

# Inadequate Access: Reforming Reproductive Health Care Policies for Women Incarcerated in New York State Correctional Facilities

KATE WALSH\*

*In February 2015, the Correctional Association of New York released a report studying the quality of and access to reproductive health care for incarcerated women and found that “[o]verall . . . reproductive health care for women in New York State prisons is woefully substandard, with women routinely facing poor-quality care and assaults on their basic human dignity and reproductive rights.”<sup>1</sup> The findings of this and other studies provide concrete evidence of the poor quality of reproductive health care available to incarcerated women and signal to legislatures that these policies should be changed.*

*Incarcerated women face three issues of particular concern relating to reproductive health care: access to gynecological examinations, sanitary supplies, and contraception. The purpose of this Note is to examine New York State policies addressing reproductive health care for incarcerated women, identify problems with them, and make recommendations for reform. This Note will examine current policies and practices of New York State correctional facilities that address gynecological examinations, sanitary supplies, and contraception, and assess why these policies are problematic from both legal and medical perspectives. Furthermore, it will recommend bringing New York’s policies in line with legal, medical, and international standards as a strategy for reform. Finally, it will advocate*

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\* Executive Notes Editor, *Colum. J.L. & Soc. Probs.*, 2016–2017. J.D. Candidate 2017, Columbia Law School. The author would like to thank Professor Philip Genty for his invaluable insight and guidance, and the staff of the *Columbia Journal of Law and Social Problems* for their hard work and support in preparing this piece for publication.

1. CORR. ASS’N OF N.Y., REPRODUCTIVE INJUSTICE: THE STATE OF REPRODUCTIVE HEALTH CARE FOR WOMEN IN NEW YORK STATE PRISONS 4 (2015), available at <http://www.correctionalassociation.org/wp-content/uploads/2015/03/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf> [<https://perma.cc/YPX8-DZ4E>].

for using existing federal and state programs including Title X to provide funding for reproductive care both prior to and after release.

## I. INTRODUCTION

Sara, a woman incarcerated in a New York State prison, waited nearly seven months for cancer treatment after finding a lump on her groin.<sup>2</sup> Another woman incarcerated in a New York State prison told researchers: “I was on birth control for endometriosis before coming into prison. . . . I was told here that we aren’t allowed birth control.”<sup>3</sup> In Michigan, women recently filed a lawsuit against Muskegon County because their correctional facility “fail[ed] to provide adequate feminine hygiene products . . . , causing them to bleed through their clothes.”<sup>4</sup>

Unfortunately, these stories of substandard access to reproductive health care are not anomalous. According to the most recently released statistics, there are 112,961 women in prison in the United States,<sup>5</sup> 2413 of which are in New York state prisons.<sup>6</sup> While women now account for approximately 7% of the U.S. prison population<sup>7</sup> and 4.5% of the New York State prison population,<sup>8</sup> reproductive health care for women remains “woefully substandard.”<sup>9</sup> This substandard care is reflected in the finding that a majority of women in New York State correctional facilities reported that they “could not see the GYN when necessary.”<sup>10</sup> Prison health care policies and procedures are also still designed for a historically male population and fail to adequately account for

2. See *id.* at 7, 44 (“The most egregious case of delays the CA learned about was a woman who waited nearly seven months for cancer treatment. She died shortly after being released.”).

3. *Id.* at 76 (ellipsis modified).

4. Complaint at 1, *Semelbauer v. Muskegon Cty.*, 2015 WL 9906265 (W.D. Mich. Dec. 4, 2014), available at [http://www.aclumich.org/sites/default/files/2014\\_MuskegonComplaint.pdf](http://www.aclumich.org/sites/default/files/2014_MuskegonComplaint.pdf) [https://perma.cc/2G7P-RY49].

5. E. ANN CARSON, U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2014 2 (2015), available at <http://www.bjs.gov/content/pub/pdf/p14.pdf> [https://perma.cc/7UAV-6SHY].

6. N.Y. DEP’T OF CORR. AND CMTY. SUPERVISION, UNDER CUSTODY REPORT: PROFILE OF UNDER CUSTODY POPULATION AS OF JANUARY 1, 2014 3 (2014), available at [http://www.doccs.ny.gov/Research/Reports/2014/UnderCustody\\_Report\\_2014.pdf](http://www.doccs.ny.gov/Research/Reports/2014/UnderCustody_Report_2014.pdf) [https://perma.cc/T4HH-Z2CX].

7. Carson, *supra* note 5, at 2 (Total prison population is 1,561,525; Total female prison population is 112,961).

8. N.Y. DEP’T OF CORR. AND CMTY. SUPERVISION, *supra* note 6.

9. CORR. ASS’N OF N.Y., *supra* note 1, at 4.

10. CORR. ASS’N OF N.Y., *supra* note 1, at 43.

women's reproductive needs.<sup>11</sup> This is particularly troubling because most incarcerated women are of reproductive age,<sup>12</sup> and furthermore because "[w]omen in prison are overwhelmingly from low-income communities"<sup>13</sup> and their time in prison may be their first or only opportunity for education about and access to gynecological care.<sup>14</sup> Women have unique health concerns distinctive from men including that: "[s]ome 6–10% of women in custody at any given time are pregnant, and about 1,400 women per year give birth while incarcerated."<sup>15</sup> Additionally, more than 80% of incarcerated women have reported a history of unplanned pregnancies,<sup>16</sup> and from a medical standpoint, pregnancies among incarcerated women may be especially high risk for a number of reasons.<sup>17</sup>

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11. See N.Y. CIVIL LIBERTIES UNION (NYCLU), ACCESS TO REPRODUCTIVE HEALTH CARE IN NEW YORK STATE JAILS 4–5 (2008), available at [http://www.nyclu.org/files/rrp\\_jail\\_report\\_030408.pdf](http://www.nyclu.org/files/rrp_jail_report_030408.pdf) [<https://perma.cc/WLX6-TZ58>] ("Most jail health care policies were 'one size fits all' for both male and female inmates, and they did not recognize that women require specific health care services such as abortion and prenatal care.").

12. See AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMMITTEE OPINION NO. 535: REPRODUCTIVE HEALTH CARE FOR INCARCERATED WOMEN AND ADOLESCENT FEMALES (2012), available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-Health-Care-for-Incarcerated-Women-and-Adolescent-Females> [<https://perma.cc/M7PE-QLDV>] [hereinafter ACOG COMM. 535]; see also Dana Schonberg, *What Women Want: A Qualitative Study of Contraception in Jail*, 105 AM. J. PUB. HEALTH 2269 (2015), available at <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302765> [<https://perma.cc/2R5D-9HGB>].

13. CORR. ASS'N OF N.Y., *supra* note 1, at 4.

14. See Jennifer G. Clarke et al., *Reproductive Health Care and Family Planning Needs Among Incarcerated Women*, 96 AM. J. PUB. HEALTH 834, 837 (2006), available at <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2004.060236> [<https://perma.cc/UF6M-EPHD>] ("Incarceration is often the only opportunity for many disenfranchised women to receive general medical care, reproductive health care, and preventive health care services.").

15. Carolyn B. Sufrin et al., *Incarcerated Women and Abortion Provision: A Survey of Correctional Health Providers*, 41 GUTTMACHER INST. PERSP. ON SEXUAL AND REPROD. HEALTH 6 (2009), available at <https://www.guttmacher.org/pubs/journals/4100609.html> [<https://perma.cc/S5UD-KVWX>].

16. See Clarke et al., *supra* note 14, at 836.

17. See Jennifer G. Clarke et al., *Improving Birth Control Service Utilization By Offering Services Pre-release Vs Postincarceration*, 96 AM. J. PUB. HEALTH 840, 840 (2006), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470571/> [<https://perma.cc/5WQT-LJWA>] ("Among incarcerated women, pregnancies are high risk for several reasons. One is that many of these women lack or fail to use prenatal care services. Another is that use of drugs among these women frequently leads to preterm deliveries, spontaneous abortions, low-birthweight infants, and preeclampsia. Moreover, their high rates of psychiatric illness often result in exposure of the fetus to teratogenic medications during treatment, and their alcohol use may cause fetal alcohol syndrome.").

Incarcerated women face specific challenges in accessing reproductive health care including gynecological examinations, sanitary supplies, and contraception.<sup>18</sup> Recent studies provide concrete evidence that prison policies and practices continue to inhibit women's access to adequate reproductive health care in these areas.<sup>19</sup> These policies are problematic from a medical and public health perspective, and may in some cases violate incarcerated people's Eighth Amendment rights to access medical care, leaving the State and some correctional facilities vulnerable to lawsuits.<sup>20</sup>

The purpose of this Note is (1) to analyze current New York State policies around reproductive health care for incarcerated women and how these policies are working in actual prisons and jails, (2) to examine why these policies are problematic from both legal and medical perspectives, and (3) to make recommendations for reform. Part II examines current New York State prison policies and practices that regulate access to gynecological examinations, sanitary supplies, and contraception; this Part specifically looks at the obstacles these policies create for incarcerated women. Part III explores why these policies may be problematic from a legal and medical perspective. Part IV evaluates current federal policies and international guidelines as possible models for changes to New York's policies. Part V recommends a possible strategy for reform: bringing state policies in line with existing legal, medical, and international standards. Finally, Part VI examines using existing federal and state programs including Title X, Medicaid, and the Affordable Care Act to fund programs that provide gynecological care and access to contraception both prior to and after release.

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18. See CORR. ASS'N OF N.Y., *supra* note 1, at 7–8 (A list of the “[t]op 10 problems related to reproductive health care” includes: “[i]nadequate access to and delays in GYN care”; “[i]nsufficient sanitary napkin and toilet paper supplies”; and “[s]everely limited access to contraception.”).

19. See CORR. ASS'N OF N.Y., *supra* note 1 (“[W]e found that reproductive health care for women in New York State prisons is woefully substandard, with women routinely facing poor-quality care and assaults on their basic human dignity and reproductive rights.”); see also Schonberg, *supra* note 12, at 2269 (“[M]edical services in correctional facilities have failed to meet the needs of this growing population. Among some of the more salient unmet medical needs is reproductive health care.”); Clarke et al., *supra* note 14, at 836 (“Despite an increased need for reproductive health services among incarcerated women who are at risk for STDs and pregnancy, they are often underserved in receipt of reproductive health and family planning services.”).

20. See *infra* Part III.A.

Although incarcerated women's inadequate access to reproductive care is a national issue and "[w]omen in prisons across the country face similar problems in accessing adequate reproductive health care and humane treatment,"<sup>21</sup> this Note will focus on correctional facilities in New York State, primarily because recent studies and reports by the Correctional Association of New York and the New York Civil Liberties Union (NYCLU) offer detailed information about how reproductive health care policies are being implemented and the ramifications of these policies on incarcerated women.

## II. CURRENT NEW YORK STATE PRISON POLICIES AND PRACTICES

New York's policies and practices regulating incarcerated women's access to gynecological care including examinations, sanitary supplies, and contraception are problematic for a number of reasons. These reasons include a lack of comprehensive written laws and policies, policies that are outdated, and policies that fail to follow standards put forth by the medical community.<sup>22</sup>

Multiple levels of state government promulgate New York's prison laws and policies. The New York State Commission of Correction (SCOC) has the power to create minimum standards for the management of correctional facilities, and it also evaluates, investigates, and oversees correctional facilities.<sup>23</sup> Title 9 of

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21. CORR. ASS'N OF N.Y., *supra* note 1, at 3.

22. See CORR. ASS'N OF N.Y., *supra* note 1, at 37 ("Some of DOCCS' reproductive health policies are adequate, but others are incomplete and outdated. Hardly any of the policies reference community standards and some stray from those standards in key areas. In some cases, such as the starting age for yearly GYN check-ups and the frequency of prenatal visits, the CA found that DOCCS' practice is actually in sync with community standards even though its written policies are not.")

23. See *Mission Statement*, NEW YORK STATE COMMISSION OF CORRECTION, <http://www.scoc.ny.gov/> [<https://perma.cc/LC8L-C9QG>] (last visited Oct. 22, 2016) ("[T]he Commission: Promulgates minimum standards for the management of correctional facilities; [and] Evaluates, investigates and oversees local and state correctional facilities and police lock-ups . . ."); see also N.Y. CORRECT. LAW § 45 (McKinney 2016) ("The commission shall have the following functions, powers and duties: . . . visit, and inspect correctional facilities . . ., appraise the management of such correctional facilities with specific attention to matters such as safety, security, health of inmates, sanitary conditions . . ., [and p]romulgate rules and regulations establishing minimum standards."); see also NYCLU, *supra* note 11, at 6 ("The legislature has granted the power to oversee county jail facilities to the State Commission of Correction (SCOC). The SCOC is charged with establishing minimum standards governing health care in New York's penal institutions.")

the New York Codes, Rules and Regulations (NYCRR) contains the minimum standards and regulations put forth by SCOC for the management of state prisons and jails including county jails and penitentiaries, facilities operated by the Office of Children and Family Services (OCFS), city jails, and state correctional facilities.<sup>24</sup>

The New York State Department of Corrections and Community Supervision (DOCCS) “is responsible for the confinement and habilitation of approximately 53,000 individuals under custody held at 54 state facilities . . . .”<sup>25</sup> DOCCS has the authority to develop and enforce the rules and regulations to implement laws enacted by the New York State Legislature.<sup>26</sup> Title 7 of the NYCRR, which contains DOCCS regulations, also contains information relating to health care for incarcerated persons.<sup>27</sup> Additional DOCCS health policies are contained in the Health Services Policy Manual, the Women’s Health Primary Care Practice Guideline, and DOCCS Directives.<sup>28</sup> The laws and policies that regulate gynecological examinations, sanitary products, and con-

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24. N.Y. COMP. CODES R. & REGS. tit. 9, § 7010 (2016) (states the minimum standards and regulations for health services in county jails and penitentiaries); *id.* § 7410 (states the minimum standards and regulations for health services in Secure Facilities Operated by the Office of Children and Family Service); *id.* § 7503.1 (states the minimum medical standards and regulations in city jails — town and village lockup); *id.* § 7651 (states the minimum standards and regulations for health services in state correctional facilities). In assessing New York State’s policies, this Note will focus on state correctional facilities and county jails and penitentiaries, because studies done by the New York Correctional Association and the NYCLU provide concrete and detailed information about the policies and practices of these facilities.

25. *About DOCCS*, N.Y. DEP’T OF CORR. AND CMTY. SUPERVISION, <http://www.doocs.ny.gov/doocs.html> [https://perma.cc/3LU7-X9CZ] (last visited Oct. 16, 2016); *see also* CORR. ASS’N OF N.Y., *supra* note 1, at 19 (“The New York State Department of Corrections and Community Supervision (DOCCS) runs all state prisons in New York.”).

26. *See Department Rules & Regulations*, N.Y. DEP’T OF CORR. AND CMTY. SUPERVISION, <http://www.doocs.ny.gov/RulesRegs/index.html> [https://perma.cc/5NEV-S88K] (last visited Mar. 1, 2016) (“The New York State Department of Corrections and Community Supervision (DOCCS) is empowered to develop and enforce the rules and regulations it finds necessary to implement laws enacted by the New York State Legislature.”).

27. N.Y. COMP. CODES R. & REGS. tit. 7 (2016).

28. *See* CORR. ASS’N OF N.Y., *supra* note 1, at 37 (“The health policies issued by DOCCS Central Office are contained in two main documents: the Health Services Policy Manual, which includes all Department policies related to the provision of health care, and the Women’s Health Primary Care Practice Guideline, a booklet DOCCS first published in 2000, and updated in 2008 and 2011, which discusses certain health concerns specific to women.”).

trapection for incarcerated women are discussed in Sections A, B, and C respectively.

### A. GYNECOLOGICAL EXAMINATIONS

There are many deficiencies in the policies that regulate gynecological examinations for incarcerated women in New York State, including that some are incomplete, vague, or fail to follow medical standards.<sup>29</sup> These deficiencies vary between the different levels of state government that promulgate relevant policies. SCOC minimum standards for both initial and ongoing health examinations, for instance, vary by type of facility. For county jails and penitentiaries, the standards addressing initial health examinations do not distinguish between men and women<sup>30</sup> and make no mention of screenings particular to women such as pregnancy tests, Pap smears, and breast examinations.<sup>31</sup> There are also no written policies addressing ongoing and follow-up medical care specific to women; in fact there is no mention of Pap smears, breast examinations, or gynecological care at all.<sup>32</sup> A study of New York jails found that individual facilities also had no written policies for routine gynecological care.<sup>33</sup>

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29. CORR. ASS'N OF N.Y., *supra* note 1, at 37 (“Some of DOCCS’ reproductive health policies are adequate, but others are incomplete and outdated. Hardly any of the policies reference community standards and some stray from those standards in key areas.”). These issues are not unique to New York State. *See* CORR. ASS'N OF N.Y., *supra* note 1, at 3 (“Women in prisons across the country face similar problems in accessing adequate reproductive health care and humane treatment . . .”).

30. *See* N.Y. COMP. CODES R. & REGS. tit. 9, § 7010.2 (2016) (the standards addressing health services do not distinguish between men and women but instead use broad language including “every inmate” and “each prisoner”); *id.* § 7002.6 (the standards addressing medical screenings do not distinguish between men and women); *id.* § 7013.7 (the standards addressing initial screening and risk assessment do not distinguish between men and women).

31. *Id.* § 7013.7 (the standards addressing initial screening and risk assessment procedures do not mention screenings particular to women); *id.* § 7010.2 (the standards addressing health services do not mention screenings particular to women); *see also* NYCLU, *supra* note 11, at 6 (“While these standards provide a general framework for policy development, they are particularly short on detail regarding women’s health care. . . . Nothing in the minimum standards distinguishes between health care for male inmates and female inmates . . .” (footnotes omitted)).

32. *See* N.Y. COMP. CODES R. & REGS. tit. 9, § 7010.2 (2016) (the standards for health services do not address Pap smears, breast examinations, or gynecological care).

33. *See* NYCLU, *supra* note 11, at 14 (“No county had a written policy in place that provided for routine gynecological care for women. Several counties sent policies that included routine testing for STIs, but none mentioned routine pelvic examinations or breast examinations.” (footnote omitted)).

State correctional facilities, on the other hand, have minimum standards that do differentiate between men and women in the initial medical assessment by calling for Pap smears and breast examinations for women,<sup>34</sup> but they still fail to address other important screenings for women including pregnancy tests. The state correctional standards neither provide for how often examinations should occur following the initial assessment, nor about ongoing gynecological examinations or follow up procedures.<sup>35</sup> Additionally, the standards for medical records in both county jails and state correctional facilities make no distinction between men and women and make no reference to medical history questions particular to women, such as pregnancy or use of contraception.<sup>36</sup>

DOCCS also has authority to develop and enforce the rules and regulations<sup>37</sup> for persons incarcerated in state prisons.<sup>38</sup> Generally, DOCCS has no written policies for certain health issues particular to women such as pregnancy tests and hysterectomies.<sup>39</sup> Some of DOCCS' policies are also incomplete: for example, while the policies discuss menopause, they do not include information on possible menopause treatments.<sup>40</sup> Furthermore, some of DOCCS' written policies do not comply with medical standards, including the starting age for yearly gynecological

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34. See N.Y. COMP. CODES R. & REGS. tit. 9, § 7651.9(b) (2016) (the standards for reception health assessments call for a "PAP smear for women" and "a breast examination for women").

35. See *id.* § 7651 (the standards addressing health services do not include information about gynecological examinations or follow-up procedures).

36. See *id.* § 7651.19 (the standards addressing medical records for state correction facilities do not distinguish between men and women); *id.* § 7010.2(j) (the standards addressing medical records for county jails do not distinguish between men and women: "[a]dequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint, medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person.").

37. See *supra* note 26 and accompanying text.

38. See *About DOCCS*, *supra* note 25 ("The New York State Department of Corrections and Community Supervision, guided by the Departmental Mission, is responsible for the confinement and habilitation of approximately 53,000 individuals under custody held at 54 state facilities and 36,000 parolees supervised throughout seven regional offices.").

39. See CORR. ASS'N OF N.Y., *supra* note 1, at 37 ("Examples of areas where DOCCS has no written policies include: Pregnancy tests[;] Hysterectomies.").

40. See *id.* at 39 ("DOCCS' policies contain a thorough explanation of menopause but no discussion of relevant treatments.").



check-ups and the frequency of breast examinations.<sup>41</sup> For instance, DOCCS' written policy for gynecological examinations states that women over age 30 should have annual gynecological check-ups.<sup>42</sup> This policy is not in line with that of The American College of Obstetricians and Gynecologists (ACOG), which recommends annual pelvic examinations for women beginning at age 21 and earlier if indicated by a patient's specific medical history.<sup>43</sup> For breast examinations, DOCCS' policy states that women should have a breast examination "with the initial exam and whenever clinically necessary."<sup>44</sup> However, ACOG recommends yearly mammography screening and clinical breast examinations beginning at age 40<sup>45</sup> and thus "[t]hese exams should be routine and not on a case-by-case basis."<sup>46</sup>

These policies affect both women's ability to access care and also the quality of care that they receive. In practice, some of these policies create obstacles that prevent incarcerated women from receiving adequate gynecological care. For example, women incarcerated in state correctional facilities reported significant delays in accessing gynecological care,<sup>47</sup> which in part may be caused by insufficient oversight, including the lack of standardi-

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41. See *id.* ("Examples of areas where DOCCS' policies do not comport with community standards include: Starting age for yearly GYN check-ups[;] Frequency of breast exams").

42. See *id.* at 188 n.102 ("Each female inmate 30 years of age or older will be offered a GYN exam and Pap test with HPV screening annually.").

43. See AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION: WELL-WOMAN VISIT 2 (2014), available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Well-Woman-Visit> [<https://perma.cc/E8WW-Y7SQ>] ("Annual pelvic examination of patients 21 years of age or older is recommended by the College. . . . The College recommends that pelvic examinations be performed only when indicated by the medical history for patients younger than 21 years.").

44. CORR. ASS'N OF N.Y., *supra* note 1, at 61.

45. See AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, STATEMENT ON REVISED AMERICAN CANCER SOCIETY RECOMMENDATIONS ON BREAST CANCER SCREENING (2015), available at <http://www.acog.org/About-ACOG/News-Room/Statements/2015/ACOG-Statement-on-Recommendations-on-Breast-Cancer-Screening> [<https://perma.cc/PGH8-GUAY>] ("ACOG maintains its current advice that women starting at age 40 continue mammography screening every year and recommends a clinical breast exam.").

46. CORR. ASS'N OF N.Y., *supra* note 1, at 61.

47. See *id.* at 43 ("More than half (54%, 434 of 798) of general survey respondents reported that they could not see the GYN when necessary."); *id.* at 7 ("A majority of women the CA heard from said they could not see a GYN when needed. The most egregious case of delays the CA learned about was a woman who waited nearly seven months for cancer treatment. She died shortly after being released.").

zation and clear requirements.<sup>48</sup> Additionally, the lack of access to female physicians and many women's preference for female physicians also creates a barrier to care.<sup>49</sup> For instance, women may prefer to see a female gynecologist for numerous reasons, including past trauma.<sup>50</sup> This is particularly important for incarcerated women, the majority of whom have experienced physical and/or sexual abuse prior to being incarcerated,<sup>51</sup> and some of whom have also experienced sexual abuse while incarcerated.<sup>52</sup>

There are also certain general medical policies that are particularly troubling in the reproductive care context. For example, DOCCS has a general policy of imposing disciplinary action on an incarcerated person for cancelling a medical appointment, and this policy applies to gynecological appointments (including abor-

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48. See *id.* at 46 (“The lack of external oversight . . . exacerbates this problem by sending the message that inaction will not have serious consequences.”).

49. See *id.* at 50 (“[M]any women wrote that they strongly prefer to see female GYNs and feel distressed when they are assigned to male providers. Forty-four percent (72 of 162) of general survey respondents who saw a male GYN while in DOCCS said that it made them feel uncomfortable talking about their needs.”).

50. See *id.* at 49 (“Being physically examined by a doctor has the potential to retraumatize women who have experienced trauma and abuse, particularly sexual violence. This is especially true for GYN exams: the focus on sensitive body parts and physical touch that often occurs during exams can trigger memories of prior abuse and cause survivors to feel violated and unsafe. Fear of being retraumatized in this way leads some survivors to avoid seeking medical care altogether.”).

51. See U.S. DEPT OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT PROFILE OF JAIL INMATES 10–11 (2002), available at <http://www.bjs.gov/content/pub/pdf/pij02.pdf> [<https://perma.cc/VYF4-LJGS>] (A Bureau of Justice report from 2002 found that 36% of incarcerated women reported that they had been sexually abused prior to incarceration, while 55% of incarcerated women reported that they had been physically abused, sexually abused, or both prior to incarceration. Further, among women who had previously been abused, 68% had been abused by an intimate partner.); see also Angela Browne, *Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women*, 22 INT'L J.L. & PSYCHIATRY 301, 313 (1999), available at <http://www.sciencedirect.com/science/article/pii/S0160252799000114> [<https://perma.cc/XD46-8K73>] (A study done at Bedford Hills in 1999 showed higher rates of abuse: 75% reported physical abuse by an intimate partner in adulthood and 59% reported sexual abuse during childhood or adolescence).

52. See Benjamin Weiser, *Suit Alleges Persistent Sexual Abuse of Female Inmates in New York State Prisons*, N.Y. TIMES (Feb. 25, 2016), <http://www.nytimes.com/2016/02/26/nyregion/6-inmates-file-suit-alleging-persistent-sexual-abuse-of-women-in-new-york-state-prisons.html> [<https://perma.cc/C4TN-7CC8>] (“Sexual abuse of female inmates is persistent in New York State prisons, six female prisoners claim in a lawsuit filed Thursday. . . . The lawsuit, which is replete with detailed allegations of guards involved in forcible sexual intercourse and other forms of sexual misconduct, verbal threats, harassment and voyeurism, seeks class-action status on behalf of all current and future inmates at the three all-women's prisons operated by the department: the Bedford Hills, Taconic and Albion correctional facilities.”).

tion appointments).<sup>53</sup> DOCCS policy also requires a correctional officer to be within eyeshot at all times during appointments,<sup>54</sup> which can be particularly problematic when a woman needs to discuss confidential information with her physician, such as her sexual history or pregnancy options.

## B. SANITARY SUPPLIES

SCOC minimum standards addressing access to sanitary supplies are vague for county jails, penitentiaries, and state correctional facilities. The standard for county jails and penitentiaries requires only that the facility provide sanitary products.<sup>55</sup> The minimum standard for state correctional facilities requires that, at admission, “all female prisoners shall be provided at facility expense with necessary feminine hygiene items in order to provide for the special hygiene needs of females.”<sup>56</sup> These policies fail to state either the quantity of sanitary napkins or tampons to be provided or the frequency with which they should be provided. The minimum standards for both county jails and penitentiaries and state correctional facilities merely state that personal hygiene items “shall be replenished or replaced as needed.”<sup>57</sup> DOCCS written policy for sanitary supplies is similarly vague and incomplete, stating only that sanitary napkins will be provided.<sup>58</sup>

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53. See CORR. ASS’N OF N.Y., *supra* note 1, at 90–91 (“DOCCS has a policy that incarcerated people will face disciplinary action if they decline to go to a medical appointment. . . . In winter 2013, DOCCS . . . issued a new policy stating that an incarcerated person will face disciplinary action for refusing to ‘obey a direct order’ only if she declines to go to a medical appointment on the day of the appointment itself.”).

54. See CORR. ASS’N OF N.Y., *supra* note 1, at 198 n.199 (“DOCCS generally requires two officers to go on hospital trips off prison grounds (one or both of whom may be armed) and requires the officers to ‘post themselves in a position that permits an unobstructed view of the inmate’ at all times during the trip. Outside hospital trip security coverage is determined by ‘the Deputy Superintendent of Security or security equivalent’ and can include as little as one unarmed officer and as much as two armed officers.” (citation omitted)).

55. See N.Y. COMP. CODES R. & REGS. tit. 9, § 7005.6(b) (2016) (“In addition to the items listed in subdivision (a) of this section, all female prisoners shall be provided at facility expense with necessary feminine hygiene items, including but not limited to: (1) tampons; and (2) sanitary napkins.”).

56. *Id.* § 7612.5(b).

57. *Id.* § 7005.6(d) (the personal health care items listed include “(1) tampons; and (2) sanitary napkins”); see also *id.* § 7612.5(c) (the personal health care items listed include “feminine hygiene items”).

58. See *id.* § 1704.5(a)(8) (“The following shall be provided or . . . made available to each inmate at time of reception: . . . sanitary napkins for female inmates.”).

The lack of specificity in all state policies regulating the availability of sanitary products for incarcerated women creates barriers to proper care: “[t]he vast majority of women the CA [Correctional Association] interviewed reported that the monthly supply of sanitary napkins DOCCS gives them does not meet their needs.”<sup>59</sup> In practice, DOCCS distributes twenty-four sanitary napkins to incarcerated women each month,<sup>60</sup> and in order to obtain more, women need a special permit from the medical department or need to be financially able to purchase them on their own through the commissary.<sup>61</sup> Procedures to obtain a medical permit were sometimes difficult and degrading.<sup>62</sup> For example, at one New York prison (which has since closed), women were required to bring their used sanitary products to the health services unit in order to receive more.<sup>63</sup>

The New York City Council recently enacted legislation that increases incarcerated women’s access to sanitary products in the city’s jails. This important piece of legislation provides that “[a]ll female inmates in the custody of the department shall be provided, at the department’s expense, with feminine hygiene products as soon as practicable upon request.”<sup>64</sup> The rest of the state has yet to update its policies but this could be used as a model for future reform, which will be discussed further in Parts IV and V.

### C. CONTRACEPTION

Access to contraception is also lacking in important respects. In a national survey of correctional health providers, 70% of the respondents stated that their institution had no formal policy on contraception.<sup>65</sup> In line with this national assessment, New

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59. CORR. ASS’N OF N.Y., *supra* note 1, at 66.

60. *See id.* (“DOCCS distributes 24 sanitary napkins to women in general population each month.”).

61. *See id.* at 66, 67 (“The challenges women face in obtaining additional sanitary napkins on their own only add to the problem. Prices for pads and tampons in prison commissaries vary widely and are prohibitive for women with few financial resources and outside support.”).

62. *E.g. id.* at 66 (“At Taconic, prison medical staff reported to the CA that only a woman who can prove she is anemic can get a permit . . .”).

63. *See id.* at 67 (“The process for getting a permit at Bayview when it was open was even more degrading. The prison required women to bring in their used sanitary napkins to prove they needed more supplies.”).

64. N.Y.C. ADMIN. CODE § 9-141 (2016).

65. *See* Carolyn B. Sufrin et al., *Contraception services for incarcerated women: a national survey of correctional health providers*, 80 *CONTRACEPTION* 561, 562 (2009),

York's policies are lacking in comprehensive, consistent guidelines, and where the policies do address contraception, they are burdensome and restrictive.

SCOC minimum standards fail to address any type of contraception at all.<sup>66</sup> However, a memorandum from SCOC in 2014 states: "Birth Control[:] Women should be permitted to continue taking previously prescribed hormonal therapy during incarceration . . . ."<sup>67</sup> DOCCS appears to recognize a few specific instances in which women can access limited forms of contraception. For example, women who participate in the Family Reunion Program, which allows incarcerated people to have visits with their family in privacy,<sup>68</sup> can receive condoms for overnight visits with their husbands.<sup>69</sup> The Correctional Association also found that women exiting prison may receive condoms when they leave the prison gates,<sup>70</sup> and women who are being treated for hepatitis C may be allowed access to prescription birth control because hepatitis C medication can cause severe birth defects.<sup>71</sup>

Officials at New York State prisons gave conflicting reports as to whether their prisons' policies allowed them to prescribe emer-

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available at <http://www.sciencedirect.com/science/article/pii/S0010782409002959> [<https://perma.cc/VNJ6-MRJC>] ("A formal institutional policy on contraception was noted by only 19% of respondents; 11% of them were unsure if their facility had a policy, and the remainder (70%) indicated that no policy existed.").

66. See generally N.Y. COMP. CODES R. & REGS. tit. 9 (2016) (SCOC minimum standards addressing health care for persons incarcerated at state correctional facilities and county jails do not mention contraception).

67. N.Y. COMM'N OF CORR., CHAIRMAN'S MEMORANDUM REPRODUCTIVE SERVICES FOR WOMEN IN JAIL 2 (2008), available at [www.scoc.ny.gov/pdfdocs/chair2008\\_4.pdf](http://www.scoc.ny.gov/pdfdocs/chair2008_4.pdf) [<https://perma.cc/UCN8SKCQ>].

68. See N.Y. DEP'T OF CORR. AND CMTY. SUPERVISION, FAMILY REUNION PROGRAM, DIRECTIVE 4500 1 (Jan. 5, 2016), available at [http://www.scoc.ny.gov/pdfdocs/chair2008\\_4.pdf](http://www.scoc.ny.gov/pdfdocs/chair2008_4.pdf) [<https://perma.cc/UCN8-SKCQ>] ("The Family Reunion Program (FRP) is designed to provide approved inmates and their families the opportunity to meet for an extended period of time in privacy. The goal of the program is to preserve, enhance, and strengthen family ties that have been disrupted as a result of incarceration.").

69. See N.Y. COMP. CODES R. & REGS. tit. 7, § 220.9 (2016) ("The facility shall provide: pillows, blankets, bed linens, towels, soap and condoms.").

70. See CORR. ASS'N OF N.Y., *supra* note 1, at 74 ("With few exceptions, DOCCS prohibits its doctors from prescribing contraceptives." Two exceptions are "for women participating in the Family Reunion Program, who can have condoms for overnight trailer visits with their husbands" and "for women returning to the community, who receive condoms when they exit the prison gates").

71. See *id.* (listing another exception to the DOCCS prohibition against its doctors prescribing contraceptives: "women enrolled in DOCCS' hepatitis C continuity-of-care program [ ] can be prescribed birth control because hepatitis C medication can cause severe birth defects").

gency contraception,<sup>72</sup> but all three prisons interviewed by the Correctional Association stated that they had not prescribed emergency contraception in the past ten years.<sup>73</sup> A survey of New York county jails found that “women were generally not permitted to continue their birth control medication unless the medical director determined that there was a medical reason to do so, and no county besides New York City had a written policy on providing EC [emergency contraception].”<sup>74</sup> Furthermore, interviews with officials at correctional facilities revealed a lack of understanding around the reasons a woman might need access to contraception while incarcerated.<sup>75</sup>

In practice, these restrictive, non-existent, and inconsistent policies make it difficult for most women to obtain contraception while incarcerated. While DOCCS policy does allow for some women to access contraception in the specific instances discussed, these policies fail to account for the variety of reasons incarcerated women may want access to prescription contraception.<sup>76</sup> Women who are sexually active prior to incarceration, during work release,<sup>77</sup> or immediately following release are at risk of pregnancy.<sup>78</sup> However, DOCCS neither provides women in its

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72. See *id.* at 78 (“Prisons gave conflicting reports about the availability of emergency contraception and PEP. Bedford reported that DOCCS does not provide emergency contraception and indicated that doctors would not write a prescription for the medication even if a woman requested it. Albion and Taconic said that doctors could, in fact, write a prescription for emergency contraception and administer it within one day.”).

73. See *id.* (“All three prisons said that they had not given out emergency contraception in the past 10 years.”).

74. NYCLU, *supra* note 11, at 16 (footnote omitted).

75. See *id.* (“Interviews with jail officials in several counties revealed that cost was the primary reason for restricting access to birth control. Jail officials also told the NYCLU that there was no chance for women to get pregnant in their facilities, and that ‘regulating a period’ was not a serious enough medical need to justify the provision of birth control medication.”).

76. See Schonberg, *supra* note 12, at 2270 (“When asked, all but 1 participant believed that birth control services should be available at the jail.”).

77. See *Temporary Release Programs*, N.Y. DEP’T OF CORR. AND CMTY. SUPERVISION, <http://www.doccs.ny.gov/ProgramServices/temprelease.html> [<https://perma.cc/J3V8-FG7K>] (last visited Aug. 16, 2016) (noting DOCCS offers “programs [that] allow inmates who are within two years of their earliest release date to become reintegrated back into their families and communities on a gradual basis”; one such program is “Work Release, which allows an inmate to leave a facility for up to 14 hours in any day to work at a job in the community or gain on-the-job training”).

78. See NYCLU, *supra* note 11, at 15 (“[W]omen are often sexually active just prior to and immediately following incarceration, and interruption in birth control creates a risk of pregnancy in both cases. Immediately ceasing contraception just after sexual activity poses a risk of pregnancy, as does failing to resume it just prior to sexual activity. For women who are held temporarily or who are repeatedly in and out of county jails, failing

work release program access to prescription contraception<sup>79</sup> nor does it currently provide women access to prescription contraception prior to release.<sup>80</sup> Women may also require access to prescription contraception for medical reasons aside from pregnancy prevention, including reducing the risk of ovarian cancer and treating endometriosis.<sup>81</sup> Although SCOC has recognized the use of birth control for hormonal therapy, in practice “[m]any women reported that DOCCS denied them hormonal contraception when they needed it for health reasons unrelated to pregnancy prevention.”<sup>82</sup>

Furthermore, denying access to emergency contraception “ignores the reality that incarcerated women are at risk of sexual assault in jail facilities.”<sup>83</sup> Women may want access to emergency contraception if they have been victims of sexual assault, but in practice these contraceptives are generally unavailable to them.<sup>84</sup>

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to take hormonal contraceptives in a timely manner could lead to unintended pregnancy or a disrupted menstrual cycle once they are released from jail.” (footnote omitted)).

79. See CORR. ASS’N OF N.Y., *supra* note 1, at 75 (“DOCCS does not give women in its work release program access to prescription birth control, even though women in the program spend time in the community and may have sexual partners there. . . . The lack of access to birth control has significant implications because women who get pregnant while participating in work release may lose their spot in the program.”).

80. See *id.* at 74 (“From 2009 to 2013, DOCCS contracted with Planned Parenthood to offer contraceptives to women at Albion, Bedford and Taconic who were within two weeks of release. Unfortunately, after funding was cut, this initiative ended in all three prisons, and women no longer have access to birth control before their release.”).

81. See NYCLU, *supra* note 11, at 15 (“Women also use hormonal contraception for a number of reasons unrelated to birth control. For example, physicians prescribe contraception for reducing the risk of ovarian cancer and controlling endometriosis.” (footnote omitted)).

82. CORR. ASS’N OF N.Y., *supra* note 1, at 76.

83. NYCLU, *supra* note 11, at 15 (footnote omitted); see also Weiser, *supra* note 52 (“Sexual abuse of female inmates is persistent in New York State prisons, six female prisoners claim in a lawsuit. . . . The lawsuit, which is replete with detailed allegations of guards involved in forcible sexual intercourse and other forms of sexual misconduct, verbal threats, harassment and voyeurism, seeks class-action status on behalf of all current and future inmates at the three all-women’s prisons operated by the department: the Bedford Hills, Taconic and Albion correctional facilities.”).

84. See CORR. ASS’N OF N.Y., *supra* note 1, at 78 (“All three prisons said that they had not given out emergency contraception in the past 10 years.”); see also NYCLU, *supra* note 11, at 15 (“Few facilities had policies in place on access to EC — only New York City had a comprehensive policy on contraception.”).

### III. NEW YORK'S POLICIES ARE PROBLEMATIC FROM BOTH LEGAL AND MEDICAL PERSPECTIVES

New York's policies that regulate incarcerated women's health care discussed above are problematic from both legal and medical perspectives. First, there are legal concerns that may leave New York State and particular facilities vulnerable to lawsuits. Second, the policies conflict with standards promulgated by the medical community as well as public health research. The legal and medical perspectives are discussed in Sections A and B, respectively.

#### A. LEGAL PERSPECTIVE

New York's policies that regulate gynecological care, sanitary supplies, and contraception may potentially violate the Eighth Amendment as well as other state and federal laws that address health care in correctional facilities.

##### 1. *Constitutional Standards*

The Eighth Amendment prohibits "cruel and unusual punishments."<sup>85</sup> In *Estelle v. Gamble*, the Supreme Court established the current standard for determining whether a denial of medical care to an incarcerated person by a correctional facility constitutes cruel and unusual punishment, stating that "[d]eliberate indifference to serious medical needs of prisoners" violates the Eighth Amendment.<sup>86</sup> The Supreme Court has held that two requirements are necessary to prove an Eighth Amendment violation.<sup>87</sup> First, "the deprivation alleged must be, objectively, 'sufficiently serious.'"<sup>88</sup> The second requirement is subjective: the defendant must have a "sufficiently culpable state of mind,"<sup>89</sup> and

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85. U.S. CONST. amend. VIII.

86. See *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976) (The Court further held that the Supreme Court has recognized "the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.").

87. See *Farmer v. Brennan*, 511 U.S. 825, 834 (1994).

88. *Id.*

89. *Id.*



“[i]n prison-conditions cases[,] that state of mind is one of ‘deliberate indifference’ to inmate health or safety.”<sup>90</sup>

The Supreme Court has not specified a precise measure of a person’s “serious medical needs”<sup>91</sup> necessary to prove the objective component of the violation. The Second Circuit has noted certain factors that should guide a court’s analysis, including: “(1) whether a reasonable doctor or patient would perceive the medical need in question as important and worthy of comment or treatment, (2) whether the medical condition significantly affects daily activities, and (3) the existence of chronic and substantial pain.”<sup>92</sup> The Second Circuit has furthermore rejected the idea that “only ‘extreme pain’ or a degenerative condition would suffice to meet the legal standard.”<sup>93</sup> Additionally, although the Second Circuit and the Supreme Court do not have clear case law on the restriction of abortion access as an Eighth Amendment violation, the Third Circuit has found that pregnancy related medical care, including non-therapeutic abortions, is considered a serious medical need.<sup>94</sup> Courts have also found that “hygiene” may be considered a “basic need deserving of Eighth Amendment protection.”<sup>95</sup> Specifically, the District Court for the Southern District of New York stated that “[t]he failure to regularly provide prisoners with . . . sanitary napkins for female prisoners

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90. *Id.*

91. *Brock v. Wright*, 315 F.3d 158, 162 (2d Cir. 2003) (“There is no settled, precise metric to guide a court in its estimation of the seriousness of a prisoner’s medical condition.”).

92. *Id.* (citing *Chance v. Armstrong*, 143 F.3d 698, 702 (2d Cir. 1998)).

93. *Id.* at 163.

94. *See Monmouth Cty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 348–49 (3d Cir. 1987) (“We find that the MCCI inmates have firmly demonstrated the seriousness of the needed medical care. . . . An elective, nontherapeutic abortion may nonetheless constitute a ‘serious medical need’ where denial or undue delay in provision of the procedure will render the inmate’s condition ‘irreparable.’”). *But see Roe v. Crawford*, 514 F.3d 789, 801 (8th Cir. 2008) (holding the Missouri Department of Corrections policy prohibiting transportation of pregnant inmates offsite for elective abortions violated the Fourteenth Amendment under the *Turner* standard but did not violate the Eighth Amendment and stating that “an elective, non-therapeutic abortion does not constitute a serious medical need, and a prison institution’s refusal to provide an inmate with access to an elective, nontherapeutic abortion does not rise to the level of deliberate indifference to constitute an Eighth Amendment violation”).

95. *See Argue v. Hofmeyer*, 80 F. App’x 427, 430 (6th Cir. 2003) (“[T]he Eighth Amendment prohibits the denial of basic needs, including hygiene . . . .”); *Flanory v. Bonn*, 604 F.3d 249, 255 (6th Cir. 2010) (“A prisoner whose inability to purchase hygiene items results from his rejection of educational status satisfies the objective and subjective requirements of an Eighth Amendment violation when he alleges a complete deprivation and shows that the deprivation resulted from a deliberate indifference to hygiene needs.”).

constitutes a denial of personal hygiene and sanitary living conditions.”<sup>96</sup>

With regard to the subjective component of the violation, the Supreme Court has held that “deliberate indifference” means recklessly disregarding a substantial risk of serious harm to an incarcerated person.<sup>97</sup> In a prison context, the prison official imposing cruel and unusual punishment must (1) be aware of the facts from which he or she could draw an inference that there is a substantial risk of serious harm and (2) actually draw that inference and believe that the incarcerated person is at substantial risk of serious harm.<sup>98</sup> To prove actual knowledge of the risk, “evidence that the risk was obvious or otherwise must have been known to a defendant is sufficient to permit a jury to conclude that the defendant was actually aware of it.”<sup>99</sup> Deliberate indifference has been found where “existing procedures have resulted in interminable delays and outright denials of medical care to suffering inmates.”<sup>100</sup> The Third Circuit also found the deliberate indifference standard to be met where a burdensome court-order release procedure created a barrier for women to obtain abortions, and the prison officials failed to even attempt to minimize the delays in access.<sup>101</sup>

Although the deliberate indifference standard and other federal laws make it challenging to bring suit,<sup>102</sup> incarcerated wom-

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96. *Atkins v. Cty. of Orange*, 372 F. Supp. 2d 377, 406 (S.D.N.Y. 2005) (citations omitted).

97. *Farmer v. Brennan*, 511 U.S. 825, 836 (1994) (“It is, indeed, fair to say that acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk.”).

98. *Id.* at 837 (“[A] prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.”).

99. *Brock v. Wright*, 315 F.3d 158, 164 (2d Cir. 2003).

100. *Todaro v. Ward*, 565 F.2d 48, 53 (2d Cir. 1977).

101. *See Monmouth Cty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987) (“First, the deliberate indifference of MCCI officials toward the medical needs of inmates exercising their constitutionally protected right to choose abortion is evidenced by the burdensome court-ordered release procedure erected as a precondition to the exercise of that choice. . . . The failure of MCCI officials even to attempt to minimize the delay in access to abortion services constitutes deliberate indifference to the medical needs of inmates electing to terminate their pregnancies.” (citations omitted)).

102. *See Rachel Roth, Do Prisoners Have Abortion Rights?*, 30 FEMINIST STUD. 373–74 (2004), available at <http://www.jstor.org/stable/20458968> [<https://perma.cc/EUN7-GQJ2>] (“Federal law severely limits prisoners’ ability to assert their rights or seek redress when they are wronged. Congress prevents legal aid lawyers who receive federal funding from

en have successfully brought challenges to the medical care provided to them at correctional facilities. In the 1970s, women incarcerated at Bedford Hills Correctional Facility in New York brought a civil rights action alleging that the medical care at the facility violated the Eighth Amendment.<sup>103</sup> In that case, *Todaro v. Ward*, the Second Circuit stated that even though a structure for the administration of medical care existed, certain procedures created barriers that impeded women from accessing care by denying or delaying medical care.<sup>104</sup> Furthermore the court found that “while a single instance of medical care denied or delayed, viewed in isolation, may appear to be the product of mere negligence, repeated examples of such treatment bespeak a deliberate indifference by prison authorities to the agony engendered by haphazard and ill-conceived procedures.”<sup>105</sup> The court upheld remedial measures imposed by the district court to reform inadequacies with health care access,<sup>106</sup> and the suit is likely one of the reasons that Bedford Hills’ medical care is stronger than that of other New York correctional facilities.<sup>107</sup>

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working on cases involving either prisoners or abortion. In addition, the 1996 Prison Litigation Reform Act (PLRA) makes it harder for prisoners to challenge the conditions of their confinement and jeopardizes existing consent decrees that order improvements in prison conditions and health care.”).

103. *Todaro*, 565 F.2d at 48.

104. *See id.* at 50 (“The existence of this structure for the administration of health care was of little avail to many prisoners for, as Judge Ward noted, certain procedures employed by the appellants significantly impeded inmate access to medical services at Bedford Hills and caused doctor-prescribed treatments and tests not to be administered promptly. As a result, essential medical services were denied, or unreasonably delayed and inmates forced to suffer needless pain.”).

105. *Id.* at 52 (the court continued, stating, “[i]ndeed, it is well-settled in this circuit that ‘a series of incidents closely related in time . . . may disclose a pattern of conduct amounting to deliberate indifference to the medical needs of prisoners.’” (quoting *Bishop v. Stoneman*, 508 F.2d 1224 (2d Cir. 1974))).

106. *See id.* at 53–54 (“While federal courts have traditionally adopted a broad hands-off attitude toward the daily problems of prison administration, ‘a policy of judicial restraint cannot encompass any failure to take cognizance of valid constitutional claims whether arising in a federal or state institution.’ Furthermore, we believe the policy of deference to state officials is less substantial when, as in the present case, matters of prison discipline and security are not at issue. We are certainly not pleased to envision the district court assuming a permanent role in the administration of medical care at Bedford Hills. But we are equally reluctant to countenance an abdication of responsibility in correcting defects in the health care system which deprives appellees of their right to constitutionally adequate medical care.” (citations omitted)).

107. *See* CORR. ASS’N OF N.Y., *supra* note 1, at 41 (“That Bedford’s medical operation is stronger than other women’s prisons is also likely the result of a class-action lawsuit, *Todaro v. Ward*, filed in 1974 by the Legal Aid Society’s Prisoners’ Rights Project on behalf of women at the prison. Until the settlement agreement ended in 2004, *Todaro* required

More recently, eight incarcerated women filed a class action that is currently pending in Michigan to bring the Muskegon County Jail (MCJ) into compliance with constitutional standards for health care in correctional facilities.<sup>108</sup> The complaint alleges unconstitutional and inhumane conditions of confinement, some of which uniquely harm women.<sup>109</sup> Notably, the complaint alleges: “[d]efendants fail to provide adequate feminine hygiene products to women detained at MCJ, causing them to bleed through their clothes.”<sup>110</sup> The complaint asserts that, by denying access to adequate sanitary products, the correctional facility violated the Eighth Amendment. However, the court dismissed the count that challenged access to sanitary products on the pleadings on the ground that the plaintiffs failed to state a plausible claim under the Eighth Amendment because each of the plaintiffs only alleged a single, temporary delay in access to feminine hygiene products.<sup>111</sup> While the court acknowledged that “hygiene” has been considered a basic need that requires Eighth Amendment protection, it found that the pleadings only stated “de minimis deprivations”<sup>112</sup> because of the “nature and duration”<sup>113</sup> of the specific situations described in the complaint. The court left open room for a challenge that alleged more than single, temporary deprivations of sanitary products.

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Bedford to improve its health services in key areas including staffing, access to care, access to HIV doctors and systems for monitoring specialty care.” (footnotes omitted)).

108. See ACLU OF MICH., ACLU OF MICHIGAN LEGAL DOCKET 24 (2015), available at <http://aclumich.org/sites/default/files/2014-2015%20Legal%20Docket.pdf> [<https://perma.cc/B5W9-W5Q2>].

109. See Complaint, *supra* note 4, at ¶¶ 1–2.

110. *Id.* at ¶ 8.

111. See Order, *Semelbauer v. Muskegon Cty.*, 2015 WL 9906265 18–19 (W.D. Mich. Sept. 11, 2015) (Docket No. 54), available at <http://www.aclumich.org/sites/default/files/054%20Opinion%20and%20Order.pdf> [<https://perma.cc/3MRQ-A6E7>] (“While ‘hygiene’ has also been generally identified as a basic need deserving of Eighth Amendment protection, the Court determines that the nature and duration of the alleged deprivations in this case similarly lead to the conclusion that Plaintiffs have not stated a plausible Eighth Amendment violation. . . . Plaintiffs’ allegations indicate only that each Plaintiff alleges a single delay in receiving feminine hygiene products during their terms of incarceration.” (citations omitted)).

112. *Id.* at 19 (“Defendants are correct that courts have routinely found that such allegations demonstrate only de minimis deprivations, which do not rise to the level of civil rights violations.”).

113. *Id.* at 18 (“While ‘hygiene’ has also been generally identified as a basic need deserving of Eighth Amendment protection, the Court determines that the nature and duration of the alleged deprivations in this case similarly lead to the conclusion that Plaintiffs have not stated a plausible Eighth Amendment violation.” (citations omitted)).

Thus, while a lawsuit challenging access to medical care is difficult to bring successfully, some of the experiences of women in New York State prisons may rise to the level necessary to make an Eighth Amendment claim.<sup>114</sup> Specifically, the case discussed above regarding a woman who was repeatedly delayed in accessing cancer treatment after finding a lump on her groin is likely to meet the objective serious medical needs standard because there is a reasonable likelihood that a cancerous lump would meet the three factors outlined in *Brock v. Wright* and courts have found that a delay in treatment for cancer constitutes an Eighth Amendment violation.<sup>115</sup> Arguably, her case also meets the subjective deliberate indifference standard because prison officials knew about her illness, and she subsequently experienced serious delays in treatment.<sup>116</sup>

Other women who have experienced serious delays in accessing gynecological care, including women who have been repeatedly denied access to sanitary supplies, may be able to bring more successful claims than the women of MCJ. The court in *Semelbauer v. Muskegon County* (relying on past decisions of multiple other courts) acknowledged that, generally, feminine hygiene products are basic needs deserving of Eighth Amendment protec-

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114. See CORR. ASS'N OF N.Y., *supra* note 1, at 7 (“The most egregious case of delays the CA learned about was a woman who waited nearly seven months for cancer treatment. She died shortly after being released.”); see also CORR. ASS'N OF N.Y., *supra* note 1, at 67 (“The prison required women to bring in their used sanitary napkins to prove they needed more supplies. . . . Bayview was also slow to grant permits and sometimes refused to grant them at all.”).

115. See *Caldwell v. D.C.*, 201 F. Supp. 2d 27, 40 (D.D.C. 2001) (upholding the finding of an Eighth Amendment violation where “[p]laintiff, however, presented evidence that treatment for his glaucoma and skin cancer was delayed for substantial periods, despite his repeated grievances. . . . The delay in providing him with medically ordered clothing and mattress cover increased the risk of future skin cancer . . .” (citation omitted)).

116. See *id.* at 44 (“One day Sara noticed a lump in her groin area and signed up for sick call. At sick call, the nurse described the lump as ‘egg-size’ and referred Sara to a nurse practitioner. Sara waited about a week to see the nurse practitioner and another week after that to get an ultrasound. It took another three weeks after the ultrasound for Sara to get her results. Even though the ultrasound results showed a fast-growing mass with blood circulation — a red flag for cancer — Sara’s case was not fast-tracked or referred to a senior doctor at the prison. Sara waited three more weeks after receiving the ultrasound results to get a biopsy and another two weeks to get the biopsy results. The biopsy results showed an advanced tumor yet Sara did not see an oncologist until two weeks later. Two more weeks went by after the oncology appointment before Sara met with a senior doctor at the prison. It was another month before Sara had surgery to remove the tumor and another month after that before she began chemotherapy and radiation.”).

tion,<sup>117</sup> and future plaintiffs can make similar arguments to the ACLU's brief in *Semelbauer* on this point.<sup>118</sup> In order to be successful, plaintiffs will also need to prove that they meet the subjective deliberate indifference standard. Plaintiffs may meet this standard by showing, similar to the women who brought suit in *Todaro v. Ward*, that repeated denials of access to adequate sanitary supplies "bespeak a deliberate indifference by prison authorities to the agony engendered by haphazard and ill-conceived procedures."<sup>119</sup> Arguably, the consistent lack of access to feminine hygiene products — due to procedures requiring them to prove their need for additional supplies through medical testing or the display of used sanitary napkins — for women incarcerated in New York State prisons meets this standard.

If suit were brought, the reasoning of the court in *Semelbauer* should not be followed by a New York court for multiple reasons. First, the court in *Semelbauer* ultimately found the claims did not rise to the level of an Eighth Amendment violation because each plaintiff alleged only a single delay of a few days or hours.<sup>120</sup> While the court does cite cases that address single or brief deprivations of hygiene items such as toilet paper and toothpaste in support of this conclusion,<sup>121</sup> the petitioners' brief refutes the similarities between these cases and *Semelbauer* by arguing that the facts of these cases are different because they involve, for in-

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117. See Order, *supra* note 111, at 18–19 (“While ‘hygiene’ has also been generally identified as a basic need deserving of Eighth Amendment protection, the Court determines that the nature and duration of the alleged deprivations in this case similarly lead to the conclusion that Plaintiffs have not stated a plausible Eighth Amendment violation.” (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *Argue v. Hofmeyer*, 80 F. App'x 427, 430 (6th Cir. 2003))).

118. See Pls.' Br. Opp'n to Defs.' Mot. Partial J. on Pleadings, *Semelbauer v. Muskegon Cty.*, 2015 WL 9906265 14–16 (W.D. Mich. July 1, 2015) (Docket No. 49), available at <http://www.aclumich.org/sites/default/files/049%20Pls%20Br%20in%20Opp%20to%20Def%20M%20for%20Partial%20J%20on%20the%20Pleadings.pdf> [<https://perma.cc/Q6Q7-BMQB>].

119. *Todaro v. Ward*, 565 F.2d 48, 53 (2d Cir. 1977).

120. See Order, *supra* note 111, at 18–19 (“[T]he Court determines that the nature and duration of the alleged deprivations in this case similarly lead to the conclusion that Plaintiffs have not stated a plausible Eighth Amendment violation. . . . Plaintiffs' allegations indicate only that each Plaintiff alleges a single delay in receiving feminine hygiene products during their terms of incarceration.”).

121. See *id.* at 19 (The court cites “*Harris v. Fleming*, 839 F.2d 1232, 1235–36 (7th Cir. 1988) (holding, where the inmate alleged he was not provided with toilet paper for five days, and that he lacked soap, toothbrush, and toothpaste for ten days and was kept in a filthy, roach-infested cell, ‘the defendants’ temporary neglect of Harris’s needs was not intentional, nor did it reach unconstitutional proportions’).”).

stance, a temporary deprivation when there was a shortage of supplies.<sup>122</sup>

Second, the court does not cite cases that discuss feminine hygiene products. The court fails to address that “incidents where Defendants ignored or mocked Plaintiffs’ pleas for sanitary supplies, leaving them to go as long as two days without supplies and causing them to bleed into their clothes,”<sup>123</sup> may provide plaintiffs with more persuasive arguments regarding serious medical need and deliberate indifference than a plaintiff who was denied toothpaste.

Third, other cases suggest that it is not necessary to show many instances of deprivation of hygiene products in order to make a successful claim.<sup>124</sup> Furthermore, the holding in *Todaro v. Ward* cautions against viewing incidents like these in isolation.<sup>125</sup> Even if a New York court were to adopt the *Semelbauer* court’s reasoning as correct, the women in New York state prisons may still be successful by showing that they experienced more than single deprivations because of the specific policies in place. According to DOCCS practices, the women are provided with 24 sanitary napkins each month, and the majority of women stated that this amount did not meet their needs.<sup>126</sup> Obtaining additional supplies can only be done by obtaining a permit, which

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122. See Pls.’ Br., *supra* note 122, at 16–17 (“Defendants cite a number of cases where-in inmates were temporarily denied toiletries on a single occasion as a disciplinary measure, *Sublett v. White*, No. 5:12CV-P180-R, 2013 WL 2303249 (W.D. Ky. May 24, 2013); because of unexpected shortages of resources, *Gilland v. Owens*, 718 F. Supp. 665 (W.D. Tenn. 1989); or because they were given an appropriate amount on a regular schedule, *Hunter v. Helton*, No. 1:10-cv-00021, 2010 WL 2405092 (M.D. Tenn. June 10, 2010).”).

123. *Id.* at 16 (citations omitted).

124. See *Atkins v. Cty. Of Orange*, 372 F. Supp. 2d 377, 405 (S.D.N.Y. 2005) (“[Plaintiff] Dawn Brown stated on two occasions that [Corrections Officer] Kelly refused to provide her with a sanitary napkin, but could not say whether Jones ever refused to give her a sanitary napkin. In addition, Jane Brown attested to the fact that she observed Dawn Brown in her cell with ‘blood all over her legs’ because she was not provided with sanitary napkins. Accordingly, summary judgment is not appropriate with respect to Dawn Brown’s claim against defendant Kelly alleging deprivation of basic hygiene products . . . .” (citations omitted)).

125. See *Todaro v. Ward*, 565 F.2d at 52 (“[W]hile a single instance of medical care denied or delayed, viewed in isolation, may appear to be the product of mere negligence, repeated examples of such treatment bespeak a deliberate indifference by prison authorities to the agony engendered by haphazard and ill-conceived procedures.”).

126. See CORR. ASS’N OF N.Y., *supra* note 1, at 66 (“The vast majority of women the CA interviewed reported that the monthly supply of sanitary napkins DOCCS gives them does not meet their needs. More than half (54%, 514 of 957) of general survey respondents said the same. . . . DOCCS distributes 24 sanitary napkins to women in general population each month. Many women expressed dismay and exasperation at the inadequate supplies.” (footnote omitted)).

is difficult.<sup>127</sup> Thus, these are not single, short incidents but rather continuous, systematic deprivations.

Additionally, women who were denied access to contraception for medical reasons such as endometriosis may have a successful claim, depending on the specific circumstances of the denial. Similar to the argument of women denied sanitary supplies, the plaintiffs would need to show that their medical reason for requiring access to prescription contraception, such as endometriosis, constitutes a serious medical need<sup>128</sup> and that because the denials were repeated and based on a policy or practice, they meet the deliberate indifference standard.

An Eighth Amendment lawsuit or even the threat of a lawsuit could have consequences that bring about reform in a variety of ways. First, in *Todaro v. Ward*, the court imposed remedial measures and ongoing monitoring by the court, which is likely the reason Bedford Hills continues to have better medical care than other state correctional facilities.<sup>129</sup> Second, lawsuits under the Eighth Amendment could lead to settlements, requiring the state or individual facilities to pay money to plaintiffs, as happened in a recent case brought against Jackson County, Missouri, by a woman who had been shackled while she was in labor at a correctional facility.<sup>130</sup> Third, a lawsuit would likely garner nega-

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127. See *supra* Part II.

128. Arguably, endometriosis would meet this standard. See MAYO CLINIC, DISEASES AND CONDITIONS: ENDOMETRIOSIS, <http://www.mayoclinic.org/diseases-conditions/endometriosis/basics/definition/con-20013968> [<https://perma.cc/WB5A-ZG4B>] (last visited Aug. 18, 2016) (defining endometriosis as “an often painful disorder in which tissue that normally lines the inside of your uterus — the endometrium — grows outside your uterus. . . . Endometriosis can cause pain — sometimes severe — especially during your period. Fertility problems also may develop. Fortunately, effective treatments are available.”). Thus, based on this definition, endometriosis may meet the three factors mentioned in *Brock v. Wright*, 315 F.3d 158 (2d Cir. 2003): (1) a reasonable doctor or patient would perceive it as important and worthy of comment or treatment; (2) the medical condition significantly affects daily activities; and (3) there is an existence of chronic and substantial pain.

129. See CORR. ASS’N OF N.Y., *supra* note 1, at 41 (“That Bedford’s medical operation is stronger than other women’s prisons is also likely the result of a class action lawsuit, *Todaro v. Ward*, filed in 1974 by the Legal Aid Society’s Prisoners’ Rights Project on behalf of women at the prison. Until the settlement agreement ended in 2004, *Todaro* required Bedford to improve its health services in key areas including staffing, access to care, access to HIV doctors and systems for monitoring specialty care.”).

130. See Press Release, ACLU, ACLU of Missouri Announces Settlement with Jackson County, MO (May 31, 2016), available at <https://www.aclu.org/news/aclu-missouri-announces-settlement-jackson-county-mo> [<https://perma.cc/9LBQ-KU5S>] (“Nearly eight months after Megon Riedel filed her lawsuit against Jackson County and three correctional officers, the case has settled. Ms. Riedel had been shackled, chained and transported by van nearly 200 miles across state while she was in labor. . . . Under the terms of the set-



tive press and public attention, as happened recently when women incarcerated in New York State prisons brought a lawsuit alleging persistent sexual abuse.<sup>131</sup>

## 2. *Other State and Federal Laws*

New York's prison policies may violate other state and federal laws. For example, New York law requires hospitals treating sexual assault victims to provide emergency contraception.<sup>132</sup> The federal Prison Rape Elimination Act (PREA) also states that "[r]esident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency

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tlement, Jackson County will pay damages to Riedel and implement written policies and procedures addressing the use of restraints and transportation guidelines for pregnant inmates and pre-trial detainees.”).

131. See Weiser, *supra* note 52 (“Sexual abuse of female inmates is persistent in New York State prisons, six female prisoners claim in a lawsuit filed Thursday. Even if abuse is reported, the women claim, corrections officers are so unlikely to be disciplined that they openly disregard policies on such behavior. The lawsuit also claims that the system for investigating complaints of staff sexual misconduct in women’s prisons is inadequate and puts women who report abuse at risk of retaliation.”).

132. N.Y. PUB. HEALTH LAW § 2805-p(2) (McKinney 2004) (“Every hospital providing emergency treatment to a rape survivor shall promptly: (a) provide such survivor with written information prepared or approved, pursuant to subdivision three of this section, relating to emergency contraception; (b) orally inform such survivor of the availability of emergency contraception, its use and efficacy; and (c) provide emergency contraception to such survivor, unless contraindicated, upon her request. No hospital may be required to provide emergency contraception to a rape survivor who is pregnant.”); see also NYCLU, *supra* note 11, at 8 (“The denial of care after sexual assault, including abortion if requested, could also violate an inmate’s constitutional rights because such care is required by state law. For example, New York State law requires hospitals to make emergency contraception available to anyone presenting as a sexual assault victim. Failure to provide these emergency services to inmates could therefore constitute an Eighth Amendment violation.” (footnote omitted)). It seems this law would apply to a prison health care clinic, as the law defines “hospital” as:

a facility or institution engaged principally in providing services by or under the supervision of a physician . . . including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service.

N.Y. PUB. HEALTH LAW § 2801 (McKinney 2016).

contraception.”<sup>133</sup> Refusal by a correctional facility’s health care unit to provide emergency contraception to a woman who has been sexually assaulted could thus violate both New York Public Health Law § 2805-p(2) and PREA, and “constitute an Eighth Amendment violation.”<sup>134</sup> As neither of these laws provides for a private right of action,<sup>135</sup> an individual would likely still need to proceed under an Eighth Amendment claim:

Though PREA does not create a private right of action to sue for violations of the Act or regulations, there may be room for litigants to argue that noncompliance with the PREA standards presents evidence that facilities are not meeting their constitutional obligations. If a state, agency or facility has maintained PREA non-compliant policies or practices, this may be evidence that officials have been deliberately indifferent to an objectively serious risk of harm.<sup>136</sup>

Violations of New York’s § 2805-p(2) could also provide similar evidence in an Eighth Amendment suit. Additionally, PREA regulations are monitored through audits by state and local agencies and thus violations could be reported in these audits.<sup>137</sup> However, enforcement of PREA on state facilities is difficult because while states stand to lose 5% of their federal funding if they do not comply with PREA, “states can avoid that penalty if they promise to use their federal funding to conform to PREA stand-

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133. Prison Rape Elimination Act (PREA), 28 C.F.R. § 115.282 (2012). PREA applies to federal as well as state correctional facilities: “the Federal government was immediately bound to implement the PREA regulations in federal prisons but states had until August 2013 to certify compliance with the regulations or potentially lose five percent of any DOJ grant funds directed towards prison funding.” ACLU, END THE ABUSE: PROTECTING LGBTI PRISONERS FROM SEXUAL ASSAULT ADVOCACY GUIDE 2 (2014), <https://www.aclu.org/files/assets/prea/012014-ACLU-PREA-Guide.pdf> [<https://perma.cc/RYS8-BKK6>].

134. NYCLU, *supra* note 11, at 8 (“Failure to provide these emergency services to inmates could therefore constitute an Eighth Amendment violation.”).

135. See ACLU, *supra* note 133, at 2 (“PREA does not create a private right of action to sue for violations of the Act or regulations . . . .” (footnote omitted)).

136. ACLU, *supra* note 135 (footnote omitted).

137. ACLU, *supra* note 135, at 1 (“The PREA regulations primarily rely on an audit system and PREA coordinators to monitor and track compliance. The regulations require agencies to conduct one audit per year of at least one third of each facility type (prison, jail, juvenile facility, overnight lockup, and community confinement facility) operated by the agency.” (footnotes omitted)).

ards in the future, and PREA provides no penalties for local agencies that fail to meet its standards.”<sup>138</sup>

New York law also requires that correctional facilities pay for an incarcerated person’s medical care,<sup>139</sup> which suggests that restricting women’s access to reproductive health care in order to cut costs may violate state law.<sup>140</sup> Again, this statute does not provide a private right of action and therefore the government would need to take action to enforce the statute. Additionally, the Supreme Court has held that the government has an “obligation to provide medical care for those whom it is punishing by incarceration”<sup>141</sup> and courts in reproductive health care cases have also stated cost cannot be a reason for prisons to deny medical care.<sup>142</sup>

## B. MEDICAL AND PUBLIC HEALTH PERSPECTIVE

New York’s health care policies for incarcerated women are problematic because they do not align with medical guidelines. In addition, New York’s policies ignore public health research that underscores the importance of access to adequate reproductive health care for the incarcerated.

### 1. *Medical Standards*

The medical community promulgates standards for providing health care to the incarcerated. The correctional health system generally operates under a set of guidelines and policies promulgated by the National Commission on Correctional Health Care (NCCHC). The Commission, in collaboration with the American

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138. ACLU, *supra* note 135, at 1 (footnotes omitted).

139. See N.Y. CORRECT. LAW § 500-h (McKinney 1991) (“Diagnoses, tests, studies or analyses for the diagnosis of a disease or disability, and care and treatment by a hospital, as defined in article twenty-eight of the public health law, or by a physician, or by a dentist to inmates of a local correctional facility which are provided by a county or the city of New York shall be available without cost or charge to the inmates receiving such examinations, care or treatment.”).

140. See NYCLU, *supra* note 11, at 16 (“Interviews with jail officials in several counties revealed that cost was the primary reason for restricting access to birth control.”).

141. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

142. See *Monmouth Cty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 346–47 (3d Cir. 1987) (“Prison officials may not, with deliberate indifference to the serious medical needs of the inmate, opt for ‘an easier and less efficacious treatment’ of the inmate’s condition. Nor may they condition provision of needed medical services on the inmate’s ability or willingness to pay.” (citations omitted)).

Public Health Association (APHA), has published standards for health services that an institution must provide to be considered a NCCHC accredited correctional health facility.<sup>143</sup> ACOG also provides recommendations for standards of care.<sup>144</sup>

In its position statements, NCCHC recognizes the current inadequacy of gynecological care for incarcerated women.<sup>145</sup> For gynecological examinations, NCCHC standards generally suggest “inquiry into current gynecological problems and pregnancy for women and female adolescents” and “recommend [ ] that clinical practice guidelines be followed for pelvic examinations and Pap smears.”<sup>146</sup> In its position statement, NCCHC recommends that at intake, medical histories should be taken that incorporate questions specific to women’s health, including questions about “menstrual cycle, pregnancies, gynecologic problems, contraception, current breastfeeding, sexual and physical abuse, and a nutritional assessment.”<sup>147</sup> The standards for both county jails and state correctional facilities in New York fail to follow this recommendation addressing medical history.<sup>148</sup> The NCCHC recommendations also address pregnancy tests stating: “[a]ll women at risk for pregnancy should be offered a pregnancy test within 48 hours of admission.”<sup>149</sup> County jails and state correctional facilities in New York also do not follow this standard, and rather

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143. See Sufrin, *Incarcerated Women and Abortion Provision*, *supra* note 15, at 10 (“The correctional health system, which is widely recognized as an important venue for caring for persons who were medically marginalized prior to incarceration, operates under a set of guidelines and policies enumerated in most cases by the National Commission on Correctional Health Care. In collaboration with the American Public Health Association, the commission has published standards for health services that an institution must provide to be an accredited correctional health facility.” (footnotes omitted)).

144. See ACOG COMM. 535, *supra* note 12, at 2–3.

145. See NAT’L COMM’N ON CORR. HEALTH CARE, POSITION STATEMENT: WOMEN’S HEALTH CARE IN CORRECTIONAL SETTINGS 1 (2014), available at [http://www.ncchc.org/filebin/Positions/Womens\\_Health\\_Care\\_in\\_Correctional\\_Settings.pdf](http://www.ncchc.org/filebin/Positions/Womens_Health_Care_in_Correctional_Settings.pdf) [<https://perma.cc/K9HW-8GLW>] (“Research on the provision of gynecological services for women in correctional settings has consistently indicated that current services are inadequate. Gynecological exams are not performed upon admission, nor are they routinely provided on an annual basis. Appropriate initial screening questions about a woman’s gynecologic history often are not asked . . .”).

146. *Id.* at 4.

147. *Id.* (citation omitted).

148. See N.Y. COMP. CODES R. & REGS. tit. 9, § 7010.2(j) (2016) (the standards addressing medical records for county jails do not recommend asking questions specific to women); *id.* § 7651.19 (the standards addressing medical records for state correction facilities do not recommend asking questions specific to women).

149. NCCHC Position Statement, *supra* note 145, at 4.

make no mention of pregnancy tests at all.<sup>150</sup> ACOG recommends a “[p]hysical examination — pelvic and breast, Pap test, and baseline mammography based on College guidelines.”<sup>151</sup> In county jails and penitentiaries, the standards addressing health care make no mention Pap smears and breast examinations.<sup>152</sup> Standards for state correctional facilities do call for Pap smears and breast examinations for women, but do not provide for how often examinations should occur following the initial assessment, nor do they provide information about ongoing gynecological examinations or follow up procedures.<sup>153</sup> DOCCS policies also do not completely align with these recommendations.<sup>154</sup>

NCCHC and ACOG also both address contraception access. ACOG broadly recommends access to “[c]ontraceptive services, including emergency contraception, based on medical need or potential risk of pregnancy.”<sup>155</sup> The NCCHC standard addressing contraception “recommends that women be provided with non-directive contraception counseling, access to emergency contraception, and continuation of current contraceptive method while incarcerated.”<sup>156</sup> New York’s policies again fall short of these rec-

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150. N.Y. COMP. CODES R. & REGS. tit. 9, § 7013.7 (2016) (the standards for county jails that address initial screening and risk assessment procedures do not mention pregnancy tests); *id.* § 7010.2 (the standards for county jails that address general health services do not mention pregnancy tests); *id.* § 7651.9 (the standards for state correctional facilities that address reception health assessments do not mention pregnancy tests); *id.* § 7651 (2016) (the standards for health services generally in state correctional facilities do not mention pregnancy tests).

151. ACOG COMM. 535, *supra* note 12, at 2.

152. *See* N.Y. COMP. CODES R. & REGS. tit. 9, §§ 7010.2, 7013.7 (2016); *see also* NYCLU, *supra* note 11, at 6 (“While these standards provide a general framework for policy development, they are particularly short on detail regarding women’s health care. For instance, correctional facilities are required to conduct an initial health screening on all inmates. The regulations do not specify, however, how soon after admission the health screening must occur or what the screening must entail, other than to ‘identify serious or life-threatening medical conditions requiring immediate evaluation and treatment.’” (footnotes omitted)).

153. N.Y. COMP. CODES R. & REGS. tit. 9, § 7651.9 (2016).

154. *See* CORR. ASS’N OF N.Y., *supra* note 1, at 37 (“Examples of areas where DOCCS’ policies do not comport with community standards include: Starting age for yearly GYN check-ups[; and] Frequency of breast exams.”).

155. ACOG COMM. 535, *supra* note 12, at 3.

156. NCCHC Position Statement, *supra* note 145, at 4; *see also id.* at 5 (“[C]orrectional facilities need to offer contraception services in a non-coercive manner while women are in custody, and allow women to continue methods they are already on, especially if their incarceration is short term or if the method is for medical reasons. Emergency contraception also needs to be made available to women, especially at intake.” (citation omitted)).

ommendations by allowing for access to contraception only in very limited circumstances.<sup>157</sup>

## 2. *Public Health Concerns*

Numerous medical studies have found the lack of access to contraception for incarcerated women to be problematic, not only from the perspective of the individual woman's health but also from a broader public health perspective. For example, studies provide evidence of the importance of access to contraception prior to release from prison. A study of women incarcerated in Rhode Island found that women reentering the community after release were at high risk for an unplanned pregnancy,<sup>158</sup> noting the difficulties women face post-release that contribute to the risk: "[u]pon returning to the community, a woman faces many competing stressors and demands — such as securing housing, employment, and food and managing family reunification — and is often confronted with the temptation of relapse into drug and/or alcohol use."<sup>159</sup> Pregnancies among incarcerated and formerly incarcerated women may also be medically high-risk due to a number of factors including a lack of access to adequate prenatal services, drug use, and mental illness.<sup>160</sup>

Additionally, women themselves have reported that they believe access to contraception prior to release is important for reentry purposes: "participants stated that offering contraception

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157. See *supra* Part II.C.

158. See Clarke et al., *supra* note 14, at 837 ("In our study . . . only 28% of the women at risk for an unplanned pregnancy used birth control consistently, and 5.6% had never used a contraceptive method during the past 3 months. Furthermore, despite having an elevated risk for pregnancy and STDs, only 1 in 5 of these women had used condoms consistently. . . . 67.2% said they were very likely or extremely likely to have sexual relations with a man within 6 months after release.").

159. *Id.*; see also Megha Ramaswamy et al., *Highly Effective Birth Control Use Before and After Women's Incarceration*, 24 J. WOMEN'S HEALTH 1, 7 (2015), available at [https://www.researchgate.net/publication/270287637\\_Highly\\_Effective\\_Birth\\_Control\\_Use\\_Before\\_and\\_After\\_Women's\\_Incarceration](https://www.researchgate.net/publication/270287637_Highly_Effective_Birth_Control_Use_Before_and_After_Women's_Incarceration) [https://perma.cc/2WFF-ZA4X] ("Offering birth control in jails prior to women's release would help them overcome barriers to contrac[ep]tive use related to logistics, financial resources, health insurance, time, and partner issues.").

160. See Clarke et al., *supra* note 17, at 840 ("Among incarcerated women, pregnancies are high risk for several reasons. One is that many of these women lack or fail to use prenatal care services. Another is that use of drugs among these women frequently leads to preterm deliveries, spontaneous abortions, low-birthweight infants, and preeclampsia. Moreover, their high rates of psychiatric illness often result in exposure of the fetus to teratogenic medications during treatment, and their alcohol use may cause fetal alcohol syndrome.").

at the jail was important because many women wanted to avoid pregnancy immediately upon returning home to pursue goals and get their lives back in order without worrying about a new child.”<sup>161</sup> Access to contraception during incarceration has led to a much higher uptake in birth control usage: “[o]ffering contraceptive services within a correctional setting led to a much higher rate of initiating birth control than solely connecting women to free contraceptive services in the community (39.1% vs 4.4%).”<sup>162</sup> Research has also shown that incarceration can provide an opportunity to educate women about proper usage of contraception, if it is provided prior to release.<sup>163</sup>

The public health community has also conducted extensive research on access to emergency contraception. In a study of correctional health providers, only 4% stated that emergency contraception was available to women incarcerated at their facility.<sup>164</sup> There is evidence that providing emergency contraception to newly arrested women is beneficial,<sup>165</sup> and many women who are eligible have expressed willingness to use emergency contraception if provided.<sup>166</sup> Allowing women access to emergency contraception could not only benefit individual women but also have cost-saving implications for prisons.<sup>167</sup>

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161. Schonberg, *supra* note 12, at 2270.

162. Clarke, *supra* note 17, at 843.

163. See Galen J. Hale et al., *The Contraceptive Needs of Incarcerated Women*, 18 J. WOMEN'S HEALTH 1222, 1225 (2009), available at [https://www.researchgate.net/publication/26693755\\_The\\_Contraceptive\\_Needs\\_of\\_Incarcerated\\_Women](https://www.researchgate.net/publication/26693755_The_Contraceptive_Needs_of_Incarcerated_Women) [<https://perma.cc/R2LB-AJSS>] (“Many women may be uncertain as to how to obtain contraceptives or how to use them; having a nurse educator explain the basics of contraceptive options and instructions as to how to use them correctly could greatly benefit such women.”).

164. Carolyn B. Sufrin et al., *Emergency Contraception for Newly Arrested Women: Evidence for an Unrecognized Public Health Opportunity*, 87 J. URB. HEALTH 244, 251 (2009), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845828/> [<https://perma.cc/5TJ7-U9KV>] (“[O]nly 4% of correctional health providers who responded to a national survey said that [emergency contraception] is available at their facilities.”).

165. See *id.* at 250–51 (“Jail is the first point of contact for women in the criminal justice system and thus represents an ideal site for screening and offering public health measures. Our results suggest that an assessment of sexual activity, pregnancy risk, and pregnancy intention when a woman first enters jail could mitigate the possibility of an undesired pregnancy if emergency contraception were available.”).

166. See *id.* at 244 (“Eighty-four (29%) women were eligible for emergency contraception. Of these, 48% indicated a willingness to take emergency contraception if offered.”).

167. See *id.* at 251 (“One dose of Plan B, the only dedicated EC product in the US, costs \$48, which is substantially less expensive than prenatal or abortion care. If 29% of all 2.6 million women arrested in this country were eligible for EC at the time of their arrest, then 750,000 women each year could potentially benefit from EC at jail intake. Without EC, an estimated 8% of these 750,000 women, or 60,000, could become pregnant from

Public health research also notes that improving gynecological care for incarcerated women provides an opportunity to reduce healthcare disparities in the U.S.<sup>168</sup>: “[i]ncarceration is often the only opportunity for many disenfranchised women to receive general medical care, reproductive health care, and preventive health care services.”<sup>169</sup>

#### IV. FEDERAL, INTERNATIONAL, AND NEW YORK CITY STANDARDS AS POSSIBLE MODELS

Three current standards for incarcerated women’s reproductive health care provide possible models for reform. The first set of standards comes from the Federal Bureau of Prisons (BOP), which is “responsible for the custody and care of federal inmates” and oversees 191,526 persons incarcerated in federal prisons.<sup>170</sup> The BOP policies are called “Program Statements” and include a statement on “Patient Care,” which generally provides standards for medical care,<sup>171</sup> as well as a statement specifically addressing women’s reproductive care: “Birth Control, Pregnancy, Child Placement and Abortion.”<sup>172</sup>

Second, international standards address health care for incarcerated women and recognize that women have distinct medical concerns. The United Nations passed guidelines for incarcerated women in 2010, “United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules).” The U.N. Bangkok Rules recognize

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having unprotected intercourse pre-arrest. EC can reduce the chances of pregnancy after unprotected sex from 8% to 1%, which could translate into an estimated 52,500 pregnancies prevented annually in the USA.”)

168. *See id.* at 252 (“Women who enter the criminal justice system generally come from socioeconomically and medically marginalized sectors of society, often with limited access to health care. Improving health care for this population is part of the larger project of reducing health disparities in our society.”).

169. Clarke et al., *supra* note 14, at 837 (“Incarceration is an opportunity to provide reproductive health services to a large population of high-risk women who might not otherwise seek health services.”); *see also* Hale, *supra* note 163, at 1222 (“For many of these women, incarceration may be the only opportunity to receive reproductive healthcare.”).

170. *About Our Agency*, FED. BUREAU OF PRISONS, <https://www.bop.gov/about/agency/> [<https://perma.cc/2C67-5MJ4>] (last visited Nov. 2, 2016).

171. FED. BUREAU OF PRISONS, PROGRAM STATEMENT 6031.01: PATIENT CARE (2014), *available at* [https://www.bop.gov/policy/progstat/6031\\_004.pdf](https://www.bop.gov/policy/progstat/6031_004.pdf) [<https://perma.cc/NK36-CTBA>].

172. FED. BUREAU OF PRISONS, PROGRAM STATEMENT 6070.05: BIRTH CONTROL, PREGNANCY, CHILD PLACEMENT & ABORTION (1996), *available at* [https://www.bop.gov/policy/progstat/6070\\_005.pdf](https://www.bop.gov/policy/progstat/6070_005.pdf) [<https://perma.cc/4BYS-89WM>].



the current lack of attention to women's specific needs and are aimed at "prison authorities and criminal justice agencies (including policymakers, legislators, the prosecution service, the judiciary and the probation service) involved in the administration of non-custodial sanctions and community-based measures."<sup>173</sup> In 2009, the World Health Organization Regional Office for Europe adopted recommendations addressing incarcerated women's health.<sup>174</sup> Finally, New York City's recent legislation addressing sanitary supplies for women incarcerated in city jails provides a new model for reform in this area. Standards for access to gynecological examinations, sanitary products, and contraception are discussed in Sections A, B, and C respectively.

## A. GYNECOLOGICAL EXAMINATIONS

### 1. *Federal Policies*

The BOP's "Patient Care" policy includes a section specific to women entitled "Female Health Care."<sup>175</sup> This BOP policy provides specific requirements for female physical examinations including pregnancy testing, breast and pelvic examinations, Pap smears, and mammograms.<sup>176</sup> The policy also shows sensitivity to the concerns that women have expressed about seeing a male

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173. UNITED NATIONS, UNITED NATIONS RULES FOR THE TREATMENT OF WOMEN PRISONERS AND NON-CUSTODIAL MEASURES FOR WOMEN OFFENDERS (THE BANGKOK RULES) 6 (2010), *available at* <https://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf> [<https://perma.cc/BM8C-YDZ3>].

174. WORLD HEALTH ORG. EUR., WOMEN'S HEALTH IN PRISON: CORRECTING GENDER INEQUITY IN PRISON HEALTH (2009), *available at* [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/76513/E92347.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf?ua=1) [<https://perma.cc/R85R-AXUD>].

175. FED. BUREAU OF PRISONS, *supra* note 171, at 27.

176. *See id.* at 27–28 ("Requirements for Routine Physical Examinations of Female Inmates. In addition to the elements described in Section 19 for complete physical examinations (long-term), the following elements apply to routine physical examinations of female inmates: A gynecological and obstetrical history, including sexual activity and any recent rape history[;] Order a pregnancy test for females of childbearing age (urine or serum) and other tests as clinically indicated[;] Conduct a breast and pelvic examination. A female staff member will be present when a male provider performs breast and pelvic examinations (except in emergency situations when a female staff member is not available)[;] Annual breast examinations will be made available to inmates upon request[;] Self-examination instructions will be given to all females at the time of the breast examination[;] Offer Pap smear; collect chlamydia, gonorrhea and/or other endo-cervical cultures from vaginal and/or anal orifices when clinically indicated. The Medical Director will ensure the availability of age-specific preventive health examinations (e.g., cervical, breast) for the female inmate population. . . . Mammography will be used as a diagnostic tool.").

physician by requiring “[a] female staff member [to] be present when a male provider performs breast and pelvic examinations . . . .”<sup>177</sup> However, similar to New York’s policy, the policy does not contain further requirements for ongoing examinations such as frequency of appointments or follow up procedures.

## 2. *International Standards*

The U.N. Bangkok Rules recognize the necessity of initial or entry medical examinations that are specific to women including determining “[t]he reproductive health history of the woman prisoner, including current or recent pregnancies, childbirth and any related reproductive health issues.”<sup>178</sup> The Rules further recognize that examinations must address women’s specific medical needs throughout detention<sup>179</sup> calling for “[p]reventive health care measures of particular relevance to women, such as Papanicolaou tests and screening for breast and gynaecological cancer . . . .”<sup>180</sup> The WHO declaration also recognizes the necessity for gender-specific medical care noting that “[s]creening programmes for reproductive diseases” should be standard procedure<sup>181</sup> and calling for examinations for breast cancer.<sup>182</sup>

Both the U.N. and WHO guidelines also address general policies that are particularly problematic in the context of gynecological care. The U.N. Bangkok Rules generally recommend that only medical staff, not corrections officers, be present during medical examinations.<sup>183</sup> The WHO declaration similarly recommends that “[w]omen in prison should be able to see a physician

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177. *Id.* at 27.

178. See UNITED NATIONS, *supra* note 173, at 12.

179. See *id.* at 13 (“Gender-specific healthcare services at least equivalent to those available in the community shall be provided to women prisoners.”).

180. *Id.* at 14–15.

181. See WORLD HEALTH ORG. EUR., *supra* note 174, at 21, 30, 42 (“A gender-sensitive health care system in prisons should reflect the special health care needs of women in prison by providing appropriate facilities and regimens and by allowing easy access to health and social support services necessary for women.”).

182. WORLD HEALTH ORG. EUR., *supra* note 174, at 30 (“Screening programmes for reproductive diseases, such as breast cancer, should be included in the standard procedure in women’s prisons.”).

183. UNITED NATIONS, *supra* note 173, at 13 (“Only medical staff shall be present during medical examinations unless . . . exceptional circumstances exist or . . . for security reasons or the woman prisoner specifically requests the presence of a member of staff. . . . If it is necessary for non-medical prison staff to be present during medical examinations, such staff should be women and examinations shall be carried out in a manner that safeguards privacy, dignity and confidentiality.”).

without the presence of prison operational staff” and that “[w]omen in prison should be given the choice to be accompanied by a woman (such as a female nurse) when visiting a physician if they prefer.”<sup>184</sup>

## B. SANITARY SUPPLIES

### 1. *Federal Policies*

The BOP’s “Patient Care” statement includes a section on sanitary products stating that the Health Services Unit “will provide only medically indicated feminine hygiene products. The institution will stock sanitary napkins.”<sup>185</sup> However, the policy, similar to New York’s, does not provide further details about how the products will be provided or the quantity of sanitary napkins that incarcerated women will be provided by the facility free of charge.

### 2. *International Standards*

Both sets of international standards address access to sanitary supplies. The U.N Bangkok Rules state that women “shall have facilities and materials required to meet women’s specific hygiene needs, including sanitary towels provided free of charge . . . .”<sup>186</sup> The WHO declaration discusses access to sanitary napkins more thoroughly, recognizing that sanitary items should be “free of charge”<sup>187</sup> and that “health care personnel do not need to approve or manage access to sanitary napkins . . . .”<sup>188</sup>

### 3. *New York City*

The New York City Council enacted legislation this year that allows women incarcerated in city jails greater access to sanitary products. This legislation states that “[a]ll female inmates in the custody of the department shall be provided, at the department’s expense, with feminine hygiene products as soon as practicable

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184. WORLD HEALTH ORG. EUR., *supra* note 174, at 33.

185. FED. BUREAU OF PRISONS, *supra* note 171, at 58.

186. UNITED NATIONS, *supra* note 173, at 11.

187. WORLD HEALTH ORG. EUR., *supra* note 174, at 3.

188. *Id.* at 21.

upon request.”<sup>189</sup> The new law was part of a package of legislation intended to increase access New York City’s shelter residents, students, and incarcerated women.<sup>190</sup> In signing the legislation Mayor de Blasio stated, “There should be no stigma around something as fundamental as menstruation. These laws recognize that feminine hygiene products are a necessity — not a luxury . . . . [W]omen in our Correction Department should be able to work toward rehabilitation and release without the indignity of inadequate access to tampons and pads.”<sup>191</sup> This legislation should serve as a model for county jails and state correctional facilities.

### C. CONTRACEPTION

#### 1. *Federal Policies*

Unlike New York, the BOP has a written policy addressing contraception access, which can be found in Program Statement 6070.05, “Birth Control, Pregnancy, Child Placement and Abortion.”<sup>192</sup> The fact that a written policy exists at all makes the BOP’s superior to New York’s. However, the policy provides for only limited access to contraception, stating: “[t]he medical indication and appropriateness of prescribing birth control in a correctional environment ordinarily is limited to hormonal replacement therapy. When a clinician believes actual birth control is medically appropriate, the Bureau Medical Director’s prior approval is required.”<sup>193</sup> The “Patient Care” Program Statement, which has been updated more recently, includes hormone replacement therapy for post-menopausal women and “[h]ormonal manipulation for menstrual irregularity” as medically appropri-

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189. N.Y.C. ADMIN. CODE § 9-141 (2016) (The law further states: “All female individuals arrested and detained in the custody of the department for at least 48 hours shall be provided, at the department’s expense, with feminine hygiene products as soon as practicable upon request. For purposes of this section, ‘feminine hygiene products’ means tampons and sanitary napkins for use in connection with the menstrual cycle.”).

190. See Press Release, N.Y.C. Office of the Mayor, Mayor de Blasio Signs Legislation Increasing Access to Feminine Hygiene Products for Students, Shelter Residents and Inmates (July 13, 2016), available at <http://www1.nyc.gov/office-of-the-mayor/news/611-16/mayor-de-blasio-signs-legislation-increasing-access-feminine-hygiene-products-students> [<https://perma.cc/2AHX-45XX>].

191. *Id.*

192. FED. BUREAU OF PRISONS, *supra* note 172.

193. FED. BUREAU OF PRISONS, *supra* note 172, at 2.

ate, but these still require approval from the Bureau's Medical Director.<sup>194</sup>

## 2. *International Standards*

The WHO declaration recognizes that women should have access to contraception while incarcerated, stating that “[w]omen in prison should always have access to condoms as well as dental dams . . . .”<sup>195</sup> The WHO does not provide further concrete recommendations about contraception but generally acknowledges a woman's right to regulate her own fertility and that this right should be maintained as much as possible in prison.<sup>196</sup> The WHO declaration, similar to the public health studies discussed above, recognizes that a woman's time in prison may be her first opportunity to receive reproductive health care and recommends taking advantage of this opportunity:

Some of the specific needs of women in prison should be tackled by taking advantage of the time they are in prison to provide education about preventing illness and maintaining good health, especially HIV and other sexually transmitted infections. . . . [T]heir time in prison may be the first time in their life they have access to health care, social support and counselling.<sup>197</sup>

Also similar to the findings of the public health studies discussed above,<sup>198</sup> the WHO recognizes that “[p]re-release preparations must be planned and provided to ensure continuity of care, and

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194. FED. BUREAU OF PRISONS, *supra* note 171, at 28 (“Prior approval of the Bureau's Medical Director is required if a clinician believes birth control is medically appropriate for a condition other than [hormone replacement therapy and hormonal manipulation as noted above].”).

195. WORLD HEALTH ORG. EUR., *supra* note 174, at 22.

196. *See id.* at 29–30 (“Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child. . . . Reproductive and sexual health rights are considerably constrained in prisons, but wherever possible, the rights should be maintained as much as possible.” (citation omitted)).

197. *Id.* at 20–21.

198. *See supra* Part III.B.2.

access to health and other services after release must be a clear part of the programme preparing for release.”<sup>199</sup>

The U.N. Bangkok Rules do not provide clear standards for contraception access but do state that “[w]omen prisoners shall receive education and information about preventive health care measures, including from HIV, sexually transmitted diseases and other, blood-borne diseases, as well as gender-specific health conditions.”<sup>200</sup>

## V. REFORMING NEW YORK’S POLICIES: BRINGING POLICIES IN LINE WITH LEGAL, MEDICAL, AND INTERNATIONAL STANDARDS

Based on the shortcomings of New York’s policies and the alternative standards discussed above, this Part recommends using legal, medical, and international standards as guides for making changes to problematic policies. Though all have room for improvement, legal standards, medical guidelines, and international standards addressing women’s reproductive care do provide possible solutions to the problems of New York State policies. Sections A, B, and C, respectively, discuss recommended revisions to policies addressing gynecological examinations, sanitary supplies, and contraception.

### A. GYNECOLOGICAL EXAMINATIONS

First, New York’s written policies addressing initial assessments and ongoing care should be revised to include rules and procedures specific to women’s health care. One of the major failings of New York’s policies is that they often fail to distinguish between health care procedures for women and men in both initial assessments and ongoing care.<sup>201</sup> The BOP has set an example that New York should follow by enacting a policy specific to women’s health care and including standards for examinations that are specific to women.<sup>202</sup> The BOP’s policy “Female Health Care” should be a baseline, further improved by following specific medical guidelines for these examinations. For example, SCOC minimum standards for both county jails and penitentiaries and

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199. See WORLD HEALTH ORG. EUR., *supra* note 174, at 40.

200. UNITED NATIONS, *supra* note 173, at 14.

201. See *supra* Part II.A.

202. See FED. BUREAU OF PRISONS, *supra* note 171, at 27–28.

state correctional facilities do not provide for women to be given pregnancy tests as part of an intake exam,<sup>203</sup> while medical recommendations call for pregnancy tests for women within 48 hours of intake.<sup>204</sup>

Second, New York's policies do not provide for medical records and histories to include questions specific to women.<sup>205</sup> New York should update its policies for medical records and histories at intake to be in line with NCCHC standards, which recommend questions specific to women's health including pregnancies and contraceptive use,<sup>206</sup> and international standards, which recommend questions about past and current pregnancies and other reproductive health issues.<sup>207</sup>

Third, policies should be revised to account for women who fail to receive adequate care because they are uncomfortable seeing a male gynecologist due to past trauma or do not want to see a physician with a corrections officer present.<sup>208</sup> Policies should be up-

203. See N.Y. COMP. CODES R. & REGS. tit. 9, § 7013.7 (2016) (standards for initial assessments at county jails do not call for pregnancy tests); *id.* at § 7010.2 (standards for health services at county jails do not mention pregnancy tests); *id.* at § 7651.9 (standards for reception health assessments at state correctional facilities do not call for pregnancy tests); *id.* at § 7651 (standards for health services generally in state correctional facilities do not mention pregnancy tests).

204. See NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 145, at 4 ("All women at risk for pregnancy should be offered a pregnancy test within 48 hours of admission. Sexually active women remain at risk for pregnancy until they go through menopause.")

205. N.Y. COMP. CODES R. & REGS. tit. 9, § 7651.19 (2016) (the standards for state correctional facility include that "[a] permanent individual medical record shall be recorded and maintained for every inmate" but do not include information specific to women such as pregnancy); *id.* § 7010.2 (the standards for county jails and penitentiaries do not include information specific to women but instead state only that "[a]dequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint, medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person").

206. See NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 145, at 4 ("Correctional institutions need to implement intake procedures that include histories on menstrual cycle, pregnancies, gynecologic problems, contraception, current breastfeeding, sexual and physical abuse, and a nutritional assessment.")

207. See UNITED NATIONS, *supra* note 173, at 12 ("The health screening of women prisoners shall include comprehensive screening to determine primary health care needs, and also shall determine: . . . The reproductive health history of the woman prisoner, including current or recent pregnancies, childbirth and any related reproductive health issues.")

208. CORR. ASS'N OF N.Y., *supra* note 1, at 50 ("[M]any women wrote that they strongly prefer to see female GYNs and feel distressed when they are assigned to male providers. Forty-four percent (72 of 162) of general survey respondents who saw a male GYN while in DOCCS said that it made them feel uncomfortable talking about their needs." (footnote omitted)); see also CORR. ASS'N OF N.Y., *supra* note 1, at 49 ("Being physically examined by a doctor has the potential to retraumatize women who have experienced trauma and

dated to provide access to female health care providers when possible, and allow access to private appointments with physicians when possible. The U.N. and WHO standards both address these issues by recommending that only medical staff be present during examinations and allowing women to be accompanied by a female nurse if they are seeing a male physician.<sup>209</sup> The BOP policy also addresses this issue by requiring that “[a] female staff member will be present when a male provider performs breast and pelvic examinations . . . .”<sup>210</sup>

Fourth, DOCCS written policies should be updated to comply with medical standards. For example, policies that address the starting age of gynecological examinations and the frequency of breast examinations should conform to medical guidelines including ACOG’s standards.<sup>211</sup>

## B. SANITARY SUPPLIES

New York’s county jails and state facilities have policies that limit the number of sanitary napkins made available to incarcerated women without regard to women’s actual needs.<sup>212</sup> The

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abuse, particularly sexual violence. This is especially true for GYN exams: the focus on sensitive body parts and physical touch that often occurs during exams can trigger memories of prior abuse and cause survivors to feel violated and unsafe. Fear of being retraumatized in this way leads some survivors to avoid seeking medical care altogether.” (footnote omitted)).

209. See UNITED NATIONS, *supra* note 173, at 13 (“If a woman prisoner requests that she be examined or treated by a woman physician or nurse, a woman physician or nurse shall be made available to the extent possible, except for situations requiring urgent medical intervention. If a male medical practitioner undertakes the examination contrary to the wishes of the woman prisoner, a woman staff member shall be present during the examination. . . . Only medical staff shall be present during medical examinations unless the doctor is of the view that exceptional circumstances exist or the doctor requests a member of the prison staff to be present for security reasons or the woman prisoner specifically requests the presence of a member of staff . . . .”); WORLD HEALTH ORG. EUR., *supra* note 174, at 33 (“Women in prison should be able to see a physician without the presence of prison operational staff, because women are less likely to report possible violence and abuse in prison in the presence of operational staff. Women in prison should be given the choice to be accompanied by a woman (such as a female nurse) when visiting a physician if they prefer.”).

210. FED. BUREAU OF PRISONS, *supra* note 171, at 27.

211. See *supra* Part II.A; see also AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 43, at 2; AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 45.

212. See CORR. ASS’N OF N.Y., *supra* note 1, at 66 (“The vast majority of women the CA interviewed reported that the monthly supply of sanitary napkins DOCCS gives them does not meet their needs.”); see also CORR. ASS’N OF N.Y., *supra* note 1, at 66 (“DOCCS distributes 24 sanitary napkins to women in general population each month.” (footnote omitted)).



WHO declaration provides an excellent standard for addressing access to feminine hygiene products, by allowing women to access as many sanitary products as they need free of charge.<sup>213</sup> New York City's new legislation also allows women to access sanitary supplies free of charge and states that they will be provided "as soon as practicable upon request."<sup>214</sup> Although allowing women unlimited access to sanitary products may cost more, the Supreme Court has held that the government has an "obligation to provide medical care for those whom it is punishing by incarceration"<sup>215</sup> and New York law requires that correctional facilities pay for an incarcerated person's medical care.<sup>216</sup>

### C. CONTRACEPTION

New York's policies regulating access to contraception for incarcerated women also have much room for improvement. First, New York should enact a uniform, written policy. SCOC minimum standards should address contraception beyond its memorandum allowing access for one particular use<sup>217</sup> and DOCCS policies should also be updated to be clear and consistent.

Second, New York's policies should be expanded to include access to contraception beyond just the limited circumstances in which it currently does.<sup>218</sup> While the BOP has a written policy in place, it only allows access to birth control for hormone replacement therapy or to regulate menstruation.<sup>219</sup> The medical stand-

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213. See WORLD HEALTH ORG. EUR., *supra* note 174, at 3, 21.

214. N.Y.C. ADMIN. CODE § 9-141 (2016).

215. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

216. See N.Y. CORRECT. LAW § 500-h (McKinney 1991) ("Diagnoses, tests, studies or analyses for the diagnosis of a disease or disability, and care and treatment by a hospital . . . or by a physician, or by a dentist to inmates of a local correctional facility which are provided by a county or the city of New York shall be available without cost or charge to the inmates receiving such examinations, care or treatment.").

217. See N.Y. STATE COMM'N OF CORR., CHAIRMAN'S MEMORANDUM: REPRODUCTIVE SERVICES FOR WOMEN IN JAIL 2 (2008), *available at* [http://www.scoc.ny.gov/pdfdocs/chair2008\\_4.pdf](http://www.scoc.ny.gov/pdfdocs/chair2008_4.pdf) [<https://perma.cc/B6A3-9G2W>] ("Women should be permitted to continue taking previously prescribed hormonal therapy during incarceration, i.e., in a manner no different from most other prescription medications prescribed by an offender's primary care physician.").

218. See *supra* Part II.C.

219. See FED. BUREAU OF PRISONS, *supra* note 171, at 28 ("Ordinarily, the medical indication and appropriateness of prescribing birth control medication in a correctional environment is limited to: [h]ormonal manipulation for menstrual irregularity [and] hormonal replacement therapy in post-menopausal women as clinically indicated. Prior approval of the Bureau's Medical Director is required if a clinician believes birth control is medically appropriate for a condition other than those noted above.").

ards discussed above should guide any written policy. For example, the NCCHC standard addressing contraception “recommends that women be provided with nondirective contraception counseling, access to emergency contraception, and continuation of current contraceptive method while incarcerated.”<sup>220</sup> ACOG broadly recommends access to “[c]ontraceptive services, including emergency contraception, based on medical need or potential risk of pregnancy.”<sup>221</sup> From a public health perspective, ACOG’s comprehensive recommendation is the most likely to account for all of the reasons that incarcerated women would want access to contraception, including high risk of pregnancy immediately following release, risk of pregnancy from a sexual assault while incarcerated, and the need for contraception due to medical issues other than pregnancy.

Third, New York’s policies should also provide for access to education about reproductive health care. Both public health studies and international standards have recognized the opportunity for women to be educated about reproductive health care while they are incarcerated.<sup>222</sup>

Finally, policies should be updated to reflect the need for continuity in pre-release and post-release reproductive care, which has also been recognized by the public health and international communities as highly important.<sup>223</sup> Part VI, *infra*, discusses how to utilize existing programs to provide funding for continuity of care.

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220. NAT’L COMM’N ON CORR. HEALTH CARE, *supra* note 145, at 4.

221. ACOG COMM. 535, *supra* note 12, at 3.

222. *See* Hale, *supra* note 163, at 1225 (“Many women may be uncertain as to how to obtain contraceptives or how to use them; having a nurse educator explain the basics of contraceptive options and instructions as to how to use them correctly could greatly benefit such women.”); *see also* UNITED NATIONS, *supra* note 173, at 14 (“Women prisoners shall receive education and information about preventive health care measures, including from HIV, sexually transmitted diseases and other, blood-borne diseases, as well as gender-specific health conditions.”).

223. *See* Clarke et al., *supra* note 17, at 843 (“Offering contraceptive services within a correctional setting led to a much higher rate of initiating birth control than solely connecting women to free contraceptive services in the community (39.1% vs 4.4%).”); *see also* Hale, *supra* note 163, at 1225 (“Many women may be uncertain as to how to obtain contraceptives or how to use them; having a nurse educator explain the basics of contraceptive options and instructions as to how to use them correctly could greatly benefit such women.”); WORLD HEALTH ORG. EUR., *supra* note 174, at 40 (“Pre-release preparations must be planned and provided to ensure continuity of care, and access to health and other services after release must be a clear part of the programme preparing for release.”).

## D. POTENTIAL ROADBLOCKS TO LEGISLATIVE REFORM

There are some potential barriers to enacting the reforms advocated for in this Note, including confusion created by the existence of multiple levels of government with responsibility for policymaking, political will, and cost. One potential roadblock to enacting these recommendations for reform is that there are multiple levels of government that promulgate policies and standards for New York's correctional facilities, which could lead to a lack of clarity as to which governmental body is responsible for initiating reforms. However, this potential drawback also leads to multiple pathways for reform. First, SCOC should make updates to reflect the reforms previously discussed, which would create much clearer and more robust minimum standards of care. A potential difficulty of using SCOC standards as the method for reform however, is that SCOC's "authority over specific policies and operations is quite limited. It cannot, for example, require counties to spend more money on health care."<sup>224</sup> SCOC does have the power though to "close any of the facilities subject to inspection which are unsafe, unsanitary . . . or which has not adhered to or complied with the rules and regulations promulgated by the commission."<sup>225</sup> Additionally, DOCCS should also take steps to update its policies contained in the Health Services Policy Manual, the Women's Health Primary Care Practice Guideline, and DOCCS Directives to be in line with the reforms discussed. Updating DOCCS policy as a method for reform would also be effective because DOCCS is "empowered to develop and *enforce* the rules and regulations . . . ."<sup>226</sup> Another potential pathway for legislative reform would be for specific counties or cities to update their poli-

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224. See NYCLU, *supra* note 11, at 7 ("There also appears to be no way to hold jail facilities accountable for the level of care provided. While the SCOC has the power to promulgate minimum standards and assess county correctional facilities' adherence to such standards, its authority over specific policies and operations is quite limited. It cannot, for example, require counties to spend more money on health care." (footnotes omitted)).

225. N.Y. COMP. CODES R. & REGS. tit. 9, § 7000.1 (2016).

226. *Department Rules and Regulations*, N.Y. DEP'T OF CORR. AND CMTY. SUPERVISION, <http://www.doccs.ny.gov/RulesRegs/index.html> [<https://perma.cc/8RY3-EVC8>] (last visited Mar. 1, 2016) (emphasis added); see also CORR. ASS'N OF N.Y., *supra* note 1, at 35 (For example, DOCCS could expand its quality improvement program to ensure compliance with reproductive health care policies: "DOCCS operates a quality improvement (QI) program in its Central Office and at individual prisons to identify and correct problems in its medical services, yet these initiatives have completely failed to establish any systematic review of the reproductive health care DOCCS provides.").

cies, as New York City did through its recent legislation addressing sanitary supplies. Still another way to promote legislative reform is through the Governor's office and state legislature.<sup>227</sup> Thus while, the existence of multiple levels of government that promulgate policies may create confusion, it also offers more options for legislative reform.

An additional potential barrier in passing legislation addressing criminal justice reform is political will. However, New York City's recent legislation providing greater access to sanitary supplies for women in city jails, as well as other recent criminal justice reforms on the state level suggest that there currently is engagement and interest from policymakers in New York.<sup>228</sup>

The cost of implementing these reforms presents an additional roadblock. Prison officials and legislators cite funding concerns as a reason to not implement new policies: "[i]nterviews with jail officials in several counties revealed that cost was the primary reason for restricting access to birth control."<sup>229</sup> However, cost cannot be regarded as a legitimate roadblock to reform for a number of reasons. First, as discussed in Part III.A.2., New York law requires that correctional facilities pay for the medical care of the incarcerated,<sup>230</sup> and furthermore federal courts have stated that cost cannot be a reason for prisons to deny medical care.<sup>231</sup> Research has also shown that providing access to reproductive care can have cost saving implications for prisons.<sup>232</sup> Finally,

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227. *E.g.* CORR. ASS'N OF N.Y., *supra* note 1, at 11 (Recommending the N.Y. Governor and Legislature "[e]nact a law that guarantees incarcerated women access to timely and quality reproductive health care . . . , [a]llocate funds for DOCCS to hire sufficient GYN staff, raise salaries for DOCCS clinical providers and create an electronic medical records system").

228. *See* The Editorial Board, *Gov. Cuomo's Push on Justice Reform*, N.Y. TIMES (Jan. 15, 2016), <http://www.nytimes.com/2016/01/16/opinion/gov-cuomos-push-on-justice-reform.html> [<https://perma.cc/XBG4-5E84>] ("Mr. Cuomo has introduced an ambitious slate of reforms . . . . The most symbolic is his renewed commitment to educating prisoners. . . . Mr. Cuomo also emphasized the value of keeping young people out of the criminal justice system in the first place. . . . In December he presented a plan to pardon up to 10,000 people who were convicted of nonviolent crimes when they were 16 or 17 and who have had clean records for at least 10 years.").

229. NYCLU, *supra* note 11, at 16.

230. *See* N.Y. CORRECT. LAW § 500-h (McKinney 1991).

231. *Monmouth Cty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 346–47 (3d Cir. 1987) ("Prison officials may not, with deliberate indifference to the serious medical needs of the inmate, opt for an easier and less efficacious treatment of the inmate's condition. Nor may they condition provision of needed medical services on the inmate's ability or willingness to pay." (citations and quotation marks omitted)).

232. *Sufrin et al.*, *supra* note 164 ("One dose of Plan B, the only dedicated EC product in the US, costs \$48, which is substantially less expensive than prenatal or abortion care.

Part VI provides a description of existing funding that can be utilized to provide access to reproductive care for incarcerated women.

Despite these roadblocks that may delay legislative action, it is ultimately in the legislature's best interest to implement reforms to avoid the consequences of lawsuits. As discussed previously, lawsuits initiated by individuals could lead to remedial judicial action at specific facilities or counties, costly settlements, and negative press attention, the threat of which should incentivize the legislature to act before a lawsuit forces reform on the judiciary's terms or costs the legislature money.<sup>233</sup>

## VI. UTILIZING EXISTING FEDERAL AND STATE PROGRAMS TO PROVIDE FUNDING FOR REPRODUCTIVE HEALTH CARE

Current federal and state programs can be used to provide funding for access to gynecological care and contraception both prior to and after release. Public health studies have determined that “[u]tilizing the public health infrastructure to deliver comprehensive family planning services to women leaving jails may be a new direction for local jurisdictions to most effectively implement community-wide family planning efforts.”<sup>234</sup> Specifically, the Affordable Care Act (ACA), Medicaid, and perhaps most importantly, Title X provide opportunities to fund women's access to gynecological care and contraception both prior to and after release from incarceration, allowing for continuity of care and a greater chance that women will utilize these services.

### A. TITLE X

Title X funding may be one solution to funding programs for continuous reproductive care, beginning while women are incarcerated and continuing after incarceration. It is the “only federal grant program dedicated solely to providing individuals with

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If 29% of all 2.6 million women arrested in this country were eligible for EC at the time of their arrest, then 750,000 women each year could potentially benefit from EC at jail intake. Without EC, an estimated 8% of these 750,000 women, or 60,000, could become pregnant from having unprotected intercourse pre-arrest. EC can reduce the chances of pregnancy after unprotected sex from 8% to 1%, which could translate into an estimated 52,500 pregnancies prevented annually in the USA.” (footnotes omitted).

233. See Part III.A.1.

234. Ramaswamy et al., *supra* note 159, at 8.

comprehensive family planning and related preventive health services.”<sup>235</sup> Title X provides family planning services that include gynecological care and access to a broad range of contraceptive methods.<sup>236</sup> The funds have more flexibility than those of Medicaid or the ACA: they are given as grants to family planning centers and can be used to provide care to individuals regardless of whether they would be eligible for other government programs.<sup>237</sup> States, local and regional entities, and public or non-profit private entities are all eligible to apply for funding.<sup>238</sup> Grantees of Title X then distribute the funds to local clinics, which include those run by state, county, or local health departments as well as private clinics like Planned Parenthood.<sup>239</sup> This allows local grantees to “structure and administer their programs to meet local needs.”<sup>240</sup>

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235. *Title X Family Planning*, U.S. DEP’T OF HEALTH AND HUMAN SERVS., <http://www.hhs.gov/opa/title-x-family-planning/> [https://perma-archives.org/warc/LZ5P-QX6R] (last visited Mar. 1, 2016).

236. *See Title X: America’s Family Planning Program*, PLANNED PARENTHOOD OF AMERICA, [http://www.ppav.org/title\\_x\\_america\\_s\\_family\\_planning\\_program](http://www.ppav.org/title_x_america_s_family_planning_program) [https://perma.cc/GD69-LWBZ] (last visited Oct. 16, 2016) (“The Title X program provides comprehensive family planning services that include a broad range of contraceptive methods and related counseling.” (citations omitted)); *see also Program Requirements for Title X Funded Family Planning Projects*, U.S. DEP’T OF HEALTH AND HUMAN SERVS., OFFICE OF POPULATION SERVS., <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf> [https://perma.cc/MD6W-BACG] (“Title X-funded projects are required to offer a broad range of acceptable and effective medically (U.S. Food and Drug Administration (FDA)) approved contraceptive methods and related services on a voluntary and confidential basis. Title X services include the delivery of related preventive health services . . .”).

237. *See Rachel Benson Gold, Going the Extra Mile: The Difference Title X Makes*, 15 GUTTMACHER POL’Y REV. 13 (2012), available at <http://www.guttmacher.org/pubs/gpr/15/2/gpr150213.html> [https://perma.cc/7NCG-E5R7] (“Title X has the flexibility the behemoth [Medicaid] lacks. Title X funds go to family planning centers up-front as grants, rather than after-the-fact as reimbursement . . . . They can be used to provide care to individuals not eligible for Medicaid or otherwise insured.” (footnotes omitted)).

238. *See Program Requirements for Title X Funded Family Planning Projects*, *supra* note 236 (“Any public or nonprofit private entity located in a state . . . is eligible to apply for a Title X family planning services project grant. Even where states apply for a family planning services grant, local and regional entities may also apply directly to the Secretary for a family planning services grant.” (internal citations omitted)).

239. *See Rachel Benson Gold, Title X: Three Decades of Accomplishment*, 4 GUTTMACHER REP. ON PUB. POL’Y 5 (2001), available at <https://www.guttmacher.org/about/gpr/2001/02/title-x-three-decades-accomplishment> [https://perma.cc/2JXD-HJNS] (“In 1999, 84 Title X grantees spread across all 50 states and the District of Columbia distributed Title X funds to local clinics. . . . Almost 60% of these sites are run by state, county or local health departments; another 14% are operated by Planned Parenthood and the rest are run by a variety of other types of agencies.”).

240. *See id.*

Providing Title X funds also has another benefit: if a facility receives the funds, in any amount, the facility is subject to Title X's standards of care.<sup>241</sup> These requirements include that:

people be given a choice of contraceptive methods (including periodic abstinence and other fertility awareness-based methods)[;] no one is coerced into accepting a particular method or any method at all[;] services are provided in the context of related reproductive health care[; and] recipients are charged fees based on their income and ability to pay.<sup>242</sup>

Thus, facilities that choose to accept Title X funds<sup>243</sup> are held to even higher standards of care than they might be otherwise under state standards and facility policies.

A study of a Rhode Island correctional facility that utilized Title X funds to offer continuous family planning and gynecological services pre- and post-release had promising results.<sup>244</sup> The study compared women who were offered access to contraceptives only after release to those who had continuing access prior to and after release.<sup>245</sup> The program included a nurse educator who "provided education on family planning, reproductive health, cancer screening, self-administered breast examinations, and prevention of sexually transmitted infections" to the women while they were in prison and worked with women post-release.<sup>246</sup> The

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241. See Gold, *supra* note 237, at 13 ("Because a center receiving Title X dollars in any amount is subject to Title X regulations and quality-of-care standards for all of its clients, Title X shapes a recipient center's entire family planning effort.")

242. *Title X: America's Family Planning Program*, *supra* note 236.

243. Title X grants fund voluntary projects. *About Title X Grants*, U.S. DEPT OF HEALTH AND HUMAN SERVS., <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/about-title-x-grants> [<https://perma-archives.org/warc/8SGU-UGM7>] (last visited Oct. 16, 2016) ("Grants under Section 1001 assist in the establishment and operation of *voluntary* family planning projects which provide a broad range of acceptable and effective family planning methods and related preventive health services . . .") (emphasis added).

244. See *generally* Clarke, *supra* note 17, at 843 ("Offering contraceptive services within a correctional setting led to a much higher rate of initiating birth control than solely connecting women to free contraceptive services in the community (39.1% vs 4.4%).")

245. See Clarke, *supra* note 17, at 841 ("The goal of this study was to evaluate 2 sequentially offered family planning service delivery systems. Phase 1 began in June 2002 and included all study participants released before February 28, 2003. During this period, family planning methods were available without charge at the CHC; however, as a result of correctional system restrictions, contraceptives could not be prescribed within the prison at that time. Phase 2 began on March 1, 2003, when contraceptive services became available to women before their release from prison. This phase included all participants released through July 15, 2004.")

246. *Id.* at 840.

study's results showed that offering access to gynecological examinations, family planning, and contraception prior to release led to a much higher uptake (39.1% vs. 4.4%) in the use of contraception.<sup>247</sup> The services “enable[d] a woman to plan for conception during times of abstinence and stability.”<sup>248</sup> The Rhode Island program provides a model for using Title X funding to ensure pre- and post-release continuity of gynecological and family planning services using existing government programs.

## B. THE AFFORDABLE CARE ACT AND MEDICAID

Provisions of the Affordable Care Act ensure that women have access to gynecological care and contraception after they are released from prison.<sup>249</sup> The Affordable Care Act provides that “[p]lans in the Health Insurance Marketplace must cover contraceptive methods and counseling for all women, as prescribed by a health care provider.”<sup>250</sup> FDA-approved contraceptive methods are covered, including birth control pills, intrauterine devices, emergency contraception, and patient education.<sup>251</sup> The Affordable Care Act also provides that formerly incarcerated people have a 60-day special enrollment period,<sup>252</sup> and people applying follow-

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247. *See id.* at 843 (“Offering contraceptive services within a correctional setting led to a much higher rate of initiating birth control than solely connecting women to free contraceptive services in the community (39.1% vs 4.4%).”).

248. Clarke, *supra* note 14, at 837; *see also* Hale, *supra* note 163, at 1225 (“[M]any women must immediately deal with other issues after release, such as housing, employment, child care, and drug and alcohol treatment, rendering them unable to allot energy toward reproductive healthcare. . . . Providing user-independent contraception prior to release from jail also allows women to make choices about birth control without pressure from their partner and ensures protection against pregnancy from the moment they walk out the door.”); *id.* at 1224 (“Women leaving jail or prison appear to be an ideal population for user-independent, long-term yet reversible birth control.”).

249. *See* Ramaswamy et al., *supra* note 159, at 8 (“Elements of the Affordable Care Act guarantee free contraceptive services for most women in the United States, including those who have left jails. Community and jail-based clinicians, public health workers, educators, and researchers could play an important role in capitalizing on these new opportunities for unintended-pregnancy prevention.”).

250. *Birth control benefits*, HEALTHCARE.GOV, <https://www.healthcare.gov/coverage/birth-control-benefits/> [<https://perma.cc/73GD-TRQN>] (last visited Mar. 1, 2016).

251. *See id.* (“FDA-approved contraceptive methods prescribed by a woman’s doctor are covered, including: Barrier methods, like diaphragms and sponges[;] Hormonal methods, like birth control pills and vaginal rings[;] Implanted devices, like intrauterine devices (IUDs)[;] Emergency contraception, like Plan B® and ella®[;] Sterilization procedures[;] Patient education and counseling.”).

252. *See Incarcerated People*, HEALTHCARE.GOV, <https://www.healthcare.gov/incarcerated-people/> [<https://perma.cc/9K3M-GHXT>] (last visited Mar. 1, 2016) (“After you’re released, you have a 60-day Special Enrollment Period to sign up for private health



ing release may also qualify for lower monthly premiums or out of pocket expenses.<sup>253</sup>

The Health Insurance Marketplace provided by the Affordable Care Act offers health insurance plans for those who do not qualify for other insurance such as Medicaid, Medicare, or private insurance through employment.<sup>254</sup> Another important ACA provision also allows those who are incarcerated to apply for Medicaid coverage while they are in prison.<sup>255</sup> This is particularly important because “[w]omen in prison are overwhelmingly from low-income communities”<sup>256</sup> and thus, many will qualify for Medicaid. While the health care coverage will not start until an incarcerated person is released, applying prior to release may help speed up access to care post-release.<sup>257</sup> Medicaid has been extremely important in financing publicly funded family planning programs and has been responsible for much of these programs’ growth.<sup>258</sup> In New York, Medicaid covers “family planning services.”<sup>259</sup> Additionally, New York State also has the Family Planning Benefit Program (FPBP) for people who are not already enrolled in Medicaid: “[t]he FPBP is a public health insurance program for New Yorkers who need family planning services, but may not be able

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coverage. During this time, you can enroll in private health insurance even if it’s outside the Marketplace open enrollment period.”)

253. *See id.* (“When you apply for health coverage after being released from incarceration, you may qualify for lower costs on monthly premiums and out-of-pocket costs. This will depend on your household size and income during the year you’re seeking coverage.”).

254. *See 5 tips about the Health Insurance Marketplace*, HEALTHCARE.GOV, <https://www.healthcare.gov/quick-guide/one-page-guide-to-the-marketplace/> [<https://perma.cc/H78X-7VGW>] (“If you don’t have health insurance through a job, Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), or another source of qualifying coverage, the Marketplace can help you get covered.”).

255. *See Incarcerated People*, *supra* note 252 (“If you’re incarcerated you can use the Marketplace to apply for Medicaid coverage in your state. Medicaid won’t pay for your medical care while you’re in prison or jail. But if you enroll in Medicaid while you’re incarcerated you may be able to get needed care more quickly after you’re released.”).

256. CORR. ASS’N OF N.Y., *supra* note 1, at 4.

257. *See Incarcerated People*, *supra* note 252 (“[I]f you enroll in Medicaid while you’re incarcerated you may be able to get needed care more quickly after you’re released.”).

258. *See Gold*, *supra* note 237, at 13 (“It would be hard to overstate the importance of Medicaid in financing the nation’s publicly funded family planning effort. The joint federal-state insurance program for lower-income Americans provides the vast majority of dollars spent on family planning and has been responsible for almost all the growth in public family planning spending over the past two decades.” (reference omitted)).

259. *Medicaid in New York State*, N.Y. STATE DEPT OF HEALTH, [https://www.health.ny.gov/health\\_care/medicaid/#services](https://www.health.ny.gov/health_care/medicaid/#services) [<https://perma.cc/DA9V-ZQFJ>] (last visited Mar. 1, 2016).

to afford them.”<sup>260</sup> The FPBP covers family planning services including most FDA approved birth control methods, emergency contraception, and counseling.<sup>261</sup>

These provisions of the ACA and New York’s Medicaid may help ensure that women have access to adequate care after their release. Facilities should provide women with the resources and education about how to enroll in Medicaid or the ACA Marketplace while they are still incarcerated and educate them on the family planning services and gynecological care that is covered.

In sum, Title X funding, the ACA, and Medicaid can all be used to offer incarcerated women access to and education about gynecological care and family planning services that can continue post-release.

## VII. CONCLUSION

New York’s policies addressing health care for incarcerated women are substandard in that they often fail to account for women’s unique health issues, particularly pertaining to reproductive health. Furthermore, some policies are silent on important issues, lack uniformity, and are vague. These issues have led to a system where incarcerated women’s basic reproductive health needs remain continuously unmet. While problematic from the perspective of incarcerated women themselves, some policies also fail to meet standards put forth by the medical community, leaving New York State and specific correctional facilities vulnerable to lawsuits challenging their constitutionality as well compliance with other federal and state regulations.

The experiences of individual women, the overall failings of New York’s prison policies, and the overwhelming public health data on the importance of providing adequate care to incarcerated women should signal to the Governor and legislature, SCOC, and DOCCS that these policies need to be changed. Legal, medi-

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260. *Family Planning Benefit Program*, N.Y. STATE DEPT OF HEALTH, [https://www.health.ny.gov/health\\_care/medicaid/program/longterm/familyplanbenprog.htm](https://www.health.ny.gov/health_care/medicaid/program/longterm/familyplanbenprog.htm) [<https://perma.cc/MA9E-9N99>] (last visited Mar. 1, 2016).

261. *See id.* (“Family Planning Services include: Most FDA approved birth control methods, devices, and supplies (e.g., birth control pills, injectables, or patches, condoms, diaphragms, IUDs); Emergency contraception services and follow-up care; Male and female sterilization; Preconception counseling and preventive screening and family planning options before pregnancy; Transportation to family planning visits; and] Retroactive coverage (up to 3 months, if eligible).” (emphasis removed)).

cal, and international standards provide starting points for changes to current policies including: distinguishing between men and women in policies for initial assessments and ongoing care, taking medical histories that ask questions specific to women's health, providing access to female health care providers when possible, providing an adequate number of sanitary products free of charge, and developing a concrete and written policy addressing contraception that accounts for the multitude of reasons that women may want access to contraception. Furthermore, existing federal programs and funding provide possible solutions to providing health care and education that starts in prison and continues post-release, giving women the best chance of actually utilizing care.