potter, 2010).

Need for Health Care in Jail

One commonality that jails do have, however, is that they incarcerate people who are representative of the most economically disadvantaged and medically underserved communities where jails are located. As I described earlier, there is a high rate of mental health issues and drug dependence and abuse among the incarcerated population, and they struggle with numerous medical comorbidities and often lack health insurance. There is an extraordinary need for health care services in jail.

Providing Health Care in Jail

Health care arrangements in jails vary. In some jails, all health care staff are employees of the city or county health department. In other jails, independent contractors provide health care on site, and some jails have contracts with clinics and hospitals in the community. Particularly true for health care providers that are contracted by the facility, Rold describes that correctional health care staff work in a "medically alien setting" (Wishart & Dubler, 1983) and may feel pressured to provide care that meets the demands of the correctional facility as opposed to health care standards endorsed by nationally recognized health organizations (Rold, 2008). This is generally not the case for health care providers who work for the city or county health department and have more authority to provide *public* health care as opposed to just *correctional* health care. In addition to the serious health care needs that jails must provide or arrange for incarcerated people—dialysis, for example—jail health care staff are also responsible for meeting the needs that are generally seen as

easily self-treated. A health care staff member must administer aspirin and Band-Aids, which adds demands on already-busy health care staff (Rold, 2008).

Funding Health Care in Jail

Jails are part of a city or county government and are funded by local taxpayers. Regardless of the health care arrangement, residents of the community where the jail is located pay for the health care of incarcerated people. If the city or county health department operates the health care for a jail, the funding for health care may come from the budget allocated to the public health department. In another situation, the Sheriff's office budget may be responsible for funding the health care, and the Sheriff's office will pay an independent contractor to provide that health care. Budgets are typically determined annually, and all health care costs need to be provided within the budget. As explained earlier, jails are legally required to provide medical care to people in their custody. Some incarcerated patients require serious medical attention or have diseases requiring expensive medications. One jail health care provider I spoke with explained,

> Our medical director is also the owner of the company that provides medical services at the jail and he's got the budget for medicine and such. An enormous, enormous chunk of his budget has to go for people who are violent and mentally ill in mental health court to keep them stable. Their injections—some of them have to be on mental health injections and they're way over $1,000 a month. It's such a problem. We had a hemophiliac in the jail. We tried so hard to get them out; $12,000 a month for their medicine. It's much more complicated than people realize.

Some jails have tight budgets while others have "deep pockets." For providers working within constrained budgets, funding influences the type of care they provide in jail.

Women's Health Care in Jail

Several factors may influence the absence or presence of comprehensive women's health care in jail. The National Commission on Correctional Health Care (NCCHC) has published standards for health care in correctional facilities, which includes some women's health issues, but adherence to these standards is optional (The National Commission on Correctional Health Care, 2014). The American College of Obstetricians and Gynecologists acknowledges that there are no federally-mandated guidelines for women's health care in jails (The American College of Obstetricians and Gynecologists, 2012). Some scholars state that women's gender-specific health care needs remain largely unmet due to their minority status in a male-dominated jail population (Sufrin, Kolbi-Molinas, et al., 2015). The size of the incarcerated female population may influence whether a jail provides comprehensive women's health care services. In some jail systems, women may be the minority, but a substantial minority, with 1,000 to 2,000 women needing health care in one jail. Additionally, the health care arrangements and specific providers and administrators may also determine the level of care that is provided to women in custody.

Contraceptive Care in Jail

Incarcerated Women Could Benefit From Contraceptive Care

Incarcerated women represent the most economically disadvantaged and medically underserved women in the communities where jails are located. Access to family planning information and free services and methods is a pressing health care need in poor communities. Ideally, women should be able to access contraceptive care in the community, and jails could provide a continuation of care (Schonberg et al., 2015), rather than a disruption of it. However, many women struggle to access contraceptive care in the community due to financial barriers. The average

incarcerated woman is of childbearing age, already has children, and had minimal access to family planning services prior to arrest. Ultimately, incarcerated women represent the population most in need of family planning information and services, yet least likely to receive contraceptive care.

Most Jails Do Not Provide Contraceptive Care

It must be noted that there are facilities that recognize the importance of contraceptive access for women in their custody and provide a range of birth control methods to women who want them (Sufrin, Baird, Clarke, & Feldman, 2017; Sufrin et al., 2009a). One study found that 38% of correctional facilities provided birth control (Sufrin et al., 2009a). Overwhelmingly though, women have limited access to continuing or initiating effective contraceptive methods in U.S. jails. The widespread institutional practice of discontinuing or denying incarcerated women access to contraceptive methods is problematic for several reasons: (a) it increases women's risk of unintended pregnancy during and after incarceration, (b) it infringes on women's ability to control their fertility, (c) it widens the power differential between correctional facilities and the women in their custody, and (d) it exacerbates reproductive oppression that marginalized women already face in the community prior to arrest.

In this dissertation, I define "comprehensive contraceptive care" as:

- allowing women to continue their hormonal methods during incarceration (primarily oral contraceptive pills and depot medroxyprogesterone acetate—"the shot," but also the vaginal ring and transdermal patch)
- a jail having emergency contraception on demand for incarcerated women; and
- providing women with the opportunity to initiate a range of contraceptive methods, including IUDs and contraceptive implants, in jail prior to release.

The two primary reasons jails do not offer comprehensive contraceptive care are: (a) contraception is perceived as unnecessary in jail, and (b) providing women with contraceptive care is presumed to be cost prohibitive.

First, in a sense, administrators perceive incarceration as a form of contraception. Jail administrators believe there is no chance an incarcerated woman can get pregnant while she is in custody; thus, helping women prevent pregnancy is not their responsibility. As mentioned earlier, women may be at risk of unintended pregnancy at intake, during incarceration, and postrelease; due to high recidivism rates women may return to jail with an unintended pregnancy. The idea that women do not need or want birth control in jail is a myth.

Second, contraceptive care, especially IUD and implant provision, is considered cost prohibitive due to more expensive up-front costs. IUDs can cost up to $1,000, and implants can cost up to $800. However the cost of IUDs and implants can be subsidized by programs including Medicaid or Title X, a federal grant program dedicated to providing low-income people with comprehensive family planning counseling and services (U.S. Department of Health & Human Services). Jail administrators may only consider the cost of the IUD or implant and not consider the costs and extra precautions that must be considered when caring for a pregnant woman in custody.

Publicly-funded systems, like Medicaid, often cover the pregnancy-related costs of unintended pregnancies in the United States (Sonfield & Kost, 2013). Resident taxes fund publicly-funded systems, including Medicaid *and* jail health care services. Essentially, providing contraceptive care in jail to women who want it is a preventative public health measure, the right thing to do, and has cost-saving potential (Frost, Sonfield, Zolna, & Finer, 2014). However, the Medicaid budget and the jail health care budget are not the same budget. Thus, jails may not be motivated to cover the costs of contraception because jails' budgets do not see the

savings associated with prevented unintended pregnancies that are funded by Medicaid.

Organizations Declare Contraceptive Care Is a Human Right

Several internationally- and nationally-known organizations have made statements declaring that universal access to contraception is a human right and part of imperative preventive care for women's health. These organizations include the Center for Reproductive Rights, the United Nations Population Fund, and the American Public Health Association. Additionally, the American College of Obstetricians and Gynecologists and the New York Civil Liberties Union have stated that incarcerated women should have universal access to contraceptive counseling and services. Despite these declarations, most jails do not consider contraceptive care a human right and incarcerated women have limited access to continuing or initiating temporary, hormonal contraceptive methods (birth control pills, intrauterine devices, etc.; Sufrin et al., 2009a).

Reproductive Life Planning and Preparation During Incarceration

Incarceration can influence women's pregnancy attitudes. Some incarcerated women may believe that a pregnancy postrelease could complicate their lives, making it difficult to get a job, find housing, reunite with their children, save money, and complete their education (Schonberg et al., 2015). Thus, some women strongly desire avoiding pregnancy within the 1st year of release. Other incarcerated women may believe that having a baby is the catalyst they need to "start over"; a new baby would help them straighten up and stop the behavior (drug use, property crimes, sex work) that keeps bringing them back to jail (Sufrin, 2017). A range of services can meet women's diverse family planning needs, including contraceptive counseling and initiation of preferred birth control methods, but also preconception counseling,

prescribing prenatal vitamins and provision of information regarding pregnancy and parenting resources such as Medicaid, Women, Infants and Children (WIC), and the Children's Health Insurance Program (CHIP) to support women who want to get pregnant after release.

Some women want to initiate birth control, but do not want to do so during incarceration. Research shows some women mistrust jail health services and believe they are being experimented on (Schonberg et al., 2015). Their concern is warranted, as there have been recent cases of prisoner abuse and incarcerated women have been victims of forced or coerced procedures, including sterilization (Johnson, 2013; Solinger, 2005). Additionally, one study found that some incarcerated women felt that taking birth control in jail would imply they were having sex with correctional officers and they would be stigmatized (Schonberg et al., 2015). Discharge planning, including Medicaid enrollment assistance, and setting appointments with community health clinics prior to release, is an alternative way to meet incarcerated women's family planning needs.

Experiencing an unintended pregnancy postrelease may complicate women's ability to reintegrate into to their community and may increase the likelihood of them returning to jail pregnant. Additionally, discontinuing a woman's contraceptive method without her consent is a violation of her bodily autonomy. This lack of contraceptive care and increased risk of unintended pregnancy are issues related to reproductive justice, which will be elaborated on in this chapter and serve as the conceptual framework for the research questions addressed in this dissertation.

Key Contributions

This dissertation contributes to three gaps in the literature regarding contraceptive availability and access in U.S. jails. First, most correctional facilities in the United States do not provide contraception to women in their custody. To help

facilities understand the importance of providing contraception to women, facilities must understand the needs of the women they house. Because jails are heterogeneous, it is important that needs assessments are done for individual facilities. As shown in the contraceptive studies review, we only have contraceptive needs information for women in six of the more than 3,000 jails in the United States. As I am writing this, there has never been a contraceptive needs assessment conducted in the Salt Lake County Jail. To address this gap, I assessed the contraceptive needs and preferences of 194 women incarcerated at the Salt Lake County Jail through surveys. I present the findings in Chapter 4.

Second, incarcerated women have been victims of sterilization abuse for over a century. While informed consent is a staple of medical procedures, there have been cases of ignoring consent protocol and making decisions—permanent contraceptive decisions—without incarcerated-patient understanding or permission. There has been very little attention paid to incarcerated women's attitudes toward sterilization outside of the California context. Although legislation has been passed, and scholars and activists have called for a prohibition of sterilization for incarcerated women, we know little about how incarcerated women feel about sterilization and their ability to access it while they are in jail. I explore incarcerated women's attitudes toward sterilization procedures for women in custody through three focus groups at the Salt Lake County Jail. I present those findings in Chapter 5.

Third, there is one published study outlining the comprehensive contraceptive programs at four U.S. correctional facilities (Sufrin et al., 2017). To date, there are no qualitative studies examining contraceptive programs (or the lack thereof) in jails through interviews with jail health care providers. Because jails serve diverse populations and are uniquely operated, it is important to understand the factors of a successful contraceptive program as well as the barriers for implementing a program. I interviewed jail health care providers in eight different jails in the United

States. I provide this account in Chapter 6.

This dissertation utilizes a reproductive justice theoretical framework to examine issues related to contraceptive access for women incarcerated in jail. In the next section, I begin by defining the origin and concept of reproductive justice and outlining its overall strengths as a theoretical framework. I will also discuss how reproductive justice is a useful theoretical framework for the research questions addressed by my dissertation.

Using a Reproductive Justice Framework

Defining Reproductive Justice

The term "reproductive justice" (RJ) was coined in November 1994 by a group of Black feminist leaders (Ross, 2017). Frustrated with the prochoice movement and its focus on birth control and abortion access by middle-class White women, many women of color activists felt that their reproductive experiences and struggles were not addressed (Luna & Luker, 2013). Women of color activists, including Loretta Ross, a leader in the RJ community, argued that the emphasis on abortion rights overlooked the reproductive struggles that many women of color and poor women were experiencing, and failed to address the socioeconomic disparities and community health issues faced by marginalized women. Marginalized women, including women of color, poor women, women with disabilities, sexual minority women and women experiencing incarceration struggled for the rights to have children and to parent the children they had. Thus, the concept of reproductive justice emphasizes the right to not have children, but also the right to have children and the right to parent with dignity in safe communities with adequate resources (Luna & Luker, 2013).

Loretta J. Ross, a human and reproductive rights activist, and leader in establishing the reproductive justice movement provides a definition of reproductive

justice:

> Reproductive justice is a contemporary framework for activism and for thinking about the experience of reproduction. It is also a political movement that splices reproductive rights with social justice to achieve reproductive justice. The definition of reproductive justice goes beyond the prochoice/prolife debate and has three primary principles: (a) the right not to have a child; (b) the right to have a child; and (c) the right to parent children in safe and healthy environments. In addition, reproductive justice demands sexual autonomy and gender freedom for every human being. (Ross, 2017, p. 9)

As important as it is to define what reproductive justice is, it is equally important to note what the term "reproductive justice" is not. As implied by the emphasis on the right to bear and raise children with dignity, reproductive justice is not meant to be an interchangeable term with abortion rights, family planning, prochoice, population control, or even reproductive health or reproductive rights (Price, 2010). Moreover, both the reproductive health framework and the reproductive rights framework focus largely on individuals instead of larger structural issues of societal level discrimination.

The reproductive health movement focuses on increasing health education and clinic services for medically marginalized women without addressing the root causes of health disparities faced by these women (Asian Communities for Reproductive Justice, 2005). The reproductive rights framework also focuses on individual women fighting for protection of legal rights to access reproductive health care services, including abortion. The reproductive rights framework operates largely on a legal level and highlights women's right to "privacy." Reproductive justice, however, recognizes that many marginalized women do not have "privacy" or a specific level of autonomy or resources required to be successful in a legal forum, which evidence clearly shows, that "the more powerful parties continue to win over the less powerful" in the courtroom (Luna & Luker, 2013, p. 329). In this dissertation, I will present findings through a reproductive justice perspective—addressing a system that oppresses the contraceptive autonomy of women

experiencing incarceration.

Reproductive Justice Is a Human Rights Issue

The reproductive justice framework relies on a human rights framework, arguing that denying people the right to control their reproductive autonomy is a violation of their rights as human beings (Ross, 2017). RJ states that people's human rights are to be respected and protected. Women have the right to make decisions about whether to become a parent and the right to access resources to fulfill those desires. Ross and Solinger claim that at its center, reproductive justice has two powerful ideas:

- Access to comprehensive health care, including reproductive health care, is a human right;
- Neither this nor any other human right can achieve the status of a right if it does not apply to all people.

Reproductive justice uses a human rights framework to promote social justice (Zucker, 2014). In line with these ideas, in this dissertation, I focus on the reproductive justice principle of the right to *not* have children. More specifically, the right to resources to avoid an unintended pregnancy. I focus exclusively on incarcerated women as a group of people who have the right to resources to avoid an unintended pregnancy. Reproductive justice proclaims that all women have the right to make autonomous decisions about if, when, and how they reproduce—incarcerated women also deserve that right (Ross, 2017).

Why Contraceptive Care for Incarcerated Women Is a Reproductive Justice Issue

Women experience numerous blows against their human rights and their reproductive rights while they are incarcerated in U.S. jails. RJ focuses on

reproductive oppressions experienced by medically marginalized women which makes an RJ framework particularly well-suited for studying women incarcerated in jail. In fact, Ross states,

> The reproductive justice/human rights framework makes claim on the incarceration system… and the health care system, to block institutional degradations associated with fertility, reproduction, and maternity or parenthood." (Ross, 2017, p. 17)

Women incarcerated in U.S. jails represent some of the most medically marginalized communities—those facing the most reproductive oppressions and in most need of reproductive justice. The reproductive lives of many incarcerated women are scrutinized, often with the justification that their class status, their criminal history, and drug use are incompatible with reproductive autonomy (Ross, 2017). In this dissertation, I use a reproductive justice framework to shine light on the historical and contemporary injustices that marginalized women have been subjected to and how this influences their contraceptive access during incarceration. In the final section of this chapter, I describe the research practices I employed for studying women's contraceptive access in a jail setting.

Reproductive Justice Principles in Research

My dissertation focuses on three separate but interrelated research questions regarding women's access to contraception during incarceration. I ask,

- *What are the contraceptive needs and method preferences of incarcerated women*? and
- *What are incarcerated women's attitudes toward sterilization availability while women are in custody?* and
- *How and why do (or why don't) correctional facilities meet the contraceptive needs and desires of incarcerated women in their custody?*

To answer these questions, I use a reproductive justice framework,

specifically by (a) putting incarcerated women and their intersectional identities at the center of my research, (b) using storytelling to give voice to an often-voiceless population, and (c) interrogating the unequal power dynamics of jail systems and the women incarcerated within them.

Woman-Centered, Intersectional Research

Reproductive justice centers marginalized women's experiences. A strength of the reproductive justice model includes its recognition of intersectionality—specifically gender, race, and class as simultaneously influencing women's reproductive experiences (Ross, 2017; Zucker, 2014). Jails in the United States disproportionately incarcerate women of color and poor women. Inside and outside of jail many of these women face reproductive challenges and discrimination unknown to most White, middle- and upper-class women. An RJ lens keeps in mind the past atrocities committed against individuals and communities while exploring contemporary issues.

There is a long history of incarcerated women experiencing reproductive oppression in the United States (Solinger, 2005). As described earlier, some women have been forcefully or coercively sterilized, while others are prohibited from having a sterilization procedure they may desperately want. Some women have been offered a reduction in a jail sentence if they have a long-acting reversible contraceptive method implanted, while other women were not allowed to continue taking their birth control pills during incarceration. Reproductive justice centers women, with their intersecting identities and their diverse reproductive histories and goals for their reproductive futures. I conducted woman-centered research to collect information about women's unique reproductive experiences and desires and inform woman-centered comprehensive contraceptive care.

Storytelling

Storytelling is a core aspect of reproductive justice. Ross states,

> Stories help us understand how others think and make decisions. They help us understand how our human rights—and the human rights of others—are protected or violated. Storytelling is a core aspect of reproductive justice practice because attending to someone else's story invites us to shift the lens—that is, to imagine the life of another person and to reexamine our own realities and reimagine our own possibilities. (Ross, 2017, p. 59)

Unfortunately, marginalized women's voices have often been silenced and their stories have gone unheard. Stories are powerful and varied. There is not one story that can describe everyone's experience. There is no such thing as a correct story, or an incorrect story; instead, "To embrace the vision of reproductive justice, one must embrace polyvocality—many voices telling their stories that together may be woven into a unified movement for human rights" (Ross, 2017, p. 59).

Sometimes, the stories that people want to hear are lifted above the stories that do not align with their beliefs and opinions. Reproductive justice issues are not one-dimensional. In my research, I strive to embrace polyvocality, to help women's voices and stories be heard, while recognizing there are numerous narratives to be shared, and numerous experiences from which to learn.

Interrogating Power Dynamics

Instead of focusing solely on individuals, reproductive justice is framed as a community-level issue, centering unequal power relations and focusing on oppressions such as sexism, racism, and classism as embedded in social systems affecting women's reproductive lives (Luna & Luker, 2013). Reproductive oppressions are enforced and perpetuated by those holding powerful positions in correctional institutions; reproductive oppressions are felt among incarcerated women on an individual level, an interpersonal level, a family level, and a community level. In regard to contraceptive access issues within correctional facilities housing women,

very little attention has been paid to those in power. A reproductive justice framework serves as a mode of analysis to examine these power differentials.

Some women face oppressions that temporarily or permanently remove their ability to have children that they may want, while others face oppressions that remove their ability to prevent pregnancies that they do not want. Many women have been disenfranchised and had decisions made for them, without their desires or autonomy being respected. For example, compulsory sterilization has been promoted as good for public health and public savings, at the same time as birth control access during incarceration has been deemed as cost-prohibitive and unnecessary. Judges, jail administrators, and doctors have had power over incarcerated women's bodies. Men—White men—have "controlled political calculations regarding what medical services women need and deserve" (Ross, 2017, p. 111). Reproductive justice is a framework that focuses on women, intersectionality, and marginalized voices, but it is also a "framework about power" (Ross, 2017, p. 111).

Conclusion

Reproductive justice highlights the fact that reproductive oppression must be analyzed through an intersectional lens, noting different systems of oppression and power and focusing on different levels—individual, interpersonal, family, community, and institutional (Asian Communities for Reproductive Justice, 2005, p. 7). This dissertation explores the topic of access and attitudes about reversible and permanent methods of contraception for incarcerated women through quantitative and qualitative research methods. I centered the research around women, acknowledging their diverse, intersectional identities. I sought women's stories, their experiences, their attitudes and their desires. I interrogated the systems of power that have continuously limited incarcerated women's reproductive autonomy.

Hundreds of thousands of women are entering and exiting jails across the

United States every year. Hundreds of thousands of women may be at risk of experiencing an unintended pregnancy because they were unable to access the contraceptive services they want and need in jail. This dissertation aims to shed light on this problem and offer evidence-based solutions.

Table 1. The Contraceptive Studies

	1	2	3	4	5	6
Author(s), Year	**Clarke et al., 2006a**	**Clarke et al., 2006b**	**Bonney et al., 2008**	**Hale et al., 2009**	**Sufrin et al., 2009**	**Pruitt et al., 2010**
Location of study	**Rhode Island**	**Rhode Island**	**Rhode Island**	**Southeast metro city**	**San Francisco County**	**Houston, Texas (55% jail)**
Sample size	484	224: 119 | 105	428	188: 108 | 80	290	484
Age (mean)	31	25 | 25	31	34 | 41	30	30
White	56%	58% | 53%	62%	37% | 40%	17%	37%
Black	16%	–	18%	59% | 55%	48%	48%
Hispanic	18%	–	20%	–	19%	13%
Mixed	–	–	–	–	8%	–
Asian/Pacific Islander	–	–	–	–	4%	–
Native American	–	–	–	–	–	–
Other	10%	42% | 47%	–	5% | 5%	4%	–
Uninsured	54%	58% | 60%	54%	–	–	–
HSD/GED+	43%	49% | 68%	44%	57% | 45%	70%	62%
Homeless	–	21% | 12%	18%	–	–	–
Catholic	–	42%	–	–	–	–
Previous incarceration	–	66% | 59%	–	–	–	–
Heterosexually active	84% (3 months before)	–	–	–	–	–
History of transactional sex	34%	–	33%	–	–	–
STI history	49%	54% | 57%	47%	–	–	–
Pregnancy history	84%	78% | 73%	84%	–	69%	91%
Unplanned pregnancy history	84%	65% | 65%	82%	–	–	–
Pregnancies	6 (median)	–	–	3.2 avg	–	–
Abortion history	35%	–	–	–	55%	–
Live births	2 (median)	–	–	2.2 avg	–	–
Used BC before arrest (time frame)	84% (ever)	10% | 8% (3 months)	61% (3 months)	ever	32% (at time of arrest)	18% of nonsterilized women (30 days prior)
Method						
Male condoms	89%	–	–	74%	1% (regular barrier)	48%
Withdrawal	–	–	–	39%	–	–
Diaphragm	–	–	–	–	–	–
Pill	70%	–	–	67%	–	42%
Patch	–	–	–	–	–	–
Ring	–	–	–	–	–	–
Injectable	30%	–	–	24%	–	35%
Tier 2	–	–	–	–	9%	–
Intrauterine Device (IUD)	8%	–	–	–	7%	–
LNG	–	–	–	–	–	–
CopperT	–	–	–	–	–	–
Implant	4% (Norplant)	–	–	–	2%	–
Sterilization	31%	–	–	43%	13%	40%
Negative pregnancy attitudes	–	51% | 56%	–	62%	23%	–
Consistent BC use	28% (in 3 months prior)	(condoms) 20% | 22%	32% (in 3 months prior)	–	–	–
Intend to use BC after release	–	–	–	58% condoms, 10% pill, 9% withdrawal	–	–
Would accept BC in Jail	–	75% | 79%	–	–	–	–
Eligible for EC at time of booking	–	–	–	–	29%	–
Accepted EC in jail	–	–	–	–	48%	–
Initiated pill	–	50%	–	–	–	–
Initiated injectable	–	48%	–	–	–	–
Initiatied IUD	–	2%	–	–	–	–

Table 1 Continued

	7	8	9	10	Summary	# of Studies
Author(s), Year	**LaRochelle et al., 2012**	**Ramaswamy, 2014**	**Ramaswamy et al., 2015**	**Schonberg et al., 2015**		
Location of study	**San Francisco County**	**Kansas City, Missouri**	**Kansas City, Missouri**	**New York City**	**Six locations**	**10**
Sample size	228	102	102 | f/u 66	32	32–484	10
Age (mean)	29	34	34 | 35	29	25–41	10
White	16%	16%	16% | 21%	16%	16–62%	10
Black	46%	72%	72% | 77%	60%	16–77%	9
Hispanic	19%	–	7% | 5%	22%	7–22%	7
Mixed	11%	1%	3% | 3%	–	1–11%	4
Asian/Pacific Islander	5%	–	–	–	4–5%	2
Native American	1%	3%	2% | 2%	3%	1–3%	4
Other	2%	7%	1% | 2%	–	1–47%	7
Uninsured	–	–	51% | 51%	31%	31–59%	5
HSD/GED+	71%	71%	71% | 67%	69%	43–71%	10
Homeless	–	–	3% | 10%	–	3–21%	3
Catholic	–	–	–	–	42%	1
Previous incarceration	–	11 months of life avg.	11 | 13 months of life	–	59–66%	3
Heterosexually active	–	–	95% | 79%	–	79–95%	2
History of transactional sex	–	–	25% | 29%	–	25–34%	3
STI history	–	–	44% | 44%	–	44–57%	4
Pregnancy history	–	–	–	91%	69–91%	6
Unplanned pregnancy history	–	61%	61% | 64%	–	61–84%	5
Pregnancies	–	–	–	–	3–6 median	2
Abortion history	54%	–	–	56%	35–56%	4
Live births	63%	2 avg	2 | 2	81% have children, 2 avg	63–81%, 2 avg.	6
Used BC before arrest (time frame)	39% (last 12 months) | 21% currently	–	3 months prior | 3 months after	Ever	Last 30 days – Ever	9
Method				–		
Male condoms	–	–	33% | 32%	100%	1% regular – 100% ever	6
Withdrawal	–	–	9% | 8%	25%	8–39%	3
Diaphragm	1% | 1%	–	–	–	1%	1
Pill	–	–	3% | 2%	63%	2%–70%	5
Patch	–	–	^	13%	< 13%	2
Ring	–	–	^	13%	< 13%	2
Injectable	–	–	^	50%	< 24–50%	5
Tier 2	10% | 28%	–	8% | 9% (Tier 2 and IUDS)	–		
Intrauterine Device (IUD)	8% | 11%	–	Included with patch, ring, injectable	^	< 7–11%	5
LNG	–	–	–	6%	6%	1
CopperT	–	–	–	6%	6%	1
Implant	2% | 2%	–	–	–	2–4%	3
Sterilization	–	31%	30% | 43%	Excluded	13–43%	6
Negative pregnancy attitudes	26% neg & 52% ambivalent	–	89% | 93%	–	23–93%	5
Consistent BC use	–	–	15% | 12%	–	12–32%	4
Intend to use BC after release	45%	–	43% used BC after release	–	9–58%	3
Would accept BC in Jail	60%	–	–	31/32 believed BC should be available	60–79%	2
Eligible for EC at time of booking	–	–	–	–	29%	1
Accepted EC in jail	–	–	–	–	48%	1
Initiated pill	–	–	–	–	50%	1
Initiated injectable	–	–	–	–	48%	1
Initiatied IUD	–	–	–	–	2%	1

CHAPTER 3

METHODOLOGY

Introduction

This dissertation examines three different research questions related to contraceptive access for women experiencing incarceration through surveys, focus groups, and interviews. My first research question is: "*What are the contraceptive needs and method preferences of women incarcerated at the Salt Lake County Jail*?," which I answer in Chapter 4. My second research question is: "*What attitudes do incarcerated women have toward sterilization occurring while in custody?,"* which I answer in Chapter 5. My third research question is: *"What mechanisms and rationales do specific jails utilize to either discontinue or continue and initiate contraceptives for women in their custody?,"* which I answer in Chapter 6.

In this chapter I describe the research methods used for the empirical studies found in Chapters 4, 5, and 6. I describe the recruitment procedures and data sources for each study as well as data collection and data analysis methods. I conclude each section with comments about issues of generalizability and limitations of each study.

Institutional Review Board Approval and Special Protections for Incarcerated Participants

The University of Utah Institutional Review Board (IRB) approved all data collection efforts. I had two studies approved by the IRB for this dissertation. The first study, IRB_00075360, approved the survey and focus group research of women

incarcerated at the Salt Lake County Jail. The second study, IRB_00098904, approved the interviews with jail health care providers.

The survey and focus group research included a vulnerable population, incarcerated women. The surveys and focus groups were approved as having minimal risk to participants. I did not exclude pregnant women from taking the survey or participating in the focus group. The IRB requested that I add the following language to the consent documents:

> Participation in this study is voluntary. You can choose not to take part. You can choose not to finish the questionnaire or skip any question you prefer not to answer [or leave the focus group at any time] without penalty or loss of benefits. Participating will not result in receiving better living conditions, medical care, quality of food, amenities, or opportunities for earnings than what is normally provided in the prison environment. Participating in the study will have no effect on parole determinations. By returning this questionnaire, you are giving your consent to participate.

I spoke with the IRB's prisoner representative to discuss compensation for the participants. In jail, incarcerated women are deprived of many basic goods that people outside of jail take for granted. I did not have funding to provide monetary compensation to 220 participants. From my previous experience as a health educator in the jail, I recalled that women enjoyed receiving a pencil and eraser every week they were in the class. The prisoner representative felt that allowing the women to keep the pencil and eraser would be an appropriate compensation and not coercive.

It was important to me to keep all survey and focus group participants de-identified. A consent cover letter was an appropriate way to consent participants without them having to tell me their names. No identifying information was collected. Survey participants handed in their surveys, to which I assigned numbers. Focus group participants knew each other's real names, but I never learned any of their names because they used an alias on their surveys and during the focus group discussion. This measure of anonymity provided a layer of protection for the participants. In the unlikely case the data were stolen or subpoenaed, it would be

impossible to identify a participant.

The interviews with jail providers were also approved. I used a consent cover letter that could be emailed to the participant prior to the interview, which they verbally confirmed having read. I had funding to compensate providers with $40 gift codes for Amazon.com.

Often, there is anecdotal dread about getting IRB approval for a study in a jail. There are assumptions that it is difficult to get approval for research involving the vulnerable, incarcerated population. I did not experience this in getting my dissertation research protocol IRB approved. I believe this is because of several reasons: (a) my research has the potential to benefit incarcerated women; (b) I had letters of support from the jail where I would be conducting research; and (c) the University of Utah IRB had an experienced prisoner representative on their review committee who was helpful to me through the process. I mention this because I believe more research should be conducted in jails to improve the experiences of people incarcerated there. Hopefully my positive research experience with the IRB can be informative for future contraceptive surveys in jails.

Chapter 4 Methodology

This chapter's research question is, "What are the contraceptive needs and method preferences of women incarcerated at the Salt Lake County Jail?" The hypothesis is that participants will have contraceptive needs that are unmet and their method preferences will be diverse.

Research Sample and Data Sources: Research Setting

The study was conducted at the Salt Lake County Jail, in Utah, with a goal to survey 200 women currently experiencing incarceration in the jail about their contraceptive needs and preferences. The facility is an adult housing complex and all

potential participants were older than 18 years of age. The Salt Lake County Jail houses women in units called pods which are described in detail in Chapter 1. Due to the structured nature and schedules of the jail, it was important to coordinate the days and times when the most women would be available to be surveyed but also reduce the possibility of a woman being approached to take the survey more than once or discuss the survey with another woman before they completed it. Ultimately, surveying 200 women in as few sessions as possible was the objective. To achieve this objective, I created a research team who could simultaneously conduct two survey sessions in different pods.

The research team consisted of four women in their mid- to late-20s. Two were non-Hispanic White and two were White-Hispanic women who were fluent in English and Spanish. The researchers worked in teams of two where English-only and bilingual researchers teamed up. Each member of the research team had to complete a background check to be approved for entry by the jail prior to the research administration days.

Procedures

I recruited survey participants from the female housing units (pods). Prior to the study day, I posted flyers with information regarding the survey in English and Spanish in the common areas of the pods. On the day of survey administration, the research teams entered the pods and made a verbal announcement explaining the survey in both English and Spanish. Women were informed their participation was voluntary and they could ask questions to a research team member at any time.

Women who agreed to participate sat in chairs around the communal television and were handed a consent cover letter, a survey, a golf pencil and rubber pencil-topping eraser. Participants were told not to write their names or any other identifying information on the survey materials and they were told they could keep

the pencil and eraser regardless of their completion of the survey. The pencil and eraser were compensation for participating. None of the participants requested surveys in Spanish. A member of the research team read aloud the consent cover letter in English and reiterated that participation was voluntary and participating in the study had nothing to do with receiving time off their sentence or any other benefits.

Participants then watched "Which Birth Control Method is Right for You?" a 12-minute contraceptive education video that was created by The CHOICE Project at Washington University School of Medicine (The CHOICE Project, 2012). The video describes common reversible contraceptive methods and the advantages and disadvantages of each method. The video lists methods in order of effectiveness: hormonal IUD, copper IUD, implant, birth control shot, birth control pill, contraceptive patch, vaginal ring, progestin-only pills, condoms, and emergency contraception. The CHOICE Project and this video promote the most effective methods of birth control, IUDs, and implants.

Participants completed the survey in the common area, multipurpose room, or their cell and then returned it to a member of the research team. The number of incarcerated women eligible to be surveyed across seven pods was 398. Among those, 202 (51%) completed the survey. One survey was incomplete and ineligible for analysis and seven participants' responses were excluded from analysis because they were over the age of 48. This left a sample of 194 participants for analysis.

Data Collection Methods

The Family Planning Services and Reintegration Effects Survey, developed for the study, consisted of 56 questions pertaining to demographic information, current and past incarcerations, sexual and reproductive history and intentions, contraceptive use prior to incarceration, contraceptive intentions and preferences for

after incarceration, and sterilization attitudes. Two blank pages were also provided in case the participant wanted to share more about her family planning history or goals with the researchers. The survey took approximately 15–25 minutes to complete. The survey scored at a fourth- to fifth-grade reading level. Research team members were available to assist participants who wanted help reading and completing the survey; however, all participants were able to complete the survey without assistance from the research team (see Appendix A for survey instrument). Of note, staples are not permitted inside the jail, so all surveys were bound using a staple-less stapler.

Measuring Pregnancy Desires

In this study, I assessed pregnancy desires through asking women if they wanted to get pregnant within the year after they were released from jail. A common query for family planning goals uses One Key Question® , which asks women "Would you like to become pregnant in the next year?" (Oregon Foundation for Reproductive Health). I added additional options for women to respond beyond "yes" or "no." How the question was asked in the survey is below.

> Do you want to get pregnant within ONE YEAR after you are released from jail? (Choose one)
> _____ Yes
> _____ No
> _____ I don't know
> _____ I don't care if I get pregnant
> _____ I can't get pregnant (menopause, hysterectomy, tubes tied, etc.)
> _____ Other (please specify) _____

This is not a perfect measure of pregnancy desire, but it is a useful tool for estimating the number of women who want to get pregnant to determine how they can be supported in planning for a healthy pregnancy. Additionally, it provides an estimate of how many women do not want to get pregnant in the next year and may be at risk of experiencing an unintended pregnancy.

Data Collection Challenges

I arranged for two consecutive Saturdays in February 2015 to administer surveys in seven pods. On the first Saturday, we were scheduled to administer surveys in pods A and B from 9:00 a.m. to 11:00 a.m., and in pods C and D from 12:30 p.m. to 2:30 p.m. and pods E and F from 6:30 p.m. to 8:30 p.m. On the second Saturday, we were scheduled to administer surveys in pod G from 9:00 a.m. to 11:00 a.m.

Regularly, jails go on "lock down," as a security precaution in the case of a medical incident or riot, for example. During a lock down, all incarcerated persons are locked in their cells, there are no programming activities allowed, no outside visitors may enter the jail, and any visitors in the jail at the time of lock down are immediately escorted out of the facility. After we completed the first survey session in pods A and B, the jail went on lock down and we were escorted out of the building without any information about how long the lock down would last or if we would be able to complete the survey administration that day. The research team members went home and I regularly called the jail to ask about the lock down status. After several hours, the lock down was over, and the study team made it to the jail to administer the surveys in pods E and F from 6:30 p.m. to 8:30 p.m. In pod E, the correctional officer on duty cut our session short at 8:00 p.m. for unknown reasons, about 30 minutes earlier than planned. Consequently, a few women were unable to complete their surveys. We collected 99 surveys on the first day of the study. For the following Saturday we rescheduled the study in pods C and D that we missed due to the lock down. On the second Saturday, we administered surveys in pods C and D from 9:00 a.m. to 11:00 a.m. and then in pod G from 12:30 p.m. to 2:30 p.m. On the second Saturday, the sergeant who coordinated the study times escorted us to an auxiliary facility, approximately a quarter mile from the main jail complex so we could survey women who were on laundry service and unable to take the survey with

the other women in their pod. We collected 103 surveys on the second Saturday for a total of 202 surveys. The IRB approval was only for 200 survey participants; after collecting 202 surveys I had to submit a report explaining that the reason I went over 200 was that I was unable to count the completed surveys between the pod sessions and only did the final count at the end of the day.

Data Analysis Methods

An IRB-approved research assistant entered the survey data into an Excel spreadsheet. I verified the completed dataset for accuracy. The dataset was uploaded into Stata 14, a statistical analysis software. Variables were constructed to capture women's demographic profiles, health and contraceptive history, as well as contraceptive preferences. Analyses for Chapter 4 proceeded in three steps. First, I conducted descriptive statistics of women's contraceptive preferences. Second, I compared women's contraceptive histories from the past 12 months with the methods in which they were interested at the time of the survey. I performed a chi-square test to assess whether the association between the most effective method used in the past 12 months is associated with the most effective type of contraceptive method in which women expressed interest. In a third analytic step, I estimated logistic regression models to estimate what predicts whether women express interest in IUDs and implants, the most effective types of reversible contraceptives.

Generalizability

The survey and this research question were designed as a needs assessment to gather information that could be used to inform the implementation of a contraceptive care program at the Salt Lake County Jail. The survey instrument was designed with guidance from an incarceration and women's health provider and

scholar after reviewing previous studies that recruited incarcerated women for contraceptive history and needs research. My previous experience with women incarcerated at the Salt Lake County Jail informed the measures I selected when designing the study to ensure women received an informal and brief contraceptive methods overview. That way they would have familiarity with the different types of contraceptive methods mentioned in the survey. I also made sure to use an elementary-level vocabulary in the survey for accessibility and readability of a study population that may have a high school diploma or less.

It is unknown from this study if the survey instrument is a reliable tool for assessing contraceptive needs and preferences for a jail population as it was only conducted at one jail. The results of the survey are not generalizable to the entire population of incarcerated women who are in custody at the Salt Lake County Jail, nor are they generalizable for all U.S. jails, as the demographic characteristics of the survey participants are very different than national profiles. However, the survey serves as an informational snapshot of the contraceptive needs and preferences of 194 women at one time point in the Salt Lake County Jail.

The primary goal of this survey was to assess the need for contraception among the participants and their preferences for specific methods. Unfortunately, due to study design errors, I am unable to confidently identify which study participants use female sterilization as a contraceptive method and am only able to estimate a range. I did not include an exclusive option for sterilization; instead, women could select "I cannot get pregnant" which could include sterilization, menopause, hysterectomy, or only having sex with women. Regardless, the survey collected data to generate estimates of how many women would be interested in initiating contraception in the Salt Lake County Jail and the distribution of contraceptive method preferences.

Limitations

This study has limitations. First, the sample size limited the type of analyses I could conduct, so the results are predominately descriptive rather than inferential. Second, Utah's incarcerated population is different from most imprisoned populations. The participants, and incarcerated women in Utah are predominately White. While there are Black, Hispanic, Asian, Native American and Pacific Islander women in the study and in the jail, Utah is not as racially diverse as many states, and the results reflect this. Additionally, the dominant Mormon culture is apparent in this study; the most prominent religious group among the survey participants was Mormon, which may influence women's reproductive lives in ways that differ from the general population.

I intentionally only surveyed women of reproductive age at the Salt Lake County Jail to identify the contraceptive needs and preferences of women in custody there and to inform discussions of implementing a family planning program at this jail in particular. I did not ask in depth questions about pregnancy, abortion, or parenthood as those subjects were outside of the scope of this study. To expand a family planning program to include men, future research would need to be done to assess their contraceptive knowledge, histories, and needs as well as attitudes about condoms, vasectomy, and supporting their female partners in consistent and correct contraceptive use.

Chapter 5 Methodology

This chapter's research question is, "What attitudes do incarcerated women have toward sterilization occurring while in custody?"

Before I describe the methodology of the Chapter 5 study, I believe it is important to provide some context for the research question. The results of the Chapter 4 survey study revealed interesting insights into participants' attitudes

toward sterilization. This warranted more exploration into incarcerated women's attitudes toward sterilization, which is consistent with feminist methods in social research (Reinharz, 1992). As I described in Chapter 2, there is prominent discourse nationally that sterilization procedures for incarcerated women should be prohibited, which is why I included questions about sterilization in the survey. Below, I will describe the survey questions and results regarding sterilization. The final three questions in the survey pertained to sterilization attitudes. Response options included "Yes," "No," "I do not know," and "Other" with an option to write in text as well. The survey included brief points of clarification and context for the questions.

For example, the following three questions are about tubal ligation (or "getting your tubes tied"):

> If a woman has a tubal ligation it means she can never get pregnant again. #53. Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?
>
> Some people worry that women who are incarcerated might feel pressured to get their tubes tied. #54. Would you worry that female inmates were being pressured into having this permanent procedure?
>
> Some lawmakers want to make it so female inmates cannot get their tubes tied while they are incarcerated. And some people think that women should have the choice to get their tubes tied, even if they are incarcerated. #55. Do you think tubal ligation, "getting your tubes tied," should be prohibited for incarcerated women?

Tables 2, 3, and 4 show the responses to questions #53, #54, and #55, respectively. The survey participants' responses show that attitudes about sterilization are diverse. However, most participants reported that incarcerated women *should have the opportunity* to be sterilized while they are in custody, and that sterilization *should not be prohibited* for women. Most respondents believed women *would not feel pressured* to be sterilized. However in all three questions, several respondents reported that they "did not know," showing ambivalent feelings toward sterilization occurring during incarceration.

Many women wrote comments down on their surveys in response to the questions. Regarding "*opportunity*," one participant wrote, "Case by case." Another participant wrote, "Wonderful idea." And another participant wrote, "Only if they aren't mentally ill." Regarding "*pressure*," one participant wrote, "50–50. Could be a problem. See both sides." Another participant wrote, "If they want it they know." Another participant wrote, "A little. It makes sense." And another wrote, "Depending on their history with kids." The most comments were written in regard to sterilization being "*prohibited*," one participant wrote, "We have all rights over our own bodies!" Another participant wrote, "If they can't support and have had multiple kids taken from them, then they need them tied." Another participant wrote, "If they continue to abuse motherhood." Another wrote, "To each person we should have our free will." Another wrote, "When they get out—since when was jail a hospital." And another participant wrote, "It should be a choice."

The responses of survey participants showed more favorability for the availability of sterilization, in contrast to the more public call for prohibition of sterilization of women in correctional custody. It is this finding that provides the background for why I chose to conduct focus groups with women in the Salt Lake County Jail to learn more about their attitudes towards sterilization.

Focus group research allows for qualitative data to be collected from multiple individuals simultaneously (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009) by engaging a small group of people in a discussion that is "focused" around a particular topic or issue (Wilkinson, 2004). Sterilization can be a controversial topic. Many research participants may be less threatened or intimidated by focus groups (Onwuegbuzie et al., 2009). I chose to conduct focus groups, to create a space where incarcerated women could informally discuss the issue of sterilization access for women in custody. Focus groups were an appropriate way to collect more information about incarcerated women's sterilization attitudes and expand on the

findings from Chapter 4. Additionally, a strength of conducting focus groups in a jail setting is that they "give voice" to a socially marginalized group that may not otherwise be heard (Morgan, 1997).

An advantage of conducting focus groups in a jail setting with women who are housed together is that it is an environment where women may feel like part of a group which can help them feel safe to share personal information (Vaughn et al., 1996). In a focus group setting, participants may discuss possible solutions to the issue being discussed (Duggleby, 2005). The issue of sterilization access for incarcerated women needs more possible solutions. Focus groups provided for incarcerated women to weigh in on a controversy that affects them.

Objective

As this is a qualitative study and meant to be more exploratory than deductive, I did not have a hypothesis, but rather I had an objective to elicit responses regarding attitudes toward sterilization availability for incarcerated women.

Research Sample and Data Sources: Research Setting

This study was conducted in the Salt Lake County Jail in Salt Lake City, Utah, in July 2016, 17 months after the survey for Chapter 4 was conducted. In Utah, sterilization of an institutionalized person is legal if a "physician ensures the person is capable of giving informed consent and that no undue influence or coercion to consent has been placed on that person by nature of the fact they are institutionalized" (Utah Code, 1988). In the jail where this study was conducted, elective sterilizations are not considered medically necessary and are not available for nonpregnant women. Pregnant women who are delivering at a local hospital while in custody may undergo sterilization procedures after childbirth, but the decision and

consent process is handled entirely by the hospital, not the jail.

Procedures

I conducted three focus groups with incarcerated women at the Salt Lake County Jail on three consecutive Saturdays in July, in three different housing units (pods) within the jail. The facility is an adult housing complex and all potential participants were older than 18 years of age. Because none of the survey participants chose to take a Spanish survey, I assumed there would not be enough women who only spoke Spanish to conduct a Spanish-only focus group; thus, I only conducted focus groups in English. Each focus group session was scheduled for 3 hours, from 8:00 a.m. to 11:00 a.m. That block of time included the announcement, recruitment, consenting, survey administration for demographic information and group comparisons, and focus group facilitation.

Participants were recruited through convenience sampling from the women who were in the pod that I entered on the day of the focus group. I was escorted into the pod by a sergeant. Once we were in the pod, all the women's cells were unlocked and most women stepped out. The sergeant introduced me as a researcher from the University of Utah and asked all the women in the pod to please listen to what I had to say. Of note, the sergeant who escorted me in and introduced me has great rapport with most of the women, as he is not a correctional officer but is in a role with the programs department, which schedules classes (yoga, alcoholics anonymous, GED preparation) that the women tend to appreciate.

I made an announcement to the entire pod in the communal area that I was conducting focus groups to learn more about women's attitudes about sterilization or someone getting their "tubes tied" while they are incarcerated. Women who were interested in participating were invited to the multipurpose room in the pod. Each group was limited to the first seven interested participants and restricted to English-

speaking women. Recruiting seven participants was the goal for each group for two reasons: (a) well-designed focus groups usually consist of between 6 and 12 participants (Krueger, 2000; Morgan, 1997), and (b) the transcription service could track up to 8 individual voices while being able to assign names to each speaker.

As is common in focus groups, researchers try to recruit participants who are similar in demographic characteristics to maximize the level of comfort among participants and foster an environment where they feel safe to share stories or beliefs with people who may have similar experiences (Morgan, 1997; Vaughn, Schumm, & Sinagub, 1996). Because there are stark differences in the experiences of White women and women of color when it comes to forced and coerced sterilization, my goal was to conduct one focus group with White women, one focus group with women of color and then determine if a racially mixed group would be appropriate for the third focus group. In the first pod, I mentioned that I was interested in recruiting White women for the first focus group. I heard one woman of color call me a racist and turn into her cell, uninterested in anything more that I had to say. The sergeant who was escorting me mentioned to me that racial tensions were very high in the jail—particularly between incarcerated people and those in positions of power, given the circumstances of increasing attention on police brutality. I learned that in jail, traditional focus group recruitment norms will not always work and may undermine your research, and reputation within the jail. I did not mention race again in the second and third pods. I relied on convenience sampling and allowed the first seven interested women to participate in the focus groups regardless of race or other characteristics.

After announcing the focus groups and asking for seven participants to proceed to the multipurpose room, a small room with an occupancy limit of 12, the participants and I set up chairs in a half-circle shape. I placed a chair in the center of them all, which had name tags with aliases on them that I had written before

entering the jail. I asked each participant to grab a name tag and put it on her shirt. I asked each participant to make note of her alias—this would be her name for the next couple of hours and these pretend names would help protect their identity and the fact they participated in the research project. Focus Group 1 had seven participants, Focus Group 2 had six participants and Focus Group 3 had seven participants. I capped the groups at seven, because eight was the maximum number of voices the transcriber could track.

Next, I gave each participant a consent cover letter, read it aloud, and asked if anyone had any questions. I then gave each participant a golf pencil and pencil-topping eraser and a copy of the same survey that I administered in the jail in 2015. The participants did not watch the CHOICE video like the pilot study participants because the objective of the focus groups was not to collect contraceptive preference information, but to collect demographic characteristic information and compare the two groups. Participants wrote their aliases on their surveys and returned the completed surveys to me and got to keep the consent document and the pencil and eraser as compensation for participating.

The audio-recorded focus groups began with each participant and myself taking turns introducing themselves (with the alias) and sharing the name of their favorite restaurant. This was done so the transcriber could differentiate the voices in the group and track the specific participant with their contributions to the discussion. There were five main prompts for the focus group and each was written on the whiteboard in the room, one at a time during the focus group and I asked follow-up questions and probed participants to continue describing their experiences throughout the focus group.

The first two main prompts were:

- In general, what are your feelings about women's reproductive health in jail?, and

- Have you heard of tubal ligation? When/under what circumstances did you first hear about tubal ligation?

I gave a description of sterilization procedures and stated that sterilization or getting one's "tubes tied" means a woman can no longer get pregnant. The last three questions pertained to sterilization procedures occurring while a woman was in custody of the jail.

- Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?

I noted that some people worry that women who are incarcerated might feel pressured to get their tubes tied and asked, c

- Would you worry that incarcerated women were being pressured into having this permanent procedure?

I mentioned that some lawmakers want to make it so female inmates cannot get their tubes tied while they are incarcerated, and some people think that women should have the choice to get their tubes tied, even if they are incarcerated. The final question was,

- Do you think tubal ligation, "getting your tubes tied," should be prohibited for incarcerated women?

The announcement, recruitment, consent process, instructions, and survey administration took approximately 1 hour. The actual audio-recorded focus groups lasted approximately 108 minutes, 78 minutes, and 90 minutes. After each focus group, the audio recording was uploaded to a professional transcription service, Landmark Associates, Inc. (thelai.com), which transcribed the audio recordings verbatim.

Data Analysis Methods

The analysis team consisted of two people, myself and Carolyn Sufrin, MD, PhD. The transcript for Focus Group 1 was 67 pages, Focus Group 2 was 41 pages, and Focus Group 3 was 43 pages. The team used constant comparison analysis. Glaser and Strauss developed the method of constant comparison first used in grounded theory research (Glaser, B. G., 1978; Glaser, B. G. & Strauss, 1967; Strauss, 1987). Constant comparison analysis can be used to analyze focus group data (Leech & Onwuegbuzie, 2007, 2008). We used constant comparison analysis to analyze the data in three stages: open coding, axial coding, and selective coding.

First, the analysis team independently conducted transcript-based, open-coding analysis. We analyzed each focus group as a unit of analysis (Morgan, 1997). We analyzed each section of the focus groups that related to a specific question or prompt. Through open coding, the research team assigned codes, or descriptors, to the data. Some examples of initial open codes include, "right to body," "forgotten and ignored," "drug use," and "need advocates." After independently open coding the transcripts, the analysis team discussed their initial findings and agreed upon the common codes. We identified the degree of consensus and dissent among the participants, and paid special attention to outliers, who discussed attitudes or experiences that diverged from the majority's comments (Onwuegbuzie et al., 2009; Sim, 1998). For example, one woman who dissented from the majority argued that women in jail may make terrible decisions out of desperation. Her dissent added richness and complexity to the data and we did not want her dissent to be censored (Kitzinger, 1994).

Second, after the codes were determined, I uploaded the coded transcripts into Dedoose, a qualitative software (Dedoose Version 7.0.23, 2016). I conducted axial coding and grouped the codes into categories. The categories included broad "parent" codes, such as *Information*, or *Rights*, or *Drugs* and additional "child" codes.

For example, under the parent code *Drugs,* child codes included *drug dependent women*, and *newborns withdrawing from drugs*. I also conducted keyword searches within the transcripts, to review the keywords-in-context (Fielding & Lee, 1998). This allowed me to understand if women used the same words similarly or differently and to compare ideas across groups.

Third, after all the transcripts had been coded, I utilized the code counts and co-occurrence functions in Dedoose to determine the frequency of each code and which codes overlapped. I also coded the excerpts by individual to determine who participated in each focus group as a prominent discussant or a quiet or silent member. This allowed me to revisit the survey responses and focus group data to determine if a woman was not participating because her comments and attitudes from the surveys were not aligned with the group. I discuss these findings in Chapter 5. Through an analysis of code frequencies and prominent discussions, I developed the themes that emerged from the focus groups and selected multiple quotes that captured the content of the groups which are presented in Chapter 5.

Internal and External Validity

The focus group outline was created after the survey data were collected and analyzed and was designed specifically for focus groups conducted in the Salt Lake County Jail. Among the 20 participants, 17 identified as White. The Salt Lake County Jail houses predominately White women, which is unusual compared to many metropolitan jails in the country where women of color are disproportionately represented and may outnumber White women. While many of the themes that emerged from the focus groups may be transferable to other jail populations, this study was designed to shine light on the issue of sterilization in a Utah context.

Challenges

It was important to me to include women who wanted to participate. Due to the nature of the jail schedule and the restricted block of time available to conduct the focus groups, I had to make broad announcements to the entire pod on the day of the focus groups. One of the only 3-hour time blocks available for me to do the study was from 8:00 a.m. to 11:00 a.m. Many women were still asleep when I arrived so I did not have the attention of every single woman in the pod. However, it seemed as if most women did step outside the cells to hear my announcement. As I mentioned earlier, when race came up on the 1st day, several women of color, as well as White women, likely lost interest in participating, which may have altered the first focus group. Also, I acknowledge that women who had negative experiences with or attitudes of sterilization may not have been interested in discussing it and therefore did not volunteer to participate. I also acknowledge that the women who did volunteer to participate may share similar, outgoing, opinionated types of personalities, and may not be representative of the jail population. I conducted the focus group between breakfast and lunch. During all focus groups, a nurse came to the pods to administer medications. Focus group participants could leave the focus group to get the medication (or for other reasons), and a couple of participants chose not to come back. This is unfortunate, but a reality of conducting research with a population who have very little control in their incarcerated lives; if they wanted to leave the focus group to watch television or walk around the pod with a friend, that is understandable.

Chapter 6 Methodology

This chapter's research question is, "What mechanisms and rationales do specific jails utilize to either discontinue or continue and initiate contraceptives for women in their custody?" The objective of this study was to interview jail health care

providers at different facilities in the United States to understand how and why correctional facilities do (or do not) meet the contraceptive needs and desires of incarcerated women in their custody.

Data Collection Methods

As mentioned in the literature review, there are over 3,000 jails in the United States operating independently. Their health care arrangements can vary dramatically, and most jails discontinue women's birth control upon arrest and do not reinitiate it or offer contraceptive care during incarceration or prior to release. To gain a better understanding of different jails' contraceptive care protocols, or the lack thereof, I conducted semistructured interviews with eight jail health care providers from eight different facilities in the United States.

This study used a combination of criterion sampling and maximum variation sampling. I set specific criteria for the participants to be eligible. Participants had to be a health care professional providing care to women incarcerated in a U.S. jail and they had to have worked in the jail for at least 1 year. Occupations could include Medical Doctor (MD), Certified Nurse Midwife (CNM), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN). This criterion ensured the participant would have knowledge of the contraceptive care available for women in custody in the facility where they work.

For maximum variation, I intentionally tried to recruit medical professionals from diverse areas of the country as well as diverse areas of the state of Utah. I made a point to interview three providers in Utah jails, since Utah is the focus of my recommendation work. I also made a point to interview a provider in California where sterilization of incarcerated women is illegal. Additionally, I wanted to ensure I interviewed providers at jails with comprehensive, well-established family planning programs offering IUDs and implants (Green Jail), and jails with some contraceptive

care programming, potentially only providing user-dependent methods *and not* IUDs and implants (Yellow Jail), and jails that have no contraception available for women in their custody (Red Jail). I created the color-coded system to reflect the level of contraceptive care available in the jail.

I recruited participants using a combination of targeted recruitment via email and social media. I sent recruitment messages to people in my network who knew jail health care providers whom they could inform of the research study. I sent study advertisements to administrators of Facebook pages for correctional health care providers. I sent the advertisement to people on LinkedIn who were affiliated with correctional health care groups and conferences. I did not recruit any participants through social media; instead, all the participants were recruited through email correspondence either directly from me or forwarded on by one of my colleagues. People gave me names and email addresses of people they knew who worked in a jail, or I was contacted directly after someone heard about my study and expressed interest in participating. I had to decline two people who were interested in participating: one because they worked in a prison and eligibility required working in a jail where women had stays less than 1 year, and another because they worked as a doula for pregnant incarcerated women, but were not a regular health care provider.

Once eligibility was established, I scheduled a 1-hour phone interview with participants for a day and time convenient for them. I emailed each participant a consent cover letter for them to read prior to the interview. The interviewee decided if they wanted me to call them or if they wanted to call me. At the arranged time, I would call them (or wait for their call) and ask if they had any questions before I turned on the audio recorder. After starting the audio recorder, I would ask the participant if they had read and understood the consent cover letter and if they agreed to be interviewed and audio recorded to which they verbally consented. I

used an interview guide in all interviews (see Appendix C). The audio-recorded interviews lasted between 44 and 97 minutes, with an average duration of 69 minutes. After each interview, the audio recording was uploaded to a professional transcription service, Landmark Associates, Inc. (thelai.com), which transcribed the audio recordings verbatim. I offered a $40 Amazon gift card to all participants, which four participants declined to accept. The gift card was emailed to participants within a few days of their participation.

Data Analysis Methods

The interviews with jail health care providers produced two types of data for analysis: (a) data about the providers and their attitudes toward contraceptive care in a jail setting, and (b) data about the facilities where the providers worked and the contraceptive care available in those facilities. While each interview only resulted in one transcript, I analyzed the transcripts and parsed out provider-level data from facility-level data. I will first discuss my data analysis strategy for the provider-level data, followed by my strategy for facility-level data.

During the interviews, I asked the providers questions about their attitudes regarding specific contraception related topics, such as professional opinions about contraception care in jail settings and professional opinions about incarcerated women having access to sterilization while in custody. These questions resulted in answers that were specific to the providers.

I used a grounded theory approach to analyze the provider-level data (Glaser, B. G. & Strauss, 1967). Specifically, I simultaneously collected and analyzed data, did not have preconceived hypotheses, and coded the transcripts using constant comparisons for specific interview responses. I employed Charmaz's constructed grounded theory approach, analyzing the data to uncover an *interpretation* of jail health care providers' attitudes regarding contraceptive care for incarcerated women

(Charmaz, 2006).

Similar to the data analysis strategy of Chapter 5, I analyzed the transcripts in three steps: open coding, axial coding, and selective coding. I read each transcript and coded answers with descriptions such as "underserved population," "public health," "not the jail's responsibility." I categorized the codes to determine themes that were more patient-centered, or jail/budget-centered. I selected excerpts that captured the sentiment of the providers to develop the themes that emerged, which I present in Chapter 6.

During the interviews, I asked the providers questions about the contraceptive health care arrangements and policies in the facility they work in, such as whether women were screened for emergency contraception eligibility at booking, and if IUDs were available for women to initiate prior to release from jail. These questions resulted in answers that were specific to the facilities.

I coded the facility-level availability or lack thereof based on predetermined categories of contraceptive care from intake, during incarceration, and prior to release. I determined the presence or absence of specific services, such as the ability to continue taking a hormonal birth control pill during incarceration. Some other categories required further analysis and coding to understand facility-level nuances, such as the availability of sterilization for incarcerated women.

Internal and External Validity

I designed the interview guide to gain an understanding of the context surrounding the community, the facility, the incarcerated women and the health care arrangements and providers at each jail. I asked broad questions and detailed questions to get a holistic picture of what factors are necessary for a comprehensive contraceptive care program in jail. I interviewed eight providers who held various positions—Medical Director, Chief Medical Officer, Ob/Gyn, PA, and RN—which

provided insight into providers' different perspectives depending on their place in the facility's staff hierarchy. Hierarchy mattered, as some interviewees were in decision-making positions while others were not. Some interviewees were more knowledgeable of the protocols and history of programs than others, depending on how long they had been at the jail and their position as an administrator. This interview guide was designed to be used to interview more health care providers all over the country. This study could be enhanced by interviewing more medical providers in rural areas, who were the most difficult to identify and recruit. Additionally, all the medical professionals interviewed were White. This study could be enhanced by interviewing people of color who provide care.

Recruitment Issues

Recruiting eight providers took 4 months. It was difficult to identify the medical director, and I typically had to "cold call" jails and ask for the name and email address of the medical director to send them a study advertisement. I sent dozens of emails but heard back from very few people. As previously mentioned, I sent an advertisement to several administrators of correctional health care Facebook pages, but did not recruit any providers through those channels. One explanation could be that medical professionals who work in jails that do not provide contraception may not have believed they were eligible, or did not feel particularly interested in the study. It was easier to recruit providers who worked in jails with robust contraceptive programs that they were proud of and happy to discuss with a researcher. I had the most luck when my colleagues sent an email to a medical director they knew, "vouching" for me. The people with whom I did have contact were very supportive, responsive, and helpful. Given their busy schedules, asking for an hour of a health care provider's time is significant. On two occasions, the provider spoke to me on the phone during their commute to or from the jail, although I am

not confident that in-person interviews would have made any difference in data quality.

Limitations

I specifically only wanted to interview jail health care providers and excluded providers who worked in prisons because the operations, populations, and circumstances surrounding contraception are very different in jails and prisons. I was fortunate to interview eight providers who all described different contraceptive care programs and diverse attitudes about contraception and sterilization availability for incarcerated women. The data collected from these eight interviews will provide useful, albeit not exhaustive, information for understanding the complex issues jails face in providing contraceptive care to women in their custody—and may even serve as frameworks for jails to replicate and implement contraceptive care programming in their facilities.

Table 2. Survey Participants' Responses to Question About

Sterilization Opportunity

If a woman has a tubal ligation it means she can never get pregnant again.

53. Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?

Response	Survey Participants *N* = 194
Yes	125 (64%)
No	33 (17%)
I don't know	29 (15%)
Other	2 (1%)
Missing	5 (3%)

Table 3. Survey Participants' Responses to Question About Sterilization Pressure

Some people worry that women who are incarcerated might feel pressured to get their tubes tied.

54. Would you worry that female inmates were being pressured into having this permanent procedure?

Response	Survey Participants *N* = 194
Yes	43 (22%)
No	110 (57%)
I don't know	32 (16%)
Other	4 (2%)
Missing	5 (3%)

Table 4. Survey Participants' Responses to Question About

Sterilization Prohibition

Some lawmakers want to make it so female inmates cannot get their tubes tied while they are incarcerated. And some people think that women should have the choice to get their tubes tied, even if they are incarcerated.

55. Do you think tubal ligation, "getting your tubes tied," should be prohibited for incarcerated women?

Response	Survey Participants *N* = 194
Yes	21 (11%)
No	132 (68%)
I don't know	26 (13%)
Other	9 (5%)
Missing	6 (3%)

CHAPTER 4

CONTRACEPTIVE NEEDS AND PREFERENCES OF WOMEN AT THE SALT LAKE COUNTY JAIL

Introduction

Women who have been involved with the criminal justice system are less likely to use contraceptives consistently and more likely to experience unintended and high-risk pregnancies than women without a history of arrest (Clarke, Hebert, et al., 2006; LaRochelle et al., 2012; Sufrin et al., 2009b, 2010). Incarceration itself can contribute to women's risk of unintended pregnancy, as it is a common institutional practice to discontinue women's hormonal contraceptive methods while they are in custody, and birth control is not offered or reinitiated prior to release (Sufrin et al., 2009a; Sufrin, Kolbi-Molinas, et al., 2015). An unintended pregnancy postrelease may complicate a woman's ability to successfully reintegrate into her community and may increase the likelihood of her recidivating and returning to jail pregnant (Clarke et al., 2010). Jails are operated on a local level, located in the cities and counties where incarcerated persons typically live and return. Thus, jail becomes a regular, recurring part of many women's lives and offers an opportunity to continue women's reproductive health care or provide family planning services that are unavailable or inaccessible to them in the community (Glaser, J. B. & Greifinger, 1993; Ramaswamy et al., 2015; Sufrin, 2017).

Incarcerated women struggle to access gender-specific health care, specifically family planning services, for several reasons, including their minority status compared to men, an administrative perception that contraception is

unnecessary in jail, or a lack of family planning providers for the facility (Maruschak, 2008; Roth, 2004; Sufrin et al., 2009a; Sufrin, Kolbi-Molinas, et al., 2015). Incarcerated women are at risk of unintended pregnancy if they had sex in the few days before arrest and either did not use contraception, or if their birth control method was disrupted in jail and they were not offered emergency contraception at the time of booking (Sufrin et al., 2010). Incarcerated women are also at risk of unintended pregnancy if they have sex in jail. Between 2011 and 2012, approximately 1,300 women incarcerated in U.S. jails reported sexual victimization by a facility staff member (Beck et al., 2013). Incarcerated women are also at risk of unintended pregnancy immediately after release if they are heterosexually active and birth control methods are not continued or initiated in jail as hormonal methods can take time to become effective (Clarke et al., 2010; New York Civil Liberties Union, 2008).

Many incarcerated women are not knowledgeable about menstruation, fertility, birth control effectiveness, or how to choose and access contraceptive methods (Allsworth et al., 2007; LaRochelle et al., 2012). Although most incarcerated women were sexually active prior to arrest, plan to have sex after release, and do not want to become pregnant in the near future (Ramaswamy et al., 2015), contraceptive use is lower among this population compared to women without an arrest history. Research has shown that 12–32% of incarcerated women consistently used birth control prior to arrest (Bonney et al., 2008; Clarke, Hebert, et al., 2006; Clarke, Rosengard, et al., 2006; LaRochelle et al., 2012; Ramaswamy et al., 2015). Additionally, there are racial differences in contraceptive use among incarcerated women, with non-Whites reporting less use of birth control than Whites (Hale et al., 2009).

Previous studies have found that 60–79% of incarcerated women would accept contraception if it was offered to them in jail or soon after release (Clarke,

Rosengard, et al., 2006; LaRochelle et al., 2012). Clarke, Rosengard, et al. (2006) found that women were much more likely to initiate birth control if offered methods in jail (39.1%) compared to those who were referred to a community health clinic for contraceptive methods postrelease (4.4%). Very few studies have focused on contraceptive method preferences among incarcerated women (Hale et al., 2009; Schonberg et al., 2015).

Sterilization, a common method of contraception (Jones et al., 2012), is a controversial issue in the context of incarceration, as there have been cases of incarcerated women undergoing forced or coerced sterilization procedures (Johnson, 2013; Ross, 2017; Roth & Ainsworth, 2014; Solinger, 2005). While many of the arguments against sterilization during incarceration are convincing and well-intentioned, there is concern that blanket prohibitions limit access to a highly effective contraceptive method for a group of women who often have limited access to birth control when they are not incarcerated. Importantly, there is a lack of research regarding the desire for sterilization among incarcerated women.

City and county jails serve diverse populations across the country and vary in population size and demographics. To ensure incarcerated women have access to family planning services, and to better understand the needs of the women in custody, surveys can be an important way of establishing needs and informing a recommendation for a population-specific family planning protocol. At the time this manuscript was written, there were no contraceptive counseling or services available for women incarcerated at the jail. This study examines the contraceptive method needs and preferences of women incarcerated at the Salt Lake County Jail.

Materials and Methods

Procedures

Survey participants were recruited from the female housing units (pods) at the Salt Lake County Jail. The study was supported by the participating jail and approved by the Institutional Review Board at the University of Utah. Flyers with information regarding the survey in English and Spanish were posted in the common areas of the pods prior to the study day. On the day of survey administration, the research team (four White women, all English speaking, two of whom are White-Hispanic, bilingual Spanish interpreters) entered the pods and made a verbal announcement explaining the survey in both English and Spanish. Women were informed their participation was voluntary and they could ask questions to a research team member at any time. Women who agreed to participate were handed a consent cover letter, a survey, a golf pencil and rubber pencil-topping eraser. Participants were told not to write their names or any other identifying information on the survey materials and they were told they could keep the pencil and eraser regardless of their completion of the survey. None of the participants requested surveys in Spanish. A member of the research team read aloud the consent cover letter in English. Participants then watched "Which Birth Control Method is Right for You?," a 12-minute contraceptive education video that was created by the CHOICE Project at Washington University School of Medicine (Secura, Allsworth, Madden, Mullersman, & Peipert, 2010). Participants completed the survey in the common area or multipurpose room and then returned it to a member of the research team. The number of incarcerated women eligible to be surveyed across seven pods was 398. Among those, 202 (51%) completed the survey. One survey was incomplete and ineligible for analysis and seven participants' responses were excluded from analysis because they were over the age of 48. This left a sample of 194 participants for analysis.

Measures

The survey, which was developed for the study, consisted of questions pertaining to demographic information, current and past incarcerations, sexual and reproductive history and intentions, contraceptive use prior to incarceration, contraceptive intentions and preferences for after incarceration, and sterilization attitudes. The options included nonhormonal, user-dependent methods such as male condom, diaphragm, and the rhythm method; hormonal, user-dependent methods such as emergency contraception, oral contraception (the pill), transdermal patch (the patch), vaginal ring (the ring), and medroxyprogesterone injection (the shot); and user-independent methods such as the subdermal implant, intrauterine devices (IUD) and sterilization.

Two blank pages were also provided in case the participant wanted to share more about her family planning history or goals with the researchers. The survey took approximately 15–20 minutes to complete. The survey scored at a fourth- to fifth-grade reading level. Research team members were available to assist participants who wanted help reading and completing the survey; however, all participants completed the survey without assistance from the research team.

Analytic Strategy and Measures

Analyses proceeded in three analytic steps. I first describe the sample and specifically contraceptive history and preferences; second, I examine the association between methods women have used in the past year and contraceptive methods they desire. Third, I estimate logistic regression models that seek to better understand what characteristics predict interest in IUDs and implants.

Contraceptive Method Measures

I created four categories of contraceptive methods to combine methods in groups by effectiveness. Sterilization (permanent contraceptive method); Tier One (user-independent, long acting reversible methods: IUDs and contraceptive implant); Tier Two (user-dependent, hormonal methods: pill, patch, ring, shot); and Tier Three (user-dependent, nonhormonal methods: condom, rhythm, diaphragm). Emergency contraception was not included in this analysis. Respondents were able to indicate the past use as well as interest in multiple contraceptive methods.

Results

Demographic Characteristics

Participants were predominately of reproductive age (median = 31 years, *SD* = 7.8) and White (62%). Over a quarter of participants were Hispanic (28%). The education level of the women was diverse; approximately one-third did not complete high school, one-third had a high school diploma or GED, and one-third had at least some college education, while 4% of those had a bachelor's degree. The majority of participants considered themselves religious (66%); one-quarter of the participants were members of the Church of Jesus Christ of Latter-day Saints (Mormon). Participants reported a median of seven times in jail (range = 1–42). Most of the women had used illicit drugs in the previous 12 months (88%). Over half of the participants did not have health insurance prior to arrest (52%) and 79% wanted help enrolling in health insurance during incarceration (see Table 5).

Sexual, Reproductive and Contraceptive Demographics

Most participants had been forced to have sex (59%) at some point in their lives. Many had had sex for money, drugs, or food (37%). Most of the participants had experienced at least one pregnancy (87%); of those, 31% had been pregnant in

jail. Nearly a quarter (24%) of participants had had at least one abortion and 24% had placed at least one child in an adoptive home. Over half of the women had custody of a dependent-age child (55%) at the time of their arrest. The majority (57%) had used at least one contraceptive method in the 12 months before incarceration—one-third used condoms, 17% used an IUD, and other methods were used by fewer than 10% of the participants. Over one-third of participants reported that they had a problem with their partner not wanting to use birth control or condoms prior to incarceration (32%) and 23% foresaw issues with their partner's willingness to use birth control or condoms in the future.

The participants responded to the question, "Do you want to get pregnant within ONE YEAR after you are released from jail?," of which 22% responded "Yes," 53% responded "No," 13% responded "Do not know," 3% responded "Do not care," and 11% responded "Cannot." Most women reported they felt they knew enough about contraception in the past to choose an appropriate method for themselves (66%), and the participants overwhelmingly reported that the Contraceptive CHOICE video helped them better understand the methods of birth control that were available (94%). Only 41% planned on using birth control. However, 67% of participants reported that they would be interested in initiating contraceptive methods in jail (see Table 6).

Contraceptive Method Preferences

Respondents selected specific methods of birth control in which they were interested. The women could select as many methods as they wanted. The results of most preferred to least preferred were as follows: male condom (46%); IUD (26%; 12% reported they were specifically interested in the Mirena®, and 3% reported they were interested in the Paragard® specifically); the subdermal implant (21%); the shot (21%); the pill (17%); sterilization (16%); the patch (9%); the ring (9%);

emergency contraception (9%); fertility awareness (7%); and diaphragm (2%). One-quarter of participants (25%) reported they either did not want or did not need birth control (some reasons included that they wanted to/did not care if they get pregnant, had hysterectomy or tubal ligation, only had sex with women; see Table 7).

As shown in Table 7, participants could select as many methods as interested them. Table 8 shows distribution of prior use compared to current interest in methods by effectiveness, and includes a participant if they selected at least one of the methods in that category. In the 12 months prior to the current incarceration, 57% used at least one contraceptive method, 3–11% reported sterilization use, 23% used a Tier One method, 16% used a Tier Two method, and 34% used a Tier Three method. Just over 16% of participants reported interest in sterilization, nearly 60% reported interest in Tier One methods, 47% reported interest in Tier Two methods, and 56% reported interest in Tier Three methods (see Table 8).

Table 8 illustrates past contraceptive use and current interest based on all responses. In a next step, I categorized individuals based on the most effective method they have used in the past 12 months and the most effective method that currently interested them. A chi-square test shows that those two measures are significantly associated rather than independent. However, in many cases, people's method interest tends to shift up toward more effective methods.

Table 9 shows that women who used an IUD or implant before jail were most interested in an IUD or implant at the time of the survey. Among women who used the pill, patch, ring, or shot prior to arrest, over half were still interested in those methods, but 44% were interested in an IUD or implant. Among women who used only condoms, fertility awareness, or another Tier Three method, 53% were interested in an IUD or implant at the time of survey.

I created a measure to capture all possible contraceptive combinations that a

participant reported interest in. Table 10 shows the distribution of participants' representation in contraceptive categories. Women were only represented in one category that captured all the different types of methods they were interested in, according to effectiveness. Twenty-two percent of participants were only interested in IUDs or implants. Among the 16% of women who were interested in sterilization, only 4% were only interested in sterilization. The others also reported interest in reversible methods.

Among the 162 women who expressed interest in contraception, there was the most interest in Tier One methods, IUDs and contraceptive implants. Results from logistic regressions (shown in Table 11) illustrate that some participants were more likely to desire Tier One methods than others. Table 11 Shows odds ratios from logistic regressions tests of each variable's association with interest in an IUD or implant.

Younger women were more interested in IUDs and implants than older participants (*OR* 0.959 $p = <0.05$); non-Hispanic White women were nearly five times more likely to report interest in IUDs and implants than women of color (*OR* 4.790 $p = <0.05$); women who used birth control in the 12 months prior to the current incarceration were two and a half times more likely to report interest in IUDs and implants than women who did not use birth control in the year before the current incarceration (*OR* 2.553 $p = <0.01$). Women who reported interest in initiating birth control while in jail were nearly three times more likely to be interested in an IUD or implant than women not interested in initiating birth control in jail (*OR* 2.791 $p = <0.01$; see Table 11).

When controlling for age, race and ethnicity, and education, the use of birth control in the 12 months prior to incarceration and interest in initiating birth control in jail remain statistically significant factors associated with IUD and implant interest. In the logistic regression Model 3, including age, race and ethnicity, education, and

both prior birth control use and interest in initiating birth control in jail, non-Hispanic White women are eight times more likely to be interested in IUDs and implants than women of color (see Table 12).

Discussion

The findings from this survey reflect not only a need for contraceptive services among the participants, but also a desire for birth control among the women incarcerated at the Salt Lake County Jail. First, the majority of women (57%) were using birth control in the 12 months prior to arrest; 16% had used a user-dependent hormonal method such as the pill, ring, patch or shot. In the jail studied, birth control pills, patches, rings and shots are discontinued upon arrest and emergency contraception is not offered at time of booking. IUDs and implants are not available, removed, or reinserted in the jail studied.

The participants used IUDs and implants at a rate (23%) on par with the general Utah population (Boulet et al., 2016). There are several possible explanations for the relatively high LARC use rate in Utah compared to the general U.S. population, which is 12% (Kavanaugh, Jerman, & Finer, 2015). In Salt Lake County, Title X funded community health centers offer IUDs on a sliding scale or for free. Women are also able to get an IUD or implant without a copayment through Medicaid or the Primary Care Network, a health plan offered by the Utah Department of Health. And the University of Utah Hospital has a Ryan Residency Training LARC program, which provides women with IUDs and implants prior to discharge from the hospital after they have given birth (Eggebroten, Sanders, & Turok, 2016).

Most of the participants reported either negative or ambivalent pregnancy attitudes; 53% reported they did not want to get pregnant in the next year, 13% reported they did not know how they felt about a pregnancy in the next year, and 3% reported they did not care if they got pregnant in the next year. While 69% of

participants had negative or ambivalent pregnancy attitudes, only 41% of participants in this study planned to use birth control after release. However the majority of participants (67%) were interested in initiating birth control in jail, particularly IUDs and implants. This may suggest a lack of contraceptive availability outside of the jail, and thus an increased desire to initiate birth control before release.

There were participants with positive pregnancy attitudes, with 22% reporting they wanted to get pregnant in the year after release. Even among the 40 participants who stated a desire for pregnancy in the next year, 20 (50%) reported they would be interested in initiating birth control in jail prior to release. Several women may desire pregnancy in the year after release but not immediately after release. Incarceration presents an opportunity to provide preconception counseling and education with incarcerated women to help them prepare for healthy pregnancies for those who want to be pregnant. Contraception initiation in jail may allow women who want to get pregnant in the next year an opportunity to avoid pregnancy until they are reintegrated into their community and life and ready for pregnancy.

Contraceptive counseling and services would be a valuable and desired service for the women incarcerated at this jail and would likely contribute to preventing unintended pregnancies within this population. The results from this study suggest a demand for all methods of birth control, but particularly IUDs and implants. The findings from this study also show differences in contraceptive preferences associated with age, race and ethnicity, education, contraceptive history, pregnancy intentions, prior jail experiences, and perceived issues with partner's contraceptive compliance. However, all women should receive standardized contraceptive counseling, all methods should be available, and standard of care and consent procedures should reflect that of family planning services outside of the jail

environment. Women should be given information about where to continue contraceptive care after release. Due to the high recidivism rate in this population, keeping detailed medical records of their contraceptive histories and current methods could help with ease of contraceptive continuation if women return to jail.

Participants in this study reported sexual and reproductive histories with numerous factors related to abuse, trauma, and loss. Nearly 60% of all participants reported being forced to have sex with a man in their lifetimes. Many of the women incarcerated at the Salt Lake County Jail are victims of sexual assault and may not have had access to counseling services to address their traumatic experiences. Additionally, 32% of participants reported having problems with their partners not wanting to use condoms or other methods of contraception. Sexual victimization and intimate partner violence and contraceptive sabotage increases women's risk of unintended pregnancy (Miller et al., 2010). These experiences must be acknowledged and medical professionals who provide contraceptive counseling and care must understand clinical best practices when discussing contraception and being aware of trauma triggers that may occur during an IUD insertion with a woman who has experienced sexual violence.

In this sample, nearly one-quarter of participants had terminated a pregnancy and one-quarter had placed a child in an adoptive home. Many women terminate pregnancies due to economic or other social circumstances and may have wanted to continue the pregnancy and parent but did not have the means to care for a(nother) child. Many women with a history of incarceration are primary caregivers, but when they are in jail, their children must be cared for by family members or the state may take custody. Women can struggle to retain legal custody of their children due to incarceration and while some women make a choice to place a child in adoptive care, many others lose children they want to care for to the state. Women who are incarcerated may have traumatic experiences related to pregnancy and parenthood

that must be taken into consideration when discussing their reproductive life goals and contraceptive needs.

A unique factor for this population is religion, due to this study being conducted in Utah, where the Mormon religion dominates. As of 2014, less than 2% of the U.S. population was Mormon, compared to 55% of Utah's population being Mormon (Pew Research Center, 2015). Approximately 24% of the participants identified as Mormon in this sample. Mormon doctrine establishes that sexual relations are reserved for marriage, and while procreation and large families are a staple of Mormonism, the Church leaves decisions about birth control to the couple (Ellsworth, 1992). Utah has a high birth rate, but also has one of the highest IUD and implant use rates in the nation, which reflects a cultural acceptability of these contraceptive methods (Boulet et al., 2016). There were no significant associations between Mormon religion and contraceptive use or preferences.

More than half (52%) of the women in this sample did not have health insurance at the time of their arrest, and on average women had been incarcerated seven times. The majority (88%) used illicit drugs in the last 12 months. Jail provides an opportunity to provide informational classes about health insurance and where to seek health care in the community. Jail also provides an opportunity to discuss the importance of prenatal care and seeking health care to manage substance dependence if a woman gets pregnant. Due to the criminalization of drug use, a woman may not feel safe presenting for prenatal care if she uses drugs. Providing facts about drug use during pregnancy without demonizing a pregnant, drug-using woman is important. Jail is an opportunity to have patient-centered contraceptive counseling as a way to empower women to have information about methods if they desire to use them. Often, contraception in the jail setting is discussed as a means to prevent drug-addicted babies, which is not woman-centered, but instead promotes a narrative that women with substance dependence

issues are bad women, or bad mothers. Contraception should be perceived as a tool for a woman to use in her holistic rehabilitation, so that she can achieve her goals and decide if and when she wants to get pregnant.

Lastly, sterilization of an incarcerated woman is the most controversial issue in regard to women's contraceptive access while in correctional custody. Among participants in this study, 16% reported interest in sterilization. Among those interested in sterilization, only 4% stated they were only interested in sterilization; the others also reported interest in other methods, including IUDs and implants, which are as effective as sterilization. In jail, women who are interested in sterilization can be counseled on IUDs and implants which they may accept and find satisfactory. There will be cases where women only want sterilization, and on a case-by-case basis, women's sterilization requests should be considered and the procedure should be handled by a medical care provider who is not affiliated with the jail and in accordance with the state's consent requirements.

Conclusions

Women's need and demand for contraception does not cease during incarceration. While the rate of female incarceration has increased in recent decades, attention to incarcerated women's family planning needs has not kept up. It is reasonable to assume that helping women have control over their fertility will improve their chances of reintegrating into the community after release, by helping them avoid an unintended pregnancy. The findings of this study are specific to the Salt Lake County Jail and are intended to inform the administrators and medical providers in making decisions about how to best implement family planning services and supplies in the jail studied; however, these findings may be transferable.

Table 5. Demographic Characteristics of all Participants, *N* = 194

Variable	Percent unless otherwise stated
Age, median (range)	31 (18–48)
Race & Ethnicity	
Non-Hispanic White	62
Hispanic, any race	28
Non-Hispanic WoC[a]	10
Education	
No HSD/GED[b]	34
HSD/GED	32
Some college+	34
Religious	66
Religion	
LDS[c]	24
Christian[d]	12
Catholic	11
Other	12
Times in jail, median (range)	7 (1–42)
Used illicit drugs in prior 12 months	88
Uninsured prior to arrest	52
Wants help enrolling in insurance	79

(a) Women of Color; (b) High School Diploma/General Education Development; (c) Church of Jesus Christ of Latter–Day Saints (Mormon); (d) Christian, other than Mormon or Catholic, including Christian (nondenominational), Baptist, and Pentecostal

Table 6. Sexual, Reproductive and Contraceptive Descriptions of all Participants by Percent, *N* = 194

Has had vaginal sex with a male	99%
History of forced sex	59%
History of transactional sex[a]	37%
Ever been pregnant[b]	**87%**
Ever been in jail while pregnant[c]	31%
Ever terminated a pregnancy[d]	24%
Ever placed child in adoptive care[e]	24%
Has custody of minor child(ren)[f]	55%
BC[g] methods used in previous 12 months	
Condom	33%
Didn't want BC	25%
Didn't need BC	22%
IUD[h]	17%
Pill	9%
Shot	7%
Implant	7%
FAM[i]	4%
Other[j]	4%
Pregnant or breastfeeding	3%
Diaphragm	2%
Patch	1%
Ring	1%
Problem with partner using BC	
In past	32%
Foresee in the future	23%
"Do you want to get pregnant in the year after you're released?"	
Yes	22%
No	53%
Don't know	13%
Don't care	3%
Can't	11%
Has known enough about BC in the past	66%
Found CHOICE video informative	94%
Plans to use BC in year after release	41%
Interested in initiating BC in jail	67%

(a) Has had sex for money, drugs, food, etc.; (b) Including pregnant at time of survey, 11 (6%) were pregnant; (c) *n* = 167; (d) *n* = 169; (e) n=169; (f) *n* = 168; (g) Birth control; (h) 16 specified hormonal IUD, 3 specified copper IUD; (i) Fertility Awareness method; (j) abstinence, sex with females, pregnant before abortion, tubes tied, can't have kids.

Table 7. Distribution of Participant Interest in Specific Methods by Percent, *N* = 192

Method	Percent of Participants Interested
Condom	46%
IUD[a]	26%
Implant	21%
Shot	21%
Pill	17%
Sterilization	16%
Patch	9%
Ring	9%
Emergency Contraception	9%
Fertility Awareness	7%
Diaphragm	2%
Don't want or need birth control	25%

(a) 11.5% reported specific interest in hormonal IUD, 2.6% reported specific interest in copper IUD

Table 8. Method Use in Previous 12 Months Compared to Method Interest at Time of Survey

Method(s) used in previous 12 months *N* = 105		**Method interest at time of survey *N* = 162***			
		Sterilization	Tier One	Tier Two	Tier Three
Sterilization6–21	(3–11%)	26 (16%)			
Tier One	44 (23%)		97 (60%)		
Tier Two	31 (16%)			76 (47%)	
Tier Three	66 (34%)				91 (56%)

Unable to identify accurate sterilization count from "Did not need birth control in the previous 12 months" responses. Sterilization range and percent estimated from cross tabulation of "didn't need birth control in the past" and "can't get pregnant" responses (Could also include menopause and only has sex with female partners.)
Tier One: Intrauterine devices (IUDs); contraceptive implants
Tier Two: The shot; the pill; the patch; the ring
Tier Three: Condoms; diaphragm; fertility awareness methods.
*162 participants reported interest in contraceptive methods

Table 9. Chi Square Association Between Methods Used Before Arrest and Method Interest at Time of Survey, by Most Effective Method

	Method of Interest			
Previous Method	Tier 1	Tier 2	Tier 3	Total
Tier 1	41 93.18	3 6.82	0 0.00	44 100.00
Tier 2	11 44.00	13 52.00	1 4.00	25 100.00
Tier 3	18 52.94	8 23.53	8 23.53	34 100.00
Total	70 67.96	24 23.30	9 8.74	103 100.00

Pearson chi2(4) = 34.3270 Pr = 0.000

Table 10. Participant Interest in Methods According to Effectiveness by Percent *N* = 162

Methods of Interest	% of Participants[a]
Tier One	22%
Tiers Two & Three	15%
Tiers One & Three	14%
Tiers One & Two & Three	11%
Tier Two	9%
Tier Three	7%
Tiers One & Two	7%
Sterilization	4%
Sterilization & Tiers One & Three	4%
Sterilization & Tiers Two & Three	3%
Sterilization & Tiers One & Two & Three	2%
Sterilization & Tier Three	1%
Sterilization & Tiers One & Two	1%
Sterilization & Tier One	1%

(a) Each participant is only counted one time in this table. For example, if a woman reported interest in an IUD and the pill and fertility awareness, she would be represented in the category "Tiers One & Two & Three" and no other category.
Sterilization – any method of female sterilization
Tier One: Hormonal & Nonhormonal IUDs, subdermal implant
Tier Two: Oral contraceptive pill, transdermal patch, vaginal ring, birth control shot
Tier Three: Condoms, diaphragm, fertility awareness methods

Table 11. Logistic Regression and Odds Ratios of Factors Associated With Participant Interest in IUDs and Implants

Variable	Odds Ratios [95% Confidence Interval]	
Age (years)	0.959*	[0.920,1.000]
Race & Ethnicity		
Non-Hispanic White	4.790*	[1.369, 16.77]
Hispanic, any race	2.430	[0.664, 8.893]
Non-Hispanic WoC [reference]		
Education		
No HSD/GED [reference]		
HSD/GED	0.963	[0.457, 2.027]
Some College+	1.303	[0.595, 2.850]
Religious	0.968	[0.484, 1.937]
Times in jail	0.988	[0.952, 1.026]
Used illicit drugs in year prior	1.230	[0.457, 3.312]
Uninsured prior to arrest	0.590	[0.311, 1.121]
History of forced sex	0.650	[0.334, 1.268]
History of sex for trade	0.781	[0.407, 1.500]
Ever been pregnant	1.582	[0.591, 4.230]
Ever been in jail while pregnant	0.876	[0.424, 1.812]
Ever terminated a pregnancy	1.241	[0.557, 2.764]
Ever placed child in adoptive care	1.189	[0.544, 2.599]
Has custody of minor child(ren)	1.970	[0.989, 3.925]
Used BCg in previous 12 months	2.553**	[1.310, 4.976]
Problem with partner using BC		
In past	0.778	[0.353,1.718]
Foresee in the future	2.212	[0.762,6.428]
Wants to get pregnant in year after release		
Yes	2.160	[0.934,4.995]
No	0.676	[0.356,1.286]
Don't know	1.202	[0.473,3.051]
Don't care	2.043	[0.208,20.08]
Can't	0.554	[0.191,1.611]
Has known enough about BC in the past	0.995	[0.505,1.962]
Plans to use BC in year after release	1.907	[0.997,3.649]
Interested in initiating BC in jail	2.791**	[1.291,6.034]

Exponentiated coefficients; 95% confidence intervals in brackets
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 12. Three Models of Logistic Regression and Odds Ratios of Factors Associated With Participant Interest in IUDs and Implants

Variable	Model 1	Model 2	Model 3
Age	0.950* [0.906,0.995]	0.948* [0.905,0.994]	0.952* [0.907,1.000]
Race & Ethnicity			
Non-Hispanic White	6.618** [1.712,25.58]	6.358** [1.692,23.90]	8.394** [2.080,33.88]
Hispanic, any race	2.505 [0.633,9.908]	2.341 [0.604,9.076]	2.765 [0.671,11.40]
Non-Hispanic WoC [reference]	1 [1,1]	1 [1,1]	1 [1,1]
Education			
No HSD/GED [reference]	1 [1,1]	1 [1,1]	1 [1,1]
HSD/GED	1.107 [0.488,2.511]	1.233 [0.535,2.839]	1.219 [0.514,2.894]
Some college+	1.057 [0.442,2.527]	1.438 [0.598,3.457]	1.219 [0.488,3.046]
Used BC in previous 12 months	2.900** [1.406,5.982]		2.681* [1.259,5.710]
Interested in initiating BC in jail		3.627** [1.562,8.425]	3.344** [1.400,7.987]

Exponentiated coefficients; 95% confidence intervals in brackets
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

CHAPTER 5

STERILIZATION ATTITUDES AMONG WOMEN AT THE SALT LAKE COUNTY JAIL

Introduction

Sterilization Abuse

Sterilization of incarcerated women is a controversial issue with a century-long history. Compulsory sterilization—legal, forced sterilization—in the United States began in 1907 when Indiana passed the first sterilization law (Stern, 2007). The laws were created to quell the reproduction of populations deemed "undesirable" and to interrupt fertility of women labeled "unfit" to be mothers (Kluchin, 2009). Definitions of who was considered "unfit" to reproduce were shaped by perceptions of poverty, race, ethnicity, intelligence, sexual deviance and promiscuity, illegitimacy, and criminality (Kluchin, 2009). Over 60,000 individuals were involuntarily sterilized between 1907 and 1963 (Carey, 1998). The majority of the victims of forced sterilization since 1920 were poor women (Schoen, 2005), disproportionately minority women (primarily Black, Native American, and Latina), and many were institutionalized for psychiatric disorders or intellectual disabilities and/or had criminal histories. Compulsory sterilization is considered by many the ultimate violation of reproductive autonomy (Ross, 2017).

Unfortunately, compulsory sterilization was often promoted under the guise of public health, with arguments that sterilization was a cost-effective method for advancing the greater good (Stern, 2005). Proponents of sterilization argued sterilizing a woman who was "unfit" to have children would save the state money by

avoiding the costs of supporting her and her children. This issue was compounded for women experiencing incarceration or other institutionalization—unethical doctors justified compulsory sterilization by citing unstable custody arrangements for children who required placement with extended family and/or state programs.

Banning Sterilization Procedures in Correctional Settings

Although courts started reversing the legality of compulsory sterilization between 1921 and the 1970s and passing laws requiring informed consent and waiting periods, sterilization abuse continued. The most recent instance of compulsory sterilization of incarcerated women was exposed in 2013 by the Center for Investigative Reporting (Johnson, 2013). Between 2006 and 2010, 148 women incarcerated in two California prisons were sterilized without their consent or pressured into giving such consent. As a response, in 2014, California banned sterilization procedures in correctional facilities and of incarcerated persons, unless the procedure is considered life-saving (SB 1135, 2014). In jails across the country, official and unofficial stances have been taken to prohibit or greatly reduce the opportunity for sterilization of incarcerated women by disallowing sterilization counseling and consenting. Additionally, several legal scholars and reproductive justice advocates have argued that a woman can never truly consent in what is an inherently coercive correctional setting and have endorsed sterilization bans in jails (Ross, 2014; Roth & Ainsworth, 2014). The pendulum has swung from an era of forced sterilization to an era of prohibited sterilization for women experiencing incarceration.

Compulsory sterilization and prohibition of sterilization bookend the sterilization issue. In their paper, "'If They Hand You a Paper, You Sign It' A Call to End the Sterilization of Women in Prison," Roth and Ainsworth (2014) argue that due to the inherently coercive environment that is a prison or jail, women can never truly

consent to a sterilization procedure. Roth and Ainsworth argue the call to end sterilization of incarcerated women is not a judgment of their decision-making abilities, but it is the only way to eradicate sterilization abuses in these settings. While blanket prohibitions may seem like a reasonable solution, they may be a violation of reproductive justice for many women experiencing incarceration who want the procedure but cannot access it.

Sterilization and Incarceration: A "Right to Have Rights" Issue

Both the historic forcing, and later prohibition of, sterilization of incarcerated women highlight the complex issue of whether or not women who are incarcerated have the right to have rights (Somers & Roberts, 2008). Incarceration can be conceptualized as a process of removing, and in some cases revoking, the individual's membership within the community (Somers & Roberts, 2008). Incarceration therefore jeopardizes "social recognition" of those who are incarcerated; that is, individuals who are incarcerated are less likely to be viewed as deserving or entitled to human or civil rights by others in society (Somers & Roberts, 2008). If you are not a member of society, you are arguably no longer afforded the "right to have rights."

The controversy surrounding sterilization procedures and incarcerated women should be reconsidered from a "rights to have rights" framework. Incarcerated women, although removed from the community, are still citizens of the society (Somers & Roberts, 2008). From a reproductive justice standpoint, reproductive rights are a human right. Therefore, women, regardless of incarceration status, should have reproductive rights, and this includes both the right to refuse sterilization and *choose* sterilization.

Postpartum Sterilization Use

As of 2012, 9.4 million women in the United States relied on sterilization as their method of birth control, which is approximately 25% of all contraceptive-using women (Daniels, 2014). Although sterilization is a popular contraceptive method, specific subgroups are more likely to use female sterilization than others. Sterilization is most common among Black and Hispanic women, women older than 35, women who are or have been married, women with two or more children, women who do not have a college education, women living outside of metropolitan areas and women who are publicly insured or uninsured (Jones et al., 2012). Unsurprisingly, sterilization is common among many women experiencing incarceration as rates of incarceration are higher for women of color who are mothers, who have less than a college education and are uninsured or using Medicaid. Many women choose sterilization as a contraceptive method after they have achieved their desired family size and do not wish to have any more pregnancies.

A Debate Over Medicaid's 30-day Waiting Period

After decades of sterilization abuses committed against marginalized women, laws were passed to reverse the legality of compulsory sterilization. As a protective measure, in 1979, Medicaid created a regulation establishing women sign a sterilization consent document at least 30 days prior to a sterilization procedure (Reid, 2014). There is a debate regarding the effectiveness of the 30-day waiting period, with some arguing that it is no longer relevant and is actually harmful for marginalized women, and others arguing the 30-day wait period is crucial for protecting marginalized women.

Some health care providers and researchers have argued that the 30-day period established by Medicaid creates additional barriers for many women in

accessing family planning services and treats publicly-insured women differently than privately-insured women (Brown & Chor, 2014). In the United States, among women sterilized within 2 years of giving birth, 70% of sterilization procedures were done postpartum (Borrero, Zite, Potter, Trussell, & Smith, 2013). If women insured by Medicaid did not sign a sterilization consent form 30 days prior to giving birth, they could not have a sterilization procedure immediately postpartum. This is not true for privately-insured women, who can consent to sterilization without a mandatory waiting period (Borrero et al., 2013; Brown & Chor, 2014).

Many reproductive justice advocates believe the 30-day wait period is a crucial protective measure and reduces sterilization abuses of marginalized women (Reid, 2014). Eleven reproductive justice organizations submitted a call for stakeholders (RJ advocates, state and federal officials, health care providers, and researchers) to engage in meaningful dialogue to address the concerns surrounding the 30-day wait period and consider if a reevaluation of the Medicaid sterilization consent document is warranted (Reid, 2014).

Utah-Specific Context

In Utah, sterilization of an incarcerated person is legal (Utah Code, 1988). Any woman wanting a sterilization procedure, including incarcerated women, must undergo an informed consent process. Medicaid requires a 30-day waiting period between the day the consent document is signed to the day of the sterilization procedure. Many women who are incarcerated at the Salt Lake County Jail have Medicaid coverage. During incarceration, their coverage ceases and all their medical care costs are absorbed by the custodial correctional facility.

Technically, a pregnant woman who is in custody at the Salt Lake County Jail is not a Medicaid patient. However, once she is admitted to the hospital for labor and delivery, her medical care can be covered by Medicaid if she is Medicaid eligible. If

she wanted postpartum sterilization, Medicaid would require a 30-day waiting period for sterilization. The authority to offer sterilization as an option to an incarcerated pregnant woman (or a woman undergoing another surgery) lies with the provider at the hospital, not the jail.

Women incarcerated at the Salt Lake County Jail receive prenatal care on site through the women's health provider. The women's health provider can counsel a woman on sterilization, but the provider cannot obtain consent for a postpartum sterilization procedure. Pregnant women may go to the hospital to give birth, but do not have the opportunity to sign a 30-day consent document for what may now be a Medicaid-funded birth. Understanding how hospitals handle sterilization requests and consenting of incarcerated women is an important area for future research.

As described in Chapter 4, many women who completed the survey at the Salt Lake County Jail were interested in initiating contraception in jail. A small percentage of participants (16%) were interested in sterilization as a birth control method. Most of the participants who were interested in sterilization were also interested in reversible methods of contraception. Counseling on nonpermanent contraceptive options is an important first step when providing family planning care to incarcerated women. However, in some cases, women experiencing incarceration may be insistent that sterilization is the contraceptive method they want and are not interested in any reversible methods.

As the Chapter 4 survey results reveal, a majority of participants believed women should have the opportunity to be sterilized while they are in custody and that the procedure should not be prohibited. These findings served as the catalyst for exploring more explicitly incarcerated women's attitudes regarding sterilization access in jail and adding perspectives to the controversial debate about sterilization in a correctional setting.

Methods

Procedures

Focus groups permitted a deeper understanding of the diverse attitudes that were revealed by the quantitative survey results. Focus groups are group discussions based on a single theme, intended to solicit participants' thoughts about the topic to better understand differences in perspectives, provide insight into what specifically influences participants' opinions and uncover themes that emerge from the discussions (Krueger, 2000).

Focus Group Design

I conducted three focus groups, each with a maximum of seven participants. I knew in advance that a professional transcription service would transcribe audio recordings of the focus groups, and the maximum number of voices that the transcription service could track was eight. This allowed for seven participants and me, the focus group facilitator, in each group. I determined three groups of up to seven participants as the necessary number of groups and participants to reach saturation (Glaser & Strauss, 1967). It was important to track the voices of the participants so that every excerpt in the transcripts could be linked to the participant who said it. I provided name tags with randomly selected pseudonyms for the members of the focus group, and these names were used throughout the recording to aid in voice differentiation and provided anonymity for participants.

I created an outline of five questions for the focus groups: one general question about women's health care in jail to start the conversation; one question about when the participants first learned about sterilization, to get a general feel of their knowledge of and background with sterilization; and the three questions from the quantitative survey regarding sterilization of incarcerated women for more in-depth discussion.

- In general, what are your feelings about women's reproductive health in jail?
- Have you heard of tubal ligation? When/under what circumstances did you first hear about tubal ligation?
- Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?
- Would you worry that incarcerated women were being pressured into having this permanent procedure?
- Do you think tubal ligation, "getting your tubes tied," should be prohibited for incarcerated women?

I wrote each question on a whiteboard during the focus groups so participants could be reminded of them during the discussion. I brought consent documents, surveys, pencils, erasers, and dry-erase markers and an audio recorder into the jail for the focus groups.

Recruitment

As detailed in Chapter 3, I recruited focus group participants from the female housing pods at the Salt Lake County Jail. I recruited on three consecutive Saturdays in three different pods, one pod each day. Three weeks of recruitment were necessary because women rarely interact with inhabitants of different pods, so word-of-mouth participation was unlikely.

Data Collection

Participants sat in chairs that were set up in a semicircle so everyone could see the whiteboard, each other, and me. I started each focus group by introducing myself and writing my name on the whiteboard. I told the participants that I was a graduate student at the University of Utah in the sociology department, and that I

was writing my dissertation about birth control access for women in jail. I informed the participants about the survey I conducted in the jail a year and a half earlier. I told them the survey participants had diverse responses to sterilization being available for women who are incarcerated and I was conducting focus groups because I wanted to learn more about the attitudes of women in the jail. I did not tell focus group participants that the majority of survey participants had favorable attitudes toward sterilization access for incarcerated women.

I placed the name tags on a chair and asked the participants to pick a name that they would like to go by for the focus group. They selected a name tag and put it on their shirts. I gave each participant a golf pencil and a rubber, pencil-topping eraser. I handed out consent cover letters and surveys (the same surveys I used in the pilot survey). I asked the participants to write their pseudonyms on the surveys. I explained what a consent letter was and read the consent letter aloud. I emphasized that the participants could leave at any time and did not have to talk about anything they did not want to talk about. Before we started I reiterated that the women could ask me any questions before we began, and that they could ask questions freely throughout our discussion.

I told the participants they could keep the consent letter, which was approved by the jail, meaning it had an approval stamp and would not be taken away from them so they could use it as writing/drawing paper after the focus group. I also told the participants they could keep the pencil and eraser as a small token of my appreciation for participating in the focus group.

After the consent process, I asked the participants to complete the survey. This was primarily done so I could collect demographic information on all the participants and to also compare their responses to the sterilization attitude questions and their comments in the focus group discussions. When they were finished, they returned their completed surveys to me. It took approximately 10–15

minutes for all the participants to complete their surveys.

I began the focus groups by asking everyone if they were ready for me to turn on the audio recorder, which sat on a chair in the center of all the participants. I turned on the audio recorder when every participant said they were ready. I explained that the recording would be "typed up" avoiding jargon like "transcribed" for the sake of clarity. I asked everyone to take turns introducing themselves with their new pseudonyms and the name of their favorite restaurant to ensure the transcriptionist could differentiate between voices. After everyone introduced themselves, I began facilitating the focus group by writing the questions on the board—additional probing questions were used to keep the discussion on track. The focus group discussions lasted between 78 and 108 minutes. Data analyses are described in detail in Chapter 3.

Results

Characteristic Comparison of Focus Groups and Survey Respondents

The survey group participants and focus group participants were similar in age and race, but differed in education level. Only 10% of the focus group participants did not complete high school compared to 34% of the survey group participants and 60% of the focus group participants had at least some college education compared to 34% of the survey group participants. Most of the survey group participants (66%) identified themselves as religious compared to only 35% of the focus group participants, and while 40% of the religious survey participants were members of the Church of Jesus Christ of Latter Day Saints (LDS/Mormon), there were no self-identified Mormon focus group participants. The median number of times the participants had been incarcerated was 7 in both the survey group and the focus groups, and ranged from a minimum of 1–2 times to a maximum of 40–42

times in jail. A majority of participants in both the survey groups (88%) and the focus groups (95%) used illicit drugs in the past 12 months. The survey group participants had a higher rate of uninsured at 52% compared to only 30% of the focus group participants not having health insurance prior to arrest. However, most of the participants in both the survey groups (79%) and the focus groups (70%) wanted help enrolling in a health insurance plan in jail (see Table 13).

Sexual, Reproductive and Contraceptive Descriptions of Survey Participants and Focus Group Participants

Virtually all the participants in both the survey groups (99%) and the focus groups (100%) had vaginal intercourse with a male prior to arrest. Unfortunately, 59% of the survey group participants had a history of forced sex and 70% of the focus group participants had been forced to have sex. Among the survey group participants, 59% had had sex for trade (drugs, money, etc.), compared to half of the focus group participants. The overwhelming majority (87%) of the survey group had ever been pregnant and all (100%) of the focus group participants had been pregnant before. Thirty-one percent of the survey group had been pregnant during incarceration and one-quarter of the focus group participants had been pregnant in jail. Among the survey group, 24% had terminated a pregnancy, 24% had placed a child in adoptive care, and 55% had custody of a child under the age of 18. Among the focus groups, 35% had terminated a pregnancy, 45% had placed a child in adoptive care, and 45% had custody of a child under the age of 18. The majority (57%) of the survey group had used birth control in the past 12 months, and 66% of survey participants felt they knew enough about birth control in the past. Among the focus group participants, 45% used birth control in the past 12 months, and 65% felt they knew enough about birth control.

Approximately one-third of participants in each group experienced problems

with their partners not wanting to use birth control in the past, and 23% of survey participants and 30% of focus group participants foresaw having problems with their partners not wanting to use birth control in the future. Among the survey participants, 22% wanted to get pregnant in the year after release compared to 15% of the focus group participants wanting to get pregnant. Over half (53%) of the survey participants do not want to get pregnant in the year after release compared to only 20% of the focus group participants. About 16% of survey participants either did not know or did not care if they got pregnant in the year after release compared to 35% of focus group participants reporting they did not know if they want to get pregnant in the year after release. And 11% of survey participants report they could not get pregnant compared to 40% of focus group participants. Finally, 41% of survey participants planned to use birth control in the year after release, but 67% of survey participants were interested in initiating contraception in jail. Among the focus group participants, 35% planned to use birth control in the year after release, but 65% were interested in initiating contraception in jail (see Table 14). Table 15 introduces the focus group participants by their chosen alias and key demographic characteristics.

The focus group participants completed the same survey as the survey group with the same questions about sterilization. Table 16 contains comparisons between the survey group respondents' and focus group respondents' answers for question #53 ("Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?")

Table 17 includes comparisons between the survey group respondents' and focus group respondents' answers for question #54 ("*Would you worry that female inmates were being pressured into having this permanent procedure?").* Table 18 shows comparisons between the survey group respondents' and focus group respondents' answers for question #55 ("*Do you think tubal ligation, "getting your*

tubes tied," should be prohibited for incarcerated women?")

Discrepancies in Focus Group Participants' Verbal Versus Written Responses

A comparison of survey responses from focus group participants to their comments on the record is necessary to illustrate the complexity of sterilization during incarceration. Discrepancies in verbal versus written responses indicate that quantitative analysis alone is not sufficient to learn about women's attitudes toward sterilization procedures. A deeper understanding of the issues facing women and their reproductive choices is available when qualitative perspectives are combined with quantitative research.

First, three of the focus group participants answered "No" to the question, "*Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?"* These participants were Jessica, Mykenzie, and Natalie. Mykenzie was not an active participant during the second focus group and did not say anything about sterilization. Mykenzie may have felt comfortable stating in the survey that she did not believe incarcerated women should have the opportunity to have their tubes tied, but did not feel comfortable discussing her opinions during the focus group which, as the results will show, were largely in support of women having the opportunity to have access to sterilization procedures during incarceration. Natalie introduced herself during the first focus group, left after we began and did not return. I would not venture to say she was uncomfortable in the focus group because she left before the discussion moved to the topic of sterilization; however, her survey response stands. Jessica answered that she did not believe incarcerated women should have the opportunity to have their tubes tied; however her excerpts from the third focus group tell a different story.

Second, six of the focus group participants answered "Yes" to the question, "*Would you worry that female inmates were being pressured into having this permanent procedure*?" These participants were Alison, Chelsea, Claudia, Elizabeth, Jessica, and Marie. All six of the participants were robust discussants in the focus groups they were in, and the nuance of their attitudes about sterilization pressure emerges in the findings.

Third, two of the focus group participants answered "Yes" to the question, "*Do you think tubal ligation, 'getting your tubes tied,' should be prohibited for incarcerated women?"* These participants were Jessica and Marie. Neither Jessica nor Marie made any comments in the focus groups about sterilization being prohibited for incarcerated women in general. On the contrary, they both discussed sterilization prohibition as discrimination of an incarcerated woman's rights and they believe women should have the choice to have their tubes tied while in custody. It is possible that they did not understand the question. The entire survey scored at a fourth-grade reading level; however, the word "prohibit" may not be understood by all.

Findings From the Focus Groups

Alison and Renee's Stories

I want to begin this section with excerpts from two of the focus group participants, Alison and Renee. Alison and Renee were both sterilized immediately following cesarean births of their third and fourth child, respectively. Alison was involuntarily sterilized and Renee consented to sterilization; however, neither of the women were considering sterilization during their pregnancy. Alison had never heard of sterilization until the moment health care providers told her they would be tying her tubes and she did not have a choice. Renee had heard of sterilization as a child—she was offered sterilization the day she gave birth and decided on it then. Both women delivered in the same hospital, but Renee was in custody of the Salt Lake

County Jail at the time.

Alison describes the circumstances surrounding her sterilization,

> When I had my third baby they (the medical staff at the hospital) said, "you have RH negative blood. Your antibodies are overactive, we refuse to give birth to this baby until we continue to tie your tubes. We're waiting for a doctor to okay it and us to do it for free." I said, "What?" What they said they did is they said they cut and tied my tubes. I'm 33 years old, one of my kids died, one was adopted and now I have my three-year-old. I can't have any more kids and I'm not happy about it. They didn't give me the choice to do anything different. That's how I found out about tying tubes, is you're gonna get your tubes tied as soon as this baby is born.

Renee's situation is different, in that she knew what sterilization was before the procedure, she consented to the procedure, and she was experiencing incarceration at the time of her childbirth and sterilization. Renee had a tubal ligation immediately after a cesarean delivery and describes the circumstances of that day,

> When I gave birth to my fourth child, my little boy he's—he'll be 15 in December—I was incarcerated. They took me because it was a scheduled cesarean. All four of my kids were cesarean and I've had one miscarriage. I would've had a total of five kids already. I'm 38 years old. However, they took me from here, from the jail, it was all planned. I knew the day I was gonna go have my baby and they had me up in medical like a month prior to them knowing my date. I knew that they were gonna take me to the hospital, I was gonna have my son and they were gonna bring me back to jail until my release date. He was gonna go into the state's custody or with family or whatever. At the time I gave birth to him, it was a cesarean, so they took me in. The officer asked if he could sit in with me and watch me. Cuz he was all excited too. He was like, "Oh my gosh I can't believe you're gonna have a cesarean, can I watch?" [Laughter] Either his wife or his sister-in-law was gonna be having a cesarean, so he wanted to see it done. I told him it was fine and we did the process and then after they handed me—after I gave birth. No, yeah they told me before. "What we wanna ask you right now is if it's gonna be okay. With the jail we wanna know what you wanna do after you have your child. After we take the baby out, do you wanna tie your tubes? Yes or no?
>
> They asked me while I was in the hospital getting ready to give birth as they were—before they were getting ready to perform the cesarean they asked me, "After we take the baby out, what do you wanna do after? Do you want us to tie your tubes? What are your plans for more children?" Because it is very unsafe to have so many cesareans after so long. They do say, "Yeah it's probably not wise for you to keep having kids." They did tell me that. That's what caused me to be anemic is from the blood loss of continuing to have cesareans through childbirth. They did ask me though and I thought about it and just as fast as I thought about it I said, "Okay I'm done. You can." He (medical provider) said, "We have another procedure as well. Renee and if you would like to do this as well that will mean you'll never be able to have

> kids ever again and we can tie them and burn them. Do you wanna do that?" I was like, "Yeah, do it." They did ask me and then it was a question up in the air between the doctors and the guard we need to call the jail and make sure that—because [laughter] they were worried about who was gonna cover the pay. She's in state's custody therefore the state would be obligated to pay. They called the jail, the jail said yes that is true we're willing to go ahead with the procedure if that's what she wants. That's how it was done. [Laughter] They called the jail we waited ten minutes and then before—they had to know before they even started the cesarean what was gonna be the final thing to finish the birth."

Kyl (Interviewer): "How did you feel about that decision?"

Renee:

> I cried. I just knew once I was laying in that bed and they asked me the question I knew. The first thought it was like, "Okay I'm done. I am. I had two girls, two boys, and I was blessed and I'm done and that's enough." I just remembered a couple of teardrops falling—it was sad. It's okay though. Because I was so into my addiction with my kids that it wasn't fair to keep having kids anymore because I wasn't sure at that point where my life was headed. My family had enough cuz they all took responsibility for my kids after I wouldn't stop using. That was enough on them and it was enough for me too to go, "Okay that would be selfish of me to continue to keep having kids after that point." I was blessed with two beautiful girls, two beautiful boys and I knew that day when they asked me in the hospital. I had to be done that would just be selfish to keep having kids.

I highlight these situations in full because there are very few stories regarding sterilization told by women experiencing incarceration and it is important to shine a light on the realities women face. Some women are forced into traumatic sterilizations when they are not incarcerated, and others are given an option while they are incarcerated. These two sterilization stories have something in common—a very short amount of time to absorb the idea of undergoing a permanent procedure that rendered them infertile.

These two stories also encompass several of the themes that emerged from the focus groups:

- themes of knowledge, or lack of knowledge, about sterilization;
- women's access to sterilization and rights to make decisions about their own bodies;

- themes of drug addiction and decision-making, and how drugs impact a woman's ability to parent and think clearly about her family planning goals;
- themes of family members and others taking care of incarcerated women's children and how they may pressure women to limit the number of children they have;
- what types of protocols can work to improve women's autonomy over their bodies but also ensure protection and time to consider the realities of sterilization. Consistent among all themes is a thread of reproductive justice issues, which I will expand on in the discussion section.

Knowledge About Sterilization

In each focus group, I described female sterilization procedures (e.g., tubal ligation) and their permanence in preventing pregnancy. All the focus group participants were familiar with sterilization as a contraceptive method, although one participant, April, had learned about sterilization only weeks before the focus group in a women's health class taught in the jail. Among the participants, two patterns emerged. The first is the source of learning about sterilization; most of the participants learned about sterilization from female family members when they were adolescents, in the context of their mother, aunt or grandmother having a sterilization procedure done, and there was generally positive regard for sterilization as a contraceptive method. Elizabeth recalls her mother telling her about sterilization,

> I was lucky. My mother was a nurse who worked for the military, and she had one [tubal ligation] very young. She had already had five kids by the time she was 23. I remember talking to her about it when I was about 12 because I got my period very young, and that's how I learned about it.

Both Renee and Victoria mentioned they were young when they heard about sterilization from their mothers who chose sterilization. "My mom's tubes were tied

when she had me. She told me at a young age about it" (Renee). "I learnt from my mom. I was there with her when they gave her the decision, I was young, for tubal ligation" (Victoria).

Other participants learned about sterilization because a family member got the procedure done and their mothers taught them about it.

> My aunt's only a year older than me because my grandma had a tubal ligation. This was in the 80s, so I don't know if it was—how they did it exactly, but she'd been—she had an ectopic pregnancy. My aunt's only a year older than me, so my grandma had her super late. That's when I learned about it. (Kimberley)

> I first heard of tubal ligation at a very young age. I probably heard of it as being mentioned as having your tubes tied. I was probably about seven or eight. It probably came up as a joke because a friend or a friend of a family member was on their sixth or seventh kid, or whatever. It was like a light subject. "Oh, you might wanna have those tubes tied." I turned to my mom, and I was like, "Mom, what's that?" and she was like, "I'll tell you later, honey." My mom was always really good with explaining things to me, so she did. (Claudia)

The second emergent theme was age of learning about sterilization. I asked each participant to tell me when she first learned about sterilization and the majority of participants learned about the procedure from women in their families between the ages of 8 and 20. Many of the women recall learning about sterilization in a positive way, understanding sterilization as something a woman does when she has achieved her family size, something that as Courtney says is "part of learnin' about bein' a mother."

Misperceptions About Sterilization

In all three focus groups, women made comments indicating some misperceptions about sterilization. Some participants believed sterilization was not permanent, and others did not know it was permanent until after they had the procedure done. One participant, Megan, believed "cauterization would be permanent" and that "tying your tubes still is a risk of getting pregnant."

In regard to her own sterilization, Courtney said, "I believe mine is irreversible, if I remember right. I don't remember right, correctly, for a hundred percent sure, but I'm pretty sure him [the doctor] sayin' that would be irreversible."

Brianne regrets her sterilization and is unsure if her current pains are associated with being sterilized,

> I have regretted that decision. I didn't know if it was permanent… When I have sex, it causes a lot of pain. I don't know if it has something to do with my tubal ligation. I don't know if I'm getting pregnant tube—like, having these tubal pregnancies. I don't really know what it is, but it's very painful. Almost stops me from even wanting to have a sexual relationship with somebody because I don't know these things.

Victoria and Marie both mention their skepticism about the permanency of sterilization. "I've heard people getting pregnant while they've got their tubes tied so that's still scary to me" (Victoria). "I feel it's permanent. If it's done right, it's permanent. If they didn't do it right then there's that chance" (Marie).

While all participants had *heard* of sterilization, they did not possess comparable levels of understanding about the effectiveness or permanency of the procedure. Hearing about sterilization from a family member is not the same as understanding the irreversible nature of the procedure—a consideration for informed consent procedures for women experiencing incarceration.

Protocols and Considerations for Sterilization and Women Experiencing Incarceration in Jail

The overwhelming majority of focus group participants expressed that women should have access to sterilization while incarcerated, both immediately after birth in custody, and as routine reproductive health care. Participants did suggest the need for protocols to prevent forced or coerced sterilizations, specifically for vulnerable persons with mental health and/or substance abuse issues. Although women did not vocalize opposition to sterilization, that does not mean they approve of it.

The dominant themes that emerged from the focus groups are

- women have a right to sterilization, even if they are incarcerated;
- drug addiction and stigmatization of drug dependence impacts women's sexual and reproductive lives and must be considered in the context of sterilization;
- incarceration influences women's state of mind and can be a time of clarity, but also a time of poor decision making; and
- protocols that include education and counseling provided by an organization outside of the jail and a waiting period can improve sterilization outcomes for women who are incarcerated.

Women Have a Right to Sterilization, Even if They Are Incarcerated

A major theme in all three focus groups is that of *rights*. Women's rights, human rights, and a right to health care. The participants state they deserve access to everything that women have access to in the general population but feel their rights are unjustly put "on hold" while they are in jail. Women want the opportunity to have their tubes tied, and a lack of opportunity is perceived as discrimination.

> [A pregnant incarcerated woman] should have the same rights that any other woman having a child should have. I don't feel that just because they're in custody that opportunity should be taken from them. Because it's a lot easier if I'm not misunderstood to do it at that point [immediately after childbirth] than at any other points. It could take that opportunity from them potentially moving forward. (Rose)

> I think a woman's body is her choice in the end. It's not the government's. It's not the system's. It's not the doctor's. It's her sole choice, these are our bodies. Whether we're making poor choices in our life or not, it's up to us in the end. (Alison)

> I don't think that the jail should be able to discriminate any woman's choice of her body or what she chooses to do while incarcerated. If the opportunity was available that would be solely her choice. (Renee)

Like Renee, when asked if they believe sterilization should be prohibited for women who are incarcerated, Rose and Jessica stated they believed prohibition of

sterilization of incarcerated women is discriminatory. "I think it's a form of discrimination" (Rose). "Discrimination against your rights" (Jessica).

In addition to discriminatory themes, several participants mentioned that immediately after birth is the "best" or "optimal" time for a tubal ligation, and that opportunity should be available for women who will give birth while in custody. Marie stated, "What's the better time after having a baby then? That's the best time I know possible."

> You still have the right to your body to make decisions for it and every other woman has that right, especially people having, like we talked about earlier, having children that that's the optimal time for them to do it as far as it being an easier process for them and everybody involved. To take that right from them I feel is discriminatory because they're incarcerated doesn't mean that they shouldn't have the same right as any other woman. (Rose)

Drug Addiction and Associated Stigma and Its Relationship to Women's Sexual and Reproductive Lives

Drug addiction is one of the most problematic issues in the participants' lives and the struggle for sobriety informed every aspect of their lives outside and inside of jail. All but one of the participants used illicit drugs in the 12 months prior to the focus group, predominately methamphetamine and heroin. The women understand that their drug use influences their sexual and reproductive lives and they described various choices and circumstances with clarity, whether it is having sex to get drugs, terminating a pregnancy because of addiction, or relinquishing custody of a child. They also have remorse for giving birth to babies who withdrew from drugs, struggle to care for the children they have, and for some, their children were taken away by the state or adopted to family members.

When they are arrested for drug related charges or seek treatment, they encounter stigmatization. Many women cycle through rehabilitation centers and jail and do not feel they can recover from or escape the environment of drug addiction.

In jail, some women sober up and reproductive health becomes a concern, but their reproductive health is not a priority "on the outs," where their priority is getting high. Victoria describes a common occurrence,

> When you first get out on that ramp [leading outside of the jail] all you're thinking is, oh, I wanna get high and then your body shuts down because it gets infected because you're not taking good care of yourself. Then here, we're eating well, we're drinking fluids, we're staying hydrated, we're getting medical care, all that stuff. On the outs, because it's fun and stuff on the outs, we don't have money, you don't think about medical. We don't think about our bodies. We're only putting the drugs into our bodies.

Several participants talked about the stigmatization they face because of their drug addiction, Kimberley states, "We're not deserving of a damn thing because we're drug addicts. Cuz you're a drug addict, you are less deserving. You're inhuman. You're scum…It's so frustrating."

The participants described the difficult realities of dealing with drug addiction and how it impacts their experience as a mother or prospective mother and their views on sterilization. Women struggle to manage their addiction and be the type of parent they want to be, so they may choose abortion, adoption, or sterilization because they themselves see drug addiction as incompatible with motherhood.

Like Renee's story about getting her tubes tied after the birth of her fourth child, some women believe sterilization is a way to stop their fertility, to stop having babies while they are dealing with a drug addiction they may never overcome. Elizabeth expressed,

> A lot of women are facing issues. They're facing issues of their drug use. Maybe they've decided they don't want to go through having to give up another child. A lot of women are basically forced into giving up their children. They don't want to go through that pain again.

Women being forced to give up their children to the state came up in all three focus groups. Some participants mentioned women who suffer from drug addiction may choose sterilization, and some recognize the sterilization abuses that have been endured by drug-addicted mothers; other participants expressed attitudes that it is a

problem for drug addicted women to have multiple children that they are not taking care of. Victoria mentioned states forcing women to be sterilized,

> I've heard like states and stuff they actually keep people that have had kids after kids that use drugs and they're addicted––their children are addicted to drugs or had kid after kid, after kid and their kid is not in your custody. They make that decision for them to tie their tubes, they don't give them the decision.

The women in these focus groups, like most women incarcerated in the United States, struggle with drug addiction. Drug addiction puts them at higher risk of unintended pregnancy and arrest. The participants are aware of the impact their drug addiction has on their sexual and reproductive lives, an awareness that is heightened during sobriety in jail. The next theme relates to how jail offers a period of sobriety for most—and how the combination of jail and sobriety leads to clarity for some and poor decision making for others, and how their state of mind relates to thoughts and decisions about sterilization.

Incarceration Influences Women's State of Mind and Can Be a Time of Clarity, but Also a Time of Poor Decision Making

It is important to note the different time points during incarceration. After arrest, women are booked into jail and asked numerous medical questions—the participants cited time of booking as problematic for any sterilization conversation. Many women are drug users, arrested for drug-related charges, and are under the influence at the time of booking. Marie states, "The last time I was booked I was still probably high."

Alison and Renee both believe women should have access to sterilization while they are incarcerated, but that during booking is not the time to broach the topic. Alison, the woman who was forcibly sterilized at age 30, expressed concerns about being asked questions related to sterilization at the time of booking,

> I just think it's [sterilization] totally a woman's choice in her life. Given her

> altered state of mind though it is scary. Cuz when we get into jail, we get asked those medical questions. Do you use, do you drink, do you have anything that we need to know about? I think they could throw that in as far as pregnancy what are your concerns and what are not your concerns right at this point? Because a lot of us are high or drunk when we're first asked those questions when we first get there. A lot of us aren't in our regular state of mind to know those answers right then and there.

Renee also believes that booking is not an appropriate time to discuss sterilization,

> Like I said before, it's solely our choice as women to do what we want with our bodies. I think it's an awareness and it's a red flag to ask us questions in an altered state of mind, when we're in jail we're not thinking in our right state of mind.

Although Renee and Alison were wary of sterilization discussions during booking procedures, several participants mention jail as a time of clarity after they have withdrawn from drugs. Many women in jail have time to think about what they want for themselves and for their children, and sterilization may be something they want but do not have access to in their communities. Rose's excerpt below encompasses many of the beliefs expressed by several participants, that jail is a good place for women to ponder sterilization,

> I personally feel like it's a good place to propose the question because, again, most of us have not been living with clear minds and when you get in here. Your awareness is so heightened like all your senses are heightened, you're really reactive to sugar, everything, because you're so clear because you've been stripped of everything it alters you in some way. I think it's a really good place to ask the question because you're in probably the clearest place you're going to be as far as your thinking about your future, you're planning it out. Usually it doesn't go as planned but I think that it's a good place to propose the question, and like I said if it's done properly through a step process, I really feel like it could be a successful thing for women incarcerated. You have a little bit more ability to think through all of the things because you have time to do that, and if you're given all the information, then you have time to read it. You're actually going to read it and you're actually going to ponder it and you're going to be talking to your peers about it because they've been in the same class with you. It's a really good place I think for the conversation to happen… So many of us, like we've said, don't take care of ourselves out there so even if we wanted to have our tubes tied, it's not going to be a priority because we're not taking care of ourselves anyway. Whereas in here, that's all you have to do is think about yourself and what you're doing to yourself. It'd be a really good time to have that option rather than have it taken from you because when you get out you might have that plan but when you get out and you run into your dealer on

the ramp and it’s all over.

A few participants agreed that sterilization should be available for women in jail but disagreed that jail is always a place of clarity for women. Kimberley, specifically, describes how jail can make women feel “hopeless” and make decisions out of desperation and that “it's easy to be coerced into making a horrible choice” in jail.

> It's really easy to be pressured into really bad choices in here. I've done it. I can't imagine being pregnant and having a kid and what that looks like and feels like to a person, especially a woman here with no support. I can't imagine. No support, no finances, nothing. What the fuck would you do?
>
> I do think that there could be pressure [to be sterilized] like, especially when you're in here because you are—I swear to God, in the U.S., jail is the most traumatizing, inhuman shit you could probably go through. They are so rude here. I'm sure they're not rude to you coming in, but even my mom coming through booking was like, "Holy shit. These people hate their jobs. They're mean." You're in a position where you feel in humanized anyway. You don't feel like a person. You've lost everything that makes you who you are. You don't know what's gonna happen in court. You don't know what's gonna happen after—it's really easy to not make the decisions that you'd normally be able to make. You might even be pressured from your family to do something. That's another issue. Counseling would be probably a really good option for somebody looking at that, having access to somebody to talk to, cuz we don't have anybody to talk to. You put in for mental health, and they're like, "Oh, fuck you."

When the question came up about whether or not participants believed women would feel pressured to get sterilized, participants mentioned that family members would pressure women to be sterilized as a bargaining chip. For example, Elizabeth postulates, “I see the potential for abused women. Low-income families. Families pressuring them, ‘I’ll bail you out if [you get sterilized]—we’re tired of you going through this.’”

In all three focus groups, participants discussed how an unaffiliated organization could be contracted to provide reproductive health and sterilization education and counseling. There was belief that an outside agency is more likely to protect women from coercion by jail staff or family members.

Outside Organizations and a Waiting Period Can Improve Sterilization Outcomes for Women Who Are Incarcerated

The participants frequently mentioned the importance of counseling and consent procedures for women considering sterilization. Participants also continuously mentioned the importance of a "completely unbiased" organization. Elizabeth suggests, "Something trusted like Planned Parenthood" should provide the counseling and consent procedures. Adding to this idea, Megan states, "And in no way would this, whoever was offering the information, could they be the ones that would benefit monetarily [from a woman's sterilization]." In all three focus groups, participants discussed what an acceptable solution could be for increasing sterilization access and minimizing risks of pressure or coercion for incarcerated women.

Participants expressed the importance of a "screening process" to assess a woman's knowledge of and interest in sterilization, as well as screening women to ensure they have the mental capacity to make a decision about sterilization. Rose describes her idea for a sterilization protocol,

> It's a process of the month. That okay you decide, "okay I wanna do this," so there's certain phases to the process of yeah, okay so you're gonna read this much and then take a test on what you've learned of what the reality of the situation is. Then you'll have another signature and then maybe a week from then after you've had time to process that. Okay do you still feel like this? Would you like to progress to the next phase? Then it's like a—let's say a two week or a 30-day process. Then once you've completed all those steps and yes you've got the greenlight to have your procedure.

Several participants mentioned that some incarcerated women will never have the mental capacity to understand or consent to a sterilization procedure while in custody, due to mental illness and/or substance abuse. Participants suggest that incarcerated women who do not have the mental capability to make a decision about sterilization will not be sterilized and they can be identified through a protocol, Jessica expressed,

> Well it'd be that screening process, again if you're not able to fill out the paperwork and be cognitive in the classes, they're gonna know if you're in the right state of mind to do this if it's properly screened. If there's proper protocol and proper paperwork that has to be done at so many stages, they're gonna figure out the people that don't know what's going on and what. There are those people, but the majority, I would say at least 75 percent of us in here do come to a state where we know what's going on.

Sterilization education is a dominant theme throughout all three focus groups. In addition to providing incarcerated women with "pamphlets" and having sterilization "classes" available so women "are actually aware and know what they're doing" and "know their rights." Participants mentioned the importance of "educating the masses." Several women expressed the need for the public to understand the health care needs of incarcerated women and the jail staff should receive information about sterilization so that they can be sensitive to the issues incarcerated women face.

When I asked "is there any type of precaution that removes the chance to pressure somebody?" Elizabeth summarized many of sentiments of the focus group participants,

> It wouldn't remove the chance [of feeling pressured]. I would think it would cut down on it, whatever they did decide to do, having this contracted out, not having the state run it or the jail. Having a contractor, something like—something trusted like Planned Parenthood come in and do the education to do it or to head it up. I wouldn't want to see—cuz that's such a personal choice. Somebody who is completely unbiased. Who comes in here and goes, "Okay, here's your options. This is what you could face doing it. This is what you look at." I wouldn't want to see the jail be any part of that process at all because—[do you want to pay for] the tubal ligation, or do you want to support the child, because people aren't lining up to adopt women who are drug addicted from jail's babies. [Laughter] Sorry. I just had to put it there. This might be their only access, and it might be their only education…. The more education, the more papers, the more consent. As long as there's education, and I think that's key. Keeping the education away from the jail staff. I just really think it needs to be an independent contractor that comes in, somebody totally independent of the jail or religious issues and all those issues that keep getting tied up with this.

Immediately before the focus groups, participants took a self-administered survey and 65% of participants reported they believed incarcerated women should have the opportunity to have their tubes tied, 65% believed incarcerated women

would not feel pressured into having this permanent procedure, and 75% believed sterilization should not be prohibited for incarcerated women. The focus group discussions expanded on these questions and allowed women to discuss the controversial topic more in-depth, to share their stories, to disagree with one another and to change each other's minds. I want to end this section by sharing a comment from Claudia that captures the sentiment of the majority of the participants,

> Do I think women should have the opportunity while incarcerated to have their tubes tied? Most definitely. Do I think it should be offered? Yes. Do I think it should be pressed? No. Do I think we should be—if there's a possibility, educated? Yes.
>
> Don't let a woman tie their tubes without them knowing and understanding and being aware of what they are undergoing and that this is a permanent option. Now, if that woman decides yes, should there be a grace period? I think it would depend on the individual. A law of a grace period, I'm not so sure. The specifics, let's haggle that later, but can we just jump the hurdle to have the fundamentals available? Yes, please.

Discussion

Sterilization of incarcerated women is a controversial issue. The jail environment is arguably inherently coercive, which causes hesitation and resistance to providing sterilization for many decision makers (jail administrators, medical providers, and policy makers). Additionally, many legal and feminist scholars and reproductive justice advocates have argued that sterilization should be prohibited for women experiencing incarceration due to a history of forced and coerced sterilization of incarcerated women. Nonetheless, almost all participants in these focus groups believed that incarcerated women should have the opportunity to be sterilized while they are in custody and that the procedure should not be prohibited. What these women are arguably touching on is their "right to have rights." Participants articulate that, although they have been incarcerated, and although they have had their

membership within the community removed, this does not negate their "right to rights" (Somers & Roberts, 2008).

A core tenet of reproductive justice is supporting the ability of all women to make and direct their own reproductive decisions (Ross, 2017). Since the 1920s and as recently as 2013, numerous incarcerated women, disabled women, low-income women and women of color had their reproductive autonomy taken from them and were sterilized because of someone else's decision about if she should have the ability to get pregnant and parent. Incarcerated women have been the target of invasive and unethical treatment in regard to their reproduction, but the majority of women in the focus groups conducted for this study believed that prohibition of sterilization also violates reproductive autonomy. The participants believed withholding sterilization as a contraceptive option was discrimination against their human rights, their women's rights, and their health care rights. When it comes to the intersection of reproduction and incarceration, the pendulum has swung from an era of forced sterilization to banning sterilization procedures for women in custody, and the issue begs for a more nuanced discussion.

There are different time points when women can undergo sterilization procedures, sterilization can be chosen as a contraceptive method, or sterilization may occur as a secondary outcome of a hysterectomy, for example. The most common time women undergo sterilization as a contraceptive method is immediately following childbirth after a woman decides she does not want to have any more pregnancies. Participants in these focus groups expressed that women who enter jail pregnant should be counseled on all their pregnancy-related options, including immediate postpartum sterilization. Focus group participants also expressed that all incarcerated women, not just pregnant incarcerated women, should be counseled on all contraceptive methods, and if a woman decides on sterilization as a contraceptive method, then the procedure should be made available to her after an established

sterilization education and consent process has been followed. Essentially, the participants believed that incarcerated pregnant women should have the same opportunities for sterilization as nonincarcerated pregnant women, and the same opportunities should be extended to nonpregnant incarcerated women too.

There were apparent misperceptions about sterilization efficacy and the participants expressed that incarcerated women could benefit from contraception education classes. The women stated they had questions about sterilization but did not feel like they had anyone trustworthy to ask. A recurrent statement among the participants included wanting birth control courses taught by an unbiased, trusted organization, like Planned Parenthood, that was not affiliated with the jail and did not see the women as "an enemy." Participants discussed education as a crucial component of the consent process, not just a consent document for women to sign, but an extensive course that describes all methods of contraception, including sterilization.

The overwhelming majority of focus group participants had a history of illegal drug use, which is true for most women incarcerated in jails in the United States. Their drug use has impacted their sexual and reproductive lives, from engaging in risky sexual behaviors, including unprotected sex and trading sex for drugs, to experiencing unintended pregnancies while struggling with drug addiction, and having difficulties managing parenthood while being addicted to drugs. The women experience shame and stigmatization because of their status as drug addicted mothers who are incarcerated. "Shame on shame on shame," as Kimberley put it. The participants experience stigmatization from their families and "society," as well as medical providers, substance abuse treatment centers, jail health care providers, and correctional officers. Many women reference drug addiction as a reason why sterilization should be available for incarcerated women, that women who struggle with drug addiction often cycle through jail and their families have to take care of

their children while the women are either getting high or incarcerated. Women mention the state takes women's children away because they are drug addicts. The criminalization of drug use ensures women are incarcerated more than they are provided substance abuse treatment, which contributes to the despair many women face in regard to their lives, and a desperation to stop having children that are taken away from them. Sterilization is not necessarily the answer to this problem. Evidence-based, gender-specific, trauma-informed substance abuse treatment may be the answer (Capezza & Najavits, 2012), and contraception can be a supplemental tool to help women focus on their sobriety without worrying about an unintended pregnancy. While sterilization may certainly be the contraceptive method that many women want, and should be available to them, contraceptive counseling should include long-acting reversible contraceptive methods such as the intrauterine device or subdermal implant which are as effective as sterilization.

In jail, women are off the streets, provided with three meals a day, detoxing from drugs, and have access to medical care that is not often available to them in their communities. Some women express that jail is a time for them to finally think, without the daily stresses of motherhood and trying to make ends meet while struggling with drug addiction or abusive partners. Some women state that in jail, they finally have a clear mind and get to think about what they want for themselves. For many women, family planning goals are on their minds. Some women want to get pregnant after they are released from jail, and jails could facilitate care for these women through preconception counseling, healthy pregnancy classes, and daily prenatal vitamins. Some women never want to experience a(nother) pregnancy, and some women do not want to get pregnant until their drug addiction is under control. For these women, jail can be a place to provide contraceptive counseling and services while they have time to learn about methods that might work for their needs. At minimum, jail provides an opportunity to inform women about all

contraceptive methods while they are not under the influence of drugs or alcohol.

While jail is a time of "clarity" for some, it is a time of "poor decision making" for others. Women may make decisions they regret out of desperation to get out of jail. Sterilization availability in jail could be used as a bartering chip for families to use against incarcerated women. Some participants mentioned they could see how families would withhold bail until a woman got her tubes tied because they are "tired of taking care of your kids." Although these participants mentioned cases where family members would pressure women in jail to be sterilized, the participants still believed sterilization should be available and it is cases like these that make education, one-on-one counseling and consent protocols so important.

While religion was not a prominent theme in the focus group discussions, it does provide context for this specific setting. None of the participants self-identified as currently active members of the Church of Jesus Christ of Latter Day Saints (Mormon), but they did allude to how the dominant Mormon culture impacts the discussion surrounding reproductive health in Utah. Participants mentioned that the Mormon culture and influence on politics is the reason so many women lack access to comprehensive sex education in public school and that women's sexuality is taboo in Utah and makes discussing sex and contraception difficult. Participants also express how the dominant Mormon culture is felt inside of the jail, with conservative correctional officers and their "temple recommend" (which establishes worthiness to enter the Mormon temples and is a symbol of devoutness to the Church) being "grossed out" by women's health care needs.

While sterilization of incarcerated women is certainly a controversial topic, findings from this study show that there are multiple voices that must be considered on this issue. During the eugenics era, nearly a century ago, women were sterilized without being involved in the decision. Now, women's access to sterilization is being removed without hearing the perspectives of the women the bans affect. Sterilization

access in jail is not a simple *all* or *nothing* issue, yet more jails lean toward *nothing.*

Sterilization in jail, like outside of jail, must be considered on a case-by-case basis, with thoughtful, comprehensive, unbiased counseling, and informed consent protocols. The doctors who sterilized incarcerated women without their consent in the case of the California sterilizations (Johnson, 2013) behaved unethically and without regard for women's reproductive autonomy. Training for providers who are unaffiliated with the jail and provide care off-site at a contracted hospital (specifically during prenatal care and childbirth) is a necessary step in creating an environment where women can be informed and consent to sterilization procedures.

In the Salt Lake County Jail, prenatal care is done in the jail clinic. If it is likely that a pregnant woman will be giving birth while she is in custody, she should receive contraceptive counseling about all methods available to her, including IUDs and implants, and if she wants sterilization, she should have the opportunity to consent to sterilization 30 days in advance of her due date. This gray area deserves attention to ensure women are getting appropriate information and time to consider sterilization and consent requirements are protecting her reproductive autonomy.

Jails are legally required to provide necessary medical care to people in their custody, but sterilization is often considered elective, and not medically necessary. While the incarcerated patient may want the procedure and the doctor may be willing to do the procedure, ultimately, the jail would be responsible for paying for the procedure, and the jail may not want to use taxpayer dollars to cover the cost of an elective sterilization procedure, or the jail may not feel comfortable having a woman in their custody sterilized.

The issue of sterilization of incarcerated women is complicated. The historical and geographic context of sterilization should be taken in to consideration when determining protocols surrounding sterilization education, counseling and consent, and procedures. The findings from this study show that most participants believe a

prohibition of sterilization during incarceration would be a violation of their rights. The participants suggest that jails should work with an unaffiliated (to the jail) organization to provide comprehensive contraceptive education, counseling and services. Long acting reversible contraception (IUD and implant) and other nonpermanent methods (pill, ring, shot) should be offered before sterilization; however, if a woman insists on sterilization as her preferred contraceptive method, she should be screened for her ability to consent to sterilization. Just as it should be provided outside of jails, education on the procedure and permanency of sterilization and informed consent are mandatory. Education and consent process should be trauma-informed as the majority of women in this study have been victims of sexual violence and have a history of drug addiction and loss of a child. Special precautions should be taken to reduce possibilities of pressure from family members or jail staff. A core tenet of reproductive justice is ensuring women have the ability to make autonomous reproductive decisions; this includes incarcerated women, and this includes sterilization decisions.

Limitations

A limitation of this study is sample size. There were 20 participants and only 17 women actively participated in the discussion. Most of the women in the Salt Lake County Jail are White (86%), 17% are Hispanic, 4% are Black, and 3% are Asian. In the focus group, 65% of participants were White, 25% were Hispanic, and 10% were Black. There were no Asian participants. Although the participants were predominately White, Hispanic women and Black women were overrepresented.

The focus group participants had higher levels of education than average for the Salt Lake County Jail population and compared to national demographics of incarcerated women. Women with strong opinions may have been drawn to the focus groups, and their prosterilization attitudes may have intimidated the few participants

who had antisterilization attitudes into not being as forthcoming with statements that countered what the majority of participants expressed. Elizabeth observed,

> The six of us sitting here are a little bit—we're more vocal. Obviously, we're all White. Obviously, we've all had access to (information and services)—even to the general population out there. I can sit and look at this table and every one of us is very vocal, very—we stand up for ourselves. Again, it's the people who come in here that want to speak.

In future research, I will seek out the voices of women who are incarcerated and are opposed to sterilization occurring while women are in custody.

The jail setting provides a unique situation for focus groups and specifically about a sensitive subject. The women in the jail pod, where participants would be recruited, were at minimum acquaintances, and some may have been friends. Participants were at least familiar with each other because they live in the same housing unit and interact with each other daily for weeks or months. This level of acquaintance may have allowed for more self-disclosure in a group of peers, or may have led to more censorship to protect their privacy in a unique communal setting.

Future research should attempt to gain more insight into the antisterilization attitudes of women in this jail. Future research should also attempt to gain more insight in the sterilization attitudes in different jails across the country. The findings from this study add to the conversation about sterilization access for incarcerated women.

Table 13. Descriptions of Survey Participants and Focus Group Participants

	Survey Group *N* = 194	Focus Group *N* = 20
Age, median (range)	31 (18–48)	32 (23–47)
Race & Ethnicity		
Non-Hispanic White	120 (62%)	13 (65%)
Hispanic, any race	54 (28%)	5 (25%)
Non-Hispanic WoC	20 (10%)	2 (10%)
Education		
No HSD/GED	66 (34%)	2 (10%)
HSD/GED	62 (32%)	6 (30%)
Some college+	65 (34%)	12 (60%)
Religious	128 (66%)	7 (35%)
Religion		
LDS	46 (24%)	0 (0%)
Christian	24 (12%)	3 (15%)
Catholic	21 (11%)	0 (0%)
Other	24 (12%)	4 (20%)
Times in jail, median (range)	7 (1–42)	7 (2–40)
Used illicit drugs in year prior	163 (88%)	19 (95%)
Uninsured prior to arrest	100 (52%)	6 (30%)
Wants help enrolling in insurance	142 (74%)	14 (70%)

Table 14. Sexual, Reproductive and Contraceptive Descriptions of Survey Participants and Focus Group Participants

	Survey Group *N* = 194	Focus Group *N* = 20
Has had vaginal sex with a male	191 (98%)	20 (100%)
History of forced sex	112 (58%)	14 (70%)
History of sex for trade	68 (35%)	10 (50%)
Ever been pregnant	167 (86%)	20 (100%)
Ever been in jail while pregnant[a]	52 (31%)	5 (25%)
Ever terminated a pregnancy[a]	40 (24%)	7 (35%)
Ever placed child in adoptive care[a]	41 (24%)	9 (45%)
Has custody of minor child(ren)[b]	93 (55%)	9 (45%)
Used BC in previous 12 months	110 (57%)	9 (45%)
Problem with partner using BC		
In past	62 (32%)	7 (35%)
Foresee in future	45 (23%)	6 (30%)
Wants to get pregnant in year after release		
Yes	42 (22%)	3 (15%)
No	102 (53%)	4 (20%)
Don't know	26 (13%)	7 (35%)
Don't care	6 (3%)	0 (0%)
Can't	21 (11%)	8 (40%)
Has known enough about BC in the past	121 (62%)	13 (65%)
Plans to use BC in year after release	77 (40%)	7 (35%)
Interested in initiating BC in jail	128 (66%)	13 (65%)

(a) *n* = 169; (b) *n* = 168;

Table 15. Focus Group Participants

Participant	Focus Group	Age	Race	Education	Times in Jail	Insurance	Sterilized	Drug Use in Past 12 months	Religious/Religion
20 participants	Three groups	Median = 32 [23–47]	85% white	60% some college+	Median = 7 [2–40]	30% uninsured	40% sterilized	95% used illicit drugs	
Megan	1	46	White	Assoc. deg	40	Medicaid	Yes	Yes	Yes / Christio Paagan Wiccan with Christ
Ida	1	29	White Hispanic	Some college	5	Medicaid	No	Yes	— / Higher Power
Natalie	1	30	White	HS diploma	15	Medicaid	No	Yes	No
Brianne	1	40	White	Assoc. deg	3	Private	Yes	Yes	No
April	1	33	White	Did not complete HS	10	Medicaid	No	Yes	Yes / Christian
Courtney	1	47	White, Cherokee	HS diploma	31	None	Yes	Yes	Yes / Christian
Claudia	1	31	White Hispanic	Some college	10	None	No	Yes	Yes / Muslim
Elizabeth	2	44	White	Bach. deg	2	Military	No	No	No
Mykenzie	2	26	White	HS diploma	6	Medicaid	No	Yes	No
Theresa	2	30	White	Some college	5	Private	No	Yes	—
Chelsea	2	26	White	HS diploma	7	Medicaid	No	Yes	—
Kimberley	2	30	White	Some college	2	Obamacare	No	Yes	No
Sophie	2	44	White Hispanic	Elementary < 8 grade	6	Medicaid	Yes	Yes	No
Alison	3	33	White	Assoc. deg	13	None	Yes	Yes	No / Spiritual
Marie	3	23	Hispanic	Assoc. deg	7	Private	No	Yes	Yes / Christian
Jessica	3	29	White	HS diploma	23	None	Yes	Yes	No
Renee	3	38	Black	Some college	40	Private	Yes	Yes	Yes / Baptist
Rose	3	36	White	Assoc. deg	2	Medicaid	No	Yes	Yes / —
Victoria	3	26	White	HS diploma	5	None	No	Yes	No
Heather	3	38	Black	Some college	3	None	Yes	Yes	No

Table 16. Survey Participants' and Focus Group Participants' Responses to Question About Sterilization Opportunity

If a woman has a tubal ligation it means she can never get pregnant again.

53. Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?

Response	Survey Participants *N* = 194	Focus Group Participants *N* = 20
Yes	125 (64%)	13 (65%)
No	33 (17%)	3 (15%)
I don't know	29 (15%)	3 (15%)
Other	2 (1%)	0 (0%)
Missing	5 (3%)	1 (5%)

Table 17. Survey Participants' and Focus Group Participants' Responses to Question About Sterilization Pressure

Some people worry that women who are incarcerated might feel pressured to get their tubes tied.

54. Would you worry that female inmates were being pressured into having this permanent procedure?

Response	Survey Participants *N* = 194	Focus Group Participants *N* = 20
Yes	43 (22%)	6 (30%)
No	110 (57%)	13 (65%)
I don't know	32 (16%)	0
Other	4 (2%)	0
Missing	5 (3%)	1 (5%)

Table 18. Survey Participants' and Focus Group Participants' Responses to Question About Sterilization Prohibition

Some lawmakers want to make it so female inmates cannot get their tubes tied while they are incarcerated. And some people think that women should have the choice to get their tubes tied, even if they are incarcerated.

55. Do you think tubal ligation, "getting your tubes tied," should be prohibited for incarcerated women?

Response	Survey Participants *N* = 194	Focus Group Participants *N* = 20
Yes	21 (11%)	2 (10%)
No	132 (68%)	15 (75%)
I don't know	26 (13%)	1 (5%)
Other	9 (5%)	1 (5%)
Missing	6 (3%)	1 (5%)

CHAPTER 6

CONTRACEPTIVE CARE IN EIGHT U.S. JAILS

Introduction

Through government programs such as Title X and Medicaid, the United States has improved access to family planning services for disadvantaged women, reduced rates of unintended pregnancy, and saved taxpayers more than $10 billion dollars (Sonfield, Hasstedt, & Gold, 2014). The cost savings generally come from helping women avoid unwanted pregnancies that would have gone on to require publicly funded pregnancy-related care. It is estimated that more than 19 million women in the United States are in need of publicly-supported contraceptive services (Sonfield et al., 2014). Among those women in need, approximately 100,000 are incarcerated in jails across the United States. Like Title X and Medicaid, jails are also publicly funded by taxpayer dollars. Jails have become an integral part of the United States social and medical safety net (Sufrin, 2017); however, the contraceptive care of many incarcerated women is either disrupted or ignored (Sufrin et al., 2009a; Sufrin, Kolbi-Molinas, et al., 2015). Jails have an opportunity to contribute to reducing unintended pregnancies, but in fact may be contributing to increasing women's risk of unintended pregnancy.

Jails Are Diverse and So Are Their Health Care Arrangements

There are more than 3,000 jails in the United States, housing drastically different populations ranging from fewer than two women to more than 2,000 women (Stephan & Walsh, 2011). These jails are legally obligated to provide health

care to persons in their custody, as established in the Eighth Amendment of the U.S. Constitution. Most commonly known for prohibiting "cruel and unusual punishment," the Eighth Amendment has been interpreted by the Supreme Court as prisoners having a right to health care. The legal right to health care for incarcerated persons is a result of the 1976 Supreme Court case *Estelle v. Gamble*, in which a prisoner, J.W. Gamble initiated a lawsuit against the Texas Department of Corrections after he injured his back doing prison labor. Gamble did not win the lawsuit, but the court's decision stated that prison officials are obligated to provide prisoners with adequate care for serious medical needs (Rold, 2008). What qualifies as "serious medical need," however, remains largely undefined. A prisoner must prove that a prison official treated them with "deliberate indifference to serious medical needs."

While unintended pregnancy is generally regarded as a public health issue worth preventing, contraception has not been considered a serious medical need. Additionally, in jail, where incarcerated populations are sex segregated, many jail officials state that there is no risk of pregnancy for incarcerated women, thus no medical necessity to prevent it. However, incarceration can in fact increase the risk of unintended pregnancy.

Unintended Pregnancy Risk and Incarceration

The majority of women who experience incarceration in U.S. jails are of reproductive age, between the ages of 18 and 45. Overwhelmingly, incarcerated women come from disadvantaged neighborhoods, have low levels of education and live below the federal poverty level, and many do not have secure housing. Women in jail have disproportionately high rates of substance abuse and mental health issues, compared to men in jail and women in the general population (Bronson & Berzofsky, 2017; Bronson et al., 2017). Women in jail are representative of a medically underserved population and often lack health insurance and struggle to

access or afford reproductive health care and effective methods of contraception in the community.

Previous research has found that incarcerated women had lower rates of contraception use compared to women in the general population and higher rates of unintended pregnancy (Clarke, Hebert, et al., 2006). Additionally, many women who come in contact with the jail system have a history of sexual violence committed against them, are more likely to have a history of sex work, and may be in relationships with men who sabotage their use of contraception (Belknap, 2014). Women who have a history of incarceration are already more likely to experience an unintended pregnancy in their lifetimes, not necessarily directly related to incarceration, but more directly related to their lack of contraceptive resources due to low levels of education, and high rates of poverty, which are also correlated with higher likelihood of arrest.

Incarceration may increase a woman's risk of unintended pregnancy, primarily at three different time points: at intake, during incarceration, and after release from jail. These different points require different types of contraceptive care. I describe the details for the different time points below.

Immediately After Arrest / At Time of Intake

A woman who has been sexually active in the days prior to incarceration may be at risk for unintended pregnancy. She could be at risk of unintended pregnancy if her hormonal birth control pill is discontinued, she is ovulating, and had sex in the previous week. While intercourse occurred before incarceration, fertilization could occur during incarceration. Reducing a woman's risk of unintended pregnancy can be accomplished by allowing her to continue taking her birth control pills on schedule.

Secondly, a woman who has been sexually active in the days prior to incarceration may be at risk of an unintended pregnancy if she did not use

contraception or had a contraceptive failure (broken condom, missed pill). Reducing this woman's risk of unintended pregnancy can be accomplished by offering emergency contraception at time of intake (Sufrin et al., 2010).

During Incarceration

In jails, women are housed in units separate from men. This sex-segregated housing structure leads many jail decision-makers to believe contraception is unnecessary in jail because women are not at risk of getting pregnant because they are not having sexual intercourse. Although this is theoretically true, it is realistically false. Heterosexual intercourse occurs in jail settings, most often in the context of a male correctional officer and a female in custody. In 2011–2012, approximately 1,300 women incarcerated in U.S. jails reported sexual victimization by facility staff (Beck et al., 2013). That number is larger than the total number of women incarcerated in Utah jails (1,100) on any given day (Minton et al., 2015). There are no reliable data to estimate how many pregnancies occur from these sexual encounters, but heterosexual sex and rape happen in jail and unintended pregnancies are possible.

Soon After Release From Jail

Many women in U.S. jails are at risk of unintended pregnancy soon after they are released from jail. Most incarcerated women are heterosexually active and plan to have sex with men after they are released. Incarceration can impact women's fertility in a variety of ways and increase a woman's risk of experiencing an unintended pregnancy.

Lifestyle factors such as nutrition, weight, stress and using drugs and alcohol can affect a woman's fertility (Sharma et al., 2013). In jail, women are unable to continue many of their regular behaviors and habits. During incarceration in most

jails, women cannot smoke cigarettes and they are not able to drink alcohol or continue using illegal drugs. In jail, women detox off drugs and have three meals available to them each day. These changes may cause women to gain or lose weight, and their fertility may be impacted by becoming healthier than they were prior to incarceration. Many women leave jail more fertile than when they entered jail and struggle to access contraception.

If women do not have access to contraception prior to their release from jail, they may have a higher risk of unintended pregnancy. Through a chart review, one study found that 52% of women who were pregnant in one facility had a prior incarceration and many women conceived within 3 months of being released from jail (Clarke et al., 2010). Facilities that provide effective methods of contraception to women in their custody may help reduce the number of unintended pregnancies that women experience after release and the number of pregnant women returning to jail.

Jails As a Site for Contraceptive Care

To date, only one nationally representative survey has been conducted assessing the contraceptive services available in U.S. correctional facilities (Sufrin et al., 2009a). The study analyzed survey responses from 286 correctional health care providers and found that 11% provided contraceptive counseling routinely and 38% provided women with a contraceptive method, either prior to release or by prescription for after release, and most often oral contraceptive pills. However, 55% of the respondents said women could not continue their preexisting contraceptive method during incarceration. Providers in jails were less likely to provide contraceptive counseling and care compared to providers in prisons and juvenile detention facilities. Some themes that emerged from the respondents' comments are that contraceptive methods were more likely to be continued for noncontraceptive

reasons, and that incarceration is a time when women's reproductive health care needs could be addressed but are not a high priority. Since this study was published, IUD and implant use has increased in the nation and research has shown that IUD and implant provision is safe and feasible for incarcerated women (Sufrin, Oxnard, Goldenson, Simonson, & Jackson, 2015).

A recent policy brief described the contraceptive programs in four U.S. correctional facilities and provides actionable insights for how administrators and health care providers can improve the family planning services they provide to women in their custody (Sufrin et al., 2017). There is a lack of qualitative information about how jail health care providers utilize IUDs and implants in their clinics and a more nuanced understanding of how contraceptive care is managed from intake, through incarceration and release.

Sterilization Abuse of Incarcerated Women

Finally, female sterilization is also an important contraceptive method that many women use to prevent pregnancy. In the United States, sterilization abuse has occurred among incarcerated women, most recently in California, where it was revealed that between 2006 and 2010, 148 women were involuntarily sterilized, either through coercion or without their knowledge (Johnson, 2013). In response, California passed a law prohibiting sterilization procedures of incarcerated persons except in cases it is deemed life-saving. There is scant information about the availability of sterilization for incarcerated women and consent protocols in U.S. jails. Additionally, we have minimal insight into how medical providers who care for women in jail feel about sterilization availability and sterilization bans for incarcerated women.

This chapter describes the contraceptive care that is or is not available to women incarcerated in eight different jails in the United States, for both reversible

and permanent contraceptive methods. Through interviews with medical providers, I collected information about protocols affecting incarcerated women's contraceptive use from the point of intake, during incarceration, and at the time of release, as well as the attitudes the providers have about reversible and permanent methods being available for women in jail. I provide these findings in hopes that information about a range of contraceptive programs may help correctional facilities implement more comprehensive contraceptive care that centers the needs of incarcerated women.

Methods

I conducted telephone interviews with eight jail health care providers in the United States. Interviews were necessary to gain a more deeper understanding of facilities' contraceptive care and providers' attitudes than could be obtained through surveys. I created an interview guide with questions about the provider's background and clinical experience. I asked providers to discuss their professional opinions about reversible contraceptive continuation and initiation in jail and their opinions about sterilization in a correctional setting. The interview included questions about the community the jail was in, as well as about the facility, the female population in custody there, and the health care staff and arrangements. I asked in-depth questions about the intake procedures related to contraception, and what types of contraceptive methods were available for continuation and initiation and the counseling and consent protocols. I also asked questions about how contraceptive programs were established, and in the case of jails without a contraceptive program, what they thought would be necessary for implementing a program (see Appendix C for interview guide).

I recruited participants through sending emails to people who worked in a jail or might know someone who worked in a jail. I sent recruitment ads to administrators of Facebook pages for correctional health workers to share with their

followers and I sent recruitment messages to people on LinkedIn who identified themselves as correctional health providers. Participants had to be a health care professional (medical doctor, MD; physician's assistant, PA; nurse practitioner, NP; or registered nurse, RN) providing care for women at a jail, and must have worked in corrections for at least 1 year. I recruited eight providers who met the eligibility requirements.

Data Collection

After screening potential participants for eligibility, study participants chose a day and time that would be convenient for them for a 1-hour telephone interview. Depending on their preference, I called them or they called me at the time of the interview. Prior to each interview, I emailed a consent document to the participants to read. At the beginning of each interview I told each participant that I was going to begin audio-recording. Once the audio-recorder was on, I asked the participant if they had read the consent document and if they agreed to be interviewed and audio-recorded, to which they gave verbal consent. The interviews lasted between 44 and 97 minutes, with an average interview length of 69 minutes. After each interview, I reminded the participants about the compensation, which was a $40 Amazon gift code that would be emailed to them. Four participants refused to accept compensation. The audio-recordings of each interview were transcribed by a professional transcription service.

Data Analysis

The data analysis strategy is detailed in Chapter 3. The objective of this chapter is to compare different facilities and rank them according to their level of comprehensive contraceptive care. I chose to keep the providers' names and the names of the facilities they work in anonymous. For sake of readability, I have

assigned color-coded names to each facility and provider. Like a stop light, I've chosen colors that range from Green to Yellow to Red. There are four facilities that I have determined have the most comprehensive contraceptive care programs, and are assigned green-related labels. Two facilities have less comprehensive care programs and have yellow-related labels and two facilities have no contraceptive care programs and are assigned red-related labels. From most comprehensive to least comprehensive, the facilities are ranked and named as:

1. Green Jail and Green Provider
2. Pine Jail and Pine Provider
3. Sage Jail and Sage Provider
4. Pear Jail and Pear Provider
5. Yellow Jail and Yellow Provider
6. Canary Jail and Canary Provider
7. Scarlet Jail and Scarlet Provider
8. Red Jail and Red Provider

Results

The Providers and Facilities

I begin this section by introducing the providers I interviewed and the facilities where they provide care (see Table 19 and Table 20) and the regions where the jails are located (see Figure 1). I then discuss the presence or absence of health care protocols and services that can reduce the risk of unintended pregnancy for incarcerated women, with a focus on reversible contraceptive methods. I describe the similarities and differences between the facilities' protocols and providers' attitudes. Lastly, I present the findings regarding providers' attitudes towards sterilization access for incarcerated women and the actual availability of sterilization—and under what circumstances—for women in these eight facilities.

The Green Jail and Provider

The Green Jail serves as the correctional facility for the entire state, is a combined jail/prison for both short and long-term stays, and is located in an urban area in New England. The Green Jail houses approximately 3,000 incarcerated people daily. Of the total jail population, 150–300 are female (5–10%). The average length of stay at the Green Jail is 3 days because so many people are released within 24 hours or less; however, the median sentence ranges from 90 days to 6 months. The Green Jail is unique as it also houses women with long-term sentences, that is, 40 years. The majority of women incarcerated at the Green Jail are White; however, women of color are overrepresented in the Green Jail compared to the general population of the state.

The Green Provider is a White female MD, MPH who has been providing care in a correctional setting since completing her training 19 years ago. She works full time as the Medical Programs Director for the State Department of Corrections that operates the health services in the Green Jail. She primarily works in an administrative role for the Green Jail.

The Pine Jail and Provider

The Pine Jail is a city jail located on an island near a densely populated urban city in the Middle Atlantic region of the United States. The Pine Jail houses approximately 1,000–1,100 incarcerated people daily. Of the total jail population, 600–650 are female (60%). The Pine Jail is the only jail in the city system that houses women. Men are also incarcerated in other facilities in the city, which explains the large female population in the Pine Jail. Again, many incarcerated people are released within 72 hours, but there is an average stay of approximately 37 days and a median stay of 2 weeks.

The Pine Provider is a White male MD who completed his training 5 years ago

and began working in a correctional setting after residency. He works full time as the Chief of Medicine and the interim Chief Medical Officer for Correctional Health Services, which is a division of a City Health and Hospital system that operates the health services in the Pine Jail. He primarily works in an administrative role.

The Sage Jail and Provider

The Sage Jail is a female-only jail in a county corrections system located in a densely populated urban county in the Pacific Southwest region of the United States. The Sage Jail houses approximately 2,200–2,300 incarcerated women daily. The average length of stay for women in the Sage Jail is 45 days. Half (50%) of the women housed at the Sage Jail are Latina, 30% are White, 15% are African American, about 6% are American Indian, and very few Asian women are incarcerated there.

The Sage Provider is a White male MD who has been a practicing OB/GYN for 2 years and contracted for correctional health care for 1½ years. He is a family planning fellow at a local School of Medicine and provides care as an attending physician and OB/GYN at the Sage Jail. He is one of four OB/GYNs contracted by the County Department of Health Services to provide women's health care at the Sage Jail.

The Pear Jail and Provider

The Pear Jail is a county jail located in an urban county in the East North Central region of the United States. The Pear Jail houses approximately 9,000 incarcerated people daily. Of the total jail population, 800–1,000 are female (9–11%). The average length of stay at the Pear Jail is 44 days. The women incarcerated at the Pear Jail are predominately African American and come from impoverished neighborhoods surrounding the jail.

The Pear Provider is a White female MD who has been providing care for 31 years as a family physician and has been involved in correctional health care for 7 years. She works full time as the Division Chief for Clinical Operations in the Department of Correctional Health of a County Health and Hospital System that operates the health services in the Pear Jail. She primarily works in a leadership role.

The Yellow Jail and Provider

The Yellow Jail is a county jail located in a county that has urban, rural, island, and nautical areas, and is located in the Pacific Northwest region of the United States. The Yellow Jail houses approximately 2,000 incarcerated people daily. Of the total jail population, 200 are female (10%). As is common in most jails, 50% of people who are booked into jail are released within 72 hours. Beyond that, the average length of stay at the Yellow Jail is 3 weeks. There is an overrepresentation of people of color incarcerated at the Yellow Jail, specifically Native Americans and African Americans relative to their general population percentages.

The Yellow Provider is a White male MD, MPH who has been providing care as a family physician for 20 years and in a correctional setting for 16 years. He works full time as the Medical Director, or Jail Health Officer for the Jail Health Services Division of Public Health for the County that operates the health services in the Yellow Jail. He primarily works in an administrative role.

The Canary Jail and Provider

The Canary Jail is a county jail located in a rural, mining community in the Intermountain West region of the United States. The Canary Jail houses approximately 70 incarcerated people daily. Of the total jail population, 10–15 are female (14–21%) and the majority are White.

The Canary Provider is a White male MD who has been practicing primarily

emergency medicine for 31 years and has been providing correctional health for 18 years. He is mostly retired, but is the Medical Director for the Canary Jail, supervising three nurses and holding clinic once every 7 to 10 days in the jail. He is contracted by the County Sheriff's Department to provide medical care for the people in custody at the Canary Jail.

The Scarlet Jail and Provider

The Scarlet Jail is a county jail located in an urban county in the Intermountain West region of the United States. The Scarlet Jail houses approximately 2,000 incarcerated people daily. Of the total jail population, about 200 are female (10%). The average length of stay is around 30 days. The Scarlet Jail is in a predominately White county and most of the women incarcerated there are White.

The Scarlet Provider is a White female PA who has been practicing for 17 years and been involved in correctional health care for 7 years. She works 1 to 2 days a week in the Scarlet Jail as the women's health care provider. She is employed as an independent contractor and reports to the Medical Director who is contracted by the County Sheriff's Department. She primarily works in a patient-care role.

The Red Jail and Provider

The Red Jail is a county jail located in a rural county with a small metropolitan population (156,000) in a county seat in the Southwest region of the United States. The Red Jail houses approximately 450 incarcerated people daily. Of the total jail population, 74–100 are female (16–22%).

The Red Provider is a White male RN who has been in nursing for 15 years and has worked as a correctional nurse for 13 years. He works full time as the senior nurse in the Red Jail primarily in a patient-care role. He is a county employee.

The Interviews

The primary objective of the interviews was to gain an understanding of the level of contraceptive care available in different facilities, as well as providers' attitudes about contraceptive care for women incarcerated in jail. First, I present the providers' responses to the question, *"In your professional opinion, should incarcerated women have access to continuing or initiating birth control while they are in custody?"* Second, I describe the contraceptive availability in the eight facilities. The results are separated into two major sections—the first section focuses on reversible methods of contraception, including emergency contraception (EC), oral contraceptive pills (pill), transdermal contraceptive patches (patch), vaginal contraceptive rings (ring), contraceptive injections (shot), subdermal implants (implant), and intrauterine devices (IUDs). The second section is focused on permanent methods of contraception, primarily female sterilization by tubal ligation.

Why Is Contraceptive Continuation and Initiation Important for Incarcerated Women?

Providers discussed different reasons why continuing or initiating contraception in jail is important. Many providers acknowledged that incarcerated women represent some of the most medically underserved people in the community, and jail is a point of care for addressing their health care needs, including reproductive health. Several providers describe the importance of continuity of care for incarcerated people; ensuring the medically-necessary prescriptions they use outside of jail are continued during their jail stay, in some cases including birth control; and birth control used for noncontraceptive reasons, such as controlling menstrual cycles or managing endometriosis. Another reason providers give for continuing and initiating birth control is that initiating contraception in jail helps women feel empowered and gives women one less thing to worry about before they

leave jail and return to the community. Lastly and most importantly, several providers report that planned pregnancies are healthier pregnancies, and providing contraceptive care in jail can help reduce the number of unintended pregnancies women experience after release, and with the high recidivism rate, that means fewer women return to jail with unplanned pregnancies. Below are the responses the providers gave to the question, *"In your professional opinion, should incarcerated women have access to continuing or initiating birth control while they are in custody?"*

> Well, it's pretty clear from our patients, especially in a jail setting, where they tend to be incarcerated for short term that many of them express the desire to avoid a pregnancy when they're released from incarceration. They plan on resuming heterosexual sex, and they would like to have that be one thing they get taken care of while they're incarcerated basically, so it's one less thing that they have to worry about when they're trying to get custody of their children, and a secure, safe place to live, and out from under an abusive relationship, that drug treatment and mental health treatment, and then all of that. If we can get them—it's the same population that would use our services as the county health safety net if they were out. We can arrange for them to have the services while they're here. That's all the better. (Pear Provider)

> Interrupting birth control may make it more difficult for women as they are released. It's part of primary care, preventive care, it helps for healthier pregnancies, and helps women to have planned pregnancies. We know that planned pregnancies are healthier pregnancies, and it also helps to empower women in a very chaotic time, the time immediately postrelease. (Green Provider)

> The number one thing that I believe that people should have access to, is continuity of care. Again, for medically necessary care. My professional opinion is that access to contraceptive methods should be continued during a period of incarceration. That makes sense to not have breaks in therapy, to the extent possible, given in the jail setting, at least, the relatively short turnaround time and relatively short lengths of stay for most people that are booked into jails. It also makes sense from the standpoint of the social situation that so many of the people that we serve in the jail are in. There's a very high rate of homelessness. Very, very high rates of substance use disorder. High rates of mental illness, compared to the general population. All of those associated with social determinants of how poverty and generally, higher barriers to access health care services of any kind in community settings.
>
> It makes sense to not have a break in therapy for someone who is at least engaged enough to have access to contraception or family planning services before coming in to jail. Make sure that we keep those going during the jail stay, so that again, they come out with intact care with regard to their family planning services and contraception services. (Yellow Provider)

> Yes. I think it gets a little tricky, depending on how long they are going to be incarcerated, for some of the shorter-acting contraceptives. I think there should be a discussion of risks and benefits if people are going to be continuing on medications for long periods of time and don't expect to be sexually active. Certainly, for jail settings, which tend to have transient and short length of stay, I think it's essential to avoid discontinuity of reproductive health services for people who come to jail for short periods of time. [As for initiating contraception while in jail] Yes, absolutely. For many of our patients, they're not engaged meaningfully in care in the community. Though jail, overall, is an intervention that is harmful to people's health, it is an opportunity to engage people in various types of services. Reproductive health is absolutely one of them. (Pine Provider)

> Yes, because it's good to get into the habit. If you have never been on birth control, it takes time to get into the habit and we're in a very safe environment. They can get any questions answered, especially if it's—if they're having any side effects. Is this normal or not? They've got a supportive and educated group of people that they can ask questions to. It's the best time for them to have access to reliable information about their bodies and about their bodies in the future. For those who have been on it in the past and wanna continue with it, just abruptly stopping any kind of hormonal contraception affects anyone in a suboptimal way and for a lot of people, they have heavy bleeding, which is why they're on birth control in the first place, and when they get out, it's very important that they have that birth control that continues, so that when they leave the jail, they are ready to be back with their significant others and not putting themselves in jeopardy of having unwanted pregnancy. (Scarlet Provider)

> "They should, yes, if for no other reason than to control or adjust their menses" (Red Provider).

> First of all, there are—this is a gross generalization, but there are two types of women who enter a jail: those who have a medical home and those who don't. Those who do may come in on birth control, and being in jail disrupts their medical care. It disrupts their access to birth control. We should be able to continue that because that is what they have prescribed for themselves not only to prevent pregnancies, which is important, especially in a jail where there's short-term stays, but also to control menstrual cycles and a lot of other reasons that women take birth control.
>
> Then the second group of women are women who don't have or haven't previously accessed the medical system or access is very limited, emergency room ways. These women come in with less information, without having seen a doctor in a while, and to be provided information on birth control, a lot of them wish to initiate at that time because this is the only time that they may have access to a physician not only to have the conversation, but actually to start especially a long-acting form of birth control or to figure out if they like a birth control method. Women see it as an opportunity to access health care to take care of some of the things that they haven't been able to take care of outside of jail. (Sage Provider)

> If they request it, yes. I think if that's something they want to have, I think it oughta be provided... That answer would have to be qualified by clarification

> of the reasons why. Obviously, if somebody has a medical reason—endometriosis, polycystic ovarian syndrome—there are a number of clinical reasons you might want to provide hormonal treatment for a woman other than just birth control. (Canary Provider)

Every provider believed that contraception should be available for women in jail, but they had varying opinions about what types of methods should be available and under what circumstances. Additionally, in some cases, providers expressed opinions that contraception should be available, but the actual availability in the facility was limited. This discrepancy was most apparent with Scarlet Provider, who believes incarcerated women should have access to all methods of contraception in jail; however, no contraceptive methods were available for continuation or initiation for women incarcerated in the Scarlet Jail. In the following section, I describe how the facilities do, or do not, meet incarcerated women's contraceptive needs and reduce their risk of unintended pregnancy.

Access to Reversible Methods of Contraception

During Incarceration

First, I describe the facilities' protocols surrounding contraception during intake and incarceration (Table 21). Second, I provide comparisons between the facilities' similarities and differences.

In the Green Jail, during intake women are asked to list their medications. Women are specifically asked if they are currently using a contraceptive method. Women are not routinely screened for emergency contraception eligibility; however, if a woman asks for the emergency contraception pill it is available and can be given to her that day. If a woman is using the oral contraceptive pill, patch, ring, or shot, the method will be continued on schedule and administered by the nurse.

In the Green Jail, all women meet individually with a health educator within the week they enter the jail. The health educator is employed by a Title X clinic in

the community and comes into the jail weekly. She has a list of women who have entered the jail since the educator was last there. She calls each one in and tells them about contraceptive services in the community and informs women about the birth control options that are available to them to initiate while they are in jail. If a woman is interested in initiating a family planning method the health educator makes an appointment for them with the ObGyn. The ObGyn is on site 2 days a week and can accommodate most family planning visits. Other providers can meet the family planning needs of patients who need to be seen when the ObGyn is not available. Women are counseled and can initiate the pill, patch, ring, or shot while in jail. When women are released they are given a 3-month supply of their method. A woman can get a hormonal IUD, a copper IUD, or an implant inserted, removed, or removed and replaced while she is incarcerated at the Green Jail.

In the Pine Jail, during intake women are asked to list their medications. Women are specifically asked if they are currently using a contraceptive method. Women are routinely screened for emergency contraception eligibility and offered emergency contraception. If a woman is using the pill, patch or shot, she is able to continue the method during incarceration. Women are not able to continue using the ring in jail, and can be switched to a different method during incarceration.

In the Pine Jail, clinic staff conduct reproductive health classes in the housing units. If women are interested in initiating a contraceptive method they are referred to the reproductive health clinic for an appointment. The reproductive health clinic is operated 1 day a week, solely for the purpose of family planning services related to contraceptive education and initiation or removal, and is primarily staffed by family physicians and family nurses. A woman will get contraceptive counseling at her first appointment at the reproductive health clinic, have time to consider the method she wants, and return to the clinic within 2 to 4 weeks to initiate the method. Women can initiate the pill, patch, or shot while in jail. A woman can get a hormonal IUD, a

copper IUD, or an implant inserted, removed, or removed and replaced while she is in the Pine Jail.

In the Sage Jail, during intake women are asked to list their medications. Women are not specifically asked if they are currently using a contraceptive method. Women are routinely screened for emergency contraception eligibility and offered emergency contraception. If a woman is using the pill, patch or shot, she is able to continue the method during incarceration. Women are not able to continue using the ring in jail, and can be switched to a different method during incarceration.

In the Sage Jail, the Sage Provider teaches a weekly reproductive life planning class to 10 women in a housing unit. Awareness about the availability of contraception is primarily through word-of-mouth unless a woman is in the facility for 6 months; then she will have a well-woman exam and be informed about available contraceptive methods. Women can request an appointment with a provider to initiate a contraceptive method. Women can initiate the pill, patch, or shot in jail. Women can also get an IUD or implant while they are incarcerated, but currently, they are transported to the contracted hospital for that appointment. Soon, IUDs and implants will be available for insertion in the jail clinic. Women can have an IUD or implant removed in the Sage Jail.

In the Pear Jail, during intake women are asked to list their medications. Women are not specifically asked if they are currently using a contraceptive method. Women are not routinely screened for emergency contraception eligibility; however, if a woman asks for the emergency contraception pill it is available and can be given to her that day. If a woman is using the oral contraceptive pill and wants to continue using the pill in jail, she will be given a pack of pills before she enters the housing unit or her pill will be distributed to her daily by a nurse. If a woman is using the patch or the ring she cannot use those methods during incarceration but she can be switched to an oral contraceptive pill during her jail stay and be given a prescription

for the patch or ring to pick up after release. If a woman is using the shot she can have her next shot scheduled for administration in the jail.

In the Pear Jail, all women have a "gyne" visit within 10 days after intake where a full family planning query is done and they are asked about their family planning goals. If a woman wants more information or wants to start a method, she is scheduled for a family planning visit approximately 2 weeks after her gyne visit. At the family planning visit she is counseled on all methods and given another 2 weeks to think about which method she wants and discuss the options with anyone she wants involved in the decision-making process (she can call her partner(s) on the phone and discuss how they feel about certain methods). Approximately 2 to 4 weeks later she will return to ask any more questions she may have and initiate the method she decides on. If at any time during this process she decides she is not interested in contraception, she does not have to get anything; it is completely voluntary. Also, if at any time during this process she learns she is going to be released from jail, she can communicate with a nurse who enters the housing unit daily that she is leaving and the nurse and provider will coordinate a "pop-up family planning clinic" and make sure the woman gets the method of contraception she desires or a prescription before her release. If a woman chooses the pill, she can be initiated on it in jail and she will get a prescription to pick up after release. If a woman chooses the ring or patch, the providers will give her a prescription that she can pick up at a pharmacy of her choice in the community within 10 days after release. A woman can initiate the shot in jail. A woman can get a hormonal IUD, a copper IUD, or an implant inserted, removed, or removed and replaced while she is incarcerated at the Pear Jail.

In the Yellow Jail, during intake women are asked to list their medications. Women are not specifically asked if they are currently using a contraceptive method. Women are not routinely screened for emergency contraception eligibility; however,

if a woman asks for the emergency contraception pill it is available. If a woman is using the pill, patch or shot, she is able to continue the method during incarceration. Women are not able to continue using the ring during incarceration and would need to request a different method if they wanted to stay on birth control in jail.

In the Yellow Jail, women can request an appointment to see a provider about birth control. She could initiate the pill, patch or shot while in jail, but contraceptive initiation in the jail is not common, which may be related to it being patient-initiated rather than routine, and women are not given a prescription for after release. A woman cannot get a hormonal IUD, a copper IUD, or an implant inserted while she is in jail. A woman cannot get an implant removed while she is in jail. Providers in the jail are discouraged from removing an IUD of incarcerated women and would likely only do so in the case of it being expired or due to problematic IUD-related symptoms.

In the Canary Jail, during intake women are asked to list their medications. Women are not specifically asked if they are currently using a contraceptive method. Women are not routinely screened for emergency contraception eligibility; however, if a woman requests it, the nurse can order it from the pharmacy and have it on site within 1 day. Women who use the pill can continue using the pill in jail if they have a pack that can be brought to the jail or a current prescription at a community pharmacy. The patch and ring are not available for women to continue in the jail and they would not be asked if they want to switch to a pill during incarceration. Women who are using the shot can be kept on schedule for their next injection. Women are able to use the pill or shot for medically necessary, noncontraceptive reasons.

In the Canary Jail, there is no routine contraceptive counseling and the nurses would not typically provide contraceptive counseling to the incarcerated women. The provider would consider giving a woman a pill or shot for contraceptive reasons, but the request to initiate is uncommon. Patches and rings are not available for initiation.

IUDs and implants are not available for initiation. IUDs and implants are not removed in the Canary Jail.

In the Scarlet Jail, during intake women are asked to list their medications. Women are not specifically asked if they are currently using a contraceptive method. Women are not routinely screened for emergency contraception eligibility and emergency contraception is not available, even if a woman requests it. Women are not able to continue using the pill, patch, ring or shot while they are in jail.

In the Scarlet Jail, women may receive contraceptive counseling from the women's health provider, but they cannot initiate any methods of contraception while they are in jail. Only in very rare cases have women been able to initiate a birth control method for medically necessary, noncontraceptive reasons. A woman can have an IUD removed while she is in jail by the on-site women's health provider. A woman cannot have an implant removed while she is in the Scarlet Jail.

In the Red Jail, during intake women are asked to list their medications. Women are not specifically asked if they are currently using a contraceptive method. Women are not routinely screened for emergency contraception eligibility and emergency contraception is not available, even if a woman requests it. Women are not able to continue using the pill, patch, ring or shot while they are in jail. If a woman uses a birth control method for a medically necessary, noncontraceptive purpose, such as managing endometriosis, she will be able to continue using it after the diagnosis has been verified.

In the Red Jail, women do not receive any contraceptive counseling. Women cannot initiate any methods of contraception while they are in jail. If a woman wants an IUD or implant removed because it is expired or bothering her, she will be transported off-site to an ObGyn's office for the procedure. She is not given an option to have an IUD or implant replaced.

Similarities and Differences in Intake Procedures

Ensuring there is no disruption to hormonal contraceptive use, screening women for recent unprotected sex, and offering emergency contraception (EC) can reduce the risk of unintended pregnancy. All facilities asked women to complete a medication list and disclose the prescriptions they use. Only two facilities specifically asked women about the contraceptive method they were using (Green, Pine). Only two facilities screened for emergency contraception eligibility (Pine, Sage). Six Facilities had emergency contraception available for women (Green, Pine, Sage, Pear, Yellow, Canary). All those had emergency contraception on site so women could take it before being sent to the housing unit, but the Canary Jail did not have emergency contraception on site and would have to order it from a local pharmacy for next-day delivery. Emergency contraception is not available in the Scarlet or Red Jails.

There is an understanding among most of the providers about the importance of having emergency contraception available for women who request it at intake, but four of the six facilities are not routinely screening for EC eligibility or offering it to women. The Pear Provider explains how the Pear Jail previously, routinely screened for EC need, and why they no longer do routine screening,

> When I first got here I thought this was gonna be my thing. That I was gonna really push the emergency contraception issue. It turns out that it really wasn't—we did a whole big survey. We tried to train our providers, and we started making sure, I mean it's available in the jail in the pharmacy, but we did not have a lot of uptake on people. Even though we were asking about whether they had unprotected sex within the previous five days, and whether they would have wanted to become pregnant at that time. We weren't getting people saying, "Yes, I want emergency contraception." We stopped asking. If somebody said that they wanted it we would obtain it. It hasn't really—it did not appear to—I was sure that was a big deal, and there were all these studies. Carolyn did the study and I heard her talk. I came back here and I was all fired up, and I was gonna do the same thing. It turned out that making arrangements for long term, long acting reversible contraception was a much more [important] issue for our patients than the issue of emergency contraception on the way in. I don't know why. It's possible that part of it is that in the last number of years, prostitution went from a felony to a misdemeanor, so fewer people are being incarcerated for sex work unless

> they're the Johns, or the pimps. The women aren't—there are fewer women coming in who are at risk because of sex work. I don't know. Certainly, there's still plenty of people who are reporting unprotected sex who say they don't wanna get pregnant, but the five day before incarceration piece doesn't really have immediacy for our patients. I don't know.

Future research is necessary to determine evidence-based best practices for universal screening for emergency contraception need in a jail setting.

Similarities and Differences in Contraceptive Continuation

Allowing women to continue their hormonal methods of contraception can reduce women's risk of unintended pregnancy. Six facilities had oral contraception available for continuation (Green, Pine, Sage, Pear, Yellow, Canary). Women were either given 1 month's or 1 week's supply of pills to have with them in their cells and take on their own, or a nurse would administer one pill daily during medication rounds. Four facilities had the patch available for continuation (Green, Pine, Sage, Yellow) which would be administered by a nurse weekly. One facility had the ring available for continuation (Green) which would be given to the woman by a nurse. Six facilities had the shot available for continuation (Green, Pine, Sage, Pear, Yellow, Canary). Women's next shot date would be determined either by asking her or verifying it with the clinic where she got the shot. The pills, patches, rings and shots would be ordered through the pharmacy. Women with an IUD or implant were able to continue using their methods in all eight facilities.

The pill. Six facilities have oral contraception available for women to continue (Green, Pine, Sage, Pear, Yellow, Canary). The providers believe in the importance of continuity of care, and see birth control pills as a simple medication to continue. The Canary Provider states, "[Pills]…for contraception or noncontraception, hormonal therapy. It just should not be discontinued."

The Green Provider describes the process of getting birth control pills as "the easiest" contraceptive method to continue, "cuz we just call the pharmacy." The

Yellow Provider mentioned the importance and ease of allowing a woman to continue using the same brand of oral contraceptive she used before incarceration, "Prescribe the contraception pills that they were already taking, why not just do that? There's no setup or takedown. It's literally placing a medication order."

The providers mention different ways to administer birth control pills to women in the jail population, either by giving women a packet of pills to self-administer daily, or by nurses giving women a pill each day. Pine Provider says that in the Pine Jail, "Oral contraceptives would be given in seven-day increments for the patient to carry and take as they would usually." The Pear Provider explains what happens if a woman lists the pill as a medication at intake,

> [They] would be asked by the PA or the doctor that night if they wanted to continue it while they were incarcerated. If they did they would get a prescription. It would depend on whether they were going to be housed in general population, in which case they would receive the pack in their hand before they went to their housing unit. If they were going to be medicated by a nurse on a dose by dose basis, then the birth control pills would be sent to the nursing unit. They probably would get it the next day.

In the Scarlet Jail, birth control pills are not available for women to continue or initiate; however, the Scarlet Provider wishes pills were available and believes pill administration could be done safely and describes,

> If they've [incarcerated women] been on oral contraceptive pills, those are ones that we do a pill count on every single day and that can be something that if there's a concern that someone else will have access to the pills, it can be done under direct supervision and then it will be safe that just that patient will be getting the birth control.

Pills are not available in the Red Jail for contraceptive use, but could be available for noncontraceptive use. Red Provider states,

> There's no chance of them getting pregnant while they're in jail, hopefully, but I think if they had a reason—I tell you, the only time I've seen that, and there's probably been a handful of those, is when they have ObGyn problems that deem the birth control to be medically necessary.

The patch and ring. Four of the facilities have the patch available for women to continue (Green, Pine, Sage, Yellow). Only the Green Jail has the ring available for

women to continue. The Pine and Sage providers were not sure if the ring was available in their facilities. In the facilities where patches or rings are not available, but pills are, a woman can be switched to a pill during her jail stay if she desires. The Pear Provider explains why patches and rings are not available in the Pear Jail,

> For security reasons, we've been asked not to start using the rings and the patches on a regular basis prior to release, but we make it easy for them [incarcerated women] to go pick up a prescription with only a 20- to 30-minute wait within the first 10 days of release from incarceration.

Although no contraceptive methods are available in the Scarlet Jail, the Scarlet Provider explains why contraceptive rings may not ever be allowed in the jail,

> I must follow the protocols for the jail. They discourage greatly people having medications prescribed to them that they have to put into orifices that aren't necessary, i.e., using a ring in the jail might not be the best option because they could put something else up there while someone's [not] watching. Anyway, it's just a bit more complicated in the jail.

In the facilities where patches are available, a nurse puts on or supervises the placement of the patch.

The shot. Six of the facilities have the shot available for women to continue (Green, Pine, Sage, Pear, Yellow, Canary). In all cases the shots are done on schedule and administered by a nurse. In some cases, women are taken for their word about when their next shot is due. In other cases, the jail health care provider will verify the shot schedule with the clinic where the woman got her most recent shot. In the Pear Jail, women can receive their shot 1 week early if they are scheduled to be released from jail. The Pear Provider explains,

> If they know they're coming in for a short time, and they're due within a week we'll give it to them. If they're not due for another month, and they're leaving in two days I won't give it to them a month early. I'll give them the referral to the family planning clinic that's part of [the County system].

In the Yellow Jail, in the case a woman wants an IUD or implant, the provider can give her a shot if she is interested as a contraceptive "bridge" to help her avoid an unintended pregnancy until she can see a provider in the community for an IUD or implant.

The Scarlet Provider says that in very rare circumstances she has given a woman a shot for noncontraceptive reasons, but explains, "We've given out a couple of Depo shots before, but it's mainly been for, like I said, you have a much better chance if you're mentally unstable and having a bleeding problem."

Similarities and Differences in Contraceptive Need

Assessment and Counseling

Three facilities had procedures for assessing all women's contraceptive needs within the first 10 days of incarceration (Green, Pine, Pear). These procedures took place at different time points. In the Pine Jail, women's contraceptive need is assessed at intake and she is referred to an on-site reproductive health clinic if she wants to initiate a method. In the Green Jail, all newly incarcerated women are seen by a health educator during their 1st week in the facility and their contraceptive needs are assessed and they are referred to an ObGyn on site to initiate a method. In the Pear Jail, all newly incarcerated women have a women's health appointment within 10 days of incarceration where their contraceptive needs are assessed. If they want to initiate a method they are referred to the family planning clinic.

Four facilities provided contraceptive counseling if the request was patient-initiated (Sage, Yellow, Canary, Scarlet). The Red Jail does not provide any routine or patient-initiated contraceptive counseling. Women could request to see a provider to discuss contraceptive methods; however, as described in the following section, except for in the Sage Jail, initiation opportunities were limited or nonexistent. Sage Provider describes the education opportunities he provides for women in The Sage Jail,

> I teach a class [in jail] for ten women a week, it's about reproductive life planning. We go through preconception counseling and pregnancy preparedness as well as birth control options, and I do discuss there what the options are. There is definitely a lot of word of mouth that it's available, and a lot of women have started it and gotten even IUDs. I think that there is a

> general understanding that those things are available, but again, word of mouth doesn't get to everybody.

For women who are interested in initiating a contraceptive method, special consent protocols have been established in some of the facilities. The facilities with the most comprehensive contraceptive programs do a dual-consent process, where women are counseled on the family planning methods available to them and then have time (2 to 4 weeks) to consider which method they want before returning to the clinic for a second appointment where initiation of a method can happen. This protocol is established to ensure women learn about contraception in a patient-centered environment, have an opportunity to speak with their partners or other women about the methods, and reduce any chances of coercion. The Pear Provider describes the counseling and consent process for women in the Pear Jail,

> It's pretty much the standard Title 10 exhaustive thing. I mean the thing that's so interesting to me is that whereas Title 10 has this huge push nationally to have single visit to try to reduce barriers to access, so that you can come in, you can get counseling, you can choose your method, you can get your method in the same visit, that's the one way that we have really seriously differed. Which is, we find that it's much better for our women who often have low health literacy coming in, and who are often clean and sober for the first time, and are finally really thinking about themselves, if we're trying to do an empowerment approach to women's bodies, we wanna give them all the information about all the methods both in writing and verbally. We wanna let them then go and talk to anybody they wanna talk to, their mom, their friend on the tier, their partner, whoever. Then we'll bring them back at a separate visit for their method. Women change their minds a lot. They'll say, "I never wanna have that IUD thing. That sounds scary." Then they'll talk to three women on the tier who have an IUD, and they love it, and whatever. They say, "Wow, five years is great." They come back and say they want the IUD. We separate out exhaustive family planning education as part of all the Title X. Title X have all these forms you have to fill out. It's the most exhaustive reproductive history you've ever… asks [questions]… It's like most of them don't know what that is. Then it has to be explained. They're asked about everything to do with gyne, and breast and whatnot, and frankly if they wanna get pregnant. That's part of it too. We'll do fertility counseling. We'll do preconceptual counseling. If they say, "I really wanna get out of here and I wanna have a baby with this guy, whatever. It's not just about family planning. It's really reproductive health counseling on the broadest scale. We try to be as woman-centered about it as we can. It's both handouts, and it's verbal, and then it's an opportunity to communicate with whoever they want to communicate with. Then it's a return visit.

In the Pine Jail, the reproductive health clinic was established after a

qualitative research project produced results that helped inform the design. The Pine Provider explains,

> I think the goal of creating a separate clinic was really to be responsive to some of the barriers that women identified, which was things like lack of trust in the health care staff in a jail setting, as well as stigmatization. Several women expressed a concern that to continue to take birth control would imply that you were having sexual relations with correctional staff, or other staff in the facility.
>
> We really wanted to create a clinic that was patient-centered and sensitive to the context of where the care was being delivered. We found that the family medicine folks who had come to this population with intentionality were the best equipped to navigate the communication issues around counseling. …Even in the case of LARC, which is reversible, of course, we still, because of the sensitivities around consent and the history, we encourage, as much as possible, a two-stage consent, which really requires two visits and a separate discussion of the risks and benefits on separate days, as much as possible. We do leave some room for clinical judgment on that.

The providers with established contraceptive care programs understand the importance of thorough, comprehensive counseling and consenting. In the Scarlet Jail, where contraception is not available, the Scarlet Provider still describes the importance of two-stage consent, if they were able to implement a program,

> To be realistic, I think it's important that you would individually meet with these patients ahead of time before giving them an IUD or Nexplanon to let them know exactly what it is, let them think about it. I think it'd have to be a two-step process. I think that that would be appropriate, especially for a lot of them, these are concepts that—they're not used to definitives. Your life is nothing about definitives. It's just hard to process sometimes.

In the meantime, while the Scarlet Jail does not have a contraceptive program, Scarlet Provider counsels women on contraception during their clinic visits, "I do it all the time," she says, and describes her interactions with the women and how she counsels them to have someone make an appointment at Planned Parenthood for them for immediately after their release,

> What I let them know is Planned Parenthood is there to help you and they have all the most up-to-date information and they want to see you and you're safe there. I let them know that they are wonderful and they'll do everything that they can to help you and for people that have insurance, it's like you can have your—well, for people who have insurance and don't have insurance. I just go when you walk out of the jail and if you spend time in a room with a male, you can get pregnant, and I said that's pretty much how the planet goes around and usually they laugh at that and say, yeah, I know, I know,

> right? I also let them know—this is awful. Standing up in the shower having your period, you can still get pregnant, just so you know. There's something about standing up in the shower, they think they can't get pregnant. I go over that a lot and I do let them know that it's like if you indeed want to—if you are sincere about this, if you have a phone number that you can talk to someone, have them make that appointment, so that appointment is set for you before you leave.

Finally, the providers described incarcerated women as very vulnerable and in need of educational opportunities, and jail as a source for that. Contraceptive counseling is also seen as a tool for empowering women who may not have much information about reproductive health or have experience making health care decisions for themselves. The Pear Provider explains,

> I feel like access to contraceptive services is an open door for access to helping women make more empowered choices about their bodies and their reproductive lives. Even the concept of making a choice about a contraceptive method could really be a new concept for some of the woman that we care for. I feel like we have a real, unbelievable teachable moment opportunity with our incarcerated women. In many ways, I mean it's horrible to be locked up, but in many ways they have fewer day to day stresses on their life. The food's all coming. The laundry's coming, or they're helping with it. At the moment they don't have to be involved with child care. They might be worried about their kids. Don't get me wrong, but they're not having to deal with needing a sitter so they can go to their doctor's appointment. They can just come to see the doctor. We have this really profound opportunity to help women think about these issues for their life. Hopefully there's a little bit of a ripple affect so that they can continue that when they get out of here.

The Scarlet Provider describes how several women she cares for lack basic life skills,

> I think it would be really great. This is actually really key, I think, and I go back to the birth control. I have had probably like four [pregnant] women that I've just had this painful, painful interview with them 'cause they'll be like well, how far along am I? "You're sixteen weeks." [Then the woman asks] "Well, how many months is that? How many weeks are in a month?" This is the honest to God truth. "How many weeks are in a month? I don't know. How many days are in a month? I really don't know." It's like okay, how many days in a week. There's so many of them that have just never thought in those concepts at all. This is a foreign concept to them. They've never been employed. They didn't have to finish school. They're just trying to survive on the streets—essentially no thought. Some people don't know how to tell time. They cannot function and get their children to function in school or make it to school when life is a foreign concept.

Similarities and Differences in Contraceptive Initiation

or Removal and Replacement

Six facilities had the pill available for initiation (Green, Pine, Sage, Pear, Yellow, Canary). Four facilities had the patch available for initiation (Green, Pine, Sage, Yellow). One facility had the ring available for initiation (Green). Six facilities had the shot available for initiation (Green, Pine, Sage, Pear, Yellow, Canary). Four facilities had the implant available for initiation (Green, Pine, Sage, Pear). Four facilities had the IUD and implant available for initiation (Green, Pine, Sage, Pear). In the Sage Jail, women were transported to a contracted hospital for IUD and implant insertion, because the Sage Jail did not have the devices on site. At the time of the interview, The Sage Jail was arranging to have IUDs and implants on site. In four facilities, women could not have an implant removed on site, and would only be transported for removal if it was deemed medically necessary (Yellow, Canary, Scarlet, Red). In three facilities, women could not have an IUD removed on site, and would be transported for removal if it was deemed medically necessary (Yellow, Canary, Red). The provider in the Scarlet Jail could remove an IUD but not replace it.

IUD and implant services. IUD and implant provision requires more training and logistics than other methods like the pill or shot. In the facilities providing IUDs and implants, the services are quite straight forward, provided by trained and experienced nurse practitioners, PA's and physicians, with a patient-centered approach to counseling. The providers where IUDs and implants are available did not mention many clinical barriers beyond the initial stage of making the space one where IUDs and implants could be inserted or removed and training people on the flow of the IUD and implant visits. In the Sage Jail, the providers arrange for women to be transported to the contracted hospital for IUD and implant insertions (IUDs and implants can be removed on site at the Sage Jail). The referral process is easy because the providers are integrated in both the jail system and the hospital system

and can expedite women's appointments. That said, as soon as IUDs and implants are stocked at the Sage Jail, all IUD and implant care will be provided on site.

In the three facilities where IUDs and implants are available on site, the providers report they are proud of the contraceptive programs and the staff of professional providers who are committed to women's health and providing great, women-centered care. Pear Provider gives an example of how they make sure women are offered exceptional contraceptive care in the Pear Jail,

> There's a particular day of the week that family planning is done in the women's division, but if a woman says, "I just got back from court. The judge is letting me out on Friday, and I really want my IUD before I leave." Which has happened. She would even ask the judge to hold her in jail so she can get her IUD before she got out. We're like, "Don't worry about it. We'll do a little one-on-one pop up family planning clinic, and call you in, and put your IUD in so you don't have to stay in jail an extra day."

The Pine Provider describes how jail can be an appropriate place for initiating IUDs and implants,

> When it comes to initiation, when done carefully and substantively, jail can be an opportunity for women to get long-acting reversible contraception as well. It's really up to the preferences of our patient population. We try to have the range of options available.

Among the providers who worked in facilities where IUDs and implants were not available, there were different attitudes about the appropriateness of jail as a setting where IUDs and implants should be provided. Two providers mentioned jail was not the best place for IUD and implant provision (Yellow, Canary). The Yellow Provider argued that there are more urgent health care needs for an incarcerated population and that the medically necessary needs make IUD and implant provision low on the priority list. The Yellow Provider believes the time it takes to counsel, consent, set up, and do an IUD or implant insertion is an opportunity cost for other, more pressing health care needs in the clinic, stating, "For the most part, placement of IUDs or contraceptive implants, it's not urgent. We just say, 'Look, we're gonna take care of the most important stuff first.'"

The Yellow Provider believes if a woman wants an IUD or implant inserted or removed, she will be better served by her primary care provider in the community.

> [Removing an IUD] It's really not a huge procedure. Where it gets to be clinically difficult, is, "Wait a minute? Why was the IUD placed? Why do you want it removed?" There's quite a bit of counseling that goes into it. Before you just reach in there and grab something, you wanna know, "Whoa, whoa, whoa. Why are we doing this? Why do you want this out? What's going on?"
>
> Is this something that it's appropriate to do in a jail setting? The last thing we want to do is overreact to someone's saying, "I just want this thing out of me," without engagement with them, and explaining, maybe clarifying. "Are these symptoms that you're having all the time, maybe it's not something that your symptoms are actually attributable to your IUD. Or maybe it is something that you would wanna talk about more with your primary care provider, before we decide to pull this out. Because if we do this, then you're going to—it's gonna be a missed opportunity if you get out and don't stay on some other method of birth control, to keep yourself from getting pregnant.

The Canary Provider states, "I don't think that correctional physicians or nurse practitioners working in corrections oughta be in the role of inserting IUDs or subcutaneous rods, or providing NuvaRings, et cetera, in jail for contraception."

Later in the interview, the Canary Provider mentions he has not had any training for IUDs and implants,

> I've had a couple of gals have come in who had a fairly recent placement of an IUD, and the strings needed to be trimmed, so occasionally I have to trim the retrieval strings that have been left too long. Even that's pretty rare. I have never removed an IUD in the county jail. It just hasn't come up, and the implants, having any of those removed is probably not the best context to do that. I think that'd be removed by the person who puts 'em in, they're gonna have them replaced. I have never placed one. It's not part of my training. Surgically, I could do it. I've done a lot of wound repairs and a lot of surgery. I can do it. I've just never trained on it.

The Scarlet Provider mentions she is trained on IUD and implant insertion and removal. She can remove IUDs in the Scarlet Jail, but not implants. She states,

> If I can see the strings, I can take the IUD out. I had one woman recently that I couldn't see the strings and she was quite frustrated with me. I'm like I'm sorry. We don't do any other extraction—we don't try to dilate it. We do not remove Nexplanon in the jail, even though it's not that difficult. It's considered a surgical procedure. That was something that some unkind person did in Congress and because they did that, I am not allowed to do that, as far as I know, in the jail.

The Scarlet Provider wants to be able to provide IUDs and implants to her

incarcerated patients and says the women are very interested in IUDs and implants, "…Long-acting reversible contraceptive agents, so many patients ask for them, I think that that would be appropriate since there's such a desire for them to have those available."

In the Red Jail, contraceptive methods are not available, but the Red Provider mentions that he and the other nurses would be interested in getting training so they could provide IUD and implants in jail. He states,

> That would be great [having IUDs and implants available] because then you have it put in and forget about it for the most part. I don't believe any of us have any [training]—as far as I know, knowing the backgrounds that all the nurses have come from, I would say no. Honestly, I don't think it would—if it's as simple as reading up on it and maybe taking a class that certifies you to do that. We're always looking for new and interesting training. I don't think it would be a huge stretch to obtain that.

IUDs and implants can be and are being inserted, removed, and replaced in jail settings across the county. Half of the facilities in this study have established protocols that make for standardized, safe, efficient, patient-centered clinic visits for counseling and initiation or removal of IUDs and implants. Half of the facilities do not have established IUD and implant provision, and cite reasons that are barriers to implementing a program, but not insurmountable barriers, as they are obstacles that the Green, Pine, Sage and Pear Jails had to overcome to establish their contraceptive programs.

Similarities and Differences in Establishing a Contraceptive Program

Four facilities have established contraceptive care programs with IUD and implant availability that began between 2003 and 2015 (Green, Pine, Sage, Pear). The Green Jail's program began in 2003; the Sage Jail's program is estimated to have begun in 2013; the Pine Jail's program began in 2014; and the Pear Jail's program began in 2015. All four providers credit a "champion" or "pioneer" with advocating for and creating the contraceptive programs in their facilities and

supportive Medical Directors and team members. In the case of these four facilities with the most comprehensive programs, the providers I interviewed were integral to the implementation or expansion of the contraceptive care in the facilities in which they work.

People in the Right Places

The Pear Provider initiated the contraceptive program in the Pear Jail. She describes her experience,

> I mean, this is how things work in the best of circumstances. I go to a conference, hear these really passionate talks. I get really charged up. I come back here, we talk to the family planning people at [the county clinic]. At first they were very unsure. I bring them over. Get them on a tier with a bunch of women who are very articulate, and say, "I really want an IUD." The family planning guru at [the county clinic] gets the bug, like, "Oh my God. These women really need us." She comes out and says, "We're gonna make this happen." We have a few little false starts with the state, and eventually convince them to just make us a satellite of the Title X grant. We have to convince the Title X people, and all that just took a little while to work out. I do think it was April of 2015. That has to be right. Yeah. It's almost two years.
>
> I mean, we're a team. It was a team effort. I feel like I lit the flame, and then a bunch of people, to extend the slightly corny analogy, kept the bellows going to keep the fire burning, and threw more logs on to keep it. My colleague who—I mean I was the brains, and she was really the brawn, because she did all the paperwork, recreated all the Title X forms, did all the training. We wrote the consent so there wouldn't be any suggestion of sterilization abuse. Which is the only main piece that Title X consent we had to modify for use within an incarcerated setting. Then, I don't even do the care anymore. I did it for a long time. Now she and another PA are the main contraceptive providers. Yeah. I will take some credit, but I could never have done it if it wasn't for Gretchen. She's now the Family Planning Clinic Director for [the jail clinics].
>
> [Also] I would say it was a supremely supportive medical director who believed in us being an advocate for our patients, and once we convinced her that this was something that needed to happen, she gave her blessing to make sure it meant pulling a provider from another clinic in order for them to staff the family planning clinic once a week or whatever. I feel like it was a health system that was amazingly supportive. Not just the people within the health system, but also the fact that the County had this very well established Title X grant that's been going on for decades. We were able to—if they were newbies and Title X didn't know them, then that would've been much harder. I had supportive city reps who were encouraging of the state being supportive of this. I had two state representatives that I'd worked with on other health-related initiatives who were giving us their support as well. Politically, it wasn't really legislative, but politically we had support. Yeah. I think it was

mostly the people, but people in the right places.

I asked each provider "Was any person, or organization in particular, responsible for implementing it [the contraceptive program]?" The Green Provider responded with a laugh, "Me. Myself and the Department of Health."

The Pine Jail's contraceptive program was pioneered by someone other than the Pine Provider, but the Pine Provider was integral in helping on an administrative level as a medical leader for the facility. He explains,

> It was pioneered by the family medicine doctor who was passionate about this work, and supported by myself and a general team of people who believe that this is important work. We gave her the tools to basically launch the program and troubleshoot the barriers as we went. Things like supplies and what kind of resources does she need, and what's the workflow around scheduling and all those things.
>
> The champion was the doctor who pioneered it. Again, that was not her original intention, coming to work and reaching out to us. Aggressive recruiting, from my own perspective, is important. Those are the key elements. I think you definitely need a champion to do the work on the ground, and a supportive medical leadership to really give that champion the resources to troubleshoot any barriers as the program gets up and running.

The Sage Provider had only been working in the Sage Jail for 1.5 years, but postulates about how the contraceptive program came to be, and identifies a specific organization and people who have been responsible for the implementation of contraceptive care in the Sage Jail,

> Having gone to the pharmacy meeting, it seems like somebody probably decided to have the initiative to go in and question and then follow through. It doesn't seem like there is a very rigorous or bureaucratic process in this, so that's surprising. It will be up to DHS [the County Department of Health Services] and their commission on women's health in jail to spearhead that and make sure that all of that's happening. Our nurse manager. She has always been very supportive and willing to help train the nurses and get things on board. My predecessor, Dr. Hess, was one of the first School of Medicine doctors who came in. She's really responsible for, I don't know if necessarily getting more contraception accessible to the inmates, but certainly making sure abortion was accessible to them.

As mentioned earlier, the Sage Provider requested IUD and implant devices be available on site so that women could have the methods inserted at the jail and not have to be transported to the hospital for those procedures. The request was

approved and IUDs and implants will soon be stocked at the Sage Jail.

Getting Facility-Wide Support

The providers also mention the importance of getting support from all the people who work with women in the jail, especially the security authority. It is imperative that the correctional officers understand that the family planning clinic helps reduce the number of women who are returning to jail with an unintended pregnancy. The Green Provider explains,

> I would say speak with security. Make sure that they understand the reason for its importance. That it goes beyond touchy feely health care. That it really can––preventing unplanned pregnancies can make security, the loads––the security staff a lot easier. Cuz it's pretty stressful to have a pregnant woman incarcerated, nobody wants that. If we can help only––just have women who are planning and want pregnancies. That is helpful to everyone. I think what happened with ours, is eventually everybody knew about it. People felt good about it, so then security, everybody would say, "Hey, we've got these services available. Why don't you access them?"

The Sage Provider echoed the sentiments of the Green Provider, stating,

> I think all jails are set up in such different ways where there's these columns of bureaucracy that don't necessarily talk to each other, so it's very important that you go up each hierarchy, whether it's the physicians, the nurses, the custody. You have to make sure everybody's on board if there's gonna be a big change and see what everybody's investment in that's gonna be. It may be as simple as custody has to bring down more patients if they're getting Depo shots, or they have to transport people to get LARC methods. That's gonna be a burden on them, so it's really important that everybody's on board.
>
> I think when you're presenting it to a bureaucracy, you got to present it as a cost-effective method, which is sometimes difficult for something like an IUD that has such high up-front cost, but when we look at recidivism of 75 percent amongst the jail population, understand that these women, if they don't leave with the contraception that they require, they may come back to jail with a pregnancy, which is certainly more expensive than any contraceptive method, no matter how they determine to end that pregnancy.
>
> That kind of bottom-line stuff is, I feel, what drives people who don't necessarily have medical acumen to say that birth control should be freely accessible to women who are incarcerated. Those people who deal with the budget and the bottom line there who have to take care of pregnant women as members of custody, whether it's a deputy or the staff that are there in the jail, they'll understand that reducing pregnancy in jail benefits everybody.

For a contraceptive program to be implemented, the providers highlighted the

importance of champions, a patient-centered team, and a supportive security staff. However, the most important people who are necessary for a successful contraceptive program are the women incarcerated in the facility.

Trust Must Be Formed Between Patient and Provider

The providers described the importance of establishing trust with the patients who may, rightfully so, be skeptical of health care provision and providers in jail. The most important aspect of providing contraceptive care is ensuring patients know that continuing or initiating contraception is available, free, and completely voluntary. The Green Provider states,

> The other really important thing I always forget, cuz it seems so obvious, is to make sure everything is voluntary, and everybody knows that all services are voluntary. If anything, if somebody's questioning it all, we do not switch people in any direction. I was there as a medical provider, and a state employee, so I think there's a long period of developing trust. Which is clearly important, developing trust. There's some people where they've got good health care on the other side. They don't need to get it here, and that's fine. They can follow up in the community, but other people, they think it is so very convenient, and great that they can get things taken care of while they're incarcerated… Yeah, so again, if they don't want it, we're always like, "You can change your mind at any time. You can let us know." There's no pressure.

Another important aspect of forming trust with the patient and making it a woman-centered health experience is facilitating comprehensive counseling and dual-point consenting, allowing women to learn about the methods and then giving them time to consider the method and speak with people in their lives that they want involved in the decision. The Sage Provider states,

> They're inmates. It is so reasonable that they have a healthy skepticism of the care that they get in jail. To overcome that is something that requires trust between all of the medical staff and the inmates. To initiate a robust contraceptive program, you have to have inmate buy-in, and that requires outreach. It's a community, and to just assume that if you're providing something that somebody needs or that they're—that we have data showing that they want, to just provide it is not enough. You really have to do outreach and education beyond what's [happening] in the clinic.
>
> I think that there's a pretty good relationship between at least us doctors and the women there. They really seem to appreciate the care that

> we provide them, and they really like the fact that we're doctors. We're taking the time, and it doesn't seem like we're at the end of our rope, taking care of them. To be able to provide continuity of care for these women is unfortunate because that means that they're in jail for a long time, but it really does, I think, help them through their medical issues as well as provide some semblance of normalcy when they're going through a pregnancy or a pregnancy loss or an abnormal Pap smear or something like that.

The Pear Provider echoes the importance of doctors who have good rapport with the women,

> Our providers are pretty—there's a pretty high trust of women in our family planning and women's health, and reproductive health providers in the jail. They're very stable. They've been here a long time. The talk on the tier is that, "Doctor Lake is a really good doctor. Doctor Rodriguez is a really good doctor."

As is the case in most jails, many women are released from jail within 72 hours. In these facilities, women who have very short stays in jail can continue their contraceptive methods, but the providers at the Green, Pear, Pine and Sage jails mention that their contraceptive initiation programs are generally utilized by women who are incarcerated for longer than 1 to 2 weeks. Women who are in and out of jail in less than 2 weeks may not have the opportunity to initiate contraception during their short stay in these facilities. The Pear Provider describes the circumstances that a woman would not receive the comprehensive contraceptive services available at the jail, and why she is comfortable with the current timeline,

> Don't forget. It's still at the jail. It's very short term. We're missing the people that are in and out in 72 hours. We're not offering them family planning services. We're probably missing the people that are in and out in a week, or ten days. I don't know that I think that's bad. I don't know, I mean to give them the education would be great, but I don't know that it would be a goal of mine to have people get family planning services within 72 hours of coming into the jail. I'd vote against that, because I would think that those women, they're not even clean yet. They haven't detoxed. They're not necessarily thinkin' straight. They haven't settled down. I would be worried about that.

The four facilities with established contraceptive programs all described well-trained physicians, physician assistants and nurse practitioners who inserted IUDs and implants as well as removed them and removed and replaced devices. They described the clinic settings where they provided IUD and implant services—typically

setting aside one clinical room where the procedures could take place 1 to 2 days a week. The facilities with contraceptive programs have staff and clinic space to run the contraceptive clinics as well as secured funding to cover the costs of IUDs and implants. Not surprisingly, the providers at facilities where IUDs and implants were not available cited a lack of trained staff, a lack of space, and a lack of funding as barriers to implementing a contraceptive care program. Funding may be the biggest obstacle for facilities in providing contraceptive care.

Similarities and Differences in How the Contraceptive Program Is Funded

Jail health care expenses are covered by taxpayer dollars. Whether the budget is managed by a county health department or an independently contracted company, the funds come from city, county, or state resident taxes. There are set budgets that the jails must provide all health care within. IUDs and implants have expensive upfront costs and may be seen as cost-prohibitive. In the case of purchasing IUDs and implant devices, two facilities specifically use Title X funding (Green, Pear). Title X is a federal grant program for family planning services. The Pine and Sage jails pay for IUDs and implants through the same budget that covers all other health care for the facility.

The providers in facilities with comprehensive contraceptive care programs stress the importance of making sure women do not have to pay for care. The Green, Pine, Sage, and Pear Providers argue that all medical services related to contraceptive continuation and initiation should be covered by the facility's health care budget as to not make cost a barrier for women who need and want to access care. The Sage Provider states,

> The experience that I have in the jail is that the Sheriff's Department covers the cost of all medical care. The women's insurance companies aren't tapped for that. I certainly don't think that the cost should be put upon the women who are entering the jail system because that would be a huge deterrent towards accessing care or accessing birth control.

The Pear Provider states,

> Medical care in our facility does not cost our patients. Our patients are part of the county health system. The county budget covers all of the services provided while they're incarcerated which includes all of the family planning services that we offer.

The Pine Provider states,

> We feel strongly that they [costs] should be part of the obligations to provide health care that is incumbent upon any state actor who incarcerates a human being. They should be provided out of the same funds by which general care for conditions like hypertension, diabetes, HIV, and STDs would be provided. In this city that is funded by the locality, by the city entirely. There are no copays for other financial costs to our patients.

The Green Provider states,

> I think it [costs of contraception] should be covered through the community. Not necessarily through a department of corrections. The actual cost of the birth control, I don't really feel strongly one way or the other, who's paying for it. We all end up paying for it in the end.

Women do not incur any costs for their contraceptive care in six of the eight jails (Green, Pine, Sage, Pear, Yellow, Red). Women are charged copays for contraception in The Canary Jail. Canary Provider expresses,

> The county also charges people a nominal fee for my services and for their prescription. I think a prescription is $10. Women of lesser—unless they can show themselves to be poor to the point that they have no money on the books, and they're basically—I'm forgetting the word right now, but they have to be—anyway, they have to have a $10 copay for birth control pill or shot, which is a relatively nominal expense for the medication.

The Pear Provider knows that the contraceptive program is budget neutral for the Pear Jail, but the Title X funds make it possible to supply women with IUDs and implants. The Pear Provider does not think she could continue providing women with IUDs and implants if she lost Title X funding,

> The fact that we were able to make it budget neutral to the County. I mean, I don't think I could've gotten it through if I had to pay, even whatever the Title X price, or I mean the 340B pricing for IUDs is like hundreds of dollars an IUD. I mean, there's no way I would have been able to pay for that… I am extremely proud of contraceptive health care capabilities of this facility. I believe it's my legacy to this place that I certainly hope this goes on, and I'm fearful that threats to Title X may have trickle down to an impact on our very vulnerable patients.

The Green Jail's contraceptive program is also funded by Title X, but the

Green Provider did not express the same concerns as Pear Provider in regards to the potential threats to Title X making the Green Jail's program unsustainable, the Green Provider said, "I think it's been in place for so long now, that I guess it's dependent on the Title X funds."

The Green Provider may feel more confident in the durability of the Green Jail's program since it has been in place for a decade longer than the Pear Jail's relatively new program.

The Pine and Sage providers report the contraceptive care is covered through the health care budget and does not rely on Title X. For the Pine Jail, some less cost-effective services were cut so the budget could go towards the contraceptive care. They mention the departments and communities that support the health care budget for these facilities are innovative and will make sure good programs, like reproductive health programs, have the funding to continue. The Pine Provider states,

> I think the independence of the health authority certainly helps something like this, because really, what's the right thing to do for patient care is a more important question than how much you cost. I had to move some resources around from other specialty services that we had identified that were not as effective as we had wanted them to be. Some budgetary savvy could know where to fund things from is still helpful.
>
> I think the advocacy community in the city is helpful. There are a lot of people who are interested in their patient population and care about what happens to them when they're incarcerated, which is not necessarily the norm around the country. We are sometimes called to task in public hearings where people will ask questions about reproductive health in a public forum. To have a good program that we're proud of is good for us in that setting. It helps us get support from the city if we need funding.

Funding a contraceptive program is a major concern for providers who work in facilities without comprehensive contraceptive care programs with IUDs and implants. Not only funding the devices, but funding the staff, health care providers and correctional officers, that would be required to run the clinic. The Canary Provider expresses,

> The only barrier I see is the county's budget, and the number of female

> officers is very limited. I deliberately recruited Nancy—just so that I could have a female nurse instead of two male nurses that do gynecologic exams and breast exams with appropriate supervision and participation, and also had to find ways to cover over the single window in the door for privacy issues. We have the capability of doing basic female genital exams and breast exams, but I think it would take staffing on the part of the county jail, the sheriff's office, to hire more female correctional officers to transition these patients to the appropriate office to obtain this care while they're in custody, or partnering with somebody like Ms. Sorenson [a nurse practitioner in the community] to come to the county jail clinic and get her comfortable with using that space to initiate an IUD.

In the Red Jail, where contraception is not provided because, "There's no chance of them getting pregnant while they're in jail, hopefully," the Red Provider states,

> I would say that if it [a contraceptive program] could be implemented, it would most likely be just implemented based on the availability and cost. I think the administrators, whatever's good for the patient that we can afford to provide is always a good thing.

The Scarlet Provider, who wants to provide contraceptive care but cannot due to Facility restrictions discusses how providing women with contraception would not be as expensive as people may think and could potentially save money. When I asked her how she believed contraceptive costs in the jail should be covered she stated,

> That's a great question and that's the problem, I think, with contraception. The entire planet will benefit from it, but the direct cost goes strictly to the county jail, and that's the whole problem, I think, with a lot of it. As far as the costs go, I think it can just be in their budget. I don't think it's something that would break the budget, per se, and I think that there's so many unbelievably expensive medications that we give as well, I think that from a cost standpoint, this might be a little bit less expensive than people think it is. It's from the county's budget that it comes out of, but the county will also have less unwanted babies in the newborn ICU because the moms try to abort them with doing more drugs. Sorry I'm getting graphic, but it's so true. Every single day, someone tries to abort these babies by doing more drugs when they find that they're pregnant and these babies have a lot of problems when they're born. I think in the long term, I think that the cost for these will outweigh the upfront cost.

I asked the Scarlet Provider to estimate how much money she thinks it would cost to implement a contraceptive program in the Scarlet Jail, to which she responded,

> I don't even know, but I bet that if you put the word out nationwide, we need another philanthropist 'cause I think a philanthropist donated like a gazillion IUD's to a whole bunch of places around the country as long as they were teaching someone else how to put an IUD in, but I bet that—I really think that there would be people who would donate services. I think if doctors would donate their services and time, I think that may cut the budget, but I bet if you had to do everything paying for everything, it would be a lot. It'd probably be—I don't know, $50,000, $60,000 'cause you have to pay for a vehicle to officers to bring 'em up to the university whereas if we had people that could bring IUD's and have an IUD clinic once a month, I don't think that would cost much at all. I guess it all depends on if we could do it in-house versus having to send them up to the hospital.

The Yellow Provider mentioned that funding is a part of every decision he has to make about the health care that is provided in the Yellow Jail,

> Funding is a part of every decision, right? You have to make a—anytime I wanna hire a new provider, "Can we afford it? How much FTE stuff can we absorb?" "If we have to go up on this provider type, where else can we cut costs to stay in budget?" We have a budget. We can't exceed that. It's a part of every single decision.

The four facilities with comprehensive contraceptive programs and IUD and implant provision had to overcome the barriers that the providers of the other facilities list. Hiring or partnering with providers who can insert and remove IUDs and implants is an expenditure, making sure there are security staff to transport women to the jail clinic or off-site clinic is an expenditure, having a space on site to provide care is an expenditure, and funding contraceptive methods, including the more expensive IUDs and implants, is an expenditure. All these expenditures, however, were deemed necessary by facilities that determined helping women prevent unintended pregnancies is a worthwhile expenditure.

Sterilization Access for Women

During the beginning of the interview, I asked each provider "In your professional opinion, should incarcerated women have access to sterilization while they are in custody?" I also asked each provider if they knew of any sterilization restrictions for their facility or state. I asked each provider if sterilization was

available for women in the facility on an elective basis and on a postpartum basis. I also asked each provider if a jail health care provider in their facility could consent an incarcerated woman for a sterilization procedure. I did not ask each provider if sterilization education or counseling was available in their facility, but the topic of sterilization education did come up in some of the interviews. First, I will present the excerpts that the providers shared regarding their professional opinions toward sterilization being accessible for incarcerated women. Second I will present findings regarding sterilization availability in the facilities and describe similarities and differences between the facilities.

"In your professional opinion, should incarcerated women have access to sterilization while they are in custody?"

Five providers specifically mentioned the history of sterilization abuse and their concerns about coercion and power differentials that could create problematic circumstances for women's decision-making abilities while they are incarcerated. A few providers believed that IUDs and implants would be a more appropriate contraceptive method for incarcerated women to receive immediately postpartum than sterilization. The providers who were most resistant to supporting sterilization access for incarcerated women also acknowledged that a blanket prohibition is not ideal, as there may be rare cases where sterilization is the only method an incarcerated woman wants and the procedure may be in her best interest. Two providers specifically mentioned that sterilization should be available for incarcerated women who want it, but are concerned with how the procedure should be funded, believing the cost should not fall on the jail.

> I would hesitate about nonreversible birth control methods. I don't feel like that's a definite should not be available, but I think only available with special protections. Maybe a committee, extra evaluations. I think there would be the rare case. I did have a situation once where a woman was having surgery for another reason, and wanted a tubal ligation at the same time, so there's a risk if you have two surgical procedures as opposed to one. I think it would be very rare. I would want it to be rare, but I wouldn't want to rule it out 100

percent… Again, I think it's something that should be limited if somebody felt very strongly, had expressed the desire for irreversible, something I'd try and avoid completely. I think there are the rare circumstances where it could be appropriate. (Green Provider)

I think our focus has been to—our focus has been on long-acting reversible contraception because we—even in the case of long-acting reversible contraception, we recognize that there are complexities around consent, which need to be taken into consideration. There's also a really unfortunate history of human rights abuse of incarcerated women that should be considered when making that.

In general, I would recommend against any woman who wanted to pursue sterilization, irreversible sterilization while incarcerated. By the same token, I'm reluctant to take any potential treatment modality off the table for a patient, solely because they are incarcerated. I think my answer is a qualified no, it should generally not be available, but with the understanding that every patient care decision should be taken on case-by-case basis. There may be extraordinary circumstances, where those issues of consent and coercion were very clearly discussed and documented. Where I might feel comfortable pursuing that, but as a general rule, no.

[In the case of an incarcerated pregnant woman delivering outside of the jail] Yeah, I mean I think that would be the case-by-case. I would want even the outside provider to understand the complexities of decision-making in an incarcerated person. I would want there to be a longitudinal relationship. If it was just in the context of labor and delivery, my concern would be that maybe they have not had a relationship to make sure that decision to pursue that is durable over time. (Pine Provider)

This is such a tough one. I guess in my professional opinion, no, but sometimes in my professional opinion, yes, because I have met a lot of women who have had such trauma related to pregnancy that the only thing they want is to have their fertility taken away, [but] might not be able to do that because in California, it's not legal. That said, there are so many—there's such an imbalance of power differential between the people who provide care and the patients when the patient is incarcerated that true consent for sterilization, I see that as a difficult thing to obtain. Considering that we have other options that are as effective and long-lasting, it's not like we're providing them with no alternatives. That's where I usually land. My opinion on that is not fully formed. (Sage Provider)

Yes. I mean, I would say they should have access to all methods, yes. Obviously with the shadow of sterilization abuse of women of color I think there are additional consent concerns that come into play with women who would be undergoing a sterilization procedure at the hospital while they were still an incarcerated person here in the jail. (Pear Provider)

"Yeah. Access to care, in general, is inclusive of all of that" (Yellow Provider).

I really think that the county should not be on the hook for that. Financially for it. It should be available, but I think that I would push for some kind of qualification for them to be rapidly placed on Medicaid and have their procedure performed under some other financial obligation than the county for that. (Canary Provider)

> Yes. Other jails—I think the San Francisco county jail at least used to do that and if someone wanted it or at least they had a IUD, but I believe that if you gave them counseling and had them come back one more time, gave them information, and then have them come back for another meeting, and if they wanna be sterilized, I think that that would be a great option and I don't know if you want—if this helps to have as your answer, but I had a woman with dysfunctional uterine bleeding who was HIV positive and we couldn't get an IUD in her. She just bled and bled and bled, and we just could not get—we had her at the OB/GYN Department at the U. We were gonna do an ablation. This was just not good. I was the one that was working on the project… Yes, and a lot of [incarcerated women] would like that [sterilization]. They have expressed an interest in it. (Scarlet Provider)

> Well, now that is a slippery slope. I would say yes. If that's something that they choose to do and it can be funded, I have no problem with that. The reason that it's a slippery slope is because of the history of women being sterilized or mentally ill people being sterilized through, I guess, what would be considered eugenics. That's where people are kind of like, oh, I don't know about all that. I mean, if it's a personal choice and that can be addressed, I personally don't have a problem with that… As long as it's initiated by the patient. The request where it would not be appropriate is we see a lot of mental illness, and it would have to be somebody who is deemed competent to make that decision. When you get into mental health, you wanna make sure that it's the patient's choice and that nothing's being forced upon that person. (Red Provider)

Sterilization Prohibited in the State

In addition to the providers' attitudes, I collected information about sterilization availability in the facilities. Specifically, I asked if they knew of any laws in the state that prohibited sterilization of an incarcerated woman, if jail health care staff could do the sterilization consent process with an incarcerated woman, and if an incarcerated woman could get be sterilized electively, or postpartum (see Table 22).

The Sage Jail is the only one of the eight facilities where it is illegal to consent and sterilize an incarcerated woman (unless the procedure would be considered life-saving). I asked the Sage Provider how he felt about this prohibition and he expressed,

> Anything that's blanket, I feel like, has the risk of missing out on the exceptions. I think we discussed this a little earlier. There have been abuses of power by physicians who have sterilized prisoners against their will in California in the last ten years, and so this law is a direct reaction to that. I think it may be an overenforcement. To me, opting for sterilization while in

> jail does seem like a treacherous—it seems like a difficult thing to fully comprehend while your autonomy is so limited, if you can really consent to that. Can you really consent to anything in jail? That's the question.
>
> Something like sterilization, which requires an additional level of forethought for an elective procedure that has lifelong consequences, I think that it's not appropriate for most women to be sterilized in prison. Again, if other options such as IUDs and implants, which have efficacy rates equal to or greater than sterilization, are available, then I think we're not doing a disservice to them by not allowing—not providing that care.

I asked the Sage Provider what he thought about other states passing a blanket prohibition of sterilization for incarcerated women and he stated,

> I would think that California would be a place that would be more progressive and more aware and on top of taking care of its prisoners, and considering that it happened here, and I imagine that it happens in other places, and it could happen in other places. Again, I don't know exactly how I feel about it. I feel like once you have a blanket restriction, you're gonna find an exception that makes the restriction seem overly restrictive. I think it's fine right now, considering—I think it's much better that women are not able to get sterilized than women are getting sterilized against their will. On the matter of autonomy, I feel like this ranks much lower than unconsented sterilization.

Sterilization Consent in Jail

Only one facility, the Pear Jail, had sterilization officially available for women in custody, either elective or postpartum. The health care staff at the jail can initiate the consent process. The health care in the jail is provided by the County Health and Hospital system, so women in the jail are considered patients of the County system. The elective and postpartum sterilization procedures are done at the County Hospital. The Pear Jail adheres to a 30-day waiting period between consent and the procedure. She explains,

> Yes. We have the forms, the State Department of Public Aid forms and all that. Yeah… If they’re not in jail for 30 days we can initiate the consent here, but if they [are pregnant and] deliver in under 30 days, then the hospital staff will not be able to perform the sterilization, cuz, again, they need to give them the time to change their minds and all that. We’re the same staff as the hospital. I mean, we all work for the County Health and Hospital System.

Out of the eight facilities, the Pear Jail is the only facility where a nonpregnant incarcerated woman can have an elective sterilization procedure solely

for contraceptive purposes, not needing a noncontraceptive, medically necessary or life-saving reason.

Postpartum Sterilization

The Sage Jail is the only facility where postpartum sterilization was absolutely not available for incarcerated women, due to state law. In the other seven facilities, there were nuances surrounding the availability of sterilization for pregnant women who would be giving birth at a contracted hospital while they were incarcerated. As mentioned above, only the Pear Jail could initiate the sterilization consent process in jail. The other six facilities knew or believed women could be sterilized at the hospital postpartum, but the consent process was under the authority of the hospital, not the jail.

The Canary Provider said that, "yes," an incarcerated woman could be sterilized postpartum, but the counseling and consent, he says, "I guess I would leave that to the surgeon who would be doing the procedure."

I asked the Pine Provider if a pregnant woman who was incarcerated at Pine Jail could be sterilized immediately postpartum, he responded,

> I think so. The actual delivery happens at our community partner. I suppose they would offer their standard range of options in that setting… We probably find out about it, because, as part of our return paperwork, but we wouldn't be involved in the decision-making in that example.

Women incarcerated at the Green Jail can be sterilized at the hospital, but the counseling and consent is not under the purview of the Green Jail: "I don't think there's a state law. They [the hospital] don't ask for preauthorization, so I know it has happened on more than one occasion."

Pregnant women at the Yellow Jail can be sterilized if they give birth at the partner hospital. The Yellow Provider states, "Yeah, that would be something that would be done, associated with the delivery, by the hospital staff, so they would

have to obtain the consent for the procedure from the patient."

Three providers specifically mention that it is not unusual for a pregnant woman to receive a sentence that corresponds with her due date, or be released from custody after delivering a baby, meaning, a judge will sentence the woman to jail until she goes into labor and delivers the baby at a contracted hospital in the community. She will be released from jail custody when she is released from the hospital. They were unsure about whether or not sterilizations were occurring at the hospital, because it was rare for them to have a woman return to jail immediately after giving birth.

The Canary Provider explains,

> In my context here, I have judges who… have actually threatened the jail commander and myself with contempt of court charges to release somebody they have sent to jail and will not stay in jail. In other environments, I think the jail commander and jail policy sort of trumps the wishes of the court, but not in this area. I think the judges see [pregnant] women being incarcerated, having two square meals a day, prenatal vitamins, fresh air and exercise as being superior to care for the infant, the fetus, as compared to being out in the community doing drugs. I can't help but agree with them, but I'm not prepared to deliver babies, and we have only very rarely had to do a vaginal exam on somebody for a miscarriage in jail. They usually get sent to the emergency room [if there is] evidence of a miscarriage. [Judges see jail] as the safest place for them, yeah, especially if they have a drug-related—which is the vast majority of them. We have women who come to term regularly in jail, and we send them to the hospital when they come into labor, their due date, whatever, and we have a verbal arrangement with all three of the doctors who deliver babies in town.

I asked the Canary Provider if he believed the judge would give a pregnant woman a longer sentence than a nonpregnant woman with the same charge. He responded,

> I couldn't answer that. You would have to ask a judge that. I would not be surprised that that would not be in the calculus of the judge in terms of "Hey, when's your due date? You've been using heroin or methamphetamine, expecting to have your baby." I would not be surprised to keep her longer in order to enforce care of the fetus and that line of thinking.

The Red Provider also recalled that pregnant women incarcerated who struggle with substance abuse were more likely to be held in custody until they gave

birth. When I asked if a pregnant woman could be sterilized postpartum, he said,

> Whoa, I don't think I've ever seen that come up where they have a tubal ligation at that time. I'm not sure. Generally, what happens is if somebody has a problem with substance abuse, the judge will order them held until the time of the delivery, at which time we would transport them to the hospital and then release them from custody. We've seen quite a bit of that, but I don't know if there's any kind of procedure that they would provide at that time if the patient requested it. I'm not sure so I can't really speak to that, unfortunately.

The Scarlet Provider also described how a due date could determine a pregnant woman's sentence and how a woman would need to ask for a tubal ligation when she goes to the hospital to deliver,

> Yeah, but I don't think they'd be coming back [after they deliver], so I think it's a different situation. What I say with my patients is I go, it is 100 percent your responsibility, and not the provider's, when you go in to see your doctor, every single time at the university, every single time, you need to bring up what you wanna do, your plans for when you're done. If you say it's an IUD every time, that's fine, but it takes some time to make sure the insurance forms are taken care of, if that's involved with it, and that there's time set aside for it. If you do wanna get your tubes tied—they're gonna be released as soon as they deliver. Some people have that for their sentence. You'll be released when you deliver, and if they do wanna get their tubes [tied], I go, it is your responsibility. It is so important that you speak to the doctor every time about that so that OR time is set aside for you and they've got the staff. I'm really emphatic about that with them.

I asked her if she had any concerns about for whom sterilization may not be a good option,

> Well, anybody who doesn't want it. I discuss these things. I can't say that I'm 100 percent, but I'm probably 99.5 percent with my patients when they come in and they're not pregnant, but they're concerned that they might be or with my patients who are pregnant, I just say what will you be using after you deliver or what are you gonna be using when you leave this jail now that you found out you're not pregnant, what will you be doing so that you don't get pregnant again. For most of them, there's an obvious sigh of relief that someone brought this up and they can discuss it with them. They don't always know what their options are or where they can get birth control, so there's a great need for a lot of them they just never had the opportunity to talk to someone about that.

Sterilization Education in Jail

Sterilization may come up during contraceptive counseling sessions as a birth control method. A few providers mentioned they would answer any questions women have about sterilization, but if the facility is not able to consent or authorize the procedure, there was not a lot of discussion about the level of education about or counseling for sterilization. Instead, providers answer patient-initiated questions.

The Sage Provider states, "I mention that it is a contraceptive option that is not currently available to them, but it would be something that may be available that they could pursue outside of jail."

The Scarlet Provider discussed how she counsels women on sterilization as a method if the women do not want to have any more children,

> I don't go into sterilization unless they ask about it. I let them—I'll say do you plan on having more children, this is your fifth child, and you are 23 years old, thank you very much. Are you having more children, and everything else, and some of them are like I don't want any more kids, so I do bring up with them that this is something if you want to, you need to bring it up to your provider at the University Hospital if you would like to get your tubes tied. I don't think this is covered by the jail at this time. However, we do have a lot of women that do get an IUD or Nexplanon implanted and they've seemed really happy with that, and it just seems like it's been a difficult procedure to get approved. That's how I put it. I don't try to push anything on someone, but I think it's my obligation to inform them that they can get pregnant again, which is fine. It's their choice, but it's important that we let them know that there are other options than getting pregnant again, especially if they don't feel like they're ready for that.

There is a consensus among most of the providers that IUDs and implants may be a more appropriate contraceptive method to give incarcerated women immediately postpartum than sterilization, and sterilization should be considered in a rare, case-by-case basis. The Scarlet Provider has attitudes that are most supportive of sterilization availability for incarcerated women.

Discussion

The jails in this study are diverse. Regionally they are located in the Northeast, the Northwest, the Southwest, and the Intermountain West. Most of the jails are located in urban settings. The jails with the most comprehensive contraceptive care are located in the Northeastern region of the United States, although future research would need to explore possibilities of regional differences using more jails. The daily jail populations range between 70 and 9,000 with female populations between 10 and 2,300. The most populous jails were also more likely to have comprehensive contraceptive care in this study. The jail populations are also racially diverse, with five providers mentioning a racial minority majority, and three jails with a White majority. The jails with majority White populations provided the least contraceptive care, which may be associated with their being located in what the providers called "conservative areas." Two of the three jails with majority White populations have health contracts with independent providers as opposed to a public health organization.

The jails house women for short-term stays. In most of the facilities, approximately half of the people who enter the jail are released within 72 hours, and while all the facilities house people with sentences of up to 1 year, or longer in rare cases, most women who are sentenced are released within 1 to 3 months. The short-term nature of jail came up in all the interviews and warrants thinking about the jail population in two different categories, those who are incarcerated for less than 1 week and those who are incarcerated for longer than 1 week. All the providers also reported issues with recidivism, the Red Jail provider stated recidivism rates as high as 80%. As previous research has shown, jail stays are typically short, but can be frequent.

The health care at the jails was either provided by a local city, county or state department of health, or by an independently contracted medical director. One major

commonality among the four facilities that provide comprehensive contraceptive care is that the health care services in the jail are provided by the local department of health or the state department of corrections—not by independently contracted medical directors. The four providers in these facilities explicitly state that a reason why their health care services are so innovative and patient-centered is because they are provided by a public health organization, not a for-profit health care contract. That said, the Yellow jail and the Red jail also have health care provided by a county health department and do not provide comprehensive contraceptive care to women in their care. The jails where health care is provided by an independently contracted health care provider, unaffiliated with a local health department, did not have innovative contraceptive care. In this study, a public health department was more likely to provide comprehensive contraceptive care with IUD and implant provision to women in jail than an independently contracted medical director.

All the providers described the overwhelming majority of their patient population as medically disadvantaged. The women housed in the eight facilities come from impoverished neighborhoods, have low levels of education and health literacy, and have numerous health issues, including substance abuse issues and mental health problems. Several of the providers understood that the health care many of these women receive in jail may be the only health care they receive; thus, they understand the importance of providing as many preventative services as possible, including family planning services.

There appear to be two different philosophical approaches to how these facilities and the people who work there provide care. One approach is about what is the bare, but necessary care incarcerated patients need—taking an approach that any elective, preventative care is outside of the scope of what is required of jail health care providers. The four facilities with little or no contraceptive care do not see themselves as potential primary care providers for these women, or if they do,

their care is restricted by time and money. They provide good, but basic care, more reactive than preventative. When it comes to contraception, these facilities and providers take the stance that women cannot get pregnant while they are incarcerated, thus preventing pregnancy is not a priority of the facility. These facilities are fully aware of the more complex care that a pregnant incarcerated woman requires, but they do not see it as an obligation of the jail to prevent pregnancies that occur outside of the jail setting even if the prenatal care and labor and delivery costs will fall on the jail for a recidivating woman.

There were several different protocols for screening a woman for emergency contraceptive need. Two jails explicitly screened for and offered emergency contraception. Six jails had emergency contraception available but did not assess women's need for it. Two of these jails are also jails with comprehensive contraceptive programs. One jail stopped screening for EC need. Future research is necessary to determine best practices for emergency contraception screening protocols.

Most of the providers discussed the importance of continuity of care. Jails should certainly ensure continuity of contraceptive care, by allowing women to continue using their birth control pills, patches, rings and shots on schedule. Incarcerated women can be given a pack of birth control pills to self-administer daily, or a nurse can administer pills on a dose-by-dose basis. None of the providers mentioned problematic situations with birth control pills. Patches can be put on by or in the presence of a nurse and rings can be given to the patient for self-administration. Only one provider mentioned vaginal contraceptive rings were available and she did not mention any negative situations or cause for concern for women using this method. Other facilities do not allow rings for women's use, and whether this decision was made before ever allowing rings is unknown. Future research is necessary to determine the feasibility and safety of having contraceptive

rings available for incarcerated women. The hormonal injection can be administered by a provider.

In this study, only two jails did not have emergency contraception or any hormonal methods (pill, patch, ring, shot) available for continuation. For one provider, she attributed this lack of care to a strained health care budget that does not prioritize contraceptive care. For another provider, he attributed the lack of contraceptive care to the perception that contraception is unnecessary in jail because women are not at risk of unintended pregnancy. Some providers may not have ever thought about how contraceptive care in jail can reduce a woman's risk of unintended pregnancy—which reduces the risk of a pregnant woman returning to jail. More outreach must be done to inform jail health care providers of the public health outcomes related to comprehensive contraceptive care in jail.

The facilities with universal contraceptive counseling can meet the contraceptive needs of more women than facilities with patient-initiated counseling sessions. Educational classes about contraception can be taught in an individual or group setting. If women are interested in learning more or initiating a method, they can request an appointment with a provider. Jails stays are short, and as I will mention below, two-stage counseling is important. Contraceptive education sessions should be offered to women shortly after they enter the jail (within 7–10 days) to meet the needs of as many women as possible.

Holistic family planning services are an important component of comprehensive contraceptive care. Women should be asked about their reproductive goals. If women want to become pregnant after release, jail is an opportunity for them to prepare for a healthy pregnancy through education, and initiating prenatal vitamins as well as learning about pregnancy and parenting resources available in the community. Women should also be counseled on contraceptive methods available to them, but their desires for pregnancy should be respected. Too often,

pregnant incarcerated women are shamed for being pregnant in jail. Women should be able to become pregnant when they want, and jail health care providers can help women prepare for pregnancy.

Jail is an appropriate place to initiate contraception when protocols are patient-centered and take into consideration the reproductive injustices that incarcerated women have faced. The 1st week of incarceration may not be an appropriate time to initiate contraceptive care. All the providers mentioned that an overwhelming majority of women who are incarcerated in their facilities struggle with substance abuse. Many women who are incarcerated are arrested for drug-related crimes, and it is common for women to enter jail under the influence of drugs or alcohol. In the first few days of incarceration, women may be detoxing off drugs. It is important that a woman is sober and thinking clearly during contraceptive counseling and initiation, thus delaying contraceptive services for at least 72 hours may be the most patient-centered approach.

Two-stage contraceptive counseling should be part of the family planning protocols. The nature of incarceration allows for women to receive contraceptive counseling and have time (weeks) to consider her contraceptive options before initiating a method. It is important to understand a woman's reproductive life goals, and if she wishes to avoid pregnancy, providers should engage in patient-centered contraceptive counseling (Dehlendorf et al., 2014). The time between appointments allows her to discuss the methods with anyone she chooses, including women she is housed with, or speaking with her partner on the phone or at visitation about the methods. A two-stage process also reduces the possibility of a woman feeling pressured into having an IUD or implant inserted.

In facilities where contraceptive care was available, providers were more likely to acknowledge the positive impact contraceptive care can have on women's lives than to mention the cost-savings related to providing care, while several

providers mentioned programs require funding, and that contraceptive programs can be budget-neutral and cost efficient, their focus for providing contraceptive care in jail was more patient-centered than budget-centered. This is a positive finding and encouraging that jail can be an appropriate setting for contraceptive care. Improving women's lives through helping them avoid unintended pregnancies should be the first objective.

In the jails where contraceptive services are available, even in the most populous jails, family planning services only required 1 to 2 days of clinical time to meet the needs of the women incarcerated there. The jail with the largest population transported women to the partner hospital clinics for IUD and implant insertions. There are numerous ways to provide contraceptive care to incarcerated women. Contraceptive care can be provided by an on-site provider or through partnerships with community hospitals, clinics with Title X funding, or schools of medicine. The providers need to be trusted by the patients and aware of the history of abuses incarcerated women have faced and skepticism women may have for health care provision in jail.

Funding and staff support is necessary for a successful program. Title X is a great source for funding a contraceptive program in jail. There are many Title X recipients across the country that a jail can become a partner with and jail health care providers should connect with Title X grantees in the state or county. Providers can seek information about Title X and program requirements on the website (HHS.gov/opa/title-x-family-planning/index.html; U.S. Department of Health & Human Services). For a durable solution, providers and administrators can seek legislative action to mandate contraceptive care in correctional facilities. Some counties appear to have deeper pockets and more supportive administrators than others when it comes to funding contraceptive programs. The providers with established contraceptive programs all mentioned the importance of having a

champion. The best contraceptive programs were implemented because of the work of motivated people who gained support, found funding either through Title X or local resources, and created protocols to provide woman-centered family planning services.

Lastly, sterilization is a complicated issue in the jail setting. All the providers were aware of sterilization abuses committed against incarcerated women and understood the importance of special precautions that must be taken to reduce the possibility of coercion. Most, but not all, of the providers believed sterilization should really only be available in rare cases, if absolutely necessary. A few providers thought sterilization should absolutely be available for incarcerated women; their hesitancies lay more in the scope of who would be funding the procedure. In one jail, women could ask for an elective sterilization, be consented in jail, and have the procedure done at the county hospital 30 days later. None of the other jails facilitated elective sterilizations. One jail was in a state where sterilization of an incarcerated woman is illegal. In the seven other jails, women could be sterilized immediately after delivering a baby. All pregnant women are transported to local hospitals to give birth. Once they are in the hospital their care is under the authority of the hospital staff not the jail. An incarcerated woman could be sterilized immediately postpartum, but all the counseling and consenting is done by the hospital. Frankly, understanding how jail health care providers feel about sterilization of incarcerated women is less important than understanding how hospital staff feel about sterilization of incarcerated women. This is an area for future research, especially because of the nuances of Medicaid and mandatory waiting periods being complicated for incarcerated women. The mandatory waiting period is set up to protect women and give them time to think about the permanent procedure. Medicaid coverage ceases once a person is in custody and the jail health care budget covers their medical costs. But there is a gray area for labor and delivery related

costs and protocols that needs to be explored. Incarcerated women are getting sterilized at hospitals after giving birth and we need to know more about the counseling and consent protocols that occur there.

This study shines some light on an underexplored area of health care for incarcerated women. Jails are incredibly diverse. The women incarcerated in U.S. jails are also diverse but still represent one of the most medically disadvantaged populations in the country. Incarcerated women's reproductive goals and needs are often overlooked in jails; however, I hope these findings show how important contraceptive care in jail can be. Unintended pregnancies can negatively impact individuals, communities and jails. Jails have an opportunity to reduce women's risk of unintended pregnancy and increase their chances for an improved life.

Figure 1. Map of Jail Locations

Table 19. Facility and Community Information

	Green Jail	Pine Jail	Sage Jail	Pear Jail	Yellow Jail	Canary Jail	Scarlet Jail	Red Jail
Region	New England	Middle Atlantic	Southwest Pacific	East North Central	Northwest Pacific	Intermountain West	Intermountain West	Southwest
Setting	Urban	Urban	Urban	Urban	Urban and Rural	Rural	Urban	Rural
Facility Type	Jail/Prison	City Jail	County Jail	County Jail	County Jail	County Jail	County Jail	County Jail
Jail Population								
Total	3,000	1,000–1,100	All female	9,000	2,000	70	2,000	450
Female	150–300	600–650	2,200–2,300	800–1,000	200	10–15	200+	74–100
Length of Stay	90 days	37 days	45 days	44 days	21 days	Less than 1 year	30 days	2 weeks to 1 year
Racial Majority	Minorities	Women of Color	Latina	Black	People of Color	White	White	White

Table 20. Provider Profiles

	Green Provider	Pine Provider	Sage Provider	Pear Provider	Yellow Provider	Canary Provider	Scarlet Provider	Red Provider
Gender	Woman	Man	Man	Woman	Man	Man	Woman	Man
Race	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian
Credentials	MD, MPH	MD	MD	MD	MD, MPH	MD	PA	RN
Years Practicing	19	5	2	31	20	31	17	15
Years in Corrections	19	5	1.5	7	16	18	7	13

Table 21. Contraceptive Continuation, Counseling and Initiation in Eight Jails

	Green Jail	Pine Jail	Sage Jail	Pear Jail	Yellow Jail	Canary Jail	Scarlet Jail	Red Jail
Intake								
List medications	✓	✓	✓	✓	✓	✓	✓	✓
Specificially asked about BC	✓	✓						
EC screening		✓	✓					
EC available	✓	✓	✓	✓	✓	✓		
Can continue pill	✓	✓	✓	✓	✓	✓		
Can continue patch	✓	✓	✓		✓			
Can continue ring	✓							
Can continue shot	✓	✓	✓	✓	✓	✓		
Incarceration								
Universal contraceptive counseling	✓	✓		✓				
Patient–initiated contraceptive counseling			✓		✓	✓	✓	
Can initiate pill	✓	✓	✓	✓	✓	✓		
Can initiate patch	✓	✓	✓		✓			
Can initiate ring	✓							
Can initiate shot	✓	✓	✓	✓	✓	✓		
Can initiate implant	✓	✓	✓	✓				
Can initiate IUD	✓	✓	✓	✓				
Released with prescription	✓		✓	✓				

Table 22. Sterilization Availability in Eight Jails

	Green Jail	Pine Jail	Sage Jail	Pear Jail	Yellow Jail	Canary Jail	Scarlet Jail	Red Jail
Antisterilization law			✔					
Sterilization consent				✔				
Elective sterilization				✔				
Postpartum sterilization	✔	✔		✔	✔	✔	✔	unknown

CHAPTER 7

CONCLUSIONS

This dissertation sought to explore incarcerated women's access to contraception in jail. I examined incarcerated women's contraceptive needs and method preferences through surveys as well as their attitudes regarding sterilization access for women in jail through focus groups. I also interviewed jail health care providers to gain an understanding of why and how they do, or do not, provide contraceptive care to their incarcerated patients. These interviews examined providers' attitudes toward sterilization of incarcerated women. Women's access to reversible and permanent methods of contraception during incarceration is a reproductive justice issue. This dissertation explored incarcerated women's contraceptive access through a reproductive justice framework, centering women's experiences, while taking into consideration race and socioeconomic health disparities, gender inequality, and power dynamics.

This dissertation examined three different research questions related to contraceptive access for women experiencing incarceration through surveys, focus groups and interviews:

In Chapter 4, I asked the research question, "What are the contraceptive needs and method preferences of women incarcerated at the Salt Lake County Jail?"

In Chapter 5, I asked the research question, "What attitudes do incarcerated women have toward sterilization occurring while in custody?"

In Chapter 6, I asked the research question, "What mechanisms and rationales do specific jails utilize to either discontinue or continue and initiate

contraceptives for women in their custody?”

In this conclusion chapter, I summarize the findings of each empirical chapter, provide implications for practice and policy, and provide broader conclusions.

Summary of Chapter 4: Contraceptive Needs and Preferences in the Salt Lake County Jail

Through self-administered surveys, I assessed the contraceptive histories, needs and preferences of 194 women incarcerated at the Salt Lake County Jail. Approximately two thirds of participants were interested in initiating a birth control method in jail. The women had diverse contraceptive method preferences. Among women interested in using birth control, 60% were interested in an IUD or implant.

Participants reported relatively low use of condoms for contraception in the previous 12 months. Condoms are the only method of contraception that also reduce the risk of sexually transmitted infections (STIs). Given the relatively high rate of STI history and interest in using condoms in the future among nearly half of participants, making condoms available for people leaving jail is an inexpensive preventative health measure to reduce the risk of unintended pregnancy and STIs.

Twenty-five participants (13%) had used the pill, patch, ring, or shot in the previous 12 months. If they were using that method at the time of arrest, it would not have been continued during incarceration or reinitiated prior to release. The current protocol at the Salt Lake County Jail is putting some women at risk of unintended pregnancy.

This study found that there are discrepancies between the methods women use and the methods in which women are interested. Among the women who were only using condoms, or fertility awareness as a contraceptive method prior to arrest, 53% of them were interested in an IUD or implant. Among women using the pill,

patch, ring, or shot prior to arrest, 44% of them were interested in an IUD or implant. Among women who were using an IUD or implant prior to arrest, 93% reported IUDs and implants were the method they were interested in using. Many women had interest in methods that were more effective than their current or most recent method. That said, not all women wanted birth control, and not all women who wanted birth control were interested in an IUD or implant. Reproductive justice advocates caution providers from assuming IUDs and implants are a magic bullet, that all women want, or a solution to poverty (Higgins, 2014).

Survey findings show that women are interested in a broad range of contraceptive methods, which underlines the importance of providing a range of contraceptive options to meet women's diverse contraceptive preferences. There is an opportunity in the Salt Lake County Jail to provide women with contraceptive services prior to release and reduce their risk of unintended pregnancy.

Women also reported interest in sterilization as a contraceptive method. Most women with an interest in sterilization also reported interest in IUDs, implants, short-acting hormonal methods, and barrier methods. Broad reproductive life planning counseling can address women's desires for sterilization and through shared-decision making, determine if sterilization is the best option for a woman, or if another method may be more appropriate for her family planning goals.

One-quarter of participants reported they either did not want or did not need birth control. Women who are not interested in birth control can benefit from reproductive life planning counseling, for example, if they plan on getting pregnant soon after release. Jail is an appropriate context for preconception counseling, starting a woman on prenatal vitamins, and providing her with resources in the community for prenatal care and parent-support programs.

Women may also be interested in birth control *and* desire pregnancy in the next year. Patient-centered reproductive counseling can help women achieve their

unique family planning goals. Reproductive justice supports women's right to have children and parent the children they have with dignity. Jails providing reproductive health care with a reproductive justice framework can support women in becoming pregnant.

In this study, more than one in three participants did not feel like they knew enough about birth control to make contraceptive decisions. Providing contraceptive education and counseling in jail is appropriate and could benefit many women who may lack knowledge about the range of contraceptive methods available to them.

In this study, survey participants watched a contraceptive counseling video, which 94% of survey participants reported was informative, but is certainly not comprehensive, unbiased, or patient-centered. The video discussed all the available contraceptive methods but was created to boost the appeal of IUDs and implants. A video is one way to provide initial contraceptive education, but all women should have the opportunity to speak with a provider and have their questions answered.

In summary, the women incarcerated at the Salt Lake County Jail have relatively high rates of contraceptive use prior to arrest compared to other studies. However, women's short-acting hormonal contraceptive methods are discontinued during incarceration and not reinitiated prior to release. Women who have made efforts to use birth control to avoid an unintended pregnancy are undermined by a jail system that perceives their contraception as unnecessary. Women have diverse preferences for contraceptive methods and would be interested in initiating birth control in jail, especially IUDs, implants, the shot, and the pill. The current policies at the Salt Lake County Jail may be increasing incarcerated women's risk of unintended pregnancy. The findings from this study provide an estimate for how many women would be interested in birth control and the range of methods they desire.

Implications for Practice

Implications for practice are summarized threefold:

1. Provide contraceptive care in the community. First, women need accessible, quality reproductive health care in the community that utilizes a reproductive justice framework to help women prepare for pregnancies they want or avoid pregnancies they do not want. Women incarcerated in jail represent the most economically disadvantaged and medically underserved population in the country. Many women are falling through the cracks of the health care safety net in the United States. For women who are eligible for Medicaid, every time they are incarcerated their Medicaid coverage ceases and they must reapply after they are released. Revolving in and out of jail several times a year can negatively impact women's ability to access health insurance coverage and health care in the community. For uninsured women who are not eligible for Medicaid, they may forego seeking health care because they cannot afford it or because the health care system is difficult to navigate. Women enter jail with health issues that could and should have been addressed in the community. A first step is bolstering efforts to provide easy-to-access, free reproductive health care to people in the community, which may reduce the burden on jail health care systems and providers.

2. Provide comprehensive contraceptive care in jail. Jail is an appropriate setting for providing comprehensive reproductive health services, contraceptive care, and a range of birth control methods for continuation and for initiation. The majority of women in jail are sexually active and do not want to get pregnant after release. Screening for and offering women emergency contraception at intake, allowing women to continue their hormonal birth control methods, and providing opportunities to initiate contraception prior to release can help women avoid unintended pregnancies. At the time of intake:

- Ask women if they have been sexually active with male partners. Keep in

mind that many incarcerated women are victims of sexual violence and engage in transactional sex, may be in need of additional care, and are at an increased risk of sexually transmitted infections.

- Ask women if they are currently using a method of birth control, and if so, what method.
- Allow women to continue using their birth control pills, patches, rings and shots on schedule, at no cost to the incarcerated patient.
- Screen women for emergency contraception (EC) eligibility and provide it at time of intake for women who want it.

During Incarceration:

- Offer reproductive life planning and contraceptive education classes to all incarcerated women, including where to access care in the community.
- Provide family planning services utilizing a reproductive justice framework, with patient-centered counseling to determine a woman's family planning goals.
- For women who desire pregnancy or do not want birth control, provide preconception counseling, initiate prenatal vitamins, and provide resources in the community for prenatal care and parental support.
- For women who want to avoid an unintended pregnancy, provide a range of methods and in-depth counseling and allow women to make decisions that align with their interests and values.
- If a woman wants an IUD or implant removed, it is imperative to ensure her request is respected and the device is removed, regardless of how much longer the device is effective. This is a crucial aspect of reproductive justice.
- Prior to release, jails should provide women with a supply of their short-acting method and resources for where to continue care in the community.

Chapter 4 examined women's contraceptive needs and preferences in the Salt

Lake County Jail and found that current contraceptive discontinuation practices may be increasing some women's risk of unintended pregnancy. Findings from this study suggest that approximately half of women between the ages of 18 and 48 would be interested in initiating a range of contraceptive methods in jail and that all long-acting, and short-acting methods of contraception should be available for women to initiate after engaging in patient-centered reproductive life planning counseling.

Contraceptive continuity and initiation in jails can contribute to reducing the rate of unintended pregnancy for incarcerated women. Jails are part of a publicly funded system and should work to create partnerships with resources in the community, including Title X funded clinics, local medical schools, departments of health and health providers, and educators who would be interested in helping establish and run a contraceptive program for the jail. Additionally, legislative efforts are an effective way to create statewide change. Legislation mandating that incarcerated women have access to family planning services in correctional facilities was passed in California in 2016. Something similar could be done in Utah.

3. Create a validated survey for assessing incarcerated women's family planning needs. My study is only the 11th assessment of incarcerated women's contraceptive histories and needs in a jail setting. With the growing female jail population and the recognition that contraceptive care is an essential part of health care, I hope that a systematic assessment of women's contraceptive needs and preferences will be made available to jails across the country. To this end, I plan to collaborate with scholars who have conducted family planning research in a jail setting as well as women who have experienced incarceration and create a survey that can be used in jails across the country to assess women's family planning needs and preferences. These surveys could inform jail health care providers how to best implement women-centered reproductive health and contraceptive care programs for their patients.

Women incarcerated in jails across the United States should have the education and resources to make decisions about their reproduction. This study contributes to a small but growing area of research determined to empower incarcerated women to have reproductive justice, and be supported in preparing for pregnancy, or avoiding pregnancy.

Summary of Chapter 5: Sterilization Attitudes of Women Incarcerated at the Salt Lake County Jail

Through three focus groups at the Salt Lake County Jail, I examined incarcerated women's attitudes toward access to sterilization for women in custody. The majority of women expressed attitudes that sterilization should be available for incarcerated women and not prohibited although some worried that women might feel pressured to be sterilized. Generally, women believed that sterilization access was a right for all women, including incarcerated women. This study contributes women's voices to the controversial sterilization issue, and suggests that despite the history of forced sterilization, completely restricting access to sterilization for incarcerated women may not be in their best interest and is not what they want.

Just under half of the participants in the focus groups had been sterilized and gave accounts of their own sterilization stories, most happening under informed, consented circumstances; one with serious regret, and one that was involuntary and traumatic. There were some misperceptions about the effectiveness of sterilization and requests for "mass education" about sterilization—education for incarcerated women, education for correctional officers, education for doctors, and education for the public. Women described how drug addiction has impacted their pregnancies and parenthood and how sterilization put an end to their experiences with unintended pregnancies, and their inability to stop using drugs throughout those pregnancies.

Most of the participants shared a distrust of jail health care providers, but a

trust for Planned Parenthood and organizations that "don't see us as the enemy" or see them as the "scum of society." The women thought up ideal processes for protecting women and allowing them the opportunities to make decisions about their own bodies; a process with education, counseling, time to think, and informed consent—all facilitated by an entity unaffiliated with the jail. Throughout all three focus groups, women declared their right to sterilization.

The focus group participants believed that postpartum sterilization should be available for pregnant women who would be giving birth while in custody. They described the time immediately postpartum as the most opportune time for a tubal ligation for a woman who wants it. Additionally, the participants believed that nonpregnant women should have access to elective sterilization. Participants believed that sterilization access is a right—a right for pregnant women and a right for nonpregnant women, regardless of incarceration status.

The participants described situations where women needed to be protected from sterilization abuse. They showed concern for women who "aren't thinkin' straight" due to drug or mental health issues, but stated that a woman's inability to comprehend or consent to sterilization should be recognized by a health provider and the consent process should stop. When the topic of "pressure" came up, of who would feel pressured into sterilization and by whom, surprisingly few participants mentioned jail staff as the source of pressure. Instead, women worried that families would pressure women into getting sterilized. They worried sterilization may be used as a bargaining chip for bail. Women did have concerns about sterilization abuse, but predominately, the participants believed they had a right to sterilization—a human right, a woman's right, an American right, and a reproductive right.

The reproductive justice framework relies on a human rights framework. These two frameworks may not always align on an issue. The reproductive justice movement falls on the side of supporting sterilization bans for incarcerated women.

The survey and focus group findings complicate this narrative, with the majority of participants falling on the side of supporting sterilization access for incarcerated women.

There are certainly things that must be taken into consideration when interpreting the focus group findings. The majority of participants were White, they were all native English speakers, and had higher levels of education than many incarcerated women. Even though the participants were not representative of a national sample of incarcerated women—they *are* incarcerated women and their attitudes and experiences matter in the sterilization debate and show how nuanced the issue actually is.

Sterilization access for incarcerated women is complex, but the findings from Chapter 5 suggest that prohibiting sterilization for incarcerated women would relinquish access to a procedure that many incarcerated women want and feel they have a right to. Findings from the focus groups are made even more urgent given the findings from the survey.

The majority of women who participated in the Chapter 4 study (86%) had experienced a pregnancy. Of those, one-third of participants had been incarcerated while they were pregnant. Nearly one-quarter of the survey participants had terminated a pregnancy. And 24% had placed at least one child in adoptive care. A staggering majority (58%) of participants had been forced to have sex with a man at some point in their life, and 37% had engaged in transactional sex. Nearly one in three participants reported problems with their partner not wanting to use contraception in the past.

Many of these women are mothers who have had to make difficult decisions about their pregnancies, and many have suffered the loss of children to adoptive homes. Understanding the higher rates of rape, abuse, and reproductive traumas for women with a history of incarceration is necessary to provide better reproductive

health care and mental health care to women in the community *and* in jail. This adds an important nuance to women's contraceptive needs and makes excluding sterilization as an option even more problematic.

Implications for Practice

Implications for practice include:

1. Reproductive life planning classes should be taught by a trusted organization and include sterilization information. The women stressed the importance of and need for reproductive health education. Incarcerated women should have access to classes in jail providing information about reproductive life planning and all methods of contraception, including sterilization. Classes should be taught by a health educator whom women trust and who is unaffiliated with the jail. Several women mentioned Planned Parenthood as a trusted organization. These classes should be broad and provide information about reproductive physiology, planning for healthy pregnancy, and a range of contraceptive methods. Women want and deserve accurate information about sterilization, and a course should be designed using a reproductive justice model.

Importantly, many of the focus group participants were unaware of the sterilization abuse of more than 200 incarcerated women that occurred in California (Johnson, 2013). In the focus groups, I told the women about the California case and the subsequent legislation banning sterilization for incarcerated women. This prompted a discussion about sterilization abuse, unethical doctors, and the importance of informed consent. Women still felt strongly about women having access to sterilization and had suggestions for how to reduce the possibility of sterilization abuse. Informing incarcerated women about reproductive injustices that have been experienced by women in correctional settings is important for giving women more context for considering sterilization while in custody.

2. Jails should provide a range of contraceptive options for incarcerated women, including IUDs and implants. For women who want to avoid pregnancy and wish to initiate contraception, a range of methods should be available for women to start in jail. Pregnant women who will be giving birth while in custody should also be counseled on all contraceptive methods if they are interested in initiating a method before they leave the hospital. Ideally, women should be counseled on contraceptive methods and given enough time to discuss the method options with anyone they wish to talk to, including their partners. A two-stage process for contraceptive counseling and initiation is in line with reproductive justice, and is a good patient-centered model for incarcerated women.

For women who are interested in sterilization, IUDs and implants should be offered as an equally effective, but reversible option. Some women will be exclusively interested in sterilization and not interested in any other method of contraception. In these cases, women should have the opportunity to have in-depth contraceptive counseling and an informed consent process with a waiting period, in line with a reproductive justice framework. Incarcerated patients should not be responsible for any contraceptive care costs.

3. Jails and hospitals need official policies and protocols for postpartum and elective sterilization of incarcerated women. Sterilization is available on a case-by-case basis for women incarcerated at the Salt Lake County Jail. Like Renee, some incarcerated women have been sterilized immediately postpartum. I am aware that other women who have given birth while in the custody of the Salt Lake County Jail have received IUDs or implants immediately postpartum. A cause of concern is the apparent lack of communication between jails housing incarcerated pregnant women and hospitals where the pregnant women give birth. Specifically, incarcerated women may be missing out on the opportunity to have a 30-day waiting period between consenting and the sterilization procedure. The Utah Medicaid Provider

manual states,

> Medicaid members who are inmates of a public institution (including jail) are not entitled to ongoing Medicaid services. The facility is responsible for all medical expenses incurred during the member's stay, unless the member becomes an inpatient in a hospital. An inmate may qualify for Medicaid for the inpatient stay days. An inmate must meet eligibility criteria for a Medicaid program. (2018)

Women who are interested in sterilization should be counseled and give informed consent at least 30 days prior to the procedure. This recommendation is made with a strong suggestion that providers who are responsible for counseling and consenting women fully understand the history of sterilization abuse that women involved with the criminal justice system have undergone and particularly how poor women of color were (and are) disproportionately affected. Reproductive life planning should be brought up in prenatal care appointments with pregnant women to give ample time for women to consider the contraceptive method they want, if any, after they give birth.

The findings from Chapter 5 show that the majority of incarcerated women believe sterilization should be available for women in jail. I have provided implications for practice that include a range of contraceptive methods being available for women, including IUDs and implants; access for postpartum and elective sterilization for women who do not want a reversible method; and education, in-depth counseling, and informed consent procedures that ensure women have time to consider sterilization and fully understand its permanency. All these recommendations should be designed using woman-centered reproductive justice frameworks and with an understanding of sterilization abuses committed against incarcerated women and poor, women of color.

Summary of Chapter 6: Contraceptive Care, or Lack Thereof, in Jails Across the United States

Through interviews with eight jail health care providers, I examined the established practices for contraceptive care in diverse institutional settings. Half of the providers reported comprehensive contraceptive care was available for their incarcerated patients, two providers reported limited contraceptive care for their incarcerated patients, and two providers reported there were no contraceptive services available for their incarcerated patients. Importantly, the facilities with comprehensive contraceptive care all had health care arrangements provided by a government (city, county, state) department of health. When patient-care and public health are prioritized above cost, contraceptive care is more likely.

The findings from Chapter 6 suggest the importance of a champion for establishing a comprehensive contraceptive program. In most cases, the champion was a doctor who saw the need for contraception in jail and decided to figure out how to implement a program. Yes, a contraceptive program requires funding, trained staff, and a supportive security authority, but first, it requires a motivated trailblazer to make it happen.

The providers who championed comprehensive contraceptive programs all had attitudes in line with the principles of reproductive justice. They understood that the women in their care were medically underserved and deserving of woman-centered, compassionate health care and access to empowering contraceptive services. The champion providers demonstrated passion for reproductive justice for the women in their care.

Jail health care providers should center the experiences and needs of their patients above costs. When jail health care providers only attend to the "serious medical needs" they miss an opportunity to provide comprehensive health care that can have lasting effects—beyond jail. One of those services is comprehensive

contraceptive care and empowering women with education and resources to avoid an unintended pregnancy or prepare for a healthy pregnancy.

During the interviews I conducted, some providers failed to see how contraceptive care in jail could positively benefit their patients' lives after release. Some providers mentioned that women could not get pregnant while they were in jail, thus providing contraception to women was unnecessary. One provider simultaneously described high recidivism rates and the stresses of caring for pregnant women in jail, failing to see how contraceptive care in jail could potentially reduce the number of women returning to jail with unintended pregnancies. All it takes is a paradigm shift, and even a provider who believes contraception is unnecessary 1 day can become a champion for comprehensive contraceptive care the next.

Implications for Practice

Implications for practice are as follows:

1. Jails should provide comprehensive reproductive life planning care. Some women want to get pregnant after they are released from jail. Health care providers in jail have an opportunity to help women plan and prepare for healthy pregnancies. Providing comprehensive, woman-centered reproductive counseling is in line with a reproductive justice model and an ideal starting point.

The four providers who worked in jails with comprehensive contraceptive care programs acknowledged that broad family planning counseling is an important way to best meet women's needs. Instead of starting with contraceptive counseling, a patient-centered approach starts with asking questions about women's reproductive goals. Providing women with space to discuss their family planning goals, free of judgment, is a crucial tenet of reproductive justice.

Reproductive justice supports women's right to have children and parent the

children they have with dignity. Jails providing reproductive health care with a reproductive justice framework can support women in becoming pregnant.

For women who are planning on being sexually active, do not want a pregnancy yet, and do not want to initiate birth control, jails can help women "plan for an accidental pregnancy" as the Green Jail provider stated. Jails can provide women with multivitamins and support women in their decision to not use birth control. Sharing information about where women can access family planning service in the community can be an empowering tool for women who do not want to initiate contraception in jail.

2. Jail is an appropriate place for contraceptive counseling. The health care providers in this study described diverse ways for providing contraceptive education. In one facility, a health educator spoke individually with each woman about her contraceptive needs and counseled her on her options within 1 week of entering jail. In another facility, groups of women met for reproductive life planning classes taught by an ObGyn. In another facility, all women received one-on-one family planning counseling with an on-site provider. Ideally, a woman should have the opportunity to receive information about all methods and the opportunity to ask questions. Then she should be scheduled for a follow up appointment to have time to consider her options and discuss the methods with anyone she wants involved in her decision. Among the providers, there was consensus for the importance of two-stage consent, and ensuring women are counseled in a patient-centered way, and receive in-depth information before they consent to a method, especially the IUD or implant.

3. Comprehensive contraceptive care should be provided in jail. Emergency contraception should be available for women at intake. Women should be asked if they are currently using birth control and then continue on their method. Women can be given a pack of pills to self-administer daily, or pills can be distributed by a nurse on a dose-by-dose basis. Women can put patches on and insert rings themselves.

Birth control shots can be provided on schedule by a nurse. One health care provider reported the facility had all short-acting methods of contraception available, the pill, patch, ring, and shot. Other providers reported for security reasons their facility did not provide the ring. Future research could examine the "security reasons" for prohibiting the vaginal contraceptive ring.

IUDs and implants are a safe and feasible option for insertion in a jail setting. Many incarcerated women want IUDs and implants and they should be provided for free to the patient. Especially for IUDs and implants, two-stage counseling and consent is beneficial to give women time to consider if they want the method. Women who want an IUD or implant removed should be able to have it removed. For jails that do not have the staff or clinic infrastructure to provide IUDs and implants on site, relationships can be established with clinics in the community to provide contraceptive care.

4. Understand the cost-effectiveness of contraception while honoring reproductive justice. The costs of contraceptive care include funding the staff members to provide contraceptive care and the contraceptive methods themselves. Some health care providers stated the jail budget could not afford contraceptive care. Contraceptive care does have costs, but it also has benefits. I hesitate to argue the cost-effectiveness of contraceptive care. I hesitate, not because I believe there is not cost savings associated with contraceptive care; rather, I hesitate to make contraceptive care a target of cost savings.

There are cost savings associated with contraceptive care; in fact there is a substantial return on investment of approximately $7.09 for every public dollar spent (Frost, Finer, & Tapales, 2008; Frost et al., 2014). Approximately 65% of unintended pregnancies that result in birth are paid for by public insurance programs (Sonfield & Kost, 2013). Helping women avoid unintended pregnancies literally saves billions of dollars every year (Sonfield & Kost, 2013).

Although jail health care providers may know that unintended births are costly to publicly funded health systems, jail providers may be unmotivated to cover the up-front cost of contraception because the jail budget does not see the savings. Incarcerated women's birth-related costs are often covered by Medicaid or other public insurance, not the jail. Public funds cover jail health care costs and Medicaid costs, just from different budgets. Jails may not see the cost-effectiveness of spending their budget to benefit the Medicaid budget. Future research should examine the cost-effectiveness of jails providing comprehensive contraceptive care. I must reiterate, contraception should only be offered on a voluntary basis, and it is crucial that a reproductive justice framework is incorporated into all contraceptive services in jails and a variety of methods should be available, not just the most cost-effective.

Controlling women's fertility for "the good of the public" has been done before and it should never be done again. Birth control should not be offered as an incentive for a sentence reduction as it recently was in Tennessee (Dwyer, 2017). Birth control should not be offered or implied because a woman has had "enough" babies. Only women should decide how to manage their fertility.

For women who do want contraception in jail, it is imperative that contraceptive care is entirely free to the patient. Cost of contraception can be a barrier for many women trying to access care and all contraceptive services should be covered by the jail. This point was unanimous among the jail health care providers who offered comprehensive contraceptive care in their facilities. In one facility, where contraceptive care was not comprehensive, incarcerated patients had to pay $10 for a pack of oral contraceptive pills and $10 for a Depo-Provera shot. Many packs of pills can be purchased for under $5 or provided for free at community health centers like Planned Parenthood or Title X clinics. For women who had Medicaid or private insurance prior to arrest, their birth control pills were likely free.

The provider stated that $10 for one pack of pills is a "nominal cost." I disagree. Many incarcerated women live below the federal poverty level and $10 may truly be cost-prohibitive and they may forego their birth control while in jail due to cost. When it comes to considering the costs of contraceptive care in jail, contraception is cost-effective, but should always be free for the patient.

5. Educate jail health care providers about the importance of comprehensive contraceptive care. There are more than 3,000 jails in the United States. In these jails, there are tens of thousands of correctional health care providers. Providers may have the opportunity to learn about comprehensive contraceptive programs for incarcerated women if they attend correctional health conferences or read correctional health journals. For example, one provider who was a champion for the contraceptive program in the facility she worked in mentioned she learned about contraceptive care from a leading scholar at a conference. She returned to work "fired up" and got to work implementing a program. However, not all providers attend conferences or read journals.

Champions for change do not necessarily have to work within a jail. Anyone can be a reproductive justice champion and work to educate jail decision-makers about the benefits of providing comprehensive contraceptive care to incarcerated women. One provider mentioned that a local Planned Parenthood affiliate created the conversation that ultimately led to the jail creating a comprehensive contraceptive care program.

As a publicly funded system, the funding public has the right to ask what types of contraceptive services are available in the jail and demand that services and standard of care improve. Too often, incarcerated women are a forgotten population, and unfortunately, too many people believe that contraception is not an important thing to provide to women in jail who want it. I want to change that narrative, from one of contraceptive absence to contraceptive access.

Broader Conclusions

This dissertation focused on women in one specific subset of the penal system, yet any research on the topic would be incomplete if it did not address the issue of mass incarceration more broadly. Jails are overcrowded and the incarceration rate is increasing while the crime rate is not. Improving women's reproductive health care in jail is important; however, reducing the number of women in U.S. jails is paramount.

Reduce the Number of Women in U.S. Jails

Both the survey group participants and the focus group participants had been in jail an average of seven times; some participants had been in jail as many as 42 times. The jail health care providers also described high recidivism rates among their incarcerated patients. One provider stated the recidivism rate was 80%. There is a mass incarceration problem in the United States, with astronomically high numbers of people from disadvantaged communities being incarcerated.

The term "hyperincarceration" acknowledges that the same people are being incarcerated numerous times over the course of their lives. More must be done to reduce the number of women in United States jails, who are disproportionately poor, women of color, who have mental health and drug dependence issues. This will require community organizing and legislative action—and an overhaul of the prison-industrial complex.

The prison-industrial complex, which includes jails, contributes to systemic racism and systemic classism. As described in Chapter 2, jails and prisons warehouse bodies that societies have deemed as worthless. Michelle Alexander argues, "The system operates through our criminal justice institutions, but it functions more like a caste system than a system of crime control" (Alexander, 2012, p. 13). Having a history of incarceration increases a person's chances of having a future of

incarceration. The United States must stop incarcerating poor women of color who are not an actual danger to society. It will be an enormous undertaking, but a necessary one.

Incarceration has negative implications for women and their children. A principle of reproductive justice is supporting women in parenting the children they have in dignity. Incarceration impedes women's ability to parent their children. Efforts should be made to keep women out of jail and with their families or in rehabilitative programs that allow them to be involved in their children's lives.

Broader Implications for the Field of Sociology

This study demonstrated contraceptive needs and preferences of incarcerated women and highlighted the complex institutional context in which services are provided or, perhaps more often, not provided. In addition to the policy implications outlined above, the findings from this study speak to the broader theme of gender inequality. Not providing women with access to birth control means in many instances limiting women's ability to control their own fertility. Marginalized women often experience sexual victimization, and suffer from mental health and addiction problems. Reproductive life planning and contraceptive care with an emphasis on reproductive justice would be a way to improve women's overall well-being and help them lead the lives they desire. Paternalistic approaches that limit women's choices, even in the guise of protecting women are just another example of taking away women's control over their own bodies and lives. Although this study points out many challenges and gaps in health care provision, it also shows that there is potential to provide comprehensive care in challenging environments. It is imperative we continue seeking the voices and lifting the stories of women.

APPENDIX A

CONTRACEPTIVE HISTORY, NEEDS, AND PREFERENCES SURVEY

Contraceptive History, Needs and Preferences Survey

1. Have you ever done this survey before? (If Yes, please do not complete it again.)

_____ Yes _____ No

2. How old are you? I am _____ years old.

3. What is your race? (Check all that apply)

_____ White or Caucasian

_____ Black or African American

_____ American Indian or Alaska Native

_____ Asian

_____ Native Hawaiian or Pacific Islander

_____ Other (specify) _____

4. Do you consider yourself Latina or Hispanic?

_____ Yes _____ No

5. Were you born in the United States?

_____ Yes _____ No

a. If No, in what country were you born? _____

b. If No, how many years have you lived in the United States?

_____ years.

6. Is English the language you use most of the time?

_____ Yes _____ No

a. If No, what is your preferred language? _____

7. What is your highest level of education? (Choose one)

_____ No schooling completed, or less than 1 year

_____ Nursery, kindergarten, and elementary (grades 1–8)

_____ High school (grades 9–12, no degree)

_____ High school graduate (or equivalent [GED])

_____ Some college (1–4 years, no degree)

_____ Associate's degree (including occupational or academic degrees)

_____ Bachelor's degree (BA, BS, AB, etc)

_____ Master's degree (MA, MS, MENG, MSW, etc)

_____ Doctoral degree (PhD, EdD, etc.)

_____ Other (please specify) _____

8. How many times have you been in jail? (If this is your first time in jail write 1)

_____ time(s)

9. How many times have you been in prison?

_____ time(s)

10. How long is the **entire** sentence you are serving now?

_____ Less than one WEEK

_____ Two to Four WEEKS

_____ Two to Three MONTHS

_____ Four to Six MONTHS

_____ Six MONTHS to one YEAR

_____ I have not had a trial yet

_____ I do not have a sentence yet

_____ Other (please specify) _____

11. Do you plan to live in Utah for at least one year after you are released from jail?

_____ Yes _____ No _____ I don't know

a. If "No", or "I don't know", where do you think you will live? _____

12. What health insurance did you have before you were incarcerated?

_____ None

_____ Medicaid

_____ Private Health Insurance

_____ Purchased exchange (Obamacare)

_____ Other (specify) _____

13. What health insurance will you have after you are released from jail?

_____ None

_____ Medicaid

_____ Private Health Insurance

_____ Purchased exchange (Obamacare)

_____ Other (specify) _____

14. Would you be interested in having help signing up for health insurance while you are in jail?

_____ Yes _____ No _____ I don't know

15. Have you <u>ever</u> had vaginal sex with a male partner before? (His penis in your vagina)

_____ Yes _____ No

16. Do you think you will have vaginal sex with a male partner within **<u>1 month</u>** after you are released from jail?

_____ Yes _____ No _____ I don't know

17. Do you think you will have vaginal sex with a male partner within **<u>12 months</u>** after you are released from jail?

_____ Yes _____ No _____ I don't know

18. Are you pregnant now?

_____ Yes _____ No (If No, go to question 21) _____ I don't know

19. If you are pregnant now, what are your plans for the pregnancy?

_____ Deliver the baby and parent the baby

_____ Deliver the baby and place for adoption

_____ Terminate the pregnancy (abortion)

_____ I don't know

20. If you are pregnant now, do you think you will deliver your baby while you are incarcerated?

_____ Yes, I think I will be incarcerated when I deliver

_____ No, I think I will be released before I deliver

_____ I don't know

21. Have you ever been pregnant before? (If you are pregnant now, mark Yes)

_____ Yes _____ No (If No, go to question 29) _____ I don't know

22. When was the LAST time you were pregnant? (regardless of pregnancy outcome)

_____ I am pregnant now

_____ Within the last 12 MONTHS

_____ One to Two YEARS ago

_____ Three to Four YEARS ago

_____ Over Five YEARS ago

23. Have you ever been incarcerated while you were pregnant?

_____ Yes, I have been pregnant while I was in jail/prison (or am pregnant now)

_____ No, I have never been pregnant while I was in jail/prison (or this is your first time in jail and you are not pregnant)

_____ Other, (please specify) _____

24. How many babies have you given birth to?

_____ 0 _____ 1 _____ 2 _____ 3 _____ 4

_____ 5 _____ 6+

25. How many miscarriages have you had?

_____ 0 _____ 1 _____ 2 _____ 3 _____ 4

_____ 5 _____ 6+

26. How many abortions have you had?

_____ 0 _____ 1 _____ 2 _____ 3 _____ 4

_____ 5 _____ 6+

27. How many children have you placed in an adoptive home?

_____ 0 _____ 1 _____ 2 _____ 3 _____ 4

_____ 5 _____ 6+

28. How many children (under the age of 18) are in your legal custody?

_____ 0 _____ 1 _____ 2 _____ 3 _____ 4

_____ 5 _____ 6+

29. Have you ever been forced or coerced to have sex with a man when you did not want to?

_____ Yes _____ No _____ I don't know

30. Have you ever had a sexually transmitted disease or infection (STD / STI)? (Check all that apply)

_____ Chlamydia

_____ Gonorrhea

_____ Genital Herpes

_____ Hepatitis B

_____ Pubic Lice (Crabs)

_____ Scabies

_____ Syphilis

_____ Human Immunodeficiency Virus (HIV)

_____ Human Papilloma Virus (HPV / cervical cancer / genital warts)

_____ Trichomoniasis

_____ I don't know

_____ I have never had an STD / STI

_____ I have never been tested for an STD / STI

_____ Other (please specify) _____

31. Do you want to get pregnant within ONE YEAR after you are released from jail? (Choose one)

_____ Yes

_____ No

_____ I don't know

_____ I don't care if I get pregnant

_____ I can't get pregnant (menopause, hysterectomy, tubes tied, etc.)

_____ Other (please specify) _____

32. On a scale of 1 to 5, with 1 being the lowest and 5 being the highest, how much do you AGREE with this statement:

I want to be pregnant within ONE YEAR of being released from jail.

_____ 1 I don't want to be pregnant within one year of being released

_____ 2

_____ 3 I don't care either way

_____ 4

_____ 5 I want to be pregnant within one year of being released

33. On the same scale of 1 to 5, how much do you AGREE with this statement:

I would be very upset if I were pregnant right now.

_____ 1 I would not be upset at all if I were pregnant

_____ 2

_____ 3 I don't care either way

_____ 4

_____ 5 I would be very upset if I were pregnant

34. Do you plan to use birth control within the first 12 MONTHS after you are released from jail?

_____ Yes _____ No _____ I don't know

35. Where would you most likely get birth control when you are released from jail?

_____ Doctor's office

_____ Community Clinic (like Planned Parenthood)

_____ Hospital

_____ I will only use condoms

_____ Friend or family member

_____ I already have a long term form of birth control (IUD / Implanon)

_____ I don't need birth control (menopause / tubes tied / etc.)

_____ I don't plan to use birth control

_____ Other (please specify) _____

36. How do you plan to pay for your birth control when you are released from jail?

_____ I will pay for it with my own money

_____ Someone else I know will pay for it

_____ I expect it will be free at a clinic

_____ My insurance will pay for it (Medicaid / private insurance)

_____ I don't know how I will pay for birth control, but I want it

_____ I don't need birth control (menopause / tubes tied / etc.)

_____ I don't plan to use birth control

_____ Other (please specify) _____

37. If birth control were offered to you in jail for free before you were released, would you want it?

_____ Yes _____ No _____ I don't know

38. What kind of birth control are you interested in? (Check all that apply)

Hormonal:

_____ Birth control pill ("the pill")

_____ Birth control patch (Ortho Evra™)

_____ Birth control ring (Nuva Ring™)

_____ Birth control shot (Depo-Provera™)

_____ Emergency contraception pill (Plan B™, "the morning after pill")

_____ In-arm implant (Implanon™ / Nexplanon™ / Norplant™)

_____ Intra-Uterine Device (IUD)

** If interested in an IUD, circle **Mirena**™ (hormonal) or **ParaGard**™ (copper) or **both**

Barrier:

_____ Condom (male condom or female condom)

_____ Diaphragm or Cervical Cap

Other:

_____ Tubal ligation (tubes tied)

_____ Fertility awareness method (keeping track of your ovulation)

_____ Any other form of birth control? (please specify) _____

_____ I don't want or need birth control

39. What kind of birth control were you using in the TWELVE MONTHS BEFORE you were incarcerated? (Check all that apply)

Hormonal:

_____ Birth control pill ("the pill")

_____ Birth control patch (Ortho Evra™)

_____ Birth control ring (Nuva Ring™)

_____ Birth control shot (Depo-Provera™)

_____ Emergency contraception pill (Plan B™, "the morning after pill")

_____ In-arm implant (Implanon™ / Nexplanon™ / Norplant™) ⇝ Circle which one you had/have

** Do you still have an in-arm implant? _____ Yes _____ No

_____ Intra-Uterine Device (IUD) (Mirena™ or ParaGard™) ⇝ Circle which one you had/have

** Do you still have an IUD? _____ Yes _____ No

Barrier:

_____ Condom (Male condom or Female condom)

_____ Diaphragm or Cervical Cap

Other:

_____ Fertility awareness method (keeping track of your ovulation)

_____ I was pregnant or breastfeeding

_____ Any other form of birth control? (please specify)_____

_____ I didn't need birth control (menopause / tubes tied / abstinent / sex with females / etc.)

_____ I didn't want birth control

40. Where did you get birth control before you came to jail?

_____ Doctor's office

_____ Community Clinic (like Planned Parenthood)

_____ Hospital

_____ I only used condoms

_____ Friend or family member

_____ I didn't need birth control (menopause / tubes tied / abstinent /sex with females / etc.)

_____ I didn't want birth control

_____ Other (please specify) _____

41. How did you pay for your birth control before you came to jail?

_____ I paid for it with my own money

_____ Someone else I know paid for it

_____ My insurance paid for it (Medicaid / private insurance)

_____ I got it free at a clinic

_____ I didn't need birth control (menopause / tubes tied / abstinent / sex with females / etc.)

_____ I didn't want birth control

_____ Other (please specify) _____

42. Has it been a problem to pay for birth control in the year before you came to jail?

_____ Yes, it has been a big problem

_____ No, it has not been a problem

_____ It has been a small problem

_____ Not applicable (I either did not want or did not need birth control)

_____ Other (please specify)_____

43. Do you think paying for birth control will be a problem when you are released from jail? (Choose one)

_____ Yes, it will be a big problem

_____ It will be a small problem

_____ No, it will not be a problem

_____ Not applicable (I either do not want or do not need birth control)

_____ Other (please specify) _____

44. Which of the following statements best applies to you?

_____ In the past, I have known enough about birth control to choose the right method for me

_____ In the past, I have **not** known enough about birth control to choose the right method for me

_____ Other, (please specify) _____

45. In the year before you were incarcerated, did you have a problem with your male sex partner(s) not wanting to use birth control or condoms?

_____ Yes, it has been a big problem

_____ It has been a small problem

_____ No, it has not been a problem

_____ Not applicable (I either did not want or did not need birth control or didn't have a male sex partner in the last year)

_____ Other (please specify) _____

46. Do you think you will have a problem with your male sex partner(s) not wanting you to use birth control or condoms in the year following your release? (Choose one)

_____ Yes, it will be a big problem

_____ It will be a small problem

_____ No, it will not be a problem

_____ Not applicable (I either do not want or do not need birth control or won't have a male sex partner in the year after I am released)

_____ Other (please specify) _____

47. Have you ever had vaginal sex with a man so that you could get drugs, money, food, or a place to stay? (Choose one)

_____ Yes _____ No

_____ I can't remember _____ Other (please specify)_____

48. Did you use illegal drugs within twelve months before you came to jail this time?

_____ Yes _____ No

_____ I don't know _____ Other (please specify) _____

49. What illegal drugs did you use in the TWELVE MONTHS before you came to jail? (Check all that apply)

_____ Methamphetamine (meth) _____ Heroin

_____ Cocaine (coke / crack) _____ Marijuana (weed / pot)

_____ Hallucinogens (ecstasy / LSD) _____ Prescription pills (not your prescription or abused)

_____ I can't remember _____ I have never used illegal drugs

_____ Other (please specify) _____

50. If there were a research study that gave free birth control to women in jail and then interviewed participants for one year after they were released, would you be interested in being a part of that study?

_____ Yes, I WOULD WANT BIRTH CONTROL in jail and I would be interviewed three times during the first year after I am released.

_____ Yes, but I WOULD NOT WANT BIRTH CONTROL, but I would be interviewed three times during the first year after I am released.

_____ I am interested, but I do not plan on living in Utah for one year after I am released.

_____ No, I would not be interested in participating.

_____ I don't care

_____ I don't know

_____ Other (please specify) _____

51. Did the video about birth control that you watched before the survey help you better understand what types of birth control are available to you?

_____ Yes _____ No

52. Do you consider yourself religious?

_____ Yes _____ No

a. If Yes, what religion? _____

b. How important is religion in your life?

_____ Very important _____ A little important _____ Not important

The following three questions are about tubal ligation (or "getting your tubes tied").

If a woman has a tubal ligation it means she can never get pregnant again.

53. Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?

_____ Yes _____ No

_____ I don't know _____ Other (please specify) _____

Some people worry that women who are incarcerated might feel pressured to get their tubes tied.

54. Would you worry that female inmates were being pressured into having this permanent procedure?

_____ Yes _____ No

_____ I don't know _____ Other (please specify) _____

Some lawmakers want to make it so female inmates cannot get their tubes tied while they are incarcerated. And some people think that women should have the choice to get their tubes tied, even if they are incarcerated.

55. Do you think tubal ligation, "getting your tubes tied," should be prohibited for incarcerated women?

_____ Yes _____ No

_____ I don't know _____ Other (please specify) _____

56. If you feel like doing so, please use the rest of the paper provided to write about your family planning goals for the first twelve months after you are released from jail. You can include why you do or do not want to get pregnant and how you think a pregnancy in the first year after you are released would affect your life.

THANK YOU! You are finished with the survey. Please give your survey to the researcher.

APPENDIX B

GUIDE FOR FOCUS GROUPS

In general, what are your feelings about women's reproductive health in jail?

How many of you have heard of tubal ligation?

When/under what circumstances did you first hear about tubal ligation?

I'm going to ask you three questions about tubal ligation (or "getting your tubes tied").

If a woman has a tubal ligation it means she can never get pregnant again.

1. Do you think women who are incarcerated should have the opportunity to have their tubes tied, permanently losing their ability to be pregnant in the future?

Some people worry that women who are incarcerated might feel pressured to get their tubes tied.

2. Would you worry that incarcerated women were being pressured into having this permanent procedure?

Some lawmakers want to make it so female inmates cannot get their tubes tied while they are incarcerated. And some people think that women should have the choice to get their tubes tied, even if they are incarcerated.

3. Do you think tubal ligation, "getting your tubes tied," should be prohibited for incarcerated women?

APPENDIX C

GUIDE FOR JAIL HEALTH CARE PROVIDER INTERVIEWS

Interview Outline

To start, please tell me your position title and credentials

How long have you been a practicing provider since your training?

How long have you worked in corrections?

How long have you worked with incarcerated women?

What type of practice settings have you worked in outside of the jail setting previously or currently?

What is your Race/Ethnicity?

What is your Gender Identity? Pronouns?

In your professional opinion, should incarcerated women have access to continuing or initiating birth control while they are in custody?

Why?
Why not?
All methods?
How should costs be covered?

In your professional opinion, should incarcerated women have access to sterilization while they are in custody?

Why?
Why not?
Any circumstance?
How should costs be covered?

Can you describe the community (either city or county) that this jail is located in?

population size,
demographics of race,
ethnicity,
class,
age,
and any special circumstances, for example, is this community an immigrant destination or does it have a unique religious or political climate?

Can you describe the correctional facility in general, and more specifically the female population in custody here?

What is the percentage of females compared to males incarcerated here?
Approximately how many women are housed here each day?
What is the housing capacity for females?
How long is the average stay?
What are the demographic characteristics of the women incarcerated here?

Homeless?
Served in a branch of the military?
Common medical issues?

Can you tell me about the administration, staff, health care providers at this facility?

For example, approximately how many people work here?
How many medical providers?
Is there a women's health clinic or designated provider?
What type of background does that provider have? Ob/Gyn?
How frequently do women have access to the clinic/provider?

Can you tell me about this facility's health care arrangements?

For example, are health care staff employed by the facility, or contracted, or does all or most health care happen off site?

Are you involved in making decisions about health care services for this facility?

Who (else) is involved in making decisions about health care services for this facility?

Before moving on to the next topic, do you have anything else to add about the community, this facility, or the health care arrangements in general?

Next I am going to ask questions about contraceptive access for incarcerated women in this facility.

Does this facility have a protocol for assessing a woman's birth control use and need at the time of booking?

For example, at booking, are women asked if they use birth control and what method?

Is there a way to assess if a woman uses a method for noncontraceptive purposes? (bleeding or pain control)

Are women asked if they would like to <u>continue</u> birth control while they are in jail?

Are women asked if they would like to <u>initiate</u> birth control while they are in jail?

Are women asked if they have had unprotected sex in the last 5 days?

Are women offered emergency contraception?

Are women routinely given a pregnancy test? OR asked if they'd like one?

If a woman is pregnant is she asked about her plans for the pregnancy?

If a woman wants to terminate a pregnancy, (how) does the jail facilitate abortion services?

Does this facility have a protocol for allowing women to continue their method of birth control during incarceration?

How is birth control method determined? Does the woman need to provide proof of method use?

How are hormonal birth control methods like the pill, patch, ring or shot provided? In the housing unit, facility clinic or off site?

For a woman who had an implant or IUD at the time of booking, is it possible for her to have an implant or IUD removed or replaced during incarceration? In the facility clinic or off site?

Does this facility have a protocol for allowing women to initiate a method of birth control during incarceration?

Do birth control initiation services happen on site? Off-site? Partnership with community providers?

How are women counseled on their options for contraception?

Is it possible for a woman to start the pill, patch, ring or shot?

Is it possible for a woman to get an IUD or implant during incarceration? In the facility clinic or off site?

If a woman receives contraceptive care in jail, is she counseled on where to continue contraceptive care outside of jail?

Is there a social worker or anyone who helps facilitate care coordination?

Where do women typically receive contraceptive care in the community?

Veteran clinic in the area?

Homeless clinics that you are aware of that provide contraceptive care?

Title X clinic / Planned Parenthood / Health Department / Federally qualified health center?

Do women have access to sterilization procedures during incarceration at this facility?

If a pregnant woman gives birth while in custody, can she be sterilized immediately postpartum?

What type of sterilization counseling and consent process does she have?

Can a nonpregnant woman be electively sterilized while in custody?

Do you know of any specific restrictions against sterilization for this facility or this state?

Before moving on to the next topic, do you have anything else to add about the contraceptive health care arrangements at this facility in general?

Next I am going to ask questions about the history (or future) of the contraception program/protocol in this facility.

If there are contraception services, how long has birth control been available for women in this facility?

Can you tell me about how the contraception program was established?

Was any person(s) or organization(s), in particular, responsible for implementing it?

Can you tell me about any champions, or positive factors that helped in the process of implementing a contraception program?

Can you tell me about any barriers, concerns, or issues that came up in the process of implementing a contraception program?

Is this contraception program guaranteed or is it reliant on specific funding, contracts, relationships, or administrators?

If there are not contraception services, do you know if birth control was ever available for women in this facility?

Do you believe birth control will/may be available for women in this facility in the future?

Can you tell me what would be necessary for a contraception program to be established in this facility?

Who or what could help in the process of implementing a contraception program?

What barriers, concerns, issues do you foresee coming up if a contraception program was considered or implemented?

Would a contraception program be guaranteed or reliant on specific funding, contracts, relationships, or administrators?

Do you have anything else you would like to add?

Thank you for participating

REFERENCES

Adams, S., Leukefeld, C. G., & Peden, A. R. (2008). Substance abuse treatment for women offenders: A research review. *Journal of Addictions Nursing*, *19*(2), 61–75. doi:10.1080/10884600802111648

Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of colorblindness* (Rev. ed. with foreword by Cornel West). New York, NY: New Press.

Allsworth, J. E., Clarke, J. G., Peipert, J. F., Hebert, M. R., Cooper, A., & Boardman, L. A. (2007). The influence of stress on the menstrual cycle among newly incarcerated women. *Womens Health Issues*, *17*(4), 202–209. doi:10.1016/j.whi.2007.02.002

The American Civil Liberties Union. (1993). *Norplant: A new contraceptive with the potential for abuse*. Retrieved from https://www.aclu.org/other/norplant-new-contraceptive-potential-abuse

The American Civil Liberties Union. (2012). *The shackling of pregnant women & girls in U.S. prisons, jails, & youth detention centers.* Retrieved from https://www.aclu.org/other/aclu-briefing-paper-shackling-pregnant-women-girls-us-prisons-jails-youth-detention-centers

The American College of Obstetricians and Gynecologists. (2012). *Reproductive health care for incarcerated women and adolescent females* (Committee Opinion No. 535). Retrieved from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co535.pdf

American Public Health Association. (2015). *Universal access to contraception.* Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/12/17/09/14/universal-access-to-contraception

Asberg, K., & Renk, K. (2013). Comparing incarcerated and college student women with histories of childhood sexual abuse: The roles of abuse severity, support, and substance use. *Psychological Trauma-Theory Research Practice and Policy*, *5*(2), 167–175. doi:10.1037/a0027162

Asian Communities for Reproductive Justice (n.k.a. Forward Together). (2005). *A new vision for advancing our movement for reproductive health, reproductive rights and reproductive justice*. Retrieved from https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf

Bailey, M. J., Malkova, O., & Norling, J. (2014). Do family planning programs decrease poverty? Evidence from public census data. *CESifo Economic*

Studies, *60*(2), 312–337.

Barnett, J. C., & Vornovitsky, M. (2016). *Health insurance coverage in the United States: 2015*. Retrieved from https://www.census.gov/library/publications/2016/demo/p60-257.html

Beck, A. J., Berzofsky, M., Caspar, R., & Krebs, C. (2013). *Sexual victimization in prisons and jails reported by inmates, 2011–2012*. Washington, D.C.: U.S. Bureau of Justice Statistics. Retrieved from https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf

Belknap, J. (2014). The invisible woman: Gender, crime, and justice (4th ed.). Stamford, CT: Cengage Learning.

Biggs, M. A., Gould, H., & Foster, D. (2013). Understanding why women seek abortions in the US. *BMC Women's Health, 13*(29). doi: 10.1186/1472-6874-13-29

Bonney, L. E., Clarke, J. G., Simmons, E. M., & Rich, J. D. (2008). Racial/ethnic sexual health disparities among incarcerated women. *Journal of the National Medical Association*, *100*(5), 553.

Borrero, S., Zite, N., Potter, J. E., Trussell, J., & Smith, K. (2013). Potential unintended pregnancies averted and cost savings associated with a revised Medicaid sterilization policy. *Contraception, 88*(6), 691–696. doi:10.1016/j.contraception.2013.08.004

Boulet, S., D'Angelo, D., Morrow, B., Zapata, L., Berry-Bibee, E., Rivera, M., . . . Koroelinger, C. (2016). Contraceptive use among nonpregnant and postpartum women at risk for unintended pregnancy, and female high school students, in the context of Zika preparedness—United States, 2011–2013 and 2015. Retrieved from https://www.cdc.gov/mmwr/volumes/65/wr/mm6530e2.htm

Bronson, J., & Berzofsky, M. (2017). *Indicators of mental health problems reported by prisoners and jail inmates, 2011–2012.* Retrieved from https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009* (NCJ 250546). Retrieved from https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf

Brown, P. B., & Chor, P. J. (2014). Adding injury to injury: Ethical implications of the Medicaid sterilization consent regulations. *Obstetrics & Gynecology, 123*(6), 1348–1351. doi:10.1097/AOG.0000000000000265

Capezza, N. M., & Najavits, L. M. (2012). Rates of trauma-informed counseling at substance abuse treatment facilities: Reports from over 10,000 programs. *Psychiatric Services (Washington, D.C.), 63*(4), 390. doi:10.1176/appi.ps.201000560

Carey, A. C. (1998). Gender and compulsory sterilization programs in America: 1907–1950. *Journal of Historical Sociology, 11*(1), 74–105.

doi:10.1111/1467-6443.00054

Carson, E. A., & Golinelli, D. (2013). Prisoners in 2012. *Bureau of Justice Statistics, December, 2*(3).

Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis: London. Thousand Oaks, CA: Sage Publications.

The CHOICE Project (Producer). (2012). Which birth control method is right for you? Retrieved from https://www.youtube.com/watch?v=u9SHoy1C3tU

G., Hebert, M. R., Rosengard, C., Rose, J. S., DaSilva, K. M., & Stein, M. D. (2006). Reproductive health care and family planning needs among incarcerated women. *American Journal of Public Health, 96*(5), 834–839. doi:10.2105/ajph.2004.060236

Clarke, J. G., Phipps, M., Tong, I., Rose, J., & Gold, M. (2010). Timing of conception for pregnant women returning to jail. *Journal of Correctional Health Care, 16*(2), 133–138.

Clarke, J. G., Rosengard, C., Rose, J. S., Hebert, M. R., Peipert, J., & Stein, M. D. (2006). Improving birth control service utilization by offering services prerelease vs postincarceration. *American Journal of Public Health, 96*(5), 840–845.

Cleland, J., Conde-Agudelo, A., Peterson, H., Ross, J., & Tsui, A. (2012). Contraception and health. *The Lancet, 380*(9837), 149–156.

Daniels, K. (2014). *Current contraceptive status among women aged 15–44 : United States, 2011–2013*. Hyattsville, Maryland: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Dedoose Version 7.0.23. (2016). Web application for managing, analyzing, and presenting qualitative and mixed method research data. Los Angeles, CA: SocioCultural Research Consultants, LLC. Retrieved from www.dedoose.com

Dehlendorf, C., Krajewski, C., & Borrero, S. (2014). Contraceptive counseling: Best practices to ensure quality communication and enable effective contraceptive use. *Clinical Obstetrics & Gynecology, 57*(4), 659–673. doi:10.1097/GRF.0000000000000059

Dehlendorf, C., Rodriguez, M. I., Levy, K., Borrero, S., & Steinauer, J. (2010). Disparities in family planning. *American Journal of Obstetrics and Gynecology, 202*(3), 214–220. doi:10.1016/j.ajog.2009.08.022

Dehlendorf, C., Ruskin, R., Grumbach, K., Vittinghoff, E., Bibbins-Domingo, K., Schillinger, D., & Steinauer, J. (2010). Recommendations for intrauterine contraception: A randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *American Journal of Obstetrics and Gynecology, 203*(4), 319.e311-319.e318. doi:10.1016/j.ajog.2010.05.009

Duggleby, W. (2005). What about focus group interaction data? *Qualitative Health*

Research, 15(6), 832–840. doi:10.1177/1049732304273916

Dwyer, C. (2017). Judge promises reduced jail time if Tennessee inmates get vasectomies. *National Public Radio (NPR)*. Retrieved from http://www.npr.org/sections/thetwo-way/2017/07/21/538598008/judge-promises-reduced-jail-time-if-tennessee-inmates-get-vasectomies

Eggebroten, J., Sanders, J., & Turok, D. (2016). Patient uptake and outcomes: An immediate postpartum IUD and implant program. *Obstetrics & Gynecology, 127*(s1), 117S–117S.

Ellsworth, H. S. (1992). Birth control. In *Encyclopedia of Mormonism* (pp. 116–117). New York, NY: Macmillan.

Fielding, N. G., & Lee, R. M. (1998). *Computer analysis and qualitative research*. Thousand Oaks, CA: Sage.

Finer, L. B., & Zolna, M. R. (2011). Unintended pregnancy in the United States: Incidence and disparities, 2006. *Contraception, 84*(5), 478–485. doi:10.1016/j.contraception.2011.07.013

Finer, L. B., & Zolna, M. R. (2014). Shifts in intended and unintended pregnancies in the United States, 2001–2008. *American Journal of Public Health*, 104 Suppl 1, S43–48. doi:10.2105/AJPH.2013.301416

Finer, L. B., & Zolna, M. R. (2016). Declines in unintended pregnancy in the United States, 2008–2011. *New England Journal of Medicine, 374*(9), 843–852. doi:10.1056/NEJMsa1506575

Flavin, J. (2009). Our bodies, our crimes: The policing of women's reproduction in America. New York, NY: New York University Press.

Food and Drug Administration. (2017). *Birth control: Medicines to help you.* Retrieved from https://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm

Foster, D. G., & Kimport, K. (2013). Who seeks abortions at or after 20 weeks? *Perspectives on Sexual and Reproductive Health, 45*(4), 210–218. doi:10.1363/4521013

Frost, J. J., & Darroch, J. E. (2008). Factors associated with contraceptive choice and inconsistent method use, United States, 2004. *Perspectives on Sexual and Reproductive Health, 40*(2), 94–104. doi:10.1363/4009408

Frost, J. J., Finer, L. B., & Tapales, A. (2008). The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. *Journal of Health Care for the Poor and Underserved, 19*(3), 778–796.

Frost, J. J., Singh, S., & Finer, L. B. (2007). Factors associated with contraceptive use and nonuse, United States, 2004. *Perspectives on Sexual and Reproductive Health, 39*(2), 90–99. doi:10.1363/3909007

Frost, J. J., Sonfield, A., Zolna, M. R., & Finer, L. B. (2014). Return on investment: A fuller assessment of the benefits and cost savings of the U.S. publicly funded family planning program. *Milbank Quarterly, 92*(4), 696–749. doi:10.1111/1468-0009.12080

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory strategies for qualitative research.* Chicago, IL: Aldine.

Glaser, J. B., & Greifinger, R. B. (1993). Correctional health care: A public health opportunity. *Annals of Internal Medicine, 118*(2), 139.

Greenberg, G. A., & Rosenheck, R. A. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services, 59*(2), 170–177. doi:10.1176/appi.ps.59.2.170

Gu, S., Sivin, I., Du, M., Zhang, L., Ying, L., Meng, F., . . . Wang, D. (1995). Effectiveness of Norplant? Implants through seven years: A large-scale study in China. *Contraception, 52*(2), 99–103. doi:10.1016/S0010-7824(95)00141-7

Hale, G. J., Oswalt, K. L., Cropsey, K. L., Villalobos, G. C., Ivey, S. E., & Matthews, C. A. (2009). The contraceptive needs of incarcerated women. *Journal of Women's Health (2002), 18*(8), 1221. doi:10.1089/jwh.2008.1296

Harlow, C. W. (2003). *Education and correctional populations*. Retrieved from https://www.bjs.gov/content/pub/pdf/ecp.pdf

HealthyPeople.gov. (n.d.). *Family planning*. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning

Henrichson, C., Rinaldi, J., & Delaney, R. (2015). *The price of jails: Measuring the taxpayer cost of local incarceration.* Retrieved from Vera Insitute of Justice website: https://www.vera.org/publications/the-price-of-jails-measuring-the-taxpayer-cost-of-local-incarceration

Herd, P., Higgins, J., Sicinski, K., & Merkurieva, I. (2016). The implications of unintended pregnancies for mental health in later life. [Abstract]. *The American Journal of Public Health, 106*(3), 421. doi:10.2105/AJPH.2015.302973

Higgins, J. A. (2014). Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. *Contraception, 89*(4), 237–241. doi:10.1016/j.contraception.2014.01.027

Hollin, C. R., & Palmer, E. J. (2006). Criminogenic need and women offenders: A critique of the literature. *Legal and Criminological Psychology, 11*(2), 179–195. doi:10.1348/135532505X57991

Huebner, B. M., Dejong, C., & Cobbina, J. (2010). Women coming home: Long-term patterns of recidivism. *Justice Quarterly, 27*(2), 225–254.

doi:10.1080/07418820902870486

James, D. (2004). *Profile of jail inmates, 2002*. Retrieved from https://www.bjs.gov/content/pub/pdf/pji02.pdf

Johnson, C. (2013). Female inmates sterilized in California prisons without approval. *The Center for Investigative Reporting*. Retrieved from https://www.revealnews.org/article/female-inmates-sterilized-in-california-prisons-without-approval/

Jones, J., Mosher, W., & Daniels, K. (2012). Current contraceptive use in the United States, 2006–2010, and changes in patterns of use since 1995. *National Health Statistics Reports*, (60), 1–26.

Joseph, J. G., Joshi, S. V., Lewin, A. B., & Abrams, M. (1999). Characteristics and perceived needs of mothers with serious mental illness. *Psychiatric Services (Washington, D.C.), 50*(10), 1357. doi:10.1176/ps.50.10.1357

Kavanaugh, M. L., Jerman, J., & Finer, L. B. (2015). Changes in use of long-acting reversible contraceptive methods among U.S. women, 2009–2012. *Obstetrics & Gynecology, 126*(5), 917–927. doi:10.1097/AOG.0000000000001094

Khan, M., Wohl, D., Weir, S., Adimora, A., Moseley, C., Norcott, K., . . . Miller, W. (2008). Incarceration and risky sexual partnerships in a southern U.S. city. *Bulletin of the New York Academy of Medicine, 85*(1), 100–113. doi:10.1007/s11524-007-9237-8

Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness, 16*(1), 103–121. doi:10.1111/1467-9566.ep11347023

Kluchin, R. M. (2009). *Fit to be tied: Sterilization and reproductive rights in America, 1950–1980*. New Brunswick, NJ: Rutgers University Press.

Krueger, R. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Kruttschnitt, C. (2013). Gender and crime. *Annual Review of Sociology, 39*(1), 291–308. doi:10.1146/annurev-soc-071312-145605

LaRochelle, F., Castro, C., Goldenson, J., Tulsky, J. P., Cohan, D. L., Blumenthal, P. D., & Sufrin, C. B. (2012). Contraceptive use and barriers to access among newly arrested women. *Journal of Correctional Health Care, 18*(2), 111–119. doi:10.1177/1078345811435476

Lee, J., Vlahov, D., & Freudenberg, N. (2005). Primary care and health insurance among women released from New York City jails. *Journal of General Internal Medicine*, 20, 124–124.

Leech, N. L., & Onwuegbuzie, A. J. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School Psychology Quarterly, 22*(4), 557–584. doi:10.1037/1045-3830.22.4.557

Leech, N. L., & Onwuegbuzie, A. J. (2008). Qualitative data analysis: A compendium of techniques and a framework for selection for school psychology research and beyond. *School Psychology Quarterly, 23*(4), 587–604. doi:10.1037/1045-3830.23.4.587

Liss-Schultz, N. (2014). California legislature votes to ban sterilization of inmates. *Rewire.news.* Retrieved from https://rewire.news/article/2014/08/22/california-legislature-votes-ban-sterilization-inmates/

Luna, Z., & Luker, K. (2013). Reproductive justice. *Annual Review of Law and Social Science, 9*(1), 327–352. doi:10.1146/annurev-lawsocsci-102612-134037

Maruschak, L. M. (2008). *Medical problems of prisoners*. U.S. Department of Justice. Retrieved from https://www.bjs.gov/content/pub/pdf/mpp.pdf

Massoglia, M., & Pridemore, W. A. (2015). Incarceration and health. *Annual Review of Sociology, 41*(1), 291–310. doi:10.1146/annurev-soc-073014-112326

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., . . . Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception, 81*(4), 316–322. doi:10.1016/j.contraception.2009.12.004

Minton, T. D. (2015). *Census of jails: Population changes, 1999–2013* (NCJ 248627). Retrieved from https://www.bjs.gov/content/pub/pdf/cjpc9913.pdf

Minton, T. D., Ginder, S., Brumbaugh, S. M., Smiley-McDonald, H., & Rohloff, H. (2015). *Census of jails: Population changes, 1999–2013*. Retrieved from https://www.bjs.gov/content/pub/pdf/cjpc9913.pdf

Minton, T. D., & Zeng, Z. (2016). *Jail inmates in 2015* (NCJ 250394). Retrieved from https://www.bjs.gov/content/pub/pdf/ji15.pdf

Mirowsky, J. (2003). *Education, social status, and health*. New York, NY: A. de Gruyter.

Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

National Commission on Correctional Health Care. (2014). *Women's health care in correctional settings*. Retrieved from http://www.ncchc.org/women%E2%80%99s-health-care

New York Civil Liberties Union. (2008). *Access to reproductive health care in New York state jails*. Retrieved from https://www.nyclu.org/sites/default/files/publications/nyclu_pub_healthcare_jails.pdf

Ocen, P. (2012). Punishing pregnancy: Race, incarceration and the shackling of pregnanct prisoners. *California Law Review*, (100), 1–54.

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L., & Zoran, A. G. (2009). A

qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods, 8*(3), 1–21. doi:10.1177/160940690900800301

Oregon Foundation for Reproductive Health (Producer). *One key question*. Retrieved from http://www.orfrh.org/onekeyquestion/

Peipert, J. F., Madden, T., Allsworth, J. E., & Secura, G. M. (2012). Preventing unintended pregnancies by providing no-cost contraception. *Obstetrics & Gynecology, 120*(6), 1291–1297. doi:http://10.1097/AOG.0b013e318273eb56

Peugh, J., & Belenko, S. (1999). Substance-involved women inmates: Challenges to providing effective treatment. *The Prison Journal, 79*(1), 23–44. doi:10.1177/0032885599079001003

Pew Research Center. (2015). *America's changing religious landscape*. Retrieved from http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/

Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: Theory, evidence, and policy implications. *Journal of Health and Social Behavior, 51*(1_suppl), S28–S40. doi:10.1177/0022146510383498

Potter, R. H. (2010). Jails, public health, and generalizability. *Journal of Correctional Health Care, 16*(4), 263–272. doi:10.1177/1078345810378252

Price, K. (2010). What is reproductive justice?: How women of color activists are redefining the pro-choice paradigm. *Meridians, 10*(2), 42–65. doi:10.2979/meridians.2010.10.2.42

Pruitt, S. L., von Sternberg, K., Velasquez, M. M., & Mullen, P. D. (2010). Condom use among sterilized and nonsterilized women in county jail and residential treatment centers. *Womens Health Issues, 20*(6), 386–393. doi:10.1016/j.whi.2010.06.007

Raj, A., Rose, J., Decker, M. R., Rosengard, C., Hebert, M. R., Stein, M., & Clarke, J. G. (2008). Prevalence and patterns of sexual assault across the life span among incarcerated women. *Violence Against Women, 14*(5), 528–541. doi:10.1177/1077801208315528

Ramaswamy, M., Chen, H. F., Cropsey, K. L., Clarke, J. G., & Kelly, P. J. (2015). Highly effective birth control use before and after women's incarceration. *Journal of Womens Health, 24*(6), 530–539. doi:10.1089/jwh.2014.4942

Ramaswamy, M., & Kelly, P. J. (2014). Factors associated with sterilization use among women leaving a U.S. jail: A mixed methods study. *BMC Public Health*, 14. doi:10.1186/1471-2458-14-773

Reid, D. (2014). *Reproductive justice advocates: Don't roll back sterilization consent rules*. Rewire. Retrieved from https://rewire.news/article/2014/04/02/reproductive-justice-advocates-dont-

roll-back-sterilization-consent-rules/

Reinharz, S. (1992). *Feminist methods in social research*. New York, NY: Oxford University Press.

Rich, J. D., Wakeman, S. E., & Dickman, S. L. (2011). Medicine and the epidemic of incarceration in the United States. *The New England Journal of Medicine, 364*(22), 2081–2083. doi:10.1056/NEJMp1102385

Rocca, C. H., & Harper, C. C. (2012). Do racial and ethnic differences in contraceptive attitudes and knowledge explain disparities in method use? *Perspectives on Sexual and Reproductive Health, 44*(3), 150–158. doi:10.1363/4415012

Rold, W. J. (2008). Thirty years after Estelle v. Gamble: A legal retrospective. *Journal of Correctional Health Care, 14*(1), 11–20. doi:10.1177/1078345807309616

Ross, L. (2014). *Eugenicists never retreat, they just regroup: Sterilization and reproductive oppression in prisons*. Rewire. Retrieved from https://rewire.news/article/2014/06/12/eugenicists-never-retreat-just-regroup-sterilization-reproductive-oppression-prisons/

Ross, L. (2017). *Reproductive justice: An introduction*. Oakland, CA: University of California Press.

Roth, R. (2004). Do prisoners have abortion rights? *Feminist Studies, 30*(2), 353–381. doi:10.2307/20458968

Roth, R., & Ainsworth, S. L. (2014). "If they hand you a paper, you sign it": A call to end sterilization of women in prison. *Hastings Women's Law Journal, 26*(1), 7–50.

Sacks, J. Y. (2004). Women with co-occurring substance use and mental disorders (COD) in the criminal justice system: A research review. *Behavioral Sciences & The Law, 22*(4), 449.

SB 1135, Inmates: Sterilization. (2014). California State Legislature. Retrieved from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140SB1135

Schoen, J. (2005). *Choice & coercion: Birth control, sterilization, and abortion in public health and welfare*. Chapel Hill, NC: University of North Carolina Press.

Schonberg, D., Bennett, A. H., Sufrin, C., Karasz, A., & Gold, M. (2015). What women want: A qualitative study of contraception in jail. *American Journal of Public Health*, 105(11), 2269–2274. doi:10.2105/ajph.2015.302765

Secura, G. M., Allsworth, J. E., Madden, T., Mullersman, J. L., & Peipert, J. F. (2010). The contraceptive CHOICE project: Reducing barriers to long-acting reversible contraception. *American Journal of Obstetrics & Gynecology, 203*(2), 115 e111-117. doi:S0002-9378(10)00430-8 [pii]10.1016/j.ajog.2010.04.017

Sharma, R., Biedenharn, K. R., Fedor, J. M., & Agarwal, A. (2013). Lifestyle factors and reproductive health: Taking control of your fertility. *Reproductive Biology and Endocrinology*, 11, 66–66. doi:10.1186/1477-7827-11-66

Sim, J. (1998). Collecting and analysing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing, 28*(2), 345–352. doi:10.1046/j.1365-2648.1998.00692.x

SisterSong, Women of Color Reproductive Justice Collective, & The National Women's Health Network (2017). *Long-acting reversible contraception statement of principles* Retrieved from https://www.nwhn.org/wp-content/uploads/2017/02/LARCStatementofPrinciples.pdf

Solinger, R. (2005). *Pregnancy and power: A short history of reproductive politics in America*. New York, NY: New York University Press.

Somers, M., & Roberts, C. (2008). Toward a new sociology of rights: A genealogy of "buried bodies" of citizenship and human rights. *Annual Review of Law & Social Science, 4*, 385–425.

Sonfield, A., Hasstedt, K., & Gold, R. (2014). *Moving forward: Family planning in the era of health reform.* Retrieved from Guttmacher Institute website: https://www.guttmacher.org/sites/default/files/report_pdf/family-planning-and-health-reform.pdf

Sonfield, A., Hasstedt, K., Kavanaugh, M., & Anderson, R. (2013). *The social and economic benefits of women's ability to determine whether and when to have children*. Retrieved from Guttmacher Institute website: https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf

Sonfield, A., & Kost, K. (2013). *Public costs from unintended pregnancies and the role of public insurance programs in paying for pregnancy and infant care: Estimates for 2008*. Retrieved from Guttmacher Institute website: https://www.guttmacher.org/sites/default/files/pdfs/pubs/public-costs-of-UP.pdf

Steadman, H. J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Sciences & the Law, 23*(2), 163. doi:10.1002/bsl.640

Stephan, J., & Walsh, G. (2011). *Census of jail facilities, 2006*. Retrieved from U.S. Department of Justice website: https://www.bjs.gov/content/pub/pdf/cjf06.pdf

Stern, A. M. (2005). STERILIZED in the name of public health. *American Journal of Public Health, 95*(7), 1128–1138.

Stern, A. M. (2007). "We cannot make a silk purse out of a sow's ear" Eugenics in the Hoosier heartland. *Indiana Magazine of History, 103*(1), 3–38. Retrieved from Indiana University website: https://scholarworks.iu.edu/journals/index.php/imh/article/view/12254/1821

5

Strauss, A. L. (1987). Qualitative analysis for social scientists. New York, NY: Cambridge University Press.

Sufrin, C. (2017). Jailcare: Finding the safety net for women behind bars. Oakland, CA: University of California Press.

Sufrin, C., Baird, S., Clarke, J., & Feldman, E. (2017). Family planning services for incarcerated women: Models for filling an unmet need. *International Journal of Prisoner Health, 13*(1), 10–18. doi:10.1108/IJPH-07-2016-0025

Sufrin, C., Creinin, M., & Chang, J. (2009a). Contraception services for incarcerated women: A national survey of correctional health providers. *Contraception, 80*(6), 561–565. doi:10.1016/j.contraception.2009.05.126

Sufrin, C., Creinin, M., & Chang, J. (2009b). Incarcerated women and abortion provision: A survey of correctional health providers. *Perspectives on Sexual and Reproductive Health, 41*(1), 6–11. doi:10.1363/4100609

Sufrin, C., Kolbi-Molinas, A., & Roth, R. (2015). Reproductive justice, health disparities and incarcerated women in the United States. *Perspectives on Sexual and Reproductive Health, 47*(4), 213–219. doi:10.1363/47e3115

Sufrin, C., Oxnard, T., Goldenson, J., Simonson, K., & Jackson, A. (2015). Long-acting reversible contraceptives for incarcerated women: Feasibility and safety of on-site provision. *Perspectives on Sexual and Reproductive Health, 47*(4), 203–211. doi:10.1363/47e5915

Sufrin, C., Tulsky, J., Goldenson, J., Winter, K., & Cohan, D. (2010). Emergency contraception for newly arrested women: Evidence for an unrecognized public health opportunity. *Bulletin of the New York Academy of Medicine, 87*(2), 244–253. doi:10.1007/s11524-009-9418-8

Sussman, D. (2008). Bound by injustice: Challenging the use of shackles on incarcerated pregnant women. *Cardozo Journal of Law and Gender*, 15, 477–502.

Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states*. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf

U.S. Department of Health & Human Services. *Title X family planning*. Retrieved from https://www.hhs.gov/opa/title-x-family-planning/index.html

Utah Code, Title 62A Chapter 6 Section 102, (1988).

Utah Medicaid Provider Manual. (2018) *Inmates of public institutions division of Medicaid and health financing*. Section I: General Information. Section I, 8-3.2, 43. Retrieved from https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf

Vaughn, S., Schumm, J. S., & Sinagub, J. (1996). *Focus group interviews in education and psychology*. Sage Publications. doi: 10.4135/9781452243641

Wakefield, S., & Uggen, C. (2010). Incarceration and stratification. *Annual Review of Sociology*, 36, 387–406.

Wang, E. A., White, M. C., Jamison, R., Goldenson, J., Estes, M., & Tulsky, J. P. (2008). Discharge planning and continuity of health care: Findings from the San Francisco County jail [Author abstract]. *The American Journal of Public Health, 98*(12), 2182.

Warner, T. D., & Kramer, J. H. (2008). Closing the revolving door?: Substance abuse treatment as an alternative to traditional sentencing for drug-dependent offenders. *Criminal Justice and Behavior, 36*(1), 89–109. doi:10.1177/0093854808326743

Wendt, A., Gibbs, C. M., Peters, S., & Hogue, C. J. (2012). Impact of increasing inter-pregnancy interval on maternal and infant health. *Paediatric and Perinatal Epidemiology*, 26, 239–258. doi:10.1111/j.1365-3016.2012.01285.x

Western, B., Kling, J. R., & Weiman, D. F. (2001). The labor market consequences of incarceration. *Crime & Delinquency, 47*(3), 410–427. doi:10.1177/0011128701047003007

Wilkinson, S. (2004). Focus group research. In D. Silverman (Ed.), *Qualitiative research: Theory, method, and practice* (pp. 177–199). Thousand Oaks, CA: Sage.

Wishart, M. D., & Dubler, N. N. (1983). Health care in prisons, jails and detention centers: Some legal and ethical dilemmas. Bronx, NY: Montefiore Medical Center. As cited in K. L. Faiver. (2017). *Humane health care for prisoners: Ethical and legal challenges.* Santa Barbara, CA: Praeger.

Zucker, A. N. (2014). Reproductive justice: More than choice. *Analyses of Social Issues and Public Policy, 14*(1), 210–213.