

Improving the Provision of Reproductive Health Services to Incarcerated Women

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ABSTRACT

Many researchers in social science and criminal justice fields have shown that reproductive health services for women in prisons, jails, and other correctional facilities, including preventive screening, prenatal services, and treatment, is severely lacking. As the rates of incarcerated women continue to soar, for a multitude of political, economic, and structural reasons, it has become increasingly more critical that women's health issues, including reproductive health, are adequately addressed in the prison health setting. Correctional and health care programs differ strongly in their purpose (punishment or care), primary client served (society or individual), means employed to achieve their purpose (deprivation or therapy), use of force, type of employee training (paramilitary style or academic/clinic based), and system of beliefs. These differing paradigms must be reconciled and strong leadership developed in order to effectively address incarcerated women's basic reproductive health needs. Whereas some standards and guidelines from various organizations devoted to correctional health have been developed, there are still huge disparities and incongruities in the services offered. Suggested leadership theories and principles included in this paper to address reproductive health services for incarcerated women tend to share common elements, which are primarily collaboration, coalition building, mobilizing, creating common value and ethical standards to fit the health issue and problem solving approach, capacity building, cooperation, visionary leadership, creative solutions, and overcoming barriers in mutually beneficial ways.

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Introduction

Perusing newspaper headlines across the country, it is not uncommon to read about the frequently dubbed “crisis” of prison health care in America. In an article from the *San Francisco Chronicle*, James Sterngold (2005) wrote: “One witness after another at a state Senate hearing offered scathing testimony on deplorable health care facilities, incompetent doctors, deaths of inmates due to medical negligence, and bureaucratic red tape. State officials acknowledged that, in spite of the fact that California spends two and three times as much per inmate on health care as other states, there are Third World conditions at some prisons” (p.1).

Also in 2005, a *New York Times* journalist wrote a condemning piece that addressed the disadvantages of privatization in the context of a particularly careless for-profit prison care corporation, Prison Health Services. This corporation engaged in unethical, cost-cutting, negligent business practices. As both the privatization of prisons and the health care within its walls are a growing enterprise, with corporations standing to make \$2 billion a year on skyrocketing medical costs (von Zielbauer, 2005), it appears that the health of inmates is not a primary concern.

In terms of the relevance of prison health issues to the discipline of public health, the American Public Health Association, in collaboration with The Community Voices Initiative of the National Center for Primary Care and the Morehouse School of Medicine, sponsored a forum on topics relating to prison health care, the urgent reforms that need to be addressed, and what public health professionals

should do to help combat this growing problem (Gooden, 2005).

The focus of this paper, is reproductive health for incarcerated women. As multiple researchers have shown, reproductive health services for women in prisons, jails, and other correctional facilities, including preventive screening, prenatal services, and treatment, is severely lacking. Further, as Arriola, Braithwaite, and Newkirk (2006) articulate: “the invisibility of incarcerated women has resulted in little research and policy development that would advance their health status” (p.3). As the rates of incarcerated women continue to soar, it becomes increasingly more critical that women's health issues, including reproductive health, are adequately addressed (Satcher, 2006, p. xvii). Additionally, prison systems have historically and primarily been designed with men in mind, including the types of services offered. Subsequently, issues relating to reproductive health have frequently been overlooked. For example, a common complaint among incarcerated women is the lack of regular gynecological and breast exams (Understanding Prison Health Care, 2002).

Additionally, as Prout and Ross (1988) express:

“...there is a major conflict of care and punishment that is a fact of life in prison medicine...the same institution that is responsible for punishing offenders is also responsible for giving them care they need” (pp. 228-229).

Whereas the U.S. Constitution has upheld that prisoners are entitled to healthcare, this does not necessarily mean that adequate, humane, and ethical

treatment has been the result (Prout & Ross, 1988). With an incorporation of several leadership theories and recommendations from practitioners in the prison health care setting, I hope to illuminate how reproductive health services for incarcerated women might be improved.

Significance of the Problem

The inadequate provision of reproductive health services to incarcerated women has important public health consequences as well as ones for society as a whole. Correctional facilities are meant not only to separate out some members of society, but also to serve rehabilitative functions, so that those same individuals can be re-integrated and live healthy and productive lives. Having collaborative, visionary leadership on how to carry out these tasks is, therefore, critical.

Previous research conducted on reproductive services for incarcerated women has shown that women are not receiving adequate care. Gynecologic exams, if offered, are inconsistently available. Baseline reproductive health history screening is often not ascertained. Additionally, health care providers working in correctional health settings are often not trained in or sensitive to reproductive health issues and concerns, which is quite problematic. Due to this lack of consistent and adequate services, many reproductive health concerns go undetected (Women's Health Care in Correctional Settings, 2005). Also, women who enter the correctional system in the United States "represent a population already at high risk for communicable diseases, substance abuse, and mental health problems (Braithwaite, 2006, p.18). For example, researchers have demonstrated that incarcerated women tend to have very high rates of STIs, abnormal Pap smears, and vaginal infections (de Groot & Maddow, 2006). Recent estimates show that women in state prisons are also between 13 and 20 times more likely to be infected with HIV than women in the general population (de Groot & Maddow, 2006).

Equally troubling is the fact that "many imprisoned women are survivors of physical and sexual abuse and have lacked previous health care in their communities...moreover, despite being imprisoned and presumably safe from harm, in prisons throughout the United States, women are victims of sexual abuse by prison staff, at times during routine medical examinations (Braithwaite, 2006, p.19).

As of now, reproductive health issues are really not addressed in any sort of organized fashion (Clark, 2006). Some efforts have been made to address considerations of prenatal care and pregnancy in

prisons, but much of the rest of the reproductive health sphere needs improvements (Clark, 2006).

In terms of prenatal care, several professional associations, including the APHA, have recognized the need for guidelines with regard to the treatment of incarcerated mothers and pregnant women (Fortenberry, Warren, & Clark, 2006). Whereas many correctional facilities for incarcerated women do have basic prenatal services, non-federal prisons are not uniformly required to do so, and are frequently not provided to women unless they explicitly request those services (Fortenberry, et al., 2006).

More broadly, correctional and health care programs differ strongly in their purpose (punishment or care), primary client served (society or individual), means employed to achieve their purpose (deprivation or therapy), use of force, type of employee training (paramilitary style or academic/clinic based), and system of beliefs (Faiver, 1998). These differing paradigms must be reconciled and strong leadership developed to address incarcerated women's basic reproductive health needs effectively.

Factors Related to the Problem

As mentioned previously, most incarcerated women in the U.S. tend to come from poor communities of color, with high rates of unemployment and lack of access to services prior to their arrest (Arriola, et al., 2006). About half of incarcerated women have obtained a high school education and half are without employment upon arrest. The typical incarcerated woman in the U.S. is in her early 30s, a fact that has relevance for the types of reproductive health services that should be offered (Arriola, et al., 2006). Further describing the context of incarcerated women's lives within the larger society, Arriola, et al. (2006) write:

"It is no coincidence that the people who suffer poor health status are also the ones who are disproportionately incarcerated in the United States: the poor health status of incarcerated women reflects the inequalities that exist in the social, political, and economic structures of the larger society" (p. 4).

Over the past 10 years, the number of women in jails, prisons, and correctional facilities has increased dramatically (Arriola, et al., 2006). Researchers generally account for this increase by "an increase in minor property and drug-related crimes" (Braithwaite, 2006, p. 21). Shifting paradigms and perspectives on crime, punishment, and government responsibility in America during the 1980s included policies of deinstitutionalization and the war on

drugs. When crack-cocaine was brought into urban areas, the rates of arrest for women increased significantly (Braithwaite, 2006). This increase in arrests also was due largely to the use of mandatory minimum sentencing statutes for drug offenses, implemented in the 1980s as part of the war on drugs (Braithwaite, 2006).

Some researchers also point to sexual victimization as a factor contributing to female incarceration (Braithwaite, 2006). “Between 44 and 60 percent report having been physically or sexually assaulted at some point in their lives, and nearly 70 percent of incarcerated women were abused before the age of eighteen” (Arriola, et al., 2006, pp. 6-7). With regard to reproductive health of incarcerated women, “a history of physical and sexual abuse is highly correlated with drug abuse, prostitution, and unsafe sex practices” (Arriola, Smith, & Farrow, 2006, p.56). In addition, risky sexual behaviors in which some incarcerated women engage, such as trading sex for money or drugs, not using condoms, or having multiple partners, increases the risk of contracting HIV and other STIs (Arriola, Smith, & Farrow, 2006).

In terms of previous efforts to address the issue of correctional health care, both generally and with regard to reproductive health, there are several organizations that have made it a priority issue. First, the National Commission on Correctional Health Care (NCCHC) offers health services accreditation for correctional health facilities, but this accreditation is obtained on a voluntary basis only at the moment (Arriola, Braithwaite, & Newkirk, 2006). Additionally, the American Psychiatric Association and the American Correctional Association have created guidelines for service delivery in correctional settings (Arriola, Braithwaite, & Newkirk, 2006).

The American Public Health Association created a Task Force on Health Services in Correctional Institutions, and was the first organization to create a set of professional standards relating to correctional health care (APHA Task Force on Correctional Health Care Standards, 2003). The standards are predicated upon fundamental public health principles, such as human rights, ethics, and universal access (APHA Task Force on Correctional Health Care Standards, 2003). One specific section in the standards set forth addresses health services for women in particular, stating, “Jail and prison health programs must provide the services and facilities necessary to meet women’s health care needs, even when women are only a small proportion of the institutional population” (APHA Task Force on Correctional Health Care Standards, 2003, p.107). This standard entails a list of “satisfactory compliance” items, such as: “Periodic reproductive

system examinations, including pelvic and breast examinations, Pap tests, and mammography must be provided according to contemporary community guidelines. There must also be a system for tracking periodic examinations” (APHA Task Force on Correctional Health Care Standards, 2003, p.107). Whereas the creation of the task force and the standards of care in correctional health settings were a huge step in addressing and acknowledging the problem, they are not uniformly followed nor are they enforced.

Implications for Leadership

Before I address the provision of reproductive health services to incarcerated women from theoretical leadership frameworks, I wish to frame the issues within the larger context of professional philosophies. Policies and guidelines such as the ones set forth by the American Correctional Association utilize a comprehensive public health approach which caters to the needs of the entire individual. Some researchers contend, “Perhaps the different missions of public health and corrections may help to explain the discord between de jure and de facto treatment of pregnant women in correctional facilities” (Fortenberry, Warren, & Clark, 2006, p.175). It is morally and ethically imperative that public health and health care professionals help improve the health status of individuals regardless of crimes they may have committed (Arriola, Braithwaite, & Newkirk, 2006, p.11). However, these are not the same mission and goals of the correctional profession:

“Correctional institutions are places of punishment, while medical facilities are places of healing. Those choosing a correctional profession or a health profession start out with immensely divergent philosophies, policies, and methods. Yet, a major responsibility of correctional officials is the “care and safe custody of the confined” – a concern clearly shared by the health care profession...recognition of the differences and the similarities of these two disciplines is crucial for their effective cooperation and collaboration” (Faiver, 1998, xv).

So, whereas the philosophies are different, some of the responsibilities are the same, and it is critical to understand how these two disciplines intersect and can possibly work together in a mutually beneficial way if any improvements are to be made within the realm of correctional health care.

That being said, the first leadership theory with which I would like to address this health issue and setting is from John P. Kotter. In Kotter’s framework, leadership entails tackling three overarching

concepts. The first, aligning people, involves “communicating direction in words and deeds to everyone whose cooperation is needed to create the vision” (McDermott, personal communication, September 2007). The second task is to establish direction, which entails “developing a vision of the future, and the strategies to create it” (McDermott, personal communication, September 2007). Finally, motivating and inspiring people to overcome various barriers such as politics, bureaucracy, and resource limitations, “by satisfying basic, but often unfulfilled, human needs” (McDermott, personal communication, 2007).

Kotter’s eight-stage process for creating major change, from his widely acclaimed book, *Leading Change*, involves “establishing a sense of urgency; creating the guiding coalition; developing a vision and strategy; communicating the change vision; empowering broad-based action; generating short-term wins; consolidating gains and producing more change; and anchoring new approaches in the culture” (McDermott, personal communication, September 2007).

The second leadership theory I would like to incorporate into a discussion of reproductive health services for incarcerated women is predicated upon the notion that leaders create resonance. I am particularly interested in this theory because of the dire state of correctional health today -- the kinds of answers needed to improve health care services require new and creative changes and collaborations. Because of frequently apathetic public perspectives on issues surrounding prisoners’ well being and the often-controversial nature of prison medicine, prisoners’ entitlement to health care, and the provision of reproductive services in particular, leadership perspectives that enhance resonance and a new vision for the future are ideal. David Goleman describes six styles of leadership appropriate under this theoretical perspective, some of which are in opposition to the underlying premises and points of utility of others. Not all of these styles are necessarily appropriate for the topic and setting at hand, so I will only mention the ones that I think would have a positive influence. The first is coaching, which requires the leader to listen, encourage, counsel, delegate, and help those within the organization/agency identify strengths and weaknesses. This style is appropriate when leaders want to build capacity and long-term capabilities in their organization (McDermott, personal communication, September 2007). Leaders in this framework are also affiliative, meaning that they demonstrate leadership by promoting harmony in their organization/agency, being empathetic, and solving conflicts. This quality is useful “to heal rifts

in a team, motivate during stressful times, or strengthen connections” (McDermott, personal communication, September 2007). Another style postulated by Goleman is the visionary leader. These leaders must inspire others in their organizational setting and make each position within that organization relevant and critical to that vision. This asset is useful “when changes require a new vision, or when clear direction or radical change is needed” (McDermott, personal communication, September 2007). Goleman’s fourth leadership style is democratic. In other words, democratic leaders are interested in hearing what other people have to say and engage in team-based approaches and collaboration. This trait is useful to build consensus and ensure that input from the rest of the group/organization is being shared (McDermott, personal communication, September 2007).

Work by Wright, Hann, McLeroy, Steckler, Matulionis, et al. (2003) also bears relevance to this topic as their review of the PHELI leadership model involves critical elements of public health leadership. Some of the authors’ examples of effective change agents that are of significance include: “facilitate application of organizational change theories and concepts to various types of community and public health organizations’ facilitate and create dialogue; facilitate development of capacity to identify strategies to address acute problems; facilitate development of strategic coalitions with organizations; and identify the strategic benefits of coalitions” (Wright et al., 2003, p. 295).

In terms of transorganizational competencies and interorganizational collaborating mechanisms, Wright et al. (2003) articulate several strategies of importance for improving access and quality of reproductive health services to incarcerated women in U.S. correctional facilities, which include: “developing system structures based on knowledge of organizational learning, development, behavior and culture; identify and include key players...and stakeholders in collaborative ventures; identify shared or complementary mission and facilitate creation of common vision; create transorganizational systems based on common values and ethical standards” (Wright et al, 2003, p. 296).

Finally, it is critical that public health authorities are “interpersonally competent, politically astute, policy advocates, community mobilizers and builders, strategic opportunists, and capable of managing integrated, cross-functional teams, coalitions, and organizational groups...The focus must be on change and evolving systems within the context of organizational and community capacity building as the objective (Wright et al., 2003, p. 300).

The leadership theories and approaches that I chose to include tend to share common elements, which are primarily collaboration, coalition building, mobilizing, creating common value and ethical standards to fit the health issue and problem solving approach, capacity building, cooperation, visionary leadership, creative solutions, and overcoming barriers in mutually beneficial ways. Some strategies that may increase collaborative efforts between prison and health care staff, for example, include establishing common ground and reinforcing that “both are charged for responsibly caring for and safeguarding inmates” (Faiver, 1998, p.28). Also, it is not reasonable or even possible to expect that total agreement will take place. Instead, differences, whether in professional philosophies or codes of ethics/conduct should be acknowledged and respected (Faiver, 1998). This acknowledgment of the professionalism of the other can help create mutual respect and foster a better working relationship (Faiver, 1998). Finally, domination is not ideal in this instance; rather, collaboration, consultation, cooperation and dialogue are better ways in which to achieve common goals (Faiver, 1998). In addition, collaboration allows for each organization/group involved to address the problem, rather than place all of the responsibility on one party. For example, whereas reproductive health standards established by relevant professional organizations are not enforced in all correctional facilities, a coalition of interested parties, including the prison staff, medical staff, local public health department, local hospital, community-based organizations and social services could combine efforts to address the provision of reproductive health services to incarcerated women from those professional standards of care.

Another way to improve the reproductive health services provided to incarcerated women from the aforementioned leadership approaches might be calling for greater and more open communication between correctional staff and medical personnel (Fortenberry, et al. &, 2006). Additionally, an example of creating common value and ethical standards to fit the health issue and problem solving approach could be annual sensitivity training for all staff and medical personnel with regard to the unique needs of incarcerated women (Fortenberry, et al., 2006). Incorporating a visionary leadership framework may involve creating policies at individual correctional facilities that “explicitly forbid inappropriate treatment or mistreatment of inmates” (Fortenberry, et al., 2006). Additionally, if this policy change is not possible, advocacy and community mobilizing principles and methods can be utilized to let local, state, and regional leaders know

how important adequate correctional health care is for the inmates and the communities to which they will likely return (Fortenberry, et al., 2006).

Finally, in terms of building capacity and increased coordination of reproductive health services, it is critical for leaders to consider the importance of community based transitional planning to help reintegrate incarcerated women back into their communities. Moreover, frameworks for doing so must be made more available and utilized more by correctional facilities (Boutwell, Kendrick, & Rich, 2006). Some examples of elements of successful models would include many of the leadership goals and approaches identified earlier, such as:

“...the establishment of ongoing relationships with service providers prior to release and continuity of care with the same providers after release; comprehensive discharge planning and individualized case management; community follow up with outreach workers who personally meet with ex-offenders and assist them in keeping appointments...” (Boutwell, et al., 2006, p. 316).

Incorporation of principles of leadership that call for collaboration, cooperation, visionary changes, increased visibility and communication may help further the provision and quality of reproductive health services to incarcerated women, which has significant ramifications not only for the correctional facility, but women’s families and the communities in which they lived and may likely return.

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