REPRODUCTIVE HEALTH TECHNOLOGIES PROJECT

FAQ: Access to Emergency Contraception in U.S. Jails and Prisons

Women[i] are the fastest growing population in U.S. jails at an annual increase of 3.4%[ii] and have been imprisoned at double the rate of men since 1985.[iii] Women entering correctional facilities are typically of reproductive age[iv] and incarcerated women may have had consensual or non-consensual sex[v] immediately before or during incarceration. Because the number of incarcerated women at risk for unintended pregnancy has greatly increased, the need for information about and timely access to emergency contraception (EC) in correctional facilities is essential. Correctional facilities must fulfill their constitutional obligation to provide essential health care and leading medical groups recommend that such care include access to EC.[vi] Given the history of and potential for reproductive coercion in correctional settings,[vii] EC should be offered in a culturally-competent, patient-centered, non-directive manner.

What is the difference between jail and prison?

Jails are facilities that hold individuals awaiting trial or other court proceedings as well as individuals serving sentences typically less than a year in length. They are run by state or local governments but are usually administered through local jurisdictions. Prisons are long-term facilities that house people convicted of felonies (crimes of a more serious nature that carry longer sentences). They are run either by the federal or state government.

What is emergency contraception?

EC is a safe, effective method of birth control that can prevent pregnancy after unprotected sex or contraceptive failure. EC prevents a pregnancy from occurring and will not disrupt an existing pregnancy. EC comes in three forms: levonorgestrel pills (Plan B One-Step® and its generics), ulipristal acetate pills (brand name ella®), and the copper intrauterine device (IUD) (brand name ParaGard®). The sooner they are used after unprotected sex or contraceptive failure, the more effective they are at preventing pregnancy. Plan B One-Step® and its generics are most effective if taken within 72 hours (three days) of unprotected sex or contraceptive failure. ella® is most effective if taken within 120 hours (five days) after unprotected sex or contraceptive failure. ParaGard® must be inserted into the uterus by a health care professional and is most effective if inserted within 120 hours (five days) after unprotected sex or contraceptive failure. ParaGard® can be left in the uterus to prevent pregnancy for up to 12 years after insertion or until removed.

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[i] Though this FAQ uses female pronouns as well as the term "women" on occasion, the authors recognize that people who do not identify as women may still be able to become pregnant and may require contraception. The authors intend any policy recommendation made in this document to apply to all people with the capacity to become pregnant, regardless of gender identity or gender expression.

[ii] "Statistics on Women Offenders-2015," Court Services and Offender Supervision Agency, accessed July 20, 2016, http://www.csosa.gov/reentry/news/statistics-on-women-offenders-2015.pdf.

[iii] "Facts About the Over-Incarceration of Women in the United States," American Civil Liberties Union, accessed July 20, 2016, https://www.aclu.org/facts-about-over-incarceration-women-united-states.

[iv] Flynn LaRochelle et al., "Contraceptive Use and Barriers to Access Among Newly Arrested Women," *Journal of Correctional Health Care* 18, no. 2 (2012): 112, doi:10.1177/1078345811435476.

[v] Due to this FAQ's focus on risk of unintended pregnancy, the term "sex" mirrors the language used in the Prison Rape Elimination Act standards: "[c]ontact between the penis and the vulva or the penis and the anus, including penetration, however slight." Dep't of Justice Prison and Jail Standards, 28 C.F.R. § 115.6(b) (2016).

[vi] "Reproductive health care for incarcerated women and adolescent females," Committee Opinion no. 535, American College of Obstetricians and Gynecologists, *Obstetrics & Gynecology* 120 (2012): 425-29, 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.

[vii] Corey G. Johnson, "Female inmates sterilized in California prisons without approval," *The Center for Investigative Reporting*, July 7, 2013, http://cironline.org/reports/female-inmates-sterilized-california-prisons-without-approval-4917.

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Why would a woman in jail or prison need EC?

Many women have had sex immediately prior to entering a correctional facility. One survey found that 29% of newly arrested women had unprotected sex within five days of entering jail.[viii] Some women also experience recent sexual assault prior to their arrest. Because EC is most effective if taken as soon as possible after unprotected sex, having the option to take EC upon entering a correctional facility could greatly reduce the chance of unintended pregnancy.

There are also instances in which women may need EC *during* their incarceration. Unfortunately, sexual assault in prison is widespread. A U.S. Bureau of Justice Statistics representative reported that "nearly 200,000 people were sexually abused in American detention facilities in 2011."[ix] According to one study, 71% of incarcerated women knew of sexual relationships between fellow incarcerated women and staff.[x]

Further, some state and federal prisons may allow conjugal visits (when an incarcerated person is permitted to have a private visit with their significant other on-site, usually for the purpose of having sex). They may also release women on furlough (a temporary leave of absence from the facility) during which time she may have unprotected sex.

Screening for unintended pregnancy is especially crucial upon entering jail, where women enter from their community (increasing the likelihood of recent unprotected sex), compared to prison, where they primarily enter from another correctional facility (reducing the reduced likelihood of recent unprotected sex).

Despite this reality, only 4% of correctional providers surveyed said that EC was available in their facilities,[xi] though 48% of incarcerated women surveyed said they would take it if it was offered to them.[xii]

It is important to remember that any person facing a potential unintended pregnancy – incarcerated or not – should have the information and resources necessary to decide how to proceed. For many incarcerated women, EC may not be desirable. Correctional providers should not coerce women into choosing EC. Rather, women should be afforded the care and support necessary to continue a pregnancy for as long as they so choose.

[viii] This 63-item survey was given to women ages 18-44 within 24 hours of arrest entering the San Francisco County Jail Intake Facility from November 2008 to January 2009. 293 women were enrolled in the survey, though three surveys were later excluded because the respondents were older than 44. Carolyn B. Sufrin et al., "Emergency Contraception for Newly Arrested Women: Evidence for an Unrecognized Public Health Opportunity," *Journal of Urban Health* 87, no. 2 (2009): 248, doi: 10.1007/s11524-009-9418-8.

[ix] David Kaiser and Lovisa Stannow, "The Shame of Our Prisons: New Evidence," *The New York Review of Books*, October 24, 2013, http://www.nybooks.com/articles/2013/10/24/shame-our-prisons-new-evidence/?pagination=false.

[x] Mark S. Fleisher and Jessie L. Krienert, "The Culture of Prison Sexual Violence," the National Criminal Justice Reference Center, NCJ 216515 (2006): 11, https://www.ncjrs.gov/pdffiles1/nij/grants/216515.pdf.

[xi] This cross-sectional study sampled a nationally representative sample of 950 correctional health providers who are members of the Academy of Correctional Health Providers. 286 surveys were included in the final analysis. "Emergency Contraception for Newly Arrested Women," 251; Carolyn B. Sufrin, Mitchell D. Creinin, and Judy C. Chang, "Contraception Services for Incarcerated Women: A National Survey of Correctional Health Providers," *Contraception Journal* 80, no. 6 (2009): 562, doi:10.1016/j.contraception.2009.05.126.

[xii] Of the 293 women enrolled in the survey, 84 were eligible for EC, defined as "not pregnant, not sterilized, not using a reliable method of birth control, and had had sex without an intact condom in the previous 5 days," at time of intake. Of these 84 women, 48% "indicated a willingness to take emergency contraception if offered." "Emergency Contraception for Newly Arrested Women," 244, 246, 248.

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Do state or local laws require jails and prisons to provide EC?

State and local governments are free to pass measures protecting incarcerated women's access to EC. New York City, for instance, requires that EC be "available to those patients who have had unprotected or inadequately protected sex, or who have been sexually assaulted, within the 5 days (120 hours) prior to the reporting of the sexual encounter."[xiii] Some jurisdictions seem to mandate EC without explicitly saying so. Washington State's Department of Corrections writes that if an incarcerated woman is sexually assaulted, medical staff is to "evaluate and treat the offender as medically necessary, including [for]…prevention of pregnancy, if applicable."[xiv] And some places have policies related to reproductive health care but without detailed specifications. Nevada's regulation states that "female inmates will be provided with appropriate medical care to include screenings, diagnostic, therapeutic, and supportive care for those medical problems unique to women." It goes on to state such care includes "family planning counseling" and "gynecological consultations and/or procedures indicated for the prevention or treatment of a serious medical condition."[xv] But without explicitly mentioning EC, vague policies like Nevada's are unclear as to what exactly they require.

Unfortunately, most cities, counties, and states do not have any EC related policies for their correctional facilities. And federal facilities are not required to follow city, county, or state EC protections (meaning that even if a city, county, or state passes a law mandating EC access, a *federal* facility located in that city, county, or state would not be required to abide by it).

The good news is that more states are demonstrating a heightened awareness of the issue. Within the last year Massachusetts[xvi] and California[xvii] introduced legislation regarding incarcerated women's access to contraception.

What about federal law?

The only federal law relating to incarcerated people and EC is the Prison Rape Elimination Act (PREA),[xviii] by which federal, state, and local level facilities (both jails and prisons) must abide.[xix] PREA, among other things, requires facilities to offer incarcerated individuals "timely" information about, and access to, EC in the event of a sexual assault.[xx] "Timely" access to EC requires EC administration "within [its] window of efficacy."[xxi] However, PREA does not require correctional facilities to stock the drug on-site.[xxii]

[xiii] New York Civil Liberties Union, *Access to Reproductive Health Care in New York State Jails* 15, 46 (2008) (citing New York City Department of Health and Mental Hygiene, Correctional Health Services, Policy No. MED 29), http://www.nyclu.org/files/rrp_jail_report_030408.pdf.
[xiv] WASH. DEP'T OF CORR., POLICY NO. 610.025, MEDICAL MANAGEMENT OF OFFENDERS IN CASES OF ALLEGED SEXUAL ABUSE OR ASSAULT (Jan. 1, 2014), *available at* http://www.doc.wa.gov/policies/default.aspx?show=600.
[xv] NEV. DEPT. OF CORRECTIONS ADMIN. REG. 623.01 (2013), *available at* http://doc.nv.gov/uploadedFiles/docnvgov/content /About/Administrative_Regulations/AR%20623%20-%20042313.pdf.
[xvi] H.B. 1434, 189th Gen. Court (Mass. 2015).
[xvii] S.B. 1433, 2015-2016 Reg. Sess. (Cali. 2016).
[xviii] Prison Rape Elimination Act, 42 U.S.C. §§ 15601 et seq. (2016).
[xix] "Applicability of the Standards to Individual Settings," the National PREA Resource Center, July 9, 2013, http://www.prearesourcecenter. org/faq/applicability-of-the-standards-to-individual-settings.
[xx] 28 C.F.R. § 115.82(c).
[xxi] 77 Fed. Reg. 37106 at 37177.
[xxii] Ibid.

Jails and prisons must make EC available to individuals sexually assaulted during their incarceration by staff (an employee, volunteer, or contractor) or by another incarcerated person.[xxiii] Sex between staff and an incarcerated person is by definition a sexual assault.[xxiv] This is due to the inherent power imbalance in the staff's position of authority over the incarcerated person. Sex between two incarcerated people will only be considered an assault if there was no consent.[xxv]

In addition, PREA mandates that during intake into a facility, individuals are screened for any prior sexual assaults. If one has occurred either in the community or in another facility, the individual must be offered "a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening."[xxvi] However, the provision does not explicitly mention EC or its time-sensitive nature. Nor does PREA mandate EC availability for a sexual assault that occurred during furlough or during a conjugal visit.[xxvii]

Finally, PREA does not mandate EC access in the case of consensual sex immediately prior to intake, during furlough, during a conjugal visit, or with another incarcerated person.[xxviii] Individual facilities may offer EC under such circumstances, though it is not mandated by law. Privately run facilities must abide by PREA standards as well.[xxix] Some choose to go beyond PREA's requirements by implementing additional guidelines regarding EC. However, such guidelines are not binding law and are often not enforced.[xxx]

While PREA is a step in the right direction, not enough states are in compliance.[xxxi] Also, PREA mandates that incarcerated persons be informed of "their rights to be free from sexual abuse and…policies and procedures for responding to such incidents," within 30 days of intake.[xxxii] But facilities are not required to specifically reference EC in this intake information (though it is recommended that they include information regarding available post-assault medical services more broadly).[xxxiii] In facilities that do not provide information about EC, women may not know how EC works or that they have a right to it, potentially reducing the incentive to seek medical attention following a sexual assault.

[xxiii] 28 C.F.R. § 115.6.
[xxiv] Ibid.
[xxv] Ibid.
[xxvi] 28 C.F.R. § 115.81; Nicole Summer, "Powerless in Prison: Sexual Abuse Against Incarcerated Women," *Rewire*, December 11, 2007, https://rewire.news/article/2007/12/11/powerless-in-prison-sexual-abuse-against-incarcerated-women/.
[xxvii] PREA only mandates EC access if the assault is perpetrated by a facility's "staff member, contractor, or volunteer" or by "another inmate, detainee, or resident." 28 C.F.R. § 115.6(1).
[xxviii] Correctional facilities generally prohibit consensual sex between incarcerated individuals. Consensual sex between incarcerated individuals is considered a violation of an individual facility's rules, but not a violation of the law. Male and female populations are generally segregated within a facility. However, there may be rare circumstances in which an incarcerated person could need EC following consensual sex with another incarcerated person.
[xxix] 42 U.S.C. § 15609(7) (2016); Agency Comment, National Standards To Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37113 (adopted June 20, 2012).
[xxx] Alex Friedmann, "How the Courts View ACA Accreditation," *Prison Legal News*, October 10, 2014, https://www.prisonlegalnews.org/news/2014/oct/10/how-courts-view-aca-accreditation/.
[xxxi] "FY 2015 List of Certification and Assurance Submissions," Bureau of Justice Assistance, U.S. Department of Justice, June 29, 2015, https://www.bja.gov/Programs/15PREA-AssurancesCertifications.pdf; "PREA Letter to Governors," U.S. Department of Justice, February 25, 2015, http://www.prearesourcecenter.org/sites/default/files/content/fy2016_prea_letter_to_governors.pdf.
[xxxii] 28 C.F.R. § 115.33(b).
[xxxiii] Just Detention International, *Inmate Education Facilitator's Guide, PREA: What you Need to Know* (National PREA Resource Center 2014), http://www.prearesourcecenter.org/sites/default/files/library/prcinmateedfacilitatorsguide.pdf.

What should be done?

Leading medical, civil rights, and correctional organizations, including the American College of Obstetricians and Gynecologists (ACOG)[xxxiv] and the National Commission on Correctional Health Care,[xxxv] recommend that incarcerated women have information about and swift access to EC. **The Reproductive Health Technologies Project recommends that:**

1. Upon entering a correctional facility, women are given medically-accurate information about EC and their right to EC during their incarceration. Women are then asked if they have had unprotected sex within the last five days and are immediately offered EC as needed.
2. All correctional facilities stock a sufficient amount of EC on-site to prevent delays to EC administration. Facilities also implement protocols for immediate off-site EC access in the event that EC is not available on-site.
3. Correctional and medical staff is trained on an incarcerated person's right to EC and proper protocol when a sexual assault occurs and/or when EC is requested. Such training should include education regarding:
    - The history of reproductive coercion on poor women, immigrant women, women with disabilities, and women of color both in and outside the correctional setting;[xxxvi] and
    - How to counsel incarcerated individuals about EC in a culturally-competent, patient-centered, non-directive manner that centers individual decision-making.[xxxvii]
4. EC be made available to any incarcerated people who may be at risk of unintended pregnancy, regardless of whether:
    - The sexual encounter was consensual or non-consensual;
    - The sexual encounter was with an employee or non-employee of the facility;
    - The sexual encounter occurred within the physical confines of the facility; and
    - The sexual encounter occurred prior to or during incarceration.
5. Incarcerated people at risk for unintended pregnancy who do not wish to use EC are provided with the information, care, and resources they need to continue a potential pregnancy for as long as they so choose.

For information about your state's reproductive health policies at correctional facilities, see the American Civil Liberties Union's State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison

For more detailed information, contact your city, county, or state's department of corrections or follow these instructions to submit an open records request, using the New York Civil Liberties Union's letter as a suggested template

[xxxiv] Committee Opinion No. 535.
[xxxv] "Women's Healthcare in Correctional Settings," *National Commission on Correctional Health Care*, last updated October 2014, http://www.ncchc.org/women%E2%80%99s-health-care.
[xxxvi] Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Random House, 1997), 56; Rachel Benson Gold, "Guarding Against Coercion While Ensuring Access: A Delicate Balance," *Guttmacher Policy Review* 17 no. 3 (2014).
[xxxvii] "Emergency Contraception for Newly Arrested Women," 251; Andrea V. Jackson et al., "Racial and ethnic differences in women's preferences for features of contraceptive methods," *Contraception Journal* 93, no. 5 (2016): 406-11, doi: 10.1016/j.contraception.2015.12.010l; Christine Dehlendorf, Colleen Krajewski, and Sonya Borrero, "Contraceptive Counseling: Best Practices to Ensure Quality Communication and Enable Effective Contraceptive Use," *Clinical Obstetrics and Gynecology* 57, no. 4 (2014): 659-73, doi:10.1097/GRF.0000000000000059.

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