

ACCESS TO REPRODUCTIVE HEALTH CARE IN NEW YORK STATE JAILS

EXECUTIVE SUMMARY

Sparked by cases where women were denied access to reproductive health care while incarcerated, the NYCLU launched an investigation of policies for the provision of health care specific to women in county jails. The NYCLU sent Freedom of Information Law (FOIL) requests to 58 counties seeking information about access to a variety of reproductive health care services, including abortion, prenatal care, routine gynecological exams, contraception, and testing and treatment for HIV or sexually transmitted infections (STIs).

We found that although women incarcerated in New York State are legally entitled to reproductive health care, few county jails have policies ensuring comprehensive access to such care. The county jail system, which houses about 3,000 women at any given time, is governed at the local level with little state oversight. Without a uniform policy, the quality of health care a woman receives in a county jail depends on where she is incarcerated.

Not only is there no uniformity, but worse, in many facilities, policies on provision of health care were “one size fits all” for all inmates, regardless of gender, ignoring the fact that women require specific health care services, such as routine gynecological examinations or pregnancy screening. For example, of the 52 counties that housed female inmates, 14 counties responded that their jail facilities had no policies that dealt with any of the issues that we raised. Less than half of counties had policies specifically addressing inmates’ access to abortion, and only 23 percent provided for unimpeded access to abortion services. Policies that did address women’s health care often narrowly focused on pregnancy.

Many policies were uselessly vague, leaving jail officials to guess when making decisions about reproductive health care. Policies that give jail administrators and staff wide discretion in responding to women’s requests for reproductive health care can lead to decisions that violate the law and harm inmates. For example, women can be denied access to abortion, HIV and sexually transmitted infections can go undiagnosed and untreated, and pregnant women can be denied prenatal care. This exposes jail officials and county governments to legal liability and jeopardizes women’s health.

Jail officials are required by law to provide inmates with access to necessary medical care — but there is also significant public health benefit to doing so. Incarcerated women suffer disproportionately from lack of access to primary care and resulting poor health outcomes. Jail administrators have a unique opportunity to provide not only necessary treatment,

but also preventive health care services and screening for medical problems that often go undetected at home. Offering such services ensures that women return to their communities healthier and in less need of public health resources.

With these goals in mind, the NYCLU urges state officials and jail administrators to develop a uniform set of minimum standards to ensure that incarcerated women have access to comprehensive health care. This report contains a series of recommendations that could be immediately implemented at any county jail.

Those recommendations include developing policies that would:

- Provide routine reproductive health care including age-appropriate mammography, screening for STIs and pap tests.
- Ensure prompt access to abortion, prenatal care and pregnancy testing.
- Limit the use of restraints on pregnant women.
- Provide mental health services to women following miscarriage, abortion and birth.
- Prepare for the timely transport of pregnant women to appropriate facilities for labor and delivery.
- Allow women to retain physical custody of their newborns while incarcerated.
- Ensure testing, prevention and treatment of HIV and STIs.

I. INTRODUCTION

Before Barbara Gaddy was jailed in Jefferson County pending a court hearing on drug charges, she had scheduled an appointment for an abortion. Jail officials not only refused to transport her to the appointment or make a new one, they also harassed her. They punished Gaddy for her repeated requests for a new appointment and allegedly contacted anti-abortion activists in the community. One of those activists obtained a court order preventing Gaddy from having an abortion while in jail.¹ The jail facility had no written policies or procedures regarding access to abortion, or for that matter, any reproductive health care. Ms. Gaddy was incarcerated for just over a month; she was able to obtain an abortion only after being released from the jail.

Gina Turner² was scheduled to have an abortion the day after she was sent to jail in upstate New York to serve a 30-day sentence on a drunken driving offense. Jail officials refused to transport her to the appointment without a court order and withheld medication she needed because they said it might harm the fetus. The jail facility had no written policies or procedures regarding access to abortion. It took her lawyer several weeks to secure her release pending an appeal of her sentence. By that time, even though she was ultimately able to have an abortion, Ms. Turner was well beyond the stage of her pregnancy at which she felt comfortable with undergoing the procedure.

More than 6,000 women are incarcerated at any given time in New York State.³ Half of these women are held in more than 50 county jail facilities scattered across the state.⁴ In fact, women account for more than 25,000 admissions to county jail facilities in New York State each year,⁵ and the percentage of women being held in jails increases slightly, but steadily, each year.⁶ The vast majority of these women are serving sentences of less than a year for non-violent offenses.⁷ Most of these women are of reproductive age.⁸

Incarcerated women suffer disproportionately from poor health and lack of access to primary health care, and are at high risk for gender-specific health conditions that could easily be detected and treated while in jail.⁹ Incarceration offers an opportunity to improve public health by screening women for medical problems that often go undetected at home.¹⁰ Completely reliant on jail officials for all of their health care needs, these women present a tremendous challenge to county jail administrators who must both fulfill their legal obligations and address public health issues with limited resources.

The U.S. Constitution and New York State law guarantee the right to medical care in jail, including reproductive health care, but few correctional facilities have policies that ensure women's access to such care. Designed for jail populations that have historically been mostly male, health care policies and procedures are ill-equipped to deal with the increase in women inmates. As a result, jail administrators and even medical providers are often left to guess about legal

requirements when a woman requests care. Too often, personal opinions and lack of understanding about women’s health care combine to allow jail administrators to make the wrong decisions—harming the women in their custody and exposing jail officials to legal liability.

This is particularly problematic with regard to access to abortion. There is no systematically collected information about access to abortion services in the more than 3,000 local jails in the U.S.; however, news stories, court cases and social science research suggest that at least some jails have policies that obstruct or prevent women from obtaining abortions, such as requiring a court order before transporting a woman for an abortion or forcing her to pay for the procedure and associated costs, such as transportation expenses and staff time.¹¹

In response to our work with the women whose stories are described above, the NYCLU’s Reproductive Rights Project researched the policies and procedures in New York county jail facilities by sending Freedom of Information Law (FOIL) requests to all county jail facilities in the state.¹² We chose to focus on jails rather than the state prison system because more women spend brief amounts of time each year in jails than they do in state prisons; because there is no uniform set of policies and procedures that jails are required to adhere to; and because the percentage of women in jails is so small, we were concerned that health care policies would contain little guidance regarding women’s health care.

Our FOIL request was not limited to access to abortion; we asked for information regarding access to a variety of other reproductive health care services. During the course of our research, we broadened our inquiry and asked selected facilities about access to an even wider array of health-related issues affecting women in custody.

Ultimately, we reviewed policies, procedures and practices related to routine gynecological care, contraception, pregnancy testing, prenatal care, mental health care following miscarriage or termination of pregnancy, the use of restraints on pregnant women, transport for labor and delivery, custody of newborns, abortion, and testing and treatment for sexually transmitted infections (STIs), including HIV.

We found that relatively few counties had policies governing access to reproductive health care, and to the extent that such policies existed, they varied widely. 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. Many policies were so vague that it was impossible to discern how jail administrators were to respond to requests for care. And where health care issues specific to women were mentioned in a facility’s policy and procedures manual, the discussion was often narrowly focused on pregnancy.

And while in practice most jail officials routinely afforded inmates access to necessary care, the lack of guidance or clear policies left too much discretion to jail officials. This risks delay or denial of necessary care, which not only harms women, but can also result in legal liability for the county.

This report provides an overview of the policies and procedures affecting women’s access to reproductive health care in local correctional facilities throughout New York State, and an analysis of the legal sufficiency of various policy choices—including the absence of written policies. The report concludes with a set of recommendations that facilities can easily adopt to ensure that their legal obligations are met and that women in their custody have access to care. ■

II. BACKGROUND

A. *Health Care for Women in County Jail Facilities in New York*

Despite the large and increasing number of women housed in county facilities,¹³ there are no uniform policies that specifically guarantee reproductive health care or provide guidance to jail officials on how to respond to requests for such care. Rather, the county jail system is governed at the local level, with little central oversight, leading to an uneven patchwork of policies.

County sheriffs are charged with the care of inmates housed in county jail facilities,¹⁴ and therefore are ultimately responsible for developing policies and procedures to provide for inmates' medical care. At least seven counties contract out this obligation to private health care companies.¹⁵ In two additional counties, public benefit and non-profit corporations provide health care services for inmates¹⁶ and are responsible both for developing policies and providing services.¹⁷

The legislature has granted the power to oversee county jail facilities to the State Commission of Correction (SCOC).¹⁸ The SCOC is charged with establishing minimum standards governing health care in New York's penal institutions.¹⁹ Local jail facilities are required to have policies in place for inmate health care that are consistent with SCOC minimum standards.²⁰

While these standards provide a general framework for policy development,²¹ 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.²² The

regulations do not specify, however, how soon after admission the health screening must occur²³ or what the screening must entail, other than to "identify serious or life-threatening medical conditions requiring immediate evaluation and treatment."

²⁴ Nothing in the minimum standards distinguishes between health care for male inmates and female inmates, and there is nothing in the minimum standards that specifically addresses any of the areas covered in this report.

New York City has the power to promulgate its own rules and regulations for its correctional facilities.²⁵ The City Board of Correction has set minimum standards governing the health care of people jailed at Rikers Island, which houses inmates from the city's five boroughs.²⁶ City standards contain specific provisions for reproductive health care. For example, upon a woman's arrival at the correctional facility,²⁷ medical personnel must take a history that includes obstetrical and gynecological matters, and administer a cervical cytology screen ("pap test") and pregnancy test,²⁸ gonorrhea and chlamydia screening,²⁹ and a syphilis test.³⁰ City rules also set minimum standards for the treatment of pregnant women: they must receive counseling, assistance and care "consistent with professional standards and legal requirements."³¹ Pregnant women are also guaranteed prenatal and postpartum care.³² Moreover, city rules provide that women are entitled to abortion upon request.³³

But New York City is the exception. Most facilities outside the city do not have written policies covering these issues, and there is little guidance available to help jail officials develop policies responsive to the health care needs of women. While SCOC

minimum standards establish a floor below which the standard of care cannot drop, they contain neither details nor specific requirements for health care. Moreover, they are silent on the fact that the right to an abortion is included in the minimum level of care required of jail facilities.

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,³⁴ its authority over specific policies and operations is quite limited.³⁵ It cannot, for example, require counties to spend more money on health care.³⁶

Because state guidance on issues of health care for female inmates and reproductive health care is so scant,³⁷ many local correctional facilities look to external sources to guide their policies and decisions, including the New York State Sheriff's Association³⁸ and the National Commission on Correctional Health Care (NCCHC), an independent organization that provides accreditation and assists facilities in improving health care services.³⁹

NCCHC has set standards on both care of pregnant inmates and pregnancy counseling.⁴⁰ NCCHC's standard on "Pregnancy Counseling" states that "[p]regnant inmates are given comprehensive counseling and assistance in accordance with their expressed desires regarding their pregnancy, whether they elect to keep the child, use adoption services, or have an abortion."⁴¹ NCCHC recommends that facilities obtain a "formal legal opinion on the law relating to abortion . . . and based upon that opinion, [develop] written policy and defined procedures . . . for the correctional facility's jurisdiction."⁴² NCCHC standards provide very little guidance on reproductive health care for women who are not pregnant—breast examinations as indicated by risk factors are required as a part of inmates' health assessments,⁴³ and pelvic examinations and pap tests are

recommended, but not required, in jail settings.⁴⁴

The lack of explicit standards, uniform policies or meaningful oversight results in a system where the level of care a woman receives depends on where she is incarcerated. The lack of written policies within most facilities leaves broad discretion to jail administrators, corrections officers and medical staff as to whether and when to provide access to care. This report will discuss the legal obligations of correctional facilities to provide adequate medical care, the importance of policies geared specifically toward women inmates, and recommendations for creating a comprehensive set of policies and procedures designed to ensure adequate health care for women.

B. Legal Standards Governing Health Care in Correctional Facilities

1. The Right to Medical Care

Correctional facilities must ensure that inmates receive medical care. The Eighth Amendment to the U.S. Constitution, which protects prisoners from "cruel and unusual punishment," requires corrections officials to provide a "safe and humane environment."⁴⁵ As the Supreme Court recognized in *Estelle v. Gamble*, a landmark case governing the provision of health care in correctional facilities:

[The government has an] obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his [sic] medical needs; if the authorities fail to do so, those needs will not be met. . . . [D]enial of medical care may result in pain and suffering, which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary

standards of decency as manifested in modern legislation, codifying the common law view that “it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself.”⁴⁶

The *Estelle* decision established a two-pronged standard to determine whether correctional facilities’ actions in denying medical care violate the Eighth Amendment: (1) whether the incarcerated person’s medical needs are serious; and (2) whether officials exhibit “deliberate indifference” to those needs.⁴⁷ “Deliberate indifference” has been found where officials “erect barriers and outright denials to medical treatment.”⁴⁸ Thus, when prison or jail authorities “deny reasonable requests for medical treatment . . . and such denial exposes the inmate to ‘undue suffering or the threat of tangible residual injury,’” they violate inmates’ constitutional rights.⁴⁹

An Eighth Amendment violation occurs when jail administrators ignore the health care requirements of state law.⁵⁰ Applying these principles to reproductive health care, for example, New York State law requires jail administrators to transport an incarcerated woman who is about to give birth to an outside medical facility “a reasonable time before the anticipated birth of such child,” and provide her with “comfortable accommodations, maintenance and medical care[.]”⁵¹ A correctional facility that fails to do so could run afoul of the Eighth Amendment.⁵²

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.⁵³ Failure to provide these emergency services to inmates could therefore constitute an Eighth Amendment violation.

Denial of an inmate’s request for abortion services violates the Eighth Amendment because abortion is considered a “serious medical need” under *Estelle*, even where the abortion is not necessary to preserve the life or health of the woman.⁵⁴ Although there is some disagreement in the courts as to whether abortion is considered a serious medical need, there is no controlling law in New York on this issue. The Third Circuit Federal Court of Appeals has provided the most persuasive reasoning on this point: “[a]n elective, nontherapeutic abortion may . . . constitute a ‘serious medical need.’ . . . A serious medical need exists where denial or undue delay in provision of the procedure will render the inmate’s condition ‘irreparable.’”⁵⁵ The court found that denial of abortion care would result in “tangible harm” to the inmate, and quoted the Supreme Court’s reasoning in *Roe v. Wade*:

The detriment that the State would impose upon the pregnant woman by denying her this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with an unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases . . . the additional difficulties and continuing stigma of unwed motherhood may be involved.⁵⁶

Therefore, for a woman who has decided she does not want to continue her pregnancy, denying access to abortion poses the very types of serious and irreparable consequences that comprise the unconstitutional denial of care for a serious medical need. On these grounds, the Third

Circuit held that the facility’s policy of denying abortion care to those women who could not first obtain a court order violated the Eighth Amendment.

The use of restraints, such as ankle shackles and “belly chains”—chains that secure around an inmate’s midsection—on pregnant inmates can also violate the Eighth Amendment.⁵⁷ For example, one federal court ordered a facility in the District of Columbia to halt the practice of using restraints during labor, delivery or while the woman is in recovery following delivery.⁵⁸ As a result of a 1990 federal district court case in which a class of inmates alleged an Eighth Amendment violation due to New York City’s practice of shackling pregnant inmates, the City Department of Correction entered into a stipulation prohibiting the shackling of women during childbirth, and requiring corrections officers to consult a doctor before using restraints after delivery to determine if they are medically contraindicated.⁵⁹

2. The Right to Choose

The Supreme Court made clear more than 35 years ago that a woman has a fundamental right to decide whether or not to bear a child.⁶⁰ The Court has repeatedly reaffirmed that holding, most recently stating that “[b]efore viability, a State ‘may not prohibit any woman from making the ultimate decision to terminate her pregnancy.’”⁶¹ A state, therefore, is not permitted to create an “undue burden” on this right, “which exists if a regulation’s ‘purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before a fetus attains viability.’”⁶²

New York Law permits abortions for any reason up to 24 weeks from the beginning of pregnancy.⁶³ Beyond this period, abortions are permitted in three situations: (1) where the life of the woman is at risk;⁶⁴ (2) where the health of the woman is at risk;⁶⁵ and (3) where the fetus has a condition that is

incompatible with life, even if the woman’s health is not at risk.⁶⁶

It is firmly established that women do not surrender the fundamental right to abortion when they are incarcerated.⁶⁷ Although courts have determined that jail and prison administrators have discretion in setting policies for their facilities, that discretion is limited when constitutional rights are at stake. Thus a jail facility’s obstruction of access to abortion—whether through outright refusal to provide abortion care, or unreasonable procedural hurdles which result in delay—constitutes a violation of the woman’s right to privacy under the U.S. Constitution.⁶⁸

Courts have evaluated the constitutionality of prison and jail policies limiting women’s access to abortion and policies that restrict other constitutional rights, under a four-part test known as the *Turner* standard.⁶⁹ First, “[t]here must be a ‘valid, rational connection’ between the prison regulation and the legitimate governmental interest put forward to justify it.”⁷⁰ Second, the existence of “alternative means of exercising the right that remain open to prison inmates” is relevant to determining a policy’s reasonableness.⁷¹ Third, courts must consider the impact accommodating the right would have on other inmates and prison resources.⁷² And finally, the existence of ready alternatives to accommodate the asserted right at “de minimus” cost to valid penological interests could render a policy unreasonable or an “exaggerated response” to prison concerns.⁷³

Applying the *Turner* standard, courts have found that restricting incarcerated women’s access to abortion services is unconstitutional.⁷⁴ A requirement that a woman obtain a court order prior to scheduling an abortion, for example, has been held to comprise a constitutionally impermissible obstacle to exercising the right to choose, particularly where inmates seeking other types of medical care (most notably, prenatal care) are not subject to the same requirement.⁷⁵

Courts have emphasized the importance of providing access to abortion without delay because the ability to choose an abortion is, by its nature, of limited duration. A pregnant woman who is blocked or delayed in her effort to obtain an abortion may not be able to exercise her right if too much time passes. All states sharply limit the availability of abortion after the point of fetal viability, and many counties do not have abortion providers who perform second trimester procedures.⁷⁶ In addition, while abortion is one of the safest medical procedures available, the medical risks increase as pregnancy progresses.⁷⁷ For all these reasons, correctional facilities are obliged to provide women with timely access to abortion services.

such care, county jail facilities must pay for abortion procedures.⁸² ■

3. The Obligation to Pay for Care

New York law requires that individual counties assume the cost of providing inmates in their local correctional facilities with medical care, unless third-party health insurance covers such care.⁷⁸ This includes diagnoses, tests, and care and treatment for any condition affecting an inmate's health. Therefore, costs associated with prenatal care, labor and delivery, and STI/HIV testing and treatment, and indeed all of the health care needs covered in this report, are the obligation of individual counties.

The question of whose responsibility it is to pay arises in the context of abortion more than any other type of health care.⁷⁹ Under the Eighth Amendment, and under New York law, abortion is considered needed medical care.⁸⁰ Correctional authorities “may not condition the provision of those needed medical services that it has an affirmative duty to ensure and provide upon the woman’s ability and/or their willingness to pay.”⁸¹ Because abortion is considered to be needed medical care, because the right of an incarcerated woman to obtain an abortion cannot be conditioned on her ability to pay, and because New York law requires correctional facilities to assume the cost of

III. FINDINGS

The following section summarizes the findings of the NYCLU's survey of policies governing the provision of various types of reproductive health care in New York's county jail facilities,⁸³ analyzes the legal and public health implications of various policies (including the absence of written policies), and provides recommendations that will assist corrections officials in complying with legal requirements and ensuring quality medical care for the women in their custody. Appendix A describes our methodology, and the Freedom of Information Law (FOIL) request that we sent to county facilities is provided in Appendix B. Brief summaries of each county's policies, including specific language and citations to policy and procedure manuals, are available upon request.

A. Summary

In general, we found that there is no uniform set of policies on access to reproductive health care for county jail facilities, nor is there meaningful oversight of facilities which create their own policies. The policies that we reviewed varied widely from county to county; many counties had no written policies at all, and most covered only a few aspects of women's reproductive health care. Of the 52 facilities that housed women, we found that:

- Fourteen responded that their jail facilities had no policies that dealt with any of the issues that we raised.⁸⁴ Some of the fourteen facilities simply stated that the jail complied with the state's Corrections Law.⁸⁵
- None had a written policy on general OB/GYN care for female inmates.⁸⁶
- None had any policy or procedure on how to handle the medical needs of women who go into labor.
- Forty-six percent had written policies specifically addressing inmates' access to abortion,⁸⁷ and only 23 percent provided for unimpeded access to abortion services.⁸⁸
- Just 57 percent had written policies addressing access to prenatal care.⁸⁹ Five counties' policies explicitly allowed pregnant women to continue receiving care from their community-based providers, if possible.⁹⁰
- Only three had specific written policies regarding the use of restraints on pregnant women, and only two of those policies prohibited the practice.⁹¹
- Only Saratoga County had a written policy on the provision of mental health care treatment for women who miscarry, although 11 indicated in their written policies that mental health assessment and treatment were generally available to any woman with such needs.⁹²
- Only four had written policies on testing and treatment for sexually transmitted infections (STIs).⁹³
- Just 25 percent had written policies relating to the treatment of HIV;⁹⁴ and six additional facilities had written policies on HIV testing.⁹⁵
- Eight had written policies on the provision of post-exposure prophylaxis (PEP) for inmates exposed to HIV.⁹⁶

B. General Findings and Analysis on the Provision of Medical Care

County jail facilities in New York provide for inmate health care in three ways: (1) primarily on site by medical staff employed by the jail; (2) primarily in the community; or (3) on site by employees of private companies. Some jails have well-equipped and staffed medical units with examining tables, beds and laboratories. In those jails, medical care is provided primarily by medical staff employed by the jail, and inmates are sent for care outside of the facility only for services that the jail cannot provide. Most of New York's jails, however, have very small medical units staffed by a single registered nurse (RN) or licensed practical nurse (LPN), and can provide only the most basic services. In these jails, most medical care is provided by health care professionals in the community.

At least nine jail facilities employed private or public benefit health care companies⁹⁷ to provide inmate health care services.⁹⁸ We found few apparent differences between the policies in these facilities, and those in jails that provided most health services themselves or transported inmates to providers in the community. Surprisingly, however, we found few similarities in terms of the substance of the written policies from private or public benefit health care companies—these policies varied even among facilities utilizing the same health care company.⁹⁹

The perils of privatizing correctional health care—documented extensively with regard to at least two of these companies¹⁰⁰—lie largely in the wide discretion given to non-governmental actors. “Contracting out” inmate health care services poses two problems. First, private companies hired to perform this essential state function are charged with the conflicting tasks of delivering care and making a profit. This provides a strong incentive to cut costs,

which can result in substandard care. Second, handing over such functions to private entities raises concerns about lack of transparency and public accountability.¹⁰¹

C. Reproductive Health Care Policies

Of the 52 counties that housed women, just over half had policies that were specific to pregnant inmates or women. Logically, it would make sense to structure a policies and procedures manual with a single section covering all medical issues specific to women, such as contraception, routine gynecological care, and pregnancy and prenatal care, and several purported to do so. In practice, however, we found that policies with titles that suggested a comprehensive treatment of women's health issues were woefully incomplete in all but two cases.¹⁰²

Analysis of most counties' purportedly comprehensive policies for women's health care showed that they were narrowly focused on pregnancy. For example, Saratoga County's one-page policy “Health Care—Female Medical Care,” led with an ambitious goal: “It is the policy of the . . . [f]acility to provide all necessary specialized medical care for female inmates that may be required, consistent with standards of contemporary community health care.”¹⁰³ Yet, the policy only covered prenatal care and what to do if a woman miscarried. It said nothing about contraception, routine gynecological care, provision of emergency contraception and post-exposure prophylaxis in the case of sexual assault, or the use of restraints on pregnant women. The only mention of abortion was a statement that: “Decisions by inmates who wish to obtain an abortion will be governed by state law.”¹⁰⁴

This was typical of the policies we analyzed. What follows is a more detailed discussion of the policy provisions that did deal with specific substantive areas of

reproductive health care for women, and an analysis of the legal and health care implications of each policy.

1. Routine Gynecological Care

Women's health care needs differ from those of men. Because the vast majority of those incarcerated have always been men, health care policies for correctional settings were designed for male inmates.¹⁰⁵ But the number of women being held in correctional facilities is on the rise. Nationwide, women now account for a larger percentage of the incarcerated than ever before.¹⁰⁶

Correctional facilities are, by necessity, starting to pay attention to women's health care needs. While we certainly found evidence of this in the policies and procedures we reviewed, for the most part, policies geared towards women too narrowly focused on pregnancy, and did not reach the routine care that women require.¹⁰⁷

Incarcerated women are at high risk of a number of preventable diseases that could well be addressed by jail health care services through the provision of routine gynecological care. Rates of breast and cervical cancer, pelvic inflammatory diseases, and STIs are much higher among women who have been to jail than those who have not; and women who have been incarcerated have higher rates of domestic and sexual violence.¹⁰⁸ Women who have been incarcerated also struggle with substance abuse at higher rates than those who have not.¹⁰⁹

No county had a written policy in place that provided for routine gynecological care for women.¹¹⁰ Several counties sent policies that included routine testing for STIs, but none mentioned routine pelvic examinations or breast examinations.

There are at least three models for policies providing for routine health care for women in correctional settings—the Hampden County Sheriff's Association's

Public Health Manual for Correctional Health Care,¹¹¹ the American College of Obstetrics and Gynecology's Health and Health Care of Incarcerated Adult and Adolescent Females,¹¹² and the American Public Health Association's Standards for Health Services in Correctional Institutions.¹¹³ All recommend routine gynecological care for women in jail facilities. Each organization recommends that pelvic examinations, age-appropriate mammography (and instruction in self-breast examinations), screening for STIs (including chlamydia, gonorrhea, and syphilis), and pap tests be incorporated into routine physical examinations that are performed on all those entering correctional facilities.¹¹⁴ They also recommend that screening for domestic and sexual violence and substance abuse be included as well.¹¹⁵

As the population of women in county jail facilities increases, and there is increasing guidance on the health care needs of women, county jail facilities should adopt health care policies that take into account the distinct needs of women in their custody.

2. Contraception

For many women who are using hormonal contraceptives solely for pregnancy prevention, ceasing the use of contraception during a period of incarceration is not inherently harmful.¹¹⁶ The obvious consequence of interrupting hormonal contraceptives is the risk of pregnancy.

In theory at least, there should be no risk of pregnancy for incarcerated women. But women 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 to take hormonal contraceptives in a timely manner could lead to unintended

pregnancy or a disrupted menstrual cycle once they are released from jail.¹¹⁷

For this reason, the APHA recommends that “[w]omen should be allowed to continue hormonal contraception to maintain protection for the current menstrual cycle. They should also be allowed to begin hormonal contraception a month before their release.”¹¹⁸

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 cancer¹¹⁹ and controlling endometriosis.¹²⁰ Low doses of birth control are also used for women who are perimenopausal to control symptoms like hot flashes, and prevent bone loss and osteoporosis.¹²¹ Ceasing contraceptive medication can also cause an escalation in some women of side effects that may include nausea, vomiting and diarrhea.¹²²

Finally, the assumption that incarcerated women do not need access to contraception ignores the reality that incarcerated women are at risk of sexual assault in jail facilities.¹²³

For women who were not taking hormonal contraceptives, access to emergency contraception (EC)¹²⁴ is important if they had unprotected sexual intercourse just prior to incarceration. EC is effective up to 120 hours after unprotected sex, but is more effective the sooner it is used.¹²⁵

Few facilities had policies in place on access to EC—only New York City had a comprehensive policy on contraception.¹²⁶ The policy contained guidelines for how and when to administer the medication, as well as guidance for additional testing, evaluation, and medical care that should be made available to the patient. In addition, upon admission, female inmates were asked if they were interested in family planning services, and specifically, whether they

had a need for emergency contraceptives, and were provided with emergency contraception in the course of post-sexual assault treatment.

In other counties,¹²⁷ we 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,¹²⁸ and no county besides New York City had a written policy on providing EC. Several facilities indicated that women could continue taking birth control medication at the discretion of the jail health care professional, particularly in cases where the woman was only being held for a short time or serving an intermittent sentence (weekends in jail).

Onondaga County’s policy on “Female Hormonal Therapy” contained a rationale for permitting women to continue birth control while in jail:

Many women are incarcerated for a short period of time or repeatedly. Disruption in hormonal therapy may cause medical complications such as amenorrhea, prolonged menstrual bleeding, mood swings, ectopic pregnancy, abdominal pain, postmenopausal symptoms, or medically contraindicated pregnancy.¹²⁹

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.

County correctional facilities should adopt policies that take into consideration the length of incarceration, risk of pregnancy, and harm to individual women caused by ceasing contraception.

3. The Care and Treatment of Pregnant Women

The following section will review our findings with regard to policies governing the care and treatment of pregnant women, including testing for pregnancy, the provision of prenatal care, mental health care, the use of restraints, arrangements for labor and delivery, and the ability of women to remain with newborns following birth.

a. Pregnancy Testing

The U.S. Department of Justice estimates that nationally, 6 percent of jail inmates are pregnant upon admission.¹³⁰ Many of these women find out about their pregnancy through screenings conducted when they first enter the facility. Far fewer women receive prenatal care from the time of admission (approximately 3 percent),¹³¹ which may suggest that correctional facilities are not aware of the number of women who are pregnant in any given facility.

Only nine counties sent policies on when or whether to perform pregnancy tests. Four of those eight have written policies that provided for pregnancy testing conducted at intake on all women entering the facility,¹³² four facilities' policies provided for a verbal screening for pregnancy, and then administration of a test if the screening indicated that a test should be performed,¹³³ and Onondaga County had a policy that simply offered testing to all entering women.¹³⁴

Failing to offer pregnancy testing to women upon admission may result in a delay of necessary medical care. In addition, facilities without policies that make pregnancy testing easily accessible may incur liability should pregnancy be discovered at a later stage and, because no prenatal care was provided, result in some harm to the woman or to the fetus.

b. Prenatal Care

Prenatal care has proven to be essential in improving maternal and infant health.¹³⁵ Failure to provide prenatal care leads to poor outcomes, including low birth weight, pregnancy complications, and maternal or infant death.¹³⁶ Prenatal care that includes provisions for routine testing, nutritional and dietary supplements, regular OB/GYN visits and recommended levels of activity meets the minimum standard of care for pregnant women.¹³⁷

Incarcerated women generally are at higher risk for poor pregnancy outcomes than other women. They often come from backgrounds lacking access to routine medical care and proper nutrition. They also experience a disproportionate rate of interpersonal violence.¹³⁸ Specialized attention to early and consistent prenatal care is therefore of heightened importance for incarcerated women.

Of the many areas we explored in this report, prenatal care was the one most commonly addressed in county policies—nearly 60 percent of all counties that housed women (30 counties) had policies addressing access to prenatal care.¹³⁹ Six counties allowed pregnant women to continue receiving care from their community-based provider, if the provider was willing to continue seeing the patient, and if the medical office was not too far from the jail.¹⁴⁰

Several jails had exemplary policies that made some provision for continuation of care once the woman was released. In Onondaga County, for example, the jail's policy prioritized continuity of care, and appointments were arranged for the woman after her release, with records sent to the new health care provider.¹⁴¹ Other counties specified that upon release women be referred to the county's Prenatal Care Assistance Program (PCAP).¹⁴²

Another good way to ensure that jail administrators and staff members can make informed decisions about how to provide prenatal care is to require the jail's physician to develop a "special needs treatment plan" covering the care of pregnant women.¹⁴³ Allowing a woman to continue seeing the community-based provider she was seeing for prenatal care prior to incarceration also improves health outcomes.¹⁴⁴

Failing to address the need for comprehensive prenatal care in written policies can result in lack of care or substandard care, which can lead to poor birth outcomes for both women and their children. Facilities with no policies on prenatal care for pregnant women, as well as facilities with policies that do not provide for the range of care and consideration described in this report, should review and revise their policies and procedures consistent with the recommendations herein.

c. Mental Health Care Following Miscarriage or Termination

Pregnancy is a difficult experience for many women. It is particularly stressful for incarcerated women, most of whom know they will be separated from their newborns soon after delivery.¹⁴⁵ While women generally have access to mental health care in jail, the NYCLU sought information specifically about access to care when a woman has a miscarriage or undergoes an abortion. During the course of our visits to jail facilities and interviews with experts, we expanded the scope of our inquiry to include information about access to mental health care for women following birth.

Only one facility, Saratoga County, had explicit procedures to ensure mental health care in the event a woman had a miscarriage, although 11 counties' policies indicated that mental health assessment and treatment was generally available to any woman who needed it.¹⁴⁶ Four counties (Allegany, Niagara, Putnam and Ulster) had policies

that provided post-natal care and counseling (or post-partum care) for women who had given birth, and both Putnam and Ulster counties' policies provided women with counseling following an abortion. Several facilities indicated in written correspondence that women who miscarried would either have access to a mental health nurse, or be referred to an external service provider such as Planned Parenthood.¹⁴⁷

Correctional facility policies should take into account the mental health care needs of women who have given birth and women who miscarry, as well as women who choose to terminate their pregnancies. Aftercare referrals are important as more and more facilities are paying attention to discharge planning. The absence of language recognizing these needs may lead to policies that fail to recognize the need for mental health care treatment, resulting in a denial of essential care.

d. The Use of Restraints

The purpose of restraints in correctional facilities is to restrict the movement of prisoners and prevent escape. Restricting the movement of pregnant women, however, can cause harm to the woman, and to her fetus, particularly when restraints are applied in ways that put pressure on certain areas of the woman's body. For this reason, the use of shackles during labor and delivery violates the Eighth Amendment's prohibition of cruel and unusual punishment, and also violates international human rights norms such as the U.N. Standard Minimum Rules for the Treatment of Prisoners.¹⁴⁸

Only three counties had specific policies regarding the use of restraints¹⁴⁹ on pregnant women.¹⁵⁰ In Erie County, the jail's policies required restraints on pregnant women, but allowed for removal if the restraints impeded medical treatment;¹⁵¹ in New York City and Ulster counties, the use of restraints was restricted on pregnant women.¹⁵² The New York City Department of Correction's

policy disallowed the use of restraints on pregnant women being transported for delivery.¹⁵³ Restraints were permitted when used on pregnant women who were being transported outside of the facility for other reasons. The policy provided, however, that “[u]nder no circumstances shall a pregnant inmate be handcuffed in the rear.”¹⁵⁴ This rule was repeated in another section of the policy manual, which stated additionally that “[u]nder no circumstances shall pregnant inmates be shackled by the ankles.”¹⁵⁵

The other counties that responded to our request generally allowed some degree of discretion on the part of correctional staff in determining whether and when to use restraints on any inmate. For example, in Cattaraugus, Tioga, Rensselaer and St. Lawrence counties, the use of restraints was left entirely to the discretion of correctional staff.¹⁵⁶ Restraints were used unless medically inappropriate in Chautauqua, Fulton, Montgomery, Putnam and Westchester counties.

Several jails stated in correspondence to the NYCLU that restraints were used on pregnant women only in certain circumstances. For example, in Washington County, women were shackled and cuffed during transport, but not while they were receiving medical treatment.¹⁵⁷

Correctional facilities should weigh the purpose of restraints—to address a real security risk—and the relative risk posed by a pregnant woman, particularly one in the late stages of her pregnancy. Policies calibrated to that risk are most likely to survive legal scrutiny. Policies that require the blanket use of restraints irrespective of risk—both during transport to an outside facility and during the course of medical treatment—would run afoul of the Eighth Amendment as applied to some pregnant prisoners. And certainly, policies that authorize or result in any use of restraints that compromises the health of a woman could result in legal liability for the facility.

e. Labor and Delivery

County jails, even those equipped with well-resourced medical facilities, are not appropriate places for women to deliver their babies. State law recognizes this, and requires that an incarcerated woman be transported to an appropriate outside medical facility “a reasonable time before the anticipated birth,”¹⁵⁸ for labor and delivery. While the “reasonable time” standard may seem vague, the reality is that there is no set schedule for women to begin labor, nor is there any way to tell how long a woman will be in labor before she gives birth.¹⁵⁹ Waiting until a woman goes into labor before arranging transport may result in the baby being born in the facility or in the vehicle on the way to the hospital; on the other hand, transporting a woman before her due date may result in an unnecessarily long hospital stay.

There was no guidance on the appropriate timing for transport in any of the policies reviewed, nor in any of the standards promulgated by the NCCHC or the APHA. The only guidance to local facilities on this issue was a memorandum from SCOC legal counsel regarding the care of pregnant women and newborn children that echoed state law:

If an inmate committed to a county jail is pregnant and about to give birth to a child, the officer in charge of such institution, a reasonable time before the anticipated birth of such child, shall cause such woman to be removed from such institution and provided with comfortable accommodations, maintenance and medical care elsewhere, under such supervision and safeguards to prevent her escape from custody as he may determine, and subject to her return to such institution as soon after the birth of her child as the state of her health will permit.¹⁶⁰

Not a single policy we reviewed contained any language or procedures on how to meet the medical needs of women who go into labor. Most notably, no policies had language instructing how—or when—to transport a woman to an appropriate medical facility for delivery.

Jail staff are unlikely to look to state law or a memo that exists outside of their policies and procedures manual to determine how best to respond to a woman who goes into labor. Jail facilities, therefore, should include this state law directive in their policies and procedures, and train staff to recognize when a woman is in labor to ensure that she is transported to a medical facility without delay for labor and delivery.

f. Custody of Infants

Allowing women to remain with their newborns for some time after birth is important for both the mother and her baby. Maternal and infant medical experts argue that critical bonding between a mother and her child takes place within the first hours, days and weeks following delivery.¹⁶¹ Extended or permanent separation during this time, particularly where the mother will be the primary caretaker of her child following her incarceration, can cause irreversible harm.¹⁶² Fostering the bond between mothers and their newborns in the jail setting is particularly important where nearly all of the women serving time in county jail facilities are released within a year of the birth of their children.¹⁶³

There are, however, other benefits to keeping mothers and their infants together during periods of incarceration. Allowing women to begin parenting while incarcerated provides an opportunity to teach parenting skills to new mothers in a supervised setting.¹⁶⁴ Studies have also shown that women are less likely to commit future crimes and are more successful in rehabilitation when they are able to form important relationships with their families.¹⁶⁵

New York law allows women who give birth while incarcerated to retain physical custody of their infants for up to one year after birth, except in extraordinary circumstances.¹⁶⁶ The NYCLU's initial FOIL request did not specifically request information about whether jails adhere to this provision of the law in practice. Only three correctional facilities responded to our FOIL request with any policies relating to infant custody,¹⁶⁷ and our interviews with experts and jail administrators indicated that few women housed in county jails were able to actually retain custody of their infants while incarcerated.

Although the State Commission of Correction has advised jail facilities of their obligations under the Corrections Law,¹⁶⁸ few facilities actually allow women to bring newborns back into the facility with them after they have given birth.

Jail officials interviewed for this report suggested that space and security constraints prevented them from allowing women to bring newborns back to the facility. Most jails do not have nursery facilities; Rikers Island jail in New York City did not have one until litigation was brought in the early 1980s.¹⁶⁹ Even when jails do have nursery facilities where women and their infants can stay together, women are routinely denied the ability to keep their newborns with them, ostensibly based on a determination that such a decision is in the “best interest of the child.” However, the factors to be considered in determining the child’s best interest are essentially left to the unbridled discretion of jail administrators.¹⁷⁰

We recognize that allowing mothers to retain custody of their infants while in jail may require facilities to allocate additional resources to create space appropriate for women with their newborns (for example, cribs and single cells with access to running water). Ultimately, however, accommodating women’s rights under this provision of the Corrections Law is in the best interests of

the infants, and provides long-term benefits for both mothers and their children.¹⁷¹ It may also serve to decrease the chances that women will re-offend upon release.¹⁷²

4. Abortion Services

a. Access to Abortion

Interviews with jail administrators on the subject of scheduling abortions revealed that for the most part, they saw facilitating referrals and transportation to abortion providers as just “part of the job,” as it is for other medical procedures that are not available on site. However, less than half of the facilities that housed women had policies specifically addressing women’s access to abortion.¹⁷³ Only 13 counties had policies that appeared to allow timely access to abortion services,¹⁷⁴ with only six counties including specific referral procedures, such as the name of an agency or a phone number.¹⁷⁵

Six counties simply stated that the jail would follow “state law” in determining whether or not to grant a woman’s request.¹⁷⁶

Oswego County required that jail officials approve the procedure prior to scheduling an appointment.¹⁷⁷ The county’s policy provided that a woman requesting an abortion must notify the facility’s medical staff; the jail physician would then evaluate the request and briefs the sheriff and the jail administrator, who in turn, were advised to contact the district attorney or the county attorney for guidance.¹⁷⁸

Several facilities sent the NYCLU policies that dealt with “elective” procedures. In some cases, it was clear that abortion was not considered under the protocol for “elective” procedure because the subject was dealt with elsewhere in the policies and procedures manuals. But in others, abortion was likely considered to fall under the policy on “elective” procedures. Indeed, some jail administrators suggested during interviews that abortions not sought to protect the

health of the woman could be considered “elective” procedures. They said requests for those abortions would be evaluated accordingly by medical staff and likely denied.

Counties that have policies on elective procedures but not on abortion specifically are particularly problematic because abortion is generally characterized as being either “medically necessary” — performed to preserve the life or health of the woman — or “elective,” which simply means that the woman has chosen to terminate her pregnancy. Abortion should be distinguished from other elective procedures such as capping teeth or breast reduction surgery — both procedures that jail officials said would be routinely denied, unless the underlying conditions were life threatening. Without a written policy on abortion, confusion in terminology likely could lead a jail official to mischaracterize an abortion that is not needed to save the life or the health of the woman as an “elective” medical procedure, and deny it. Confusion over the meaning of “elective” also could lead to prison officials demanding that women pay for their abortions, which would deny many incarcerated women access to the procedure.

Finally, none of the policies, even the most comprehensive, contained timeframes to provide guidance to jail administrators or health care professionals regarding when to respond to requests for abortion, although a nurse at one facility acknowledged that “[a]bortion has a time limit . . . you want to do it quicker.”¹⁷⁹

The lack of written policies to guide the actions of jail administrators and health care staff could lead to delay or denial of medical care to address abortion. A woman could be denied her right to choose to terminate her pregnancy, be forced to continue her pregnancy, or be exposed to riskier abortion procedures. Any of these consequences could lead to violations of women’s rights

to abortion under the Eighth and Fourteenth Amendments.¹⁸⁰

Policies that require or suggest that a legal opinion be sought each time a woman requests an abortion could also cause an undue delay in ensuring women access to abortion as it could take several weeks—or longer—to obtain a legal opinion.

Policies that simply refer jail administrators to state law presumably mean that pregnant women have access to abortion services so long as the abortion is legal in the state. However, such policies give no further guidance on how a woman can request an abortion or how such services will be delivered to her—nor do they provide guidance to jail officials who may not be aware of the legal status of abortion in New York. Under such policies, health care professionals are left guessing as to the appropriate response.

b. Counseling Requirements

Eighteen counties required that a woman requesting an abortion receive counseling prior to scheduling an appointment for the procedure (in 15 of those counties, counseling was provided by health care staff in the facility itself; the remaining three required that a community-based practitioner provide counseling).¹⁸¹ Some facilities specified that counseling must “not be slanted towards one viewpoint,”¹⁸² and some policies contained a proviso that “staff will support the pregnant inmate in whatever choice she makes regarding her wishes for the outcome of the pregnancy.”¹⁸³

Policies that require counseling of a woman who requests abortion services are problematic when they pose an undue delay or create a barrier to care. Obtaining informed consent from a pregnant woman prior to an abortion, which entails providing her with accurate information about the risks and benefits of the procedure, is standard practice for any medical treatment and is

the responsibility of the abortion provider.¹⁸⁴ Counseling differs from informed consent and requires a discussion with the woman about her feelings and concerns about the pregnancy and her decision. Abortion providers routinely offer both information about the procedure and counseling around the woman’s choice.

As with all medical care, counseling must be timely and conducted by trained professionals. Counseling offered by health care staff from an OB/GYN or a state-licensed facility that routinely counsels women on abortion procedures would not be problematic because staff at such a facility would be trained in counseling. But policies that rely solely on jail staff to conduct counseling are inappropriate. Counseling by jail personnel, who may not be trained in this area, runs the risk of being biased—either for or against abortion. Moreover, this sort of “counseling” could amount to a waiting period, as the staff member providing counseling may be personally opposed to abortion and attempt to block or delay access to care. A nurse in a rural county facility told the NYCLU: “If they are saying they want an abortion the same day they are sentenced, for example, I usually tell them to think about it and I’ll follow up with them in a few days. They have to request it from me.”¹⁸⁵

c. Costs

Unless a woman has third-party insurance, counties bear the cost of an inmate’s medical care, except for some types of care that are deemed “elective.”¹⁸⁶ Perhaps because many jail officials believe that the law is very clear on the counties’ obligation to fund needed medical care, only seven counties had specific policies regarding the cost of abortion services.¹⁸⁷ Three counties specified that the cost for the procedure be borne exclusively by either the facility (Albany) or the county (Cattaraugus and Franklin).

However, several facilities’ policies were clearly not consistent with the law. Chenango

County's policy stated that the woman or her relatives were primarily responsible for paying for the procedure, but if they were unable to pay, the county would bear the cost. Policies in Monroe and Orange counties specifically indicated that the cost for abortion services be borne exclusively by the woman or her relatives. Both counties' policies stated that the woman or her relatives must provide the funding for the procedure before scheduling an appointment.

Some administrators and even some health care providers in the jails expressed a private sentiment that they were conflicted about assisting women in obtaining abortions by providing funding, and that they believed that the cost should not be borne by taxpayers.

One administrator candidly told the NYCLU:

Just thinking not as a jail administrator or someone that has to oversee a policy, but as a taxpayer, I don't know if I really appreciate someone coming in here and the taxpayers paying for this. But that's just a personal feeling. But I know that it is shared with a number of people. If the inmate comes in and has to have procedures, then by all means we have to take care of them. If they are elective, should the taxpayers pay for this? It's a question I guess more philosophical than anything else. If the law says we have to do it, we have to do it.¹⁸⁸

* * *

In sum, the absence of clear policy guidelines leaves too much discretion to local jail administrators and health care staff who may have strong opinions about abortion, particularly on the issue of whether government money should pay for such

procedures. Even administrators who are not opposed to abortion may misconstrue their legal obligations to meet a woman's need for an abortion that they consider to be "elective." In addition, even in facilities that provide women with access to abortion services, the lack of written policies leaves women vulnerable to potential shifts in practice should the administration of the facility change.

5. Testing and Treatment for Sexually Transmitted Infections (STIs), including HIV

Incarcerated women are disproportionately affected by STIs, including HIV.¹⁸⁹ Often women do not become aware that they have an STI until they are incarcerated and tested during a routine health screen. However, routine testing in jails for these infections is rare; a national study showed that only 12 to 47 percent of jails offered routine testing for syphilis, gonorrhea, or chlamydia, and most offered testing only to symptomatic individuals or those who requested it.¹⁹⁰

Because testing for STIs and HIV is not routine, statistics on the number of women who have various STIs is scant. Experts estimate that among women in correctional facilities nationally, 35 percent test positive for syphilis, 27 percent for chlamydia and 8 percent for gonorrhea.¹⁹¹ Given their high rates of infection, incarcerated women may also be at higher risk for cervical cancer, but the risk and prevalence have not been systematically evaluated nationally or locally.¹⁹²

Rates of HIV infection among women in jail in New York City, however, are estimated to be as high as 18 percent.¹⁹³ In fact, New York City holds nearly 30 percent of all jail inmates known to be HIV positive in the 50 largest jails nationwide,¹⁹⁴ and rates of HIV are "two to three times higher among women than men in almost all correctional systems in the U.S."¹⁹⁵

Only four counties had written policies on testing and treatment for sexually transmitted infections (STIs).¹⁹⁶ Thirteen counties had written policies relating to the treatment of HIV,¹⁹⁷ and six additional counties had written policies on HIV testing.¹⁹⁸ Only eight counties had policies in place on access to non-occupational post-exposure prophylaxis (nPEP) for inmates exposed to HIV.¹⁹⁹ Seven counties had policies that did not mention nPEP specifically, but that required post-sexual assault treatment either in-house or in a local emergency room, for inmates who were sexually assaulted.²⁰⁰ The standard of care in those facilities would include discussion of whether nPEP was appropriate. Four additional counties had policies on the provision of nPEP for occupational exposure, meaning that staff members who are exposed to HIV on the job were provided with nPEP.²⁰¹

Unlike most other areas of women's health care, there is significant guidance on testing, treating and preventing STIs and HIV among those in correctional settings. The APHA and NCCHC both recommend that inmates routinely be screened for STIs.²⁰² Because of constant changes in treatment protocols for STIs and HIV, both organizations recommend that correctional facilities treat inmates with STIs consistent with CDC's Sexually Transmitted Diseases Treatment Guidelines,²⁰³ and HIV consistent with either CDC Guidelines²⁰⁴ or guidelines periodically issued by the U.S. Department of Health and Human Services (DHHS).²⁰⁵

Two issues unique to treatment of inmates who are HIV positive in jail facilities that NCCHC and APHA standards do not deal with, however, are the importance of continuity of treatment for those receiving antiretroviral treatment (ARVs),²⁰⁶ and the need for nPEP²⁰⁷ for inmates exposed to HIV just prior to or during incarceration.

In general, any prescription drugs that inmates have prior to incarceration are taken

from them at the time of arrest and they are not permitted to take prescription medication until they are evaluated by a physician.²⁰⁸ Unfortunately, in many jail facilities, particularly in rural areas, inmates are not able to see health care providers who have the ability to prescribe medication for several days. Ensuring prompt attention from jail physicians is particularly important for those inmates who are HIV positive and already taking a regimen of HIV medication. For those who are taking ARVs, uninterrupted treatment is crucial, as resistance to the medication can develop after just a few days.²⁰⁹

While nPEP is highly effective in preventing HIV infection if the course of therapy is initiated within 72 hours after exposure to the virus, there are significant side effects from the medication that women should discuss with a physician. In light of the seriousness of HIV infection and the likelihood of intense side effects from nPEP, jail officials should make counseling with a health care professional available to all women who have been exposed to HIV and would potentially benefit from nPEP.²¹⁰ Such health care professionals should follow guidelines for the use of nPEP from the New York State Department of Health.²¹¹

The Monmouth County Correctional Institution in New Jersey (MCCI) has served as a model for the care and treatment of HIV positive inmates in jail facilities.²¹² MCCI's policy focuses on five areas: medical treatment, education, counseling, prevention and continuity of care. Women who enter MCCI with HIV are maintained on their current drug regimen, and the facility attempts to obtain the woman's medical records from her current treatment provider. Newly diagnosed inmates are sent for laboratory tests and medical evaluations, and they are started on a course of treatment that may include the initiation of antiretroviral therapy.²¹³ Education regarding HIV transmission and prevention is offered to both HIV positive and negative inmates.

Jail staff are trained in how to conduct workshops on preventing transmission of the disease. Finally, when inmates are released, they are given a copy of their most recent laboratory and other tests, a summary of their medical history, and a referral to a local clinic. If possible, jail staff schedule an appointment for them in the community. Inmates are also given a limited supply of medication upon release.

Jail facilities that implement written policies and procedures that reflect the MCCI model, as well as the recommendations from NCCHC and the APHA, will ensure that women have access to the standard of care that is both constitutionally adequate and designed to promote optimal health outcomes. Jail physicians providing HIV- and STI-related primary care should provide that care in accordance with CDC guidelines that reflect the accepted standard of care. ■

IV. CONCLUSION

The availability and quality of reproductive health care for women in New York State’s county jails varies widely from county to county. It appears that there has never been an attempt to ensure that all jail facilities have uniform policies—or, for that matter, any policies at all—in place to guide the decisions jail administrators and their staff make regarding health care decisions unique to women. For the most part, facilities lack comprehensive policies and where they do have policies that specifically address health care for women, such policies are narrowly focused on prenatal care.

In practice, it appears that even in the absence of written policies, many jail facilities respond to requests from women for health care, including abortion, appropriately and in a timely manner. Too often, however, such requests are granted purely at the discretion of local jail officials. Without clear, written policies to guide their decisions, jail facilities run the risk of individual staff members declining requests for or delaying legally mandated health care. This is particularly true of the facility’s legal obligation to ensure access to abortion: Jail administrators are apt to wrongly consider a request for abortion that is not necessary to preserve the health or life of the woman as “elective,” and thus deny access, as they routinely do with regard to other “elective” procedures. Staff may not recognize the practical and constitutional implications of denying or delaying access to abortions. Moreover, the lack of uniformity means that the quality and type of care women receive is entirely dependent on where they are incarcerated.

There are, however, a number of exemplary policy provisions throughout

the state that may be used as models. In interviews with the NYCLU, the State Commission on Correction, jail administrators and health care practitioners have expressed a willingness to work towards a uniform set of model policies on reproductive health care for women.

Jail administrators are under tremendous pressure to run jails safely and efficiently with limited resources. Inmates, particularly women, have greater health care needs than other members of the general public.²¹⁴ Since most do not have health insurance, the counties shoulder the cost for their health care. But jail administrators also have a unique opportunity to provide preventive health care services that benefit not only individual women, but public health. Women who are properly screened and treated for preventable conditions while they are incarcerated return to the community healthier and pose less of a burden on community health care resources.

By adopting uniform policies and procedures for providing reproductive health care, and ensuring that staff is well-trained to handle requests for such care, jail administrators can ensure that the needs of women are met, provide preventive care that could reduce the burden on county health care resources, and insulate themselves from potential liability for denial of care.

The recommendations set forth here were developed by using selected policies and procedures from a number of different facilities across the state and policy recommendations from respected national health care organizations. We believe that the majority of these recommendations

could be immediately implemented in any jail facility with minimal cost. We invite both state and local officials to join us in a dialogue about how to incorporate our recommendations into a uniform set of minimum standards to ensure that women in jail facilities have access to comprehensive care, regardless of where they serve their sentence. ■

V. RECOMMENDATIONS

Routine Reproductive Health Care

Sensitive and dignified pelvic examinations, age-appropriate mammography (and instruction in self-breast examinations), screening for STIs (including chlamydia, gonorrhea and syphilis), and cervical cytology screens (pap tests) should be offered as part of the routine physical examinations performed on all women upon admission. Screening for domestic and sexual violence and substance abuse should also be incorporated into the routine care that women receive.

Access to Contraception

Emergency contraception should be made available on site to women who enter the facility having experienced a sexual assault or unprotected sex up to 120 hours prior to incarceration, or those who experience sexual assault in the facility within the effective time period. It is important that this medication be available on site because of the limited time period of effectiveness. Women should be permitted to continue taking previously prescribed hormonal contraception or hormonal replacement therapy during incarceration. County correctional facilities should have policies and procedures in place that allow women to continue taking hormonal contraception immediately following admission and through their first menstrual cycle to prevent unintended pregnancy due to sexual activity just prior to incarceration. Such policies and procedures should also ensure an individual assessment of each woman's need to continue contraception on a longer-term basis. This assessment should include whether hormonal contraception is used for any condition other than preventing pregnancy, the length of the woman's stay at the jail, and an evaluation of potential side effects should birth control

be halted. Such policies and procedures should also provide for commencement of contraception just prior to release.

Pregnancy Testing

Health care staff should assess all entering women for the likelihood of pregnancy, and offer pregnancy testing to any woman who requests it at any time. Before being offered a test, women should be advised by a health care professional of the range of options available to them while they are incarcerated. Those options should include prenatal care and assistance for those who choose to carry their pregnancies to term, as well as abortion or assistance with adoption.

Prenatal Care

Correctional facilities should have policies in place that ensure that medical staff assess the needs of the woman and recommend a treatment plan that corresponds to community standards of care including transportation to regular prenatal care appointments, special nutrition needs, dietary supplements, recommended activity levels and housing assignments, safety concerns, and regularly scheduled medical examinations and testing. Continuation of care with the woman's existing prenatal care provider should be arranged if possible and if the woman so wishes. If this is not possible due to geographic constraints or the unwillingness of the provider, health care staff should attempt, with the consent of the woman, to obtain the woman's treatment records. In addition, best practices suggest that policies address continuation of care following release by, among other things, arranging for appointments, transferring records, and assisting with enrollment in public health insurance programs such as PCAP.

Mental Health Care Following Miscarriage, Abortion and Birth

Mental health assessments and services should be available to women after they give birth in order to identify and treat post-partum depression. The same services should be made available to women who miscarry or who terminate their pregnancies while incarcerated.

Use of Restraints

County jail facilities should have clear policies forbidding the use of belly chains and ankle shackles on pregnant women, regardless of their stage of pregnancy. Jail officials should use the least restrictive type of restraints when transporting pregnant women for care, and ensure that a woman's hands are secured in front of her body, not behind her back, when she is pregnant and being transported for any reason. Pregnant women should not be restrained during the provision of medical care unless there is some demonstrable security risk. Restraints never should be used on a woman who is giving birth. Following delivery, restraints should be used only if there is a demonstrable security risk.

Timely Transport for Labor and Delivery

Correctional facilities should have written policies in place that advise jail staff of the state law requiring timely transfer of women to appropriate facilities for labor and delivery. They should ensure that correctional officers and health care staff are trained to recognize the signs that a woman is in labor and arrange for timely transportation to an appropriate medical facility.

Infant Custody

Correctional facilities should have written policies and procedures in place in accordance with the Corrections Law, allowing women to retain physical custody of their newborns at the facility.

Access to Abortion

First and foremost, county correctional facilities should have written policies stating that women have the right to have an abortion. Such policies must provide guidance to jail officials about how to handle a woman's request for abortion services. Such policies must also provide that as soon as a woman says she wishes to terminate her pregnancy, jail officials are to schedule the first available appointment with a licensed qualified provider or a community-based health center to terminate the pregnancy as authorized by law. Counseling should be provided by clinic staff employed by an abortion provider or a state-licensed health care facility upon request of the woman. It should never be provided by jail personnel who do not have sufficient training in this area, or by any other unlicensed facility. Transportation should be provided by the facility, and all costs for the procedure should be covered by the facility or the county, unless the woman has third-party health coverage that applies.

Testing, Treatment, and Prevention of STIs, including HIV

A comprehensive policy on the management of STIs and HIV in a county correctional facility would include seven components: (1) *Testing*. Confidential testing for STIs, Hepatitis C and HIV should be made available to all women at admission and anytime during incarceration. (2) *Access to medication*. Women entering the facility who are already being treated for STIs and HIV must be permitted to continue taking currently prescribed medication immediately upon incarceration to avoid interruption of treatment. (3) *Treatment*. Women should have access to primary care and referrals to specialists treating STIs and HIV. Women testing positive while incarcerated should be seen as soon as possible by a health care provider specializing in the treatment and care of patients with STIs or HIV for a baseline assessment and development of a treatment plan. Women with STIs should have access to treatment consistent with

CDC Clinical Guidelines. Women with HIV/AIDS should have access to treatment consistent with CDC and U.S. Department of Health and Human Services guidelines.

(4) *Nutrition*. Women with HIV should have access to nutritional supplements as per guidelines.

(5) *Confidentiality*. The facility should have a policy in place to inform jail personnel about laws and regulations protecting the confidentiality of information relating to a woman's health status.

(6) *Prevention*. For inmates exposed to HIV while they are incarcerated or just prior to incarceration, non-occupational post-exposure prophylaxis (nPEP) should be offered within 72 hours of exposure. During incarceration, women should be offered information about the prevention of STI and HIV transmission.

(7) *Discharge Planning*. At a minimum, women should be provided with information about how to access medication, ongoing medical care, and social services upon release. Best practices suggest that policies provide for arranging follow-up appointments with community-based providers, transfer of medical records (upon consent) to those providers, and assistance with obtaining public health insurance. ■

Acknowledgements

The report was written by Corinne Carey and edited by Galen Sherwin and Michael Cummings. Ariel Samach, the program assistant for the Reproductive Rights Project, provided invaluable substantive and technical assistance from start to finish. Jennie Woltz, who worked with RRP as a fellow from the law firm of Milbank, Tweed, Hadley & McCloy, also edited and cite-checked the report with the assistance of Joyce Chang and Brian Garzione.

Considerable assistance was provided by NYCLU interns Grace Pickering, Emilie Adams and Lindsey Zwicker who did preliminary research, reviewed documents and made innumerable phone calls to encourage jail officials to respond to our Freedom of Information Law request. NYCLU interns Andrea Gittleman and Olivia Lieber provided additional research assistance during the editing process. The report was designed by Tara DiGerlando, who donated her time.

A number of outside experts contributed to the report as well, by providing valuable insights and reviewing initial drafts. These experts were: Rachel Roth, Ph.D., independent scholar and Soros Justice Fellow; Jeanne Flavin, Ph.D., associate professor of sociology, Fordham University; Megan McLemore, researcher, HIV/AIDS and Human Rights Program, Human Rights Watch; Tamar Kraft-Stolar, director of the Women in Prison Project of the Correctional Association of New York; and from the Legal Aid Society's Prisoners' Rights Project, Dori A. Lewis, senior supervising attorney, and Lisa Freeman, staff attorney. Diana Kasdan, staff attorney from the ACLU Reproductive Freedom Project, and Jackie Walker and Amy Fettig from the ACLU's National Prison Project provided critical feedback at various stages of the project.

The project was funded through a generous grant from the ACLU Reproductive Freedom Project.

Endnotes

¹ John Sullivan, *Judge Temporarily Bars County Inmate from Having Abortion*, N.Y. Times, Mar. 4, 2000, at B2.

² Gina Turner is a pseudonym; her real name is not revealed in this report because she is currently facing re-sentencing on these charges.

³ State Commission of Correction, County Jail Population Statistics—October 1, 2007 (on file with NYCLU) (SCOC 2007 Population Statistics) (1,910 women in all county jail facilities excluding Rikers Island in New York City out of a total 16,873 inmates); The Correctional Association of New York, *Prisoner Profile 1* (2006), available at http://www.correctionalassociation.org/PVP/publications/prisoner_profile_2006.pdf. (Of a total of 2,800 in state prison, 4.5 percent were women; of a total of 14,000 people in custody in New York City's Rikers Island jail, approximately 8.5 percent were women, for a total of 1,190); Bureau of Justice Statistics, *Prison and Jail Inmates at Midyear 2006* 6, Tbl. 11 (2007) (BJS Statistics 2006), available at <http://www.ojp.usdoj.gov/bjs/abstract/pjim06.htm> (Of a total 63,295 state and federal prisoners in New York, approximately 3,798 were women).

⁴ New York Correction Law defines a local correctional facility as

any place operated by a county or the city of New York as a place for the confinement of persons duly committed to secure their attendance as witnesses in any criminal case, charged with crime and committed for trial or examination, awaiting the availability of a court, duly committed for any contempt or upon civil process, convicted of any offense and sentenced to imprisonment therein or awaiting transportation under sentence to imprisonment in a correctional facility, or pursuant to any other applicable provisions of law.

N.Y. Correct. Law §§ 2(16), 40(2) (McKinney 2007).

⁵ State Commission of Correction, *Local Correctional Facilities in New York State—2005, County Admissions Received From Courts Within Their County* (on file with NYCLU) (SCOC 2005 County Admissions). This figure does not reflect the precise number of women incarcerated in county jail facilities each year because the state does not account for women who may be admitted more than once within a year. Telephone interview with Mike Donegan, Counsel, State Comm'n of Corr. (Feb. 11, 2008). In fact, women account for over 25,000 admissions to county jail facilities in New York State each year. As of June 2007, county correctional facilities held 16,406 inmates; an additional 14,120 were housed in the New York City jail facility at Rikers Island. New York State Commission on Corrections, *Inmate Population Statistics*, <http://www.scoc.state.ny.us/pop.htm> (last visited Sept. 7, 2007). Close to 17 percent of the state's jail population are women, SCOC 2005 County Admissions, and the percentage of women being held in jails has been increasing slightly, but steadily, each year. BJS Statistics 2006, *supra* note 3.

Local correctional facilities are established pursuant to the New York Constitution, as exercised and codified in the New York Correction and County Laws. See N.Y. Const. art. XVII, § 5; N.Y. Correct. Law §§ 2(16), 40(2); N.Y. County Law § 217 (McKinney 2004) (“Each county shall continue to maintain a county jail as prescribed by law.”). Counties do not have to operate one facility on their own but instead may, in the interests of efficiency and economy, join forces with another county in order to house their inmates. N.Y. Gen. Mun. Law § 431 (McKinney 2007).

⁶ BJS Statistics 2006, *supra* note 3 at 6, Tbl. 11.

⁷ See Lawrence A. Greenfeld & Tracy L. Snell, *Women Offenders, Bureau of Justice Statistics Special Report 6*, Tbl. 15 (Dec. 1999), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/wo.pdf> (last visited Jan. 19, 2008). County jail facilities also house people awaiting trial and those awaiting transfer to prison following a conviction, N.Y. Correct. Law § 500-a (McKinney 2007); those who are serving state sentences where state jail facilities are unable to accommodate them (prisoners serving state sentences in city or county jail facilities are referred to as “Coram nobis” prisoners, see *id.* § 601(b) (McKinney 2007)); state prisoners who are brought to the city for court proceedings, including family court hearings, *id.* § 500-a(1)(c); and witnesses requiring security before testifying in criminal court. *Id.* § 500-a(1)(a)-(b).

⁸ American College of Obstetricians and Gynecologists (ACOG), *Health and Health Care of Incarcerated Adult and Adolescent Females*, in *Special Issues in Women's Health* 89 (2005) (ACOG Special Issues).

⁹ ACOG, *Guidelines for Perinatal Care* 87 (6th ed. 2007) (ACOG Guidelines); Jeanne Flavin, *Our Bodies, Our Crimes: Justice and Reproductive Rights in America* (working title) (NYU Press ed.) (forthcoming) (on file with NYCLU). Indeed, incarcerated women may even suffer from more medical problems than their male counterparts. In a survey done by the U.S. Department of Justice's Bureau of Justice Statistics on medical problems of jail inmates, "[m]ore than half (53 percent) of female jail inmates reported having a current medical problem, compared to about a third (35 percent) of male inmates." Laura M. Maruschak, *Bureau of Justice Statistics Special Report: Medical Problems of Jail Inmates* 1 (2006), available at <http://www.ojp.gov/bjs/pub/pdf/mpji.pdf>.

¹⁰ Hampden County Sheriff's Department, *A Public Health Manual for Correctional Health Care* 1 (2002) (Public Health Manual), available at <http://www.mphaweb.org/documents/PHModelforCorrectionalHealth.pdf>. The Hampden County Sheriff's Department in Ludlow, Massachusetts serves as a national model for correctional health care. The Public Health Manual was developed with a grant from the Ford Foundation, and in consultation with the National Commission on Correctional Health Care (NCCCHC) and the Massachusetts Public Health Association (MPHA). In addition to providing a model of health care in jail settings, the Manual also points to cost-savings and reductions in recidivism that the Sheriff's Department attributes in part to the increased quality of inmate health care. *Id.* at 8-9.

¹¹ Rachel Roth, *Searching for the State: Who Governs Prisoners' Reproductive Rights?*, 11(3) *Social Politics* 421-22#(2004), and Rachel Roth, *Do Prisoners Have Abortion Rights?*, 30(2) *Feminist Studies* 358-360 (2004); Flavin, *supra* note 9.

¹² New York State has 62 counties, but because the jail facility in New York City houses inmates from five counties, we sent FOIL requests to 57 counties and the City of New York. A copy of the original FOIL request sent to each county correctional facility can be found in Appendix B.

¹³ See *supra* notes 3-7.

¹⁴ See N.Y. Correct. Law § 500-c(1) (McKinney 2007) ("Whenever the term 'sheriff' is used in this chapter, such term shall be deemed to include the warden, superintendent, or other person in charge of a local correctional facility."). In New York City, the Commissioner of Correction has responsibility for the management, care and custody of the inmate. N.Y. Correct. Law § 500-c(2). See also N.Y.C. Charter § 623(2) (2007).

¹⁵ Correctional Medical Services (CMS) provides for inmate health care in Albany, Monroe, and Orange counties; Correctional Health Services (CHS) provides for inmate health care in Westchester county; Prison Health Services, Inc. provides health care for inmates in Dutchess County and at Rikers Island, which houses inmates from New York City's five boroughs; and Correctional Medical Care, Inc. provides services in Tompkins County. AmeriCor, Inc. provides services in Putnam County (documents on file with NYCLU).

¹⁶ Schenectady Family Health Services provides health care in Schenectady County; Nassau Health Care Corporation provides health care in Nassau County. The Nassau Health Care Corporation is a public benefit corporation. NHCC: *Our History*, <http://www.numc.edu/htmls/ourhistory.htm> (last visited Oct. 10, 2007). Schenectady Family Health Services, which does business as the Hometown Health Foundation, is a private nonprofit community based health center. Hometown Health Centers, *Who We Are*, http://www.hometownhealthcenters.org/who_we_are.htm (last visited Oct. 10, 2007).

¹⁷ The sole exception is in New York City, where policies are developed by the City's Department of Health and provided to the private companies, that are charged with actually delivering those services. Telephone interview with Vivian Toan, Counsel, Dep't of Health and Mental Hygiene (DOHMH), Division of Health Care Access and Improvement in New York, N.Y. (Oct. 17, 2007).

¹⁸ N.Y. Correct. Law § 41 (McKinney 2003). The New York State Constitution mandates the existence of the SCOC. N.Y. Const. art. 17, § 5.

¹⁹ N.Y. Correct. Law § 45(6) (McKinney 2008); 9 N.Y.C.R.R. § 7500.1(b)(1) (McKinney 2008).

²⁰ *Id.* § 7010.1(a).

²¹ Under these standards, all county facilities are required by law to appoint a jail physician. N.Y. Correct. Law § 501 (McKinney 2003); 9 N.Y.C.R.R. § 7010.2(a). Further, they are required to appoint one physician licensed by the state of New York for every jail in the county. N.Y. Correct. Law §§ 501, 94 (McKinney 2003).

²² 9 N.Y.C.R.R. §§ 7013.3(a)(2) (McKinney 2008); 7010.1(b).

²³ *Id.* § 7010.2(b)(1).

²⁴ *Id.* § 7010.1(b).

²⁵ The New York City Charter provides for a Board of Correction, which has the power to establish minimum standards for the care and custody of all those held under its jurisdiction. N.Y.C. Charter § 626(e).

²⁶ 40 R.C.N.Y. § 3-02 (2007), health screening of inmates, *id.* § 3-04, and medical treatment. *Id.* § 3-06.

²⁷ *Id.* § 3-04(b).

²⁸ *Id.* § 3-04(b)(2)(x). While the city facility must offer gynecological exams and testing, female inmates may refuse such exams. Board of Corrections Health Care Minimum Standards, 40 RCNY §§ 3-04(b), 3-02(b)(2).

²⁹ 40 R.C.N.Y. § 3-04(b)(2)(v)(D).

³⁰ *Id.* § 3-04(b)(2)(v)(C).

³¹ *Id.* § 3-06(e)(1).

³² *Id.* § 3-06(e)(2).

³³ *Id.* § 3-06(e)(3).

³⁴ N.Y. Correct. Law § 45(3); 9 N.Y.C.R.R. § 7500.1 (a), (b)(1). The SCOC can take action against facilities that fail to meet these minimum standards, and has the power to close down any correctional facility failing to comply with them. *See* N.Y. Correct. Law § 45(8); 9 N.Y.C.R.R. § 7500.1(b)(6). It can also recommend remedial action to enable compliance and issue directives requiring compliance. *See* N.Y. Correct. Law § 46(4) (McKinney 2003).

³⁵ *See, e.g., Brody v. McMahon*, 684 F. Supp. 354, 356 (N.D.N.Y. 1988) (dismissing plaintiffs' attempt to bring § 1983 suit against SCOC because the powers of the SCOC are not supervisory).

³⁶ The SCOC cannot require counties to spend money on services, nor can the rules "conflict with [sheriffs'] statutory duty of safekeeping of prisoners confined to their custody." *See McNulty v. Chinlund*, 406 N.Y.S.2d 558, 561 (App. Div. 1978). For example, where a county does not comply with the requirement for recreational exercise for inmates, the SCOC cannot commandeer county resources by mandating that the county build an outdoor recreational facility space. *N.Y. State Comm'n of Corr. v. Ruffo*, 530 N.Y.S.2d 469, 471-2 (N.Y. Sup. Ct. 1988). Compliance with the regulations will only be required by the courts where failure to comply makes conditions unconstitutional; furthermore, violation of a minimum standard does not necessarily implicate a constitutional violation. *See Powlowski v. Wullich*, 479 N.Y.S.2d 89, 95 (N.Y. App. Div. 1984) ("[E]nforcement of these [SCOC] standards is a matter for the Commission of Corrections or others in the executive branch of government and not for the courts. . . . [W]hile the state commission minimum standards are certainly relevant, it by no means follows that what the state commission may have established as a minimum for a given practice or condition is the same as the minimum that a court may find to be constitutionally acceptable.").

³⁷ Not only is there no guidance from the state commission, the State Department of Correction, which runs the state's prison facilities, does not have policies or procedures that counties can look to for models, either. In response to our FOIL request, the only policies that the state sent that it determined were responsive to our request were policies relating to HIV testing, STI treatment guidelines, procedures in cases of sexual assault, and inmate health care during transfers.

³⁸ In response to inquiries from jail administrators in some of the counties, New York State Sheriffs Association (NYSSA) issued a letter brief reviewing case law on abortion in county facilities from different jurisdictions, with particular attention to whether an inmate has a right to abortion, and who bears the cost. Letter from Thomas A. Mitchell, Counsel, New York State Sheriffs' Assoc., Inc. to Barry Virts, Chief Deputy, Wayne County Sheriff's Office (Feb. 10, 2006) (on file with NYCLU) citing *Bryant v. Maffucci*, 923 F.2d 979 (2d Cir. 1991) (dismissing claim brought by an inmate unable to obtain an abortion due to the delay of the correctional facility because such delay was found to be mere negligence; but citing with approval case law establishing the inmate's right to abortion). NYSSA concluded that inmates do have a fundamental right to abortion, but, because courts have not clearly addressed the use of public funds for the procedure, it was unable to answer questions about whether local correctional facilities would be required to provide such funding.

³⁹ Description of the National Commission on Correctional Health Care (NCCHC), <http://www.ncchc.org/about/index.html> (last visited Sept. 14, 2007). The American Public Health Association (APHA) publishes Standards for Health Services in Correctional Institutions, but none of the county correctional facilities in New York cited APHA Standards as a model for their own policies. APHA standards are more comprehensive than NCCHC standards, *see infra* note 40, and include detailed recommendations on hormonal contraception; detection and treatment of sexually transmitted infections (STIs) and HIV; availability of condoms; cervical cytology (pap tests); screening for gonorrhea, chlamydia, and other vaginal infections; and instruction in breast examination and age-appropriate mammography. APHA, Standards for Health Services in Correctional Institutions 107-09 (2003) (APHA Standards) (on file with NYCLU).

⁴⁰ NCCHC standards suggest that: “Pregnant inmates receive timely and appropriate prenatal care, specialized obstetrical services when indicated, and postpartum care.” NCCHC, *Standards for Health Services in Jails*, 105-06 (2003) (NCCHC Standards). NCCHC plans to issue a new version of its Standards in Spring 2008; the provisions described and quoted in this report from 2003 are identical to the 2008 version, a draft of which is on file with NYCLU. NCCHC states that the intent of the standard is to ensure that “pregnant inmates receive services as they would in the community.” The organization sets forth several “compliance indicators,” which have been adapted by county jails as their procedures:

1. All aspects of the standards are addressed by written policy and defined procedures.
2. Prenatal care includes:
 - a. medical examinations;
 - b. laboratory and diagnostic tests (including offering HIV testing and prophylaxis when indicated); and
 - c. advice on appropriate levels of activity, safety precautions, and nutritional guidance and counseling.
3. A list of specialized obstetrical services is maintained.
4. There is a written agreement with a community facility for delivery.
5. There is documentation of appropriate postpartum care.
6. A list is kept of all pregnancies and their outcomes.

⁴¹ NCCHC Standards, *supra* note 40, at 109-110.

⁴² APHA standards, in contrast, state: “Women prisoners must have access to family planning services, including abortion counseling and services on request.” APHA Standards, *supra* note 39.

⁴³ NCCHC Standards, *supra* note 40, at 61.

⁴⁴ *Id.*

⁴⁵ *Estelle v. Gamble*, 429 U.S. 97 (1976).

⁴⁶ *Id.* at 100 (citations omitted).

⁴⁷ *Id.* at 104-105; *See also Monmouth County Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 346 (3d Cir. 1987) (quoting *Westlake v. Lucas*, 537 F.2d 857, 860 (6th Cir. 1976)).

⁴⁸ *Monmouth*, 834 F.2d at 347.

⁴⁹ *Id.* at 346 (quoting *Westlake*, 537 F.2d at 860.).

⁵⁰ *Estelle*, 429 U.S. at 103-104.

⁵¹ NY Correct. Law § 611 (McKinney 2008) (relating to births to inmates of correctional institutions and care of children of inmates of correctional institutions).

⁵² *See Estelle*, 429 U.S. at 103-104. However, courts may be reluctant to spell out exactly what correctional facilities must do. *See also Women Prisoners of the D.C. Dep’t of Corr. v. District of Columbia*, 877 F. Supp. 634 (D.D.C. 1994) (*Women Prisoners I*). Women inmates in a number of correctional facilities in the District of Columbia filed a class action lawsuit challenging a number of conditions of confinement, including the inadequacy of health care specific to women. The court found that the facilities had violated the inmate’s equal protection rights as well as violated their Eighth Amendment rights. The court ordered broad relief for the women inmates, and directed the facility to take specific measures to provide women inmates with obstetrical and gynecological care, including establishing a prenatal clinic, hiring additional staff, implementing health screens and regular gynecological

examinations specifically for female inmates that include pelvic and breast examinations, pap tests, gonorrhea cultures, education in contraception and mammography for high risk women, and routine prenatal care. *Women Prisoners of the D.C. Dep't of Corr. v. District of Columbia*, 877 F. Supp. 634, *vacated in part, modified in part by Women Prisoners of the D.C. Dep't of Corr. v. District of Columbia*, 899 F. Supp. 659 (D.D.C. 1995) (*Women Prisoners II*). On appeal, the Court of Appeals for the D.C. Circuit invalidated the lower court's order, finding that the lower court's order was unduly intrusive and exceeded its authority by exercising pendant jurisdiction over local law claims. The Court of Appeals in that case stated that: "These may all be highly desirable measures, but the Supreme Court has repeatedly warned against such detailed marching orders." *Women Prisoners of the D.C. Dep't of Corr. v. District of Columbia*, 93 F.3d 910, 923 (D.C. Cir. 1996) (*Women Prisoners III*).

⁵³ New York State mandates that a hospital that treats a victim of rape promptly provide the victim written information about emergency contraception (EC), orally inform such patients about the availability and efficacy of EC, and provide EC to the patient, if requested, unless contraindicated. N.Y. Pub. Health Law § 2805-p(2) (McKinney 2008). Additionally, the fact that the U.S. Department of Health and Human Services recommends that all victims of sexual assault be administered prophylaxis for sexually transmitted infections would also be relevant to a determination of whether the facility met constitutional standards for provision of medical care. Dawn K. Smith, et al., *Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services*, Morbidity & Mortality Wkly Rep. Vol. 54 (RR02), at 12-13 (Jan. 21, 2005), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm>

⁵⁴ See *Monmouth*, 834 F.2d at 349; but see *Roe v. Crawford*, No. 06-3108, 2008 WL 187513 (8th Cir. Jan. 22, 2008); *Victoria W. v. Carpenter*, 369 F.3d 475 (5th Cir. 2004).

⁵⁵ *Monmouth*, 834 F.2d at 349.

⁵⁶ *Id.* (quoting *Roe v. Wade*, 410 U.S. 113, 153 (1973)).

⁵⁷ Domestic and international human and civil rights advocacy organization have paid considerable attention to the use of restraints on pregnant women. An extensive report issued by Amnesty International found that thirty-eight state departments of corrections, including New York, and the Federal Bureau of Prisons may use restraints on pregnant women in the third trimester. See Amnesty International, *Key Findings: Use of Restraints on Pregnant Women in Custody*, http://www.amnestyusa.org/Abuse_of_Women_in_Custody/Key_Findings_Use_of_Restraints_on_Pregnant_Women_in_Custody/page.do?id=1108300&n1=3&n2=39&n3=720, (Amnesty Report) (last visited Sept. 12, 2007). See also Roxanne Nelson, *AJN Reports: Laboring in Chains: Shackling Pregnant Inmates, Even During Childbirth, Still Happens*, 106(10) Am. J. Nursing 25 (Oct. 2006); Adam Liptak, *Prisons Often Shackle Pregnant Inmates in Labor*, N.Y. Times, Mar. 2, 2006, at A16. According to Amnesty International, only six correctional departments have written policies prohibiting use of restraints on inmates during labor and birth (Connecticut, DC, Florida, Rhode Island, Washington and Wyoming); Hawaii, Iowa and Kansas reported they have no policy but that practice is not to restrain women during labor and birth; Alabama, California, Missouri, Montana, New Mexico, New York, South Dakota and Texas do not use restraints during labor and delivery, but it was unclear if this was based on policy or practice. In addition, the report found that twenty-four state departments of corrections, including New York, require that an officer be present in the delivery room while an inmate is in labor. Some departments, including New York, require the officer to be female. N.Y. Correct. Law § 605-a ("Whenever any female inmate is conveyed to an institution in the state department of correction pursuant to sentence or commitment, such female inmate shall be accompanied by at least one female officer.") Amnesty International's report did not examine the practice in county jails.

⁵⁸ *Women Prisoners of the D.C. Dep't of Corr. v. District of Columbia*, 877 F. Supp. 634, 646 (1994), *vacated in part and modified in part by Women Prisoners of D.C. Dep't of Corr. v. District of Columbia*, 899 F. Supp. 659 (D.D.C. Aug 14, 1995) (subsequent decision did not affect the judgment on shackling). The court's order stated that:

The Defendants shall develop and implement a protocol concerning restraints used on pregnant and postpartum women which provides that a pregnant prisoner shall be transported in the least restrictive way possible consistent with legitimate security reasons. Specifically, the protocol shall provide:

- a. The Defendants shall use no restraints on any woman in labor, during delivery, or in recovery immediately after delivery.
- b. During the last trimester of pregnancy up until labor, the Defendants shall use only leg shackles when transporting a pregnant woman prisoner unless the woman has demonstrated a history of assaultive behavior or has escaped from a correctional facility.

⁵⁹ Stipulation and Order of Settlement in *Reynolds v. Sielaff*, 81 Civ 107 para. 85 (S.D.N.Y. 1990). The mandate of the court order is reflected in City of New York, Department of Corrections Directive 4202, “Placement of Mechanical Security Restraints on Outposted Inmate Patients” (1990). Both of these documents are on file with the NYCLU. The settlement order states that:

DOC will not place mechanical restraints on an outposted inmates where a doctor determines that the inmate: (1) is pregnant and is admitted for delivery of the baby . . . or (4) where the use of mechanical restraints is medically contraindicated. Inmates in these categories will not be shackled when in bed, or when out of bed to ambulate, unless the inmate while at the hospital has attempted to escape or has engaged in violent behavior which presents a danger of injury.

. . .

For all other inmates, DOC will not routinely use mechanical restraints but will decide whether to use [them] on a case-by-base basis, following a review of the inmate’s medical condition and security status . . .

and must consider whether the inmate can ambulate; the seriousness of the charge (felony vs. misdemeanor); the nature of the charge (violent or non-violent); bail or remand status; infraction history; time remaining; parole status; prior criminal history; and the likelihood of escape given the circumstances.

The order applies to inmates in a facility with a hospital prison ward, but for those who are in a purely civilian hospital, the officer must request approval to use restraints under these circumstances. At least at the facility housing inmates from New York City’s five boroughs, health care standards set by the Board of Correction state that inmates should be placed in restraints only if other means are insufficient to ensure the safety of others. *Restraint Policy Changed For Pregnant Inmates*, N.Y. Times, Apr. 16, 1999, at B4. Despite the court order, women at Rikers Island continued to report that shackles were used on them:

One woman reported that her left leg was shackled to the bed and her hands were cuffed together so that she could not reach the call button; she gave birth alone in the middle of the night, with nurses and a doctor arriving a few minutes later. Following advocacy efforts and media exposure, the city promised to change its policy, evaluating each woman individually to determine whether she poses a security risk and requires more than a guard posted outside her door.

Rachel Roth, *Justice Denied: Violations of Women’s Reproductive Rights in the United States Prison System*, Ibis Reproductive Health, Cambridge, Mass., (Sept. 2004), http://www.prochoiceforum.org.uk/psy_ocr10.asp (citing Nina Siegal, *Inmates Again Shackled During Birth, Critics Say*, N.Y. Times, Apr. 11, 1999, at 1:33).

⁶⁰ *Roe v. Wade*, 410 U.S. 113 (1973).

⁶¹ *Gonzales v. Carhart*, 127 S. Ct. 1610, 1626 (2007) (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 879 (1992)).

⁶² *Id.* at 1626-27 (quoting *Casey*, 505 U.S. at 878).

⁶³ N.Y. Penal Law § 125.05(3)(b) (McKinney 2008). The New York State Department of Health has interpreted “commencement of pregnancy” as occurring two weeks after the first day of the woman’s last menstrual period (LMP). Letter from Peter J. Millock, Gen. Counsel, New York State Dep’t of Health, to Elizabeth M. Navarra, Am. Med. Services 1 (Aug. 11, 1993) (on file with NYCLU). Therefore, abortions are legal in New York when performed up to 26 weeks LMP (i.e., 24 weeks from conception).

⁶⁴ N.Y. Penal Law § 125.05(3)(a) (McKinney 2004).

⁶⁵ The United States Supreme Court has ruled that any outright state ban on post-viability abortions must contain an exception for abortions necessary to preserve the life or health of the woman. *Roe v. Wade*, 410 U.S. at 164-65; *Casey*, 505 U.S. at 846. There is some confusion on this issue because although New York’s abortion law explicitly provides an exception for the life of the woman, N.Y. Penal Law § 125.05(3)(a), it does not contain an exception to preserve the woman’s health. However, according to Supreme Court precedent, such an exception must be read into New York’s abortion law in order for it to be permissible under the United States Constitution. *Roe*, 410 U.S. at 164-165 (“For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”); *Casey*, 505 U.S. at 846 (holding that a state has the “power

to restrict abortion after fetal viability, if the law contains exceptions for pregnancies which endanger a woman's life or health"). This means that if continuation of a pregnancy poses risk to a woman's life or her health, abortion is permitted, even after 24 weeks following conception/26 weeks LMP. The Supreme Court's recent decision in *Gonzales v. Carhart*, 127 S. Ct. 1610 (2007), upholding the federal ban on one type of late-term abortion does not change this result because it concerned a ban on a particular set of steps used in performing abortions, not an outright ban on all abortions after a certain point.

⁶⁶ A state's right to ban post-viability abortion stems from its interest in protecting potential life. *Roe*, 410 U.S. at 163-164; *Casey*, 505 U.S. at 846. Therefore, it is a fetus' viability that determines when a state may impose a ban on abortion, with the exception for the life or health of the woman. *Casey*, 505 U.S. at 846. Where a fetus will never reach viability because of a biological anomaly that makes life outside of the womb impossible, a state has no interest in that potential life that would justify a blanket ban on abortion.

⁶⁷ See, e.g., *Bryant v. Maffucci*, 923 F.2d 979, 982-85 (2d Cir. 1991); *Crawford*, 2008 WL 187513, at *4; *Monmouth County Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326 (3d Cir. 1987); *Roe v. Leis*, No. C-1-00-651, 2001 WL 1842459 (S.D. Ohio Jan. 10, 2001); *Doe v. Barron*, 92 F. Supp. 2d 694 (S.D. Ohio 1999); *Doe v. Arpaio*, 150 P.3d 1258 (Ariz. Ct. App. 2007); *Victoria W. v. Larpenter*, 369 F.3d 475 (5th Cir. 2004).

⁶⁸ See, e.g., *Monmouth*, 834 F.2d at 351.

⁶⁹ *Turner v. Safely*, 482 U.S. 78 (1987). Courts have not, however, evaluated such policies by using the "undue burden" test first announced by Justice O'Connor in her dissent in *Akron v. Akron Ctr for Reprod. Health*, 462 U.S. 416 (1983), and adopted by *Planned Parenthood v. Casey*, 505 U.S. 833, 877 (1992). See e.g., *Crawford*, 2008 WL 187513, at *2. In the context of incarceration, a determination of whether a burden on a constitutional right is "due" is evaluated by looking to the penological interests of the facility, which is the *Turner* test.

⁷⁰ *Turner*, 482 U.S. at 89 (quoting *Block v. Rutherford*, 468 U.S. 576, 586 (1984)).

⁷¹ *Id.* at 90.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ See, e.g., *Crawford*, 2008 WL 187513 (holding correctional facility restriction prohibiting access to nontherapeutic abortion as a violation of the 14th Amendment under *Turner*); *Monmouth*, 834 F.2d at 342; *Arpaio*, 150 P.3d 1258 (affirming lower court's holding that policy requiring court order for non-therapeutic abortions violated inmate's constitutional rights); *Leis*, 2001 U.S. Dist. LEXIS 4348, at *10 (issuing injunction requiring county sheriff to provide inmate with access to abortion services); *Barron*, 92 F. Supp. 2d 694 (ordering director of correctional center to provide pregnant inmate with access to abortion services); *Ptaschnick v. Luzerne County Prison Bd.*, No. 3 CV-98-1887 (M.D. Penn. Nov. 20, 1998) (enjoining defendants from preventing inmate from obtaining an abortion). Cf. *Bryant v. Maffucci*, 923 F.2d 979, 986 (2d Cir. 1991) (finding no liability for prison officials for delaying inmate's abortion in part because the official prison policy provided for transportation from inmates to and from abortion facilities and "did not require pregnant inmates to receive permission either from the Department of Correction or from a court"). But see *Victoria W. v. Larpenter*, 369 F.3d 475 (5th Cir. 2004) (policy disallowing transports without a court order to outside facilities for "elective" care where such policies are applied equally to all forms of elective care survive constitutional scrutiny).

⁷⁵ *Monmouth*, 834 F.2d at 342 n.24; *Arpaio*, 150 P.3d 1258, 1267.

⁷⁶ Forty percent of New York counties have no abortion providers at all; however, a very small percentage (7 percent) of New York women reside in those counties. Guttmacher Institute, *State Facts About Abortion: New York 2* (2008), available at http://www.guttmacher.org/pubs/sfaa/new_york.html. Nationally, 67 percent of abortion providers perform some second trimester abortions, 20 percent perform abortions after 20 weeks, and 8 percent perform the procedure after 24 weeks. Guttmacher Institute, *In Brief: Facts on Induced Abortion in the United States*, http://www.guttmacher.org/pubs/fb_induced_abortion.html#2 (last visited Feb. 8, 2008).

⁷⁷ See *Monmouth*, 834 F.2d at 339. See also Willard Cates et al., *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Plan. Persp. 266 (1977) (declaring that a delay in obtaining an abortion increases the relative risk of morbidity); Linda A. Bartlett, et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729 (2004).

⁷⁸ N.Y. Correct. Law § 500-h (McKinney 2003) provides that:

1. 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.
2. Notwithstanding the provisions of subdivision one of this section, any county or the city of New York may, by local law, provide that such entity may be reimbursed for costs paid pursuant to subdivision one of this section from any third party coverage or indemnification carried by an inmate. Such third party coverage or indemnification shall first be applied against the total cost to the hospital or other provider . . .

There have been several attempts to amend this law to require non-indigent inmates to reimburse counties for their own medical care, but no such legislation has yet passed. *See, e.g.*, S.B. 1317, 230th Leg. Sess. (N.Y. 2007); S.B. 1066, 230th Leg. Sess. (N.Y. 2007); and A.B. 2190, 230th Leg. Sess. (N.Y. 2007). A county may seek reimbursement of the costs associated with the procedure from an inmate's third party health insurance to the extent that the insurance covers abortion. N.Y. Correct. Law § 500-h.

⁷⁹ *See infra* Section II.B.1.

⁸⁰ *See Monmouth*, 834 F.2d at 351; *but see Crawford*, 2008 WL 187513.

⁸¹ *Monmouth*, 834 F.2d at 351.

⁸² Medicaid is not a potential source of funding for abortions in New York because those who are incarcerated in correctional facilities are not eligible for Medicaid. N.Y. Soc. Serv. Law § 366(13)(c) (McKinney 2008).

⁸³ We sent FOIL requests to 57 of New York's 62 counties as Rikers Island, the jail facility in the New York City, houses inmates from all five of the city's counties: Kings County (Brooklyn), Richmond County (Staten Island), Bronx County (The Bronx), Queens County (Queens), and New York County (Manhattan). We treat New York City as a single county when quantifying the results of our FOIL request. There is more than one correctional facility in five counties (Erie, Monroe, Onondaga, Suffolk, and Westchester), hence, the earlier statement that women are held in more than 50 county jails throughout the state. Six counties responded to our FOIL request by stating that women are not housed in the county jail facility: Essex, Genesee, Hamilton, Livingston, Schuyler, and Seneca counties. At the time of publication, however, both Essex and Seneca counties had opened up facilities for women. Female inmates in particular are housed in counties different from those where they were convicted if their home counties do not have adequate facilities separate from the men's facilities to house women, or if there are so few female inmates that it makes more sense to pay other counties to house them rather than take up an entire wing of a county jail that could be used for more male inmates. Interview with Daniel Stewart, Comm'r, State Comm'n on Corr. in New York, N.Y. (Sept. 11, 2007). Schoharie County does not house women on a "long term basis," thus, this facility does not have "any policies for the treatment and care of the reproductive health of women who are being held in custody." Letter from John Bates, Jr., Schoharie County Sheriff's Office, Schoharie, N.Y., to NYCLU (June 15, 2007) (on file with NYCLU). As a result, the findings described herein pertain to 51 counties and New York City.

⁸⁴ Several county facilities, in written correspondence, assured the NYCLU that inmates receive whatever treatment they need, and that referrals are made by the jail medical staff to appropriate care providers. *See* Letter from Kevin E. Hale, Jail Superintendent, Office of the Sheriff, County of Orleans, to NYCLU (June 28, 2007) (on file with NYCLU); Letter from John C. Gleason, Undersheriff, Records Access Officer, Office of the Sheriff, County of Yates, to NYCLU (June 20, 2007) (on file with NYCLU). Several counties responded that they had no written policies, but they sent letters from health care professionals working in the jail giving NYCLU information about what happens in practice.

⁸⁵ *See, e.g.*, Letter from Kevin E. Hale, Jail Superintendent, Office of the Sheriff, County of Orleans, to NYCLU (June 28, 2007) (on file with NYCLU).

⁸⁶ In letters to the NYCLU, two facility health care professionals did, however, state that female inmates were provided with regular gynecological care. The medical director in Cattaraugus County stated that "Whenever possible and appropriate, inmates continue to receive care from their personal care providers. This is especially true with respect to women's reproductive health." Letter from Peter Godfrey, M.D., Cattaraugus County Jail,

to NYCLU (Mar. 23, 2007) (on file with NYCLU). The facility in Cayuga County reports having “a good working relationship with two of our local OB. Doctors, one will continue to see his patients when incarcerated, the other will see new patients for us and also see patients for GYN care.” Letter from Carol Wallace, R.N., Cayuga County Sheriff’s Office, to NYCLU (July 23, 2007) (on file with NYCLU).

⁸⁷ See policies in Albany, Allegany, Cattaraugus, Clinton, Cortland, Dutchess, Erie, Fulton, Madison, Monroe, Montgomery, Nassau, New York City, Niagara, Onondaga, Orange, Oswego, Putnam, Saratoga, Schenectady, Suffolk, Ulster, Washington, and Westchester counties. Ontario County’s policies do not specifically address access to abortion, but the county’s policy on the care and treatment of pregnant inmates mentions the need for staff to arrange for out of county care for such necessary services as high risk pregnancies and “late term abortions.” All policies cited from here forward are on file with NYCLU.

⁸⁸ See policies in Albany, Cortland, Dutchess, Erie, Madison, Monroe, New York City, Niagara, Onondaga, Putnam, Schenectady, Ulster, and Westchester counties. This determination is made on the basis of an overall evaluation of the counties’ policies taking into consideration (1) the existence of a specific policy on access to abortion; (2) the inclusion of referral procedures in the county’s policies; (3) any language that appears to allow jail officials the discretion in determining whether to grant an inmate’s request for abortion services; and (4) whether there is any language about elective procedures that requires special approval and that could be applied to abortion services; and (5) who is required to bear the cost of the procedure.

⁸⁹ See policies in Albany, Allegany, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Fulton, Madison, Monroe, Montgomery, Nassau, New York City, Niagara, Oneida, Ontario, Orange, Oswego, Putnam, Rensselaer, Saratoga, Schenectady, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Washington, and Westchester counties.

⁹⁰ See policies in Cattaraugus, Cayuga, Onondaga, Oswego, and Washington counties.

⁹¹ See policies in Erie, New York City, and Ulster counties.

⁹² See policies in Allegany, Cattaraugus, Cayuga, Montgomery, Nassau, New York City, Oneida, Ontario, Oswego, Schenectady, and Wayne counties.

⁹³ New York City has a written policy that offers routine testing to women admitted to its facility; Niagara County’s policy provides for access to STD (sexually transmitted diseases) clinics for “prostitutes;” Oneida County has a detailed policy on treatment for STIs; and Washington County refers women who test positive for STIs to Planned Parenthood for treatment.

⁹⁴ Albany County had its own policy on the treating HIV positive inmates; Cayuga County’s policy stated that if the facility does not have the capacity to care for an HIV positive inmate, other arrangements for care in the community will be made; Clinton, Fulton, and Montgomery Counties provided that an HIV positive inmate will continue to receive the treatment regimen she was receiving prior to incarceration (Montgomery County’s policy also provided that an HIV positive inmate will be treated as per the “community standard of care”); Madison County’s policy stated that the facility will provide care in accordance with New York State Minimum Standards Part 7064 (which deals only with exposure to HIV, and confidentiality in testing and treatment, *see* 9 N.Y.C.R.R. §§ 7064.1 et seq. (2008)); Jefferson, Nassau, and Ontario counties relied on NCCHC standards; Orange County specified that HIV positive inmates will be treated as per “current disease management guidelines;” Putnam County’s policy cited “national clinical practice guidelines;” Steuben County’s policy referenced Section 611 of the New York State Corrections Law (which deals only with births to inmates confined to correctional facilities and has nothing to do with HIV); Suffolk County’s policy referenced U.S. Department of Health standards; and Ulster County’s policy provided that HIV positive inmates will receive “medically indicated care.”

⁹⁵ See policies in Monroe, New York City, Niagara, St. Lawrence, Schenectady (for pregnant women only); and Westchester counties.

⁹⁶ See policies in Albany, New York City, Niagara, Onondaga, Orange, Otsego, Putnam, and Suffolk counties.

⁹⁷ There is no statutory definition of a public benefit corporation under New York Law, but they are created by statute. For example, Nassau Health Care Corporation was created by “to provide health care services and health facilities for the benefit of the residents of the state of New York and the county of Nassau, including to persons in need of health care services without the ability to pay as required by law.” N.Y. Pub. Auth. Law § 3401 (McKinney 2008).

⁹⁸ See *supra* section III.B for a discussion of which facilities contract out the provision of medical services to inmates.

⁹⁹ Compare, e.g., the policies of Albany County with the policies in Orange County regarding who bears the cost of abortion services. Both contract with CMS to provide medical services, but in Albany County, the facility bears the cost of the procedure, while in Orange County, the inmate bears the cost.

¹⁰⁰ See, e.g., Courtney Gross, *Barred Medicine: Health Care on Rikers Island*, Gotham Gazette, Feb. 11, 2008, available at <http://www.gothamgazette.com/article/issueoftheweek/20080211/200/2427>; Paul von Zielbauer, *As Health Care in Jails Goes Private, 10 Days Can Be a Death Sentence*, N.Y. Times, Feb. 27, 2005, at 1:1; William Allen & Kim Bell, *Death, Neglect and the Bottom Line Push to Cut Costs Poses Risks*, St. Louis Post-Dispatch, Sept. 27, 1998, at G1.

¹⁰¹ It appears, for example, that at least one private health care company considers itself exempt from requirements that apply to governmental entities. Correctional Medical Services (CMS) responded to our FOIL request by stating that: “CMS is a private corporation; as CMS does not meet the definition of the term ‘agency,’ it is not subject to this law.” Letter from Todd Aschbacher, Assoc. Gen. Counsel, Corr. Med. Servs, to James Campbell, Albany County Sheriff (Apr. 9, 2007) (on file with NYCLU).

CMS also opposed disclosing the policies and procedures it uses in the Albany County Jail which address the care and treatment of female patients by maintaining that they were proprietary and constituted trade secrets. *Id.* The company ultimately withdrew its objection to disclosure in this particular case and turned over its Albany County policies, but only because another county that contracts with CMS sent NYCLU its policies without sending the request through the company. CMS, however, maintains that its policies and procedures manual as a whole is “proprietary,” and “entitled to trade secret protection.” Whether this is, in fact, the case is the subject of ongoing litigation in another state. See *ACLU of Delaware v. Danberg*, 2007 WL 901592 (Del. Super. Mar. 15, 2007) (challenge to CMS objections to ACLU request for information pursuant to FOIA request).

¹⁰² The two counties that actually had policies that are as comprehensive as their titles suggest were Clinton and Fulton Counties. Clinton County jail has a policy entitled “Health Care for Female Inmates” that contains the facility’s entire set of procedures for dealing with sexual and reproductive health care, including OB/GYN services, birth control, prenatal care, delivery, child custody, abortion, and health education. Fulton County Correctional Facility has a policy titled “Health Care for Female Inmates,” which provides that “all necessary specialized health care services for female inmates that may be required consistent with standards of contemporary community health care as determined by the facility Medical Director.”

¹⁰³ Saratoga County Sheriff’s Office, Corrections Division, Essential Services, Policy and Procedures, Policy No. CD 09-02-21, “Health Care—Female Medical Care.” (on file with NYCLU).

¹⁰⁴ *Id.*

¹⁰⁵ Public Health Manual, *supra* note 10, at 80.

¹⁰⁶ NCCHC Standards, *supra* note 40, at 233; BJS Statistics 2006, *supra* note 3.

¹⁰⁷ NCCHC Standards, *supra* note 40, at 234.

¹⁰⁸ ACOG Guidelines, *supra* note 9, at 94-95; APHA Standards, *supra* note 39, at 107-108; NCCHC Standards, *supra* note 40, at 233-234.

¹⁰⁹ ACOG Guidelines, *supra* note 9, at 94-95; APHA Standards, *supra* note 39, at 107-108; NCCHC Standards, *supra* note 40, at 233-234.

¹¹⁰ In some counties, routine gynecological care is provided either at the facility or in the community, but not pursuant to written policy. For example, officials from New York City’s Department of Health told NYCLU that women are offered routine pelvic and breast examinations. Interview with Louise Cohen, Deputy Commissioner Division of Health Care Access and Improvement, N.Y.C. Dep’t of Health & Mental Hygiene, Feb. 29, 2008.

¹¹¹ Public Health Manual, *supra* note 10.

¹¹² ACOG Guidelines, *supra* note 9.

¹¹³ APHA Standards, *supra* note 39.

¹¹⁴ NCCHC Standards, *supra* note 40, at 235; ACOG Guidelines, *supra* note 9, at 93; APHA Standards, *supra* note 39, at 107-108; Public Health Manual, *supra* note 10, at 35, 42.

¹¹⁵ NCCHC Standards, *supra* note 40, at 235-236; ACOG Guidelines, *supra* note 9, at 93; APHA Standards, *supra* note 39, at 107; Public Health Manual, *supra* note 10, at 36.

¹¹⁶ MayoClinic.com, *Birth Control Pill FAQ: Benefits, Risks and Choices*, available at <http://www.mayoclinic.com/health/birth-control-pill/W000098> (last visited Jan. 19, 2008). Hormonal birth control methods, the administration of which could be affected by periods of incarceration, include oral contraceptives (“the pill”), injectable progestins which are given once every three months (Depo Provera), see U.S. Food and Drug Administration (FDA), *Protecting Against Unintended Pregnancy: A Guide to Contraceptive Choices* (June 2000), available at http://www.fda.gov/fdac/features/1997/397_baby.html; a transdermal patch which must be changed weekly (“the Patch”), see FDA, *FDA Approves First Hormonal Contraceptive Skin Patch* (Nov. 20, 2001), available at <http://www.fda.gov/bbs/topics/ANSWERS/2001/ANS01119.html>; and the vaginal contraceptive ring, which is kept in the vagina for three weeks, and taken out for one week. See FDA Office of Women’s Health, *Birth Control Guide 14* (2007), available at <http://www.fda.gov/womens/healthinformation/birthcontrolguide.pdf>.

¹¹⁷ Population Information Program, Center for Communication Programs, The Johns Hopkins School of Public Health, *Helping Women Use the Pill*, 28(2) (Series A, Number 10, Oral Contraceptives, Population) Repts. 1 (Summer 2000), available at <http://www.infoforhealth.org/pr/a10edsum.shtml>.

¹¹⁸ APHA Standards, *supra* note 39, at 87.

¹¹⁹ National Cancer Institute, *Oral Contraceptives and Cancer Risk: Questions and Answers* (2006), available at <http://www.cancer.gov/cancertopics/factsheet/Risk/oral-contraceptives> 3.

¹²⁰ American College of Obstetricians and Gynecologists, *Endometriosis* (2001), available at http://www.acog.org/publications/patient_education/bp013.cfm.

¹²¹ American Academy of Family Physicians, *Perimenopausal Women and the Use of Very-Low-Dose Birth Control Pills* (2008), available at <http://familydoctor.org/online/famdocen/home/women/reproductive/menopause/326.html>.

¹²² Population Information Program, *supra* note 117.

¹²³ Over 1500 victims reported incidents of sexual violence in local jails during 2006 alone, a marked increase over the previous year. Allen J. Beck et al., *Bureau of Justice Statistics, Special Report: Sexual Violence Reported by Correctional Authorities, 2006* 3 (2007). Approximately 18 percent of these incidents involved female victims. *Id.* In recognition of this reality, the APHA has recommended that “[b]oth men and women should be provided with condoms for HIV protection.” APHA Standards, *supra* note 39, at 87. See also ACLU, *Condom Availability in Prisons: Position Statement* (on file with NYCLU) (recommending “condoms and other barrier methods be made available to prisoners to prevent disease transmission in correctional facilities [and] prior to release.”) The National Commission on Correctional Healthcare, the United Nations Joint Program on HIV/AIDS, and the World Health Organization recommend providing access to condoms in correctional facilities in order to prevent the spread of disease, but do not specify whether condoms should be made available to both men and women. See NCCHC Standards, *supra* note 40, at 189, 233; World Health Organization, United Nations Office of Drug Control, and UNAIDS, *Effectiveness of Interventions to Manage HIV in Prisons –Provision of Condoms and Other Measures to Decrease Sexual Transmission* 12 (2007), available at http://www.who.int/hiv/idu/Prisons_condoms.pdf. These organizations do note, however, the particular vulnerability of female inmates to disease and assault.

¹²⁴ Emergency Contraception (EC), also known as postcoital contraception, “Plan B™” (the brand name of a commercially available emergency contraception medication produced by Duramed, a subsidiary of Barr Pharmaceuticals, Inc.), or “the morning after pill,” is a drug that can prevent a pregnancy from occurring if taken following an act of sexual intercourse in which a contraceptive method was used but failed, unplanned sexual intercourse, sexual assault, and/or intercourse in which no birth control method was used. David Weismiller, *Emergency Contraception*, 70 Am. Fam. Physician 707, 707 (2004). EC consists of the same hormones found in ordinary birth control pills, but is taken in a concentrated dose. *Id.* at 709 (citing David A. Grimes & Elizabeth G. Raymond, *Emergency Contraception*, 137 Annals of Internal Med. E-180, E-183 (2002)). The form of EC that is approved for prescription use in the United States by the Food and Drug Administration is known as Plan B, which consists of the contraceptive drug Levonorgestrel in tablet form. See Carton Text, *Plan B*, available at <http://www.fda.gov/cder/foi/label/1999/21045lbl.pdf> (package label) (last visited Dec. 7, 2007). See also Kristina Gemzell-Danielsson & L. Marions, *Mechanisms of Action of Mifepristone and Levonorgestrel When Used for Emergency Contraception*, 10 Human Reprod. Update 341 (2004); H.B. Croxatto et al., *Pituitary–Ovarian Function Following the Standard Levonorgestrel Emergency Contraceptive Dose or a Single 0.75-mg Dose Given on the Days Preceding Ovulation*, 70 Contraception 442 (2004). Studies have found that EC is safe and effective, and

that it has no known medical contraindications aside from a confirmed pregnancy. EC does not interfere with an established pregnancy. World Health Organization, Division of Reproductive Health, *Emergency Contraception: A Guide for Service Delivery* 22-23 (1998). When taken within 72 hours of unprotected intercourse, EC reduces the risk of pregnancy by approximately 89 percent. See Carton Text, Plan B; Weismiller, 70 Am. Fam. Physician at 709; Grimes, 137 Annals of Internal Med. at E-183; Helena von Hertzen et al., *Low Dose Mifepristone and Two Regimens of Levonorgestrel for Emergency Contraception: a WHO Multicentre Randomised Trial*, 360 The Lancet 1803 (2002). Although EC can be effective in preventing pregnancy when used up to 120 hours after intercourse, it is most effective if taken within 12-24 hours of unprotected sex. *Id.*

¹²⁵ See Weismiller, *supra* note 124, at 709; Grimes, *supra* note 124, at E-183; von Hertzen, *supra* note 124, at 1803.

¹²⁶ The policy states that “[EC] services shall be made 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. Plan B shall be made available to patients who require EC services.” New York City Department of Health and Mental Hygiene, Correctional Health Services, Policy No. MED 29, “Emergency Contraception.” (on file with NYCLU).

¹²⁷ NYCLU did not ask any specific questions about access to ongoing hormonal contraception in the initial FOIL request because we were focused on access to medical services for pregnant women; however, our scope of inquiry evolved as we visited jail facilities, and grew to encompass pregnancy prevention. Some facilities sent policies on contraception and NYCLU staff asked corrections officials and health care providers in follow up interviews whether women were able to continue taking birth control medication.

¹²⁸ See, e.g., Letter from Carol Wallace, R.N., Cayuga County Sheriff’s Office, to NYCLU (July 23, 2007) (on file with NYCLU). Both Washington and Clinton counties also allow women to continue taking birth control medication at the discretion of the facility medical staff.

¹²⁹ Onondaga County Correctional Medical and Behavioral Health Services, Policy-Procedure Manual, Policy # 453.00, “Female Hormonal Therapy” (on file with NYCLU).

¹³⁰ Greenfeld & Snell, *supra* note 7, at 8, Tbl. 19 (1999).

¹³¹ *Id.*

¹³² See policies in Nassau, Oswego, Tioga, and Ulster counties.

¹³³ See policies in Cayuga, Chemung, Erie, and Sullivan counties. Sullivan County, however, does not administer pregnancy tests at the jail; instead, women who indicate that they may be pregnant are sent to a community-based provider for an evaluation.

¹³⁴ See policies in Onondaga County.

¹³⁵ U.S. Department of Health and Human Services, Maternal and Child Health Bureau, <http://mchb.hrsa.gov/programs/womeninfants/prenatal.htm> (last visited Mar. 3, 2008) (urging women to seek prenatal care for their health and that of their baby).

¹³⁶ *Id.* (babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care).

¹³⁷ ACOG Special Issues, *supra* note 8, at 89-97 (2005). However, courts that have evaluated claims by inmates alleging inadequate medical care during pregnancy have held that while facilities are required to provide prenatal care, it is not appropriate for courts to mandate specific types of care. See *Women Prisoners III*, 93 F. 3d 910(D.C. Cir. 1996) (invalidating lower court order of specific relief in 8th Amendment claim alleging inadequacy of health care for women inmates).

¹³⁸ ACOG Guidelines, *supra* note 9; ACOG Special Issues, *supra* note 8, at 92-94; Flavin, *supra* note 9.

¹³⁹ See policies in Albany, Allegany, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Fulton, Madison, Monroe, Montgomery, Nassau, New York City, Niagara, Oneida, Ontario, Orange, Oswego, Putnam, Rensselaer, Saratoga, Schenectady, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Washington and Westchester counties. Westchester’s policies provide the most detail of any of the county correctional facilities on the delivery of prenatal care.

¹⁴⁰ See policies in Cattaraugus, Cayuga, Onondaga, Oswego, Ulster, and Washington counties. One nurse told the NYCLU that “[i]f a female inmate is pregnant and her provider is local and willing to see her, we send her. Unfortunately, as soon as a patient starts wearing orange, often [providers] don’t want to see them.” Interview with Nancy Peck, RPN, Fulton County Jail, Johnstown, N.Y. (Sept. 27, 2007).

¹⁴¹ See policies in Onondaga County.

¹⁴² See Clinton County’s policy on “Medical Procedures Pregnant Inmates.” A description of New York State’s PCAP program can be found at <http://www.health.state.ny.us/nysdoh/perinatal/en/pcap.htm> (last visited Nov. 21, 2007).

¹⁴³ Pregnant women are defined as “special needs” inmates in Allegany, Dutchess, Nassau, Ontario, Oswego, Putnam, Schenectady, Tioga, Tompkins and Ulster counties.

¹⁴⁴ Colleen Kirkham, et al., *Evidence-Based Prenatal Care*, 71(7) *Am. Fam. Physician* 1307 (2005) (“Caregiver continuity during the antenatal period has been associated with reduced interventions in labor and improved maternal satisfaction.”), available at <http://www.aafp.org/afp/20050401/1307.html>.

¹⁴⁵ Although New York Corrections Law allows women to keep newborns with them in a correctional facility up to one year after birth, N.Y. Correct. Law § 611, few facilities actually allow women to do so. See discussion on this point, *supra* Section III.C.3.f.

¹⁴⁶ See policies in Allegany, Cattaraugus, Cayuga, Montgomery, Nassau, New York City, Oneida, Ontario, Oswego, Schenectady and Wayne counties.

¹⁴⁷ See, e.g., Letter from Peter Godfrey, M.D., Cattaraugus County Jail, to NYCLU (Mar. 28, 2007) (on file with NYCLU), Letter from A. Van Alstyne, RN, Columbia County Corr. Facility, to NYCLU (Mar. 21, 2007) (on file with NYCLU).

¹⁴⁸ Standard Minimum Rules for the Treatment of Prisoners, Rule 33, Office of the High Commissioner for Human Rights, U.N. Econ. & Soc. Council [ECOSOC] Res. 663 C (XXIV) (July 31, 1957), available at http://www.unhchr.ch/html/menu3/b/h_comp34.htm; see also discussion, *supra* Section II.B.1. For example, although no facilities specifically stated that they use “belly chains”—chains that secure around an inmates’ midsection—this type of restraint puts pressure on the woman’s abdomen and could result in harm to the woman and the fetus. American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care* 87 (6th ed. 2007); Amnesty International, *Pregnant and Imprisoned in the United States*, 27(4) *Birth Vol.* 266 (2000). Two states, California and Illinois, have laws specifically forbidding the shackling of pregnant women during labor. Cal. Penal Code § 5007.7 (West 2007) (“Pregnant inmates temporarily taken to a hospital outside the prison for the purposes of childbirth shall be transported in the least restrictive way possible, consistent with the legitimate security needs of each inmate. Upon arrival at the hospital, once the inmate has been declared by the attending physician to be in active labor, the inmate shall not be shackled by the wrists, ankles, or both, unless deemed necessary for the safety and security of the inmate, the staff, and the public.”); 730 Ill. Comp. Stat. 5/3-6-7 (2007) (“[N]o handcuffs, shackles, or restraints of any kind may be used during her transport to a medical facility for the purpose of delivering her baby. Under no circumstances may leg irons or shackles or waist shackles be used on any pregnant female committed person who is in labor.”). The New York Legislature has considered legislation that would forbid the use of restraints on pregnant women. S.6895/A.3804, 229th Leg. Sess. (N.Y. 2006). Information about the bill and its sponsor are available at http://www.nyssenate18.com/press_archive_story.asp?id=636; see also Adam Liptak, *Prisons Often Shackle Pregnant Inmates in Labor*, *N.Y. Times*, Mar. 2, 2006, at A16. Introduced in both the Assembly and the Senate in New York, but failing to ever reach a floor vote, the legislation prohibits the use of restraints of any kind—including handcuffs and shackles—on any pregnant female inmate who is in labor. During all other stages of pregnancy, handcuffs would only be permitted to restrain an inmate who poses a considerable flight risk.

¹⁴⁹ Physical restraints can include handcuffs, waist or belly chains, and leg irons or shackles.

¹⁵⁰ See policies in Erie, New York, and Ulster counties.

¹⁵¹ In Erie County, pregnant inmates who are in labor are cuffed and shackled in the ambulance on the way to the hospital. Erie County Office of the Sheriff, Policy and Procedure, Policy # JMD 10.02.02 (on file with NYCLU). During labor and delivery, “cuffs and shackles may be removed so as not to impede the medical treatment being rendered.” In addition the policy manual states that following delivery, “[t]he inmate will remain cuffed, one hand, to the bed (reasonableness would allow for the cuffs to be alternated between arms and, at times, the ankle cuffed

when both hands are needed, i.e., meals, when the baby is i[n] the room). However, the cuffs may be removed when the inmate must use the bathroom facilities, or when a medical treatment requires their removal.”

¹⁵² New York City’s policies specify that shackles are never used during labor, and pregnant inmates are to be handcuffed in the front, never with their hands behind their backs; Ulster County’s policies provide that the use of pepper spray, handcuffs, and leg shackles are inappropriate for pregnant inmates.

¹⁵³ The City of New York, Department of Correction, Rose M. Singer Center, Command Level Order No. S15/04, Restraint Status for Transporting/Escorting Pregnant Inmates (on file with NYCLU).

¹⁵⁴ *Id.* There is a contradiction in Command Level Order No. S15/04, however, as the policy states that an inmate “shall only be handcuffed in the front when being transported to an outside medical facility for care or to delivery [sic].” The policy makes clear, however, elsewhere that pregnant inmates being transported for delivery are not to be restrained at all, and a subsequent Command Level Order described herein repeats this prohibition.

¹⁵⁵ The City of New York, Department of Correction, Rose M. Singer Center, Command Level Order No. 59/05. “Physical Restraints Used on Pregnant Inmates” (on file with NYCLU).

¹⁵⁶ The doctor from the Cattaraugus County facility told the NYCLU in a letter that the facility has not yet had “an inmate go into labor while incarcerated, but if this happens we would not employ restraints during labor.” Letter from Peter Godfrey, M.D., Cattaraugus County Jail, to NYCLU (Mar. 28, 2007) (on file with NYCLU).

¹⁵⁷ Letter from Julie Beecher, Supervisory Nurse, Washington County Jail, to NYCLU (June 26, 2007) (on file with NYCLU).

¹⁵⁸ NY Correct. Law § 611.

¹⁵⁹ March of Dimes, Pregnancy & Newborn Health Education Center, *Giving Birth*, available at http://www.marchofdimes.com/pnhec/240_1034.asp (last visited Feb. 5, 2008).

¹⁶⁰ Memorandum on the “Care of pregnant inmates and newborn children” from Brian Callahan, Counsel, SCOC, to Daniel J. Stewart, Chairman, New York State Comm’n of Corr. (Apr. 25, 2007) (on file with NYCLU), available at http://www.scoc.state.ny.us/pdfdocs/chair2007_5word.pdf.

¹⁶¹ Am. Med. Ass’n, Council on Scientific Affairs, *Bonding Programs for Women Prisoners and their Newborn Children*, Report 3, available at <http://www.ama-assn.org/ama/pub/category/13656.html> (last visited Feb. 12, 2008); see generally, Jeannette Crenshaw et al., *No Separation of Mother and Baby with Unlimited Opportunity for Breastfeeding*, 13(2) J. Perinat. Educ. 35 (2004), available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1599795>. See also generally Marshall H. Klaus & John H. Kennell, *Parent-Infant Bonding* (2nd ed. 1982) (discussing an important bonding period in the first days and weeks after delivery).

¹⁶² Angelina N. Chambers, *Maternal-Infant Bonding & Attachment in Incarcerated Postpartum Women* 1 (Dec. 2006) (Ph.D. dissertation, University of Texas Graduate School of Biomedical Sciences at Galveston) (on file with NYCLU) available at <http://ezproxy.library.nyu.edu:2082/pqdweb?index=17&sid=1&srchmode=1&vinst=PROD&fmt=6&startpage=-1&clientid=9269&vname=PQD&RQT=309&did=1251875561&scaling=FULL&ts=1202493831&vtpe=PQD&rqt=309&TS=1202493850&clientId=9269>.

¹⁶³ The vast majority of jail inmates are released in under a year. Only 11 percent of violent offenders and 5 percent of non-violent offenders remain in jail for a year or more; and women make up only 17 percent of the violent offenders in jail. Bureau of Justice Statistics, *Special Report: Profile of Jail Inmates, 2002* 4, Tbl. 4 (2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/pji02.pdf>.

¹⁶⁴ Bedford Hills Correctional Facility in New York offers parenting classes as part of its prison nursery. Linda Wertheimer, NPR Weekend Edition, *Prenatal Care Behind Bars* (Nov. 5, 2005), available at <http://www.npr.org/templates/story/story.php?storyId=4990886>.

¹⁶⁵ See, e.g., Janet Leban, *Mothers in Prison Need their Kids: Fostering Bonds Helps Women Go Straight and Can Keep Lost Children Out of Court*, The News Journal (Delaware), Oct. 7, 2001; Susan Hoffman Fishman & Albert S. Alissi, *Strengthening Families as Natural Support System for Offenders*, 43 Fed. Probation 16 (Sept. 1979); Norman Holt & Donald Miller, *Explorations in Inmates Family Relationships*, Research Div., CA Dep’t of Corrections Rep. 46 (1972), available at <http://www.fcnetwork.org/reading/holt-miller/holt-millersum.html>.

¹⁶⁶ See N.Y. Correct. Law § 611(2); *Apgar v. Eatuer*, 347 N.Y.S.2d 872, 876 (1973) (holding that county jail did not

have absolute discretion to separate a mother and newborn child, and that jail officials had burden of demonstrating infant would not be served by returning it to jail with inmate-mother). *But see Bailey v. Lombard*, 420 N.Y.S.2d 650 (1979) (suggesting that jail administrators must take into account a number of factors including parenting background of mother, psychiatrist's reports, offense for which mother is serving sentence and length of sentence when determining whether to allow an infant to remain with his or her mother while she is incarcerated.)

¹⁶⁷ Clinton and Fulton counties both had policies that provided: "Inmates who give birth while in custody will be permitted to keep their infant in the facility with them for up to one year." The Washington County jail facility's nurse sent a letter to NYCLU in response to our FOIL request, and appended a memo to Daniel J. Stewart, Chairman, New York State Comm'n of Corr., from Brian M. Callahan, dated April 25, 2007 on the "Care of pregnant inmates and newborn children." The letter cites the Correction Law provision.

¹⁶⁸ Memorandum on the "Care of pregnant inmates and newborn children" from Brian Callahan, Counsel, SCOC, to Daniel J. Stewart, Chairman, New York State Comm'n of Corr. (Apr. 25, 2007) (on file with NYCLU), *available at* http://www.scoc.state.ny.us/pdfdocs/chair2007_5word.pdf.

¹⁶⁹ E-mail from Dori A. Lewis, Senior Supervising Attorney, Prisoners' Rights Project, Legal Aid Soc'y, to Corinne A. Carey, Staff Attorney, NYCLU (Jan. 25, 2008, 12:10 EST) (on file with NYCLU).

¹⁷⁰ *See Edghill v. State*, Claim No. 112986 (Ct. Claims, Westchester Cty, 2007). Advocates told the NYCLU about cases where jail administrators determined that women charged with using drugs during pregnancy or women who failed to care for their other children would not be "fit" mothers, and so declined to permit them to keep newborns with them. Lewis email, *supra* note 169.

¹⁷¹ Allowing incarcerated women to care for their children in the facility will foster a mother-child bond and prevent serious developmental problems that are associated with parental separation. Leda M. Pojman, *Cuffed Love: Do Prison Babies Ever Smile?*, 10 Buff. Women's L. J. 46 (2001-2002).

¹⁷² *See* Norman Holt & Donald Miller, *supra* note 165. Two health care providers in small, rural county jail facilities also described the positive effect that the entry of an infant into the facility has had on the morale of the entire jail. Telephone interview with Ellen Kirkpatrick, RN, St Lawrence County Jail, Aug. 28, 2007; Interview with Nancy Peck, RPN, Fulton County Jail, Sept. 27, 2007.

¹⁷³ *See* policies in Albany, Allegany, Cattaraugus, Clinton, Cortland, Dutchess, Erie, Fulton, Madison, Monroe, Montgomery, Nassau, New York City, Niagara, Onondaga, Orange, Oswego, Putnam, Saratoga, Schenectady, Suffolk, Ulster, Washington and Westchester counties. Ontario County's policies do not specifically address access to abortion, but the county's policy on the care and treatment of pregnant inmates mentions the need for staff to arrange for out of county care for such necessary services as high risk pregnancies and "late term abortions." Oneida County's policies make no mention of abortion specifically, but do require that inmates receive unspecified "counseling" in the context of prenatal care.

¹⁷⁴ *See* policies in Albany, Cortland, Dutchess, Erie, Madison, Monroe, New York City, Niagara, Onondaga, Putnam, Schenectady, Ulster and Westchester counties. This determination is made on the basis of an overall evaluation of the counties' policies taking into consideration (1) the existence of a specific policy on access to abortion, (2) the inclusion of referral procedures in the county's policies, (3) any language that appears to allow jail officials the discretion in determining whether to grant an inmate's request for abortion services, and (4) whether there is any language about elective procedures that require special approval and that could be applied to abortion services. Some jail administrators in facilities which had no policies on access to abortion confirmed either in interviews or in written correspondence that the facility honors requests for abortions from female inmates. Letter from Captain Patrick A. Johnson, Warden, Chautauqua County Sheriff's Office, to NYCLU (June 27, 2007) (on file with NYCLU); Telephone interview with Bonnie Dallas, LPN, Columbia County Corr. Facility (Sept. 10, 2007). The facility has arranged for appointments for abortion, and the facility has never experienced any problem with this procedure.

¹⁷⁵ *See* policies in Cortland, Dutchess, Madison, New York City, Niagara and Onondaga counties.

¹⁷⁶ *See* policies in Clinton, Fulton, Montgomery, Nassau, Saratoga and Washington counties.

¹⁷⁷ Suffolk counties policies are unclear on this point, as they require final approval from facility staff before scheduling certain elective procedures, which are listed on a form "Procedures Which Require Special Consent" attached to the policy. Abortion is not specifically mentioned, but could certainly be interpreted as an "elective procedure" under the category "other," which is included on the form.

¹⁷⁸ Oswego County Correctional Facility, Medical Policy and Procedures, Section 10, Medical Services, Subject 10, Inmate Pregnancy, subsection (7) (on file with NYCLU). The NYCLU spoke with Oswego County's jail administrator, Mike Stafford, to see how the facility's policy operates in practice, whether the facility had ever handled a request for an inmate abortion, and what the result was. Stafford explained that in the seven years he had been with the institution, the jail had received two requests from inmates for abortion procedures, and both were granted. Telephone interview with Mike Stafford, Jail Adm'r, Oswego County Correctional Facility (Sept. 13, 2007). He told the NYCLU that the first request he handled came to him on his first day on the job. He initially thought that the facility would not grant the request, but learned from a colleague that in response to a past request, the facility had asked the County Attorney for an opinion, which directed the facility to assist the woman in obtaining the procedure. Stafford told the NYCLU that the jail relies on that initial opinion and does not seek outside counsel on a case by case basis unless there are, as he put it, "extenuating circumstances." He added, however, that he did not know what those might be. Both of the women who had requested abortion procedures while incarcerated in Oswego had been facing years' long state sentences, and so the NYCLU asked the administrator what would happen if a woman who was serving a much shorter sentence, or who was being held pending trial or release on bail, had made the same request. He acknowledged that the length of the sentence might be taken into account. He was clear to point out that no women in that situation had requested an abortion since their policies and procedures went into effect, but, he added, "If the doctor would say that there was a medical necessity or anything along that line," the request would be granted. Absent some kind of medical necessity as documented by the facility doctor, however, Stafford said that he would again seek the opinion of the County Attorney on the matter.

¹⁷⁹ Interview with Ceil Kohlmeyer, Nursing Coordinator, Health Dep't, Erie County Correctional Center, Buffalo, New York (Aug. 29, 2007).

¹⁸⁰ See *supra* section III.B.1.

¹⁸¹ Albany (prenatal care providers); Allegany (mental health staff); Cattaraugus (not specified); Cortland (facility health care staff); Dutchess (facility health care staff); Erie (facility physician & gynecologist); Monroe (facility health care staff); Montgomery (not specified); Nassau (not specified); New York City (facility health care staff); Niagara (not specified); Onondaga (Planned Parenthood staff); Orange (not specified); Putnam (OB/GYN provider); Schenectady (not specified); Suffolk (mental health staff); Ulster (obstetrician); and Westchester (not specified). Three additional counties offer, but do not require, counseling: Clinton, Fulton, and Washington.

¹⁸² See policies in Allegany, Clinton, Fulton and Washington counties.

¹⁸³ See policies in Allegany and Dutchess counties.

¹⁸⁴ National Abortion Federation, *2007 Clinical Policy Guidelines 3* (2007), available at http://www.prochoice.org/pubs_research/publications/downloads/professional_education/cpgs_2007.pdf.

¹⁸⁵ Interview with Anonymous, 2007. NYCLU has decided to withhold the name of this jail staff member, and several other jail staff that we interviewed, because their sentiments were similar to those expressed by other jail staff, and because the primary purpose of this report is to offer constructive recommendations, not shame officials that provided valuable information to us during the course of our research.

¹⁸⁶ See *supra* Section II.B.3.

¹⁸⁷ Five counties that did not specify in their policies and procedures who is responsible for costs associated with abortion services indicated in correspondence to the NYCLU that either the facility or the county bears the cost. Chautauqua (facility); Columbia (facility); New York City (city); Washington (the inmate does not pay); and Wayne (provided a letter from the New York State Sheriff's Association stating that it is likely that a court would not sanction a policy which prevented an inmate abortion because of her inability to pay). In an interview with the NYCLU, Fulton County jail officials indicated that the county would bear the cost of an inmate abortion; the facility's policies however are not so clear.

¹⁸⁸ Interview with Anonymous, 2007.

¹⁸⁹ Anne S. De Groot & Susan Cu Uvin, *HIV infection among Women in Prison: Considerations for Care*, Infectious Diseases in Corrections Report (May/June 2005), available at <http://www.idcronline.org/archives/mayjune05/article.html> ("[I]ncarcerated women are 15 times more likely to be HIV-infected compared to women in the general population."). See also ACOG Special Issues, *supra* note 8, at 89; Theodore M. Hammett, et al., *1996-1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities* 69 (US Dep't of Justice 1999), available at <http://www.ncjrs.gov/pdffiles1/176344.pdf>.

¹⁹⁰ U.S. Centers for Disease Control, *Assessment of Sexually Transmitted Diseases Services in City and County Jails -- United States, 1997* 47(21) Morbidity & Mortality Wkly. Rep. 429, 431 Tbl. 1 (1998), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00053078.htm>.

¹⁹¹ *Id.* Rates of chlamydia and gonorrhea among women incarcerated on Rikers Island in New York City are somewhat lower than this estimate. Of just over 12,036 women tested in 2007, 4.2 percent tested positive for chlamydia only, 1.1 percent for gonorrhea only, and .5 percent were co-infected. Email correspondence from Louise Cohen, Deputy Commissioner Division of Health Care Access and Improvement, New York City Dep't of Health & Mental Hygiene, to Corinne A. Carey, Staff Attorney, NYCLU (Feb. 28, 2008, 12:44EST)(on file with NYCLU). N.Y.C.

¹⁹² *Id.*

¹⁹³ Women in Prison Project, Correctional Association of New York, *Women Prisoners and HIV Fact Sheet* (2002), available at www.correctionalassociation.org/WIPP/publications/HIV_briefing_2006.pdf (citing New York City Department of Health, Bureau of Disease Intervention Services, *HIV Prevalence Update 1999* (2001)).

¹⁹⁴ Laura M. Manuschak, Bureau of Justice Statistics, *HIV in Prisons and Jails, 1999*, 9 Tbl. 8 (2001), available at <http://www.ojp.gov/bjs/pub/pdf/hivpj99.pdf>.

¹⁹⁵ Women in Prison Project, *supra* note 193.

¹⁹⁶ New York County has a written policy that offers routine testing to women admitted to its facility; Niagara County's policy provides for access to STD (sexually transmitted diseases) clinics for "prostitutes;" Oneida County has a detailed policy on treatment for STIs; and Washington County refers women who test positive for STIs to Planned Parenthood for treatment.

¹⁹⁷ *See supra* note 94.

¹⁹⁸ *See* policies in Monroe, New York, Niagara, St. Lawrence, Schenectady (for pregnant women only), and Westchester counties.

¹⁹⁹ *See* policies in Albany, New York, Niagara, Onondaga, Orange, Otsego, Putnam and Suffolk counties.

²⁰⁰ *See* policies in Chautauqua, Dutchess, Monroe, Nassau, Schenectady, Ulster (which specifically says that STI treatment is provided), and Westchester counties.

²⁰¹ *See* policies in Montgomery, Nassau, Oneida and Oswego counties.

²⁰² NCCHC, *supra* note 40, at 63; APHA, *supra* note 39, at 75-76; *see also* Public Health Manual, *supra* note 10, at 53.

²⁰³ Centers for Disease Control, *Sexually Transmitted Diseases Treatment Guidelines, 2006* 55 (RR-11) Morbidity & Mortality Wkly. Rpt. 1-94 (2006).

²⁰⁴ NCCHC, *supra* note 40, at 187.

²⁰⁵ APHA, *supra* note 39, at 67. *See* U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents* (2008), available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

²⁰⁶ Antiretroviral (ARV) therapy refers to the use of certain medications that inhibit HIV replication. New York State Department of Health AIDS Institute, HIV Clinical Resource, *Antiretroviral Therapy: August 2007 Update 1* (2007), available at <http://www.hivguidelines.org/Content.aspx>.

²⁰⁷ Non-occupational post-exposure prophylaxis (nPEP) is a course of treatment that currently includes a basic four-week regimen of two drugs for most HIV exposures, and an expanded regimen that includes the addition of a third drug for HIV exposures that pose an increased risk for transmission. Centers for Disease Control and Prevention, *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis*, 50 (RR-11) Morbidity & Mortality Wkly Rpt. 24-26 (2001), available at <http://www.cdc.gov/MMWR/preview/MMWRhtml/rr5011a1.htm>. Sexual assault where the assailant is HIV positive carries a higher degree of risk of transmission than consensual sexual activity with an infected partner. The genital trauma suffered by sexual assault victims in particular poses the greatest risk,

as tears and laceration facilitate transmission. In studies of sexual assault cases, between 40-53 percent of victims had detectable vaginal lacerations, compared with only 5 percent of women who were examined after consensual sex. Smith, *supra* note 53, at 12-13.

²⁰⁸ See 9 N.Y.C.R.R. § 7010.2 (e) (“No medication or medical treatment shall be dispensed to an inmate except as authorized or prescribed by the facility physician.”).

²⁰⁹ Hammett, *supra* note 189, at 72.

²¹⁰ *Id.* at 71-72.

²¹¹ In its protocol for HIV prophylaxis for victims of sexual assault, the Department of Health recommends that prophylaxis be initiated within two hours and no later than 36 hours following exposure. New York State Dep’t of Health AIDS Institute, *HIV Prophylaxis Following Non-Occupational Exposure Including Sexual Assault* (2008), available at http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=5978&nbr=3937.

²¹² Mary C. Krug, *HIV Management in a County Correctional Institution*, Large Jail Network Bulletin (US DOJ, Nat’l Inst. of Corrs. 1997) (nothing in this article, however, addresses any of the health care issues affecting women in particular).

²¹³ *Id.* Antiretrovirals, or ARVs, are drugs that disrupt the progression of HIV. Since their introduction in 1996, they have lengthened and improved the lives of HIV positive individuals. UNAIDS, *HIV Treatment*, <http://www.unaids.org/en/PolicyAndPractice/HIVTreatment/default.asp> (last visited Feb. 28, 2008).

²¹⁴ Maruschak, *supra* note 9, at 1. As one observer noted:

Breast, cervical, ovarian, and uterine cancer account for approximately one-quarter of all female cancer deaths among inmates. . . . Incarcerated women’s poverty, sexual histories, and lower access to health care place them at greater risk of having a persistent HPV infection or a suppressed immune system. Therefore, many women are also at a higher risk for cervical cancer. . . . With careful screening that includes a good physical examination and Pap smear testing, most lower genital tract diseases can be prevented among incarcerated women.

Flavin, *supra* note 9.