

Obstetric and Gynecologic Health Care in Correctional Settings

Position Statement

The National Commission on Correctional Health Care recognizes that the number of people requiring obstetric and gynecologic care is large and growing annually, presenting unique issues for health services. Therefore, NCCHC recommends the following:

1. Correctional facilities meet recognized community standards for sex- and gender-specific services as promoted by standards set by NCCHC.
2. Correctional health services, community clinicians, and advocacy groups collaborate to provide leadership for the development of policies and procedures that optimize sex- and gender-specific health care needs in corrections, and do so in trauma-responsive ways.
 - a. Screen all people at entry for sexual and physical trauma histories and refer for services as indicated. Perform routine pelvic and breast exams only when clinically indicated (e.g., for patients presenting with clinical symptoms or in the context of evidence-based preventive services) as they are medically unnecessary and may be traumatizing.
 - b. Make trauma-responsive, sex- and gender-appropriate counseling and treatment available for all people.
 - c. Ensure chaperones are used whenever a pelvic, breast, or other sensitive exam is performed.
3. Correctional institutions provide comprehensive services for unique sex- and gender-specific health issues:
 - a. Follow age-appropriate screening guidelines established by national organizations for STI screening, breast and cervical cancer screening, and HPV vaccination.
 - b. Implement intake procedures that include histories on menstrual cycle, prior pregnancies, gynecologic problems, STI risk factors, HPV vaccine history, current and prior contraception use, current pregnancy and postpartum status, current breastfeeding, and history of sexual and physical abuse.
 - c. Offer a pregnancy test within 48 hours of admission to and verbally screen for postpartum status (i.e., birth in the past 12 months) all females who could be pregnant or postpartum—i.e., those who are sexually active (until they go through menopause or have a hysterectomy or tubal sterilization).
 - d. Make gender-specific counseling and treatment available for people with alcohol and other substance use disorders.
 - e. Follow these recommendations for contraception and pregnancy planning:
 - i. Allow for continuation of contraceptive methods that were initiated pre-incarceration, especially if their incarceration is short term or if the method is for noncontraceptive reasons.
 - ii. Offer contraception counseling and access to initiating reversible methods of contraception in a noncoercive manner, especially in preparation for release.
 - iii. Screen for eligibility for emergency contraception at intake and ensure availability of such contraception within 5-7 days depending on the type of emergency contraception.
 - iv. Defer permanent contraception through surgical sterilization until release in most cases.
 - f. Provide people with access to an adequate, no-cost supply of menstrual products.
 - g. Address the unique health care needs of older women, including symptom management and treatment of hot flashes and other menopausal symptoms.

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4. Provide comprehensive sexual and reproductive health education to females that includes education about topics such as STIs, normal and abnormal vaginal discharge, family planning, and the menopause transition.

Discussion

In 2022, females represented 14% of adults in jails and 7% of adults in prisons in the United States.^{1,2} While the number of incarcerated males has declined in recent years, the number of incarcerated females continues to rise. Rates of substance use disorder, prior trauma and abuse, mental illness, and sexually transmitted infections (STIs) are high among women incarcerated, and higher than those of men incarcerated, and these factors intersect with various adverse social determinants of health that characterize their preincarceration lives.³

Moreover, the majority of females incarcerated are younger than 45¹ and therefore have specific reproductive health needs. Research on the provision of gynecologic and other sex-specific and gender-specific health care services for females incarcerated is limited, but what does exist has identified neglect of these health care needs.⁴ A consistent trend demonstrates that the majority of females in custody are in jails rather than in prison facilities, resulting in a disproportionate need for obstetric and gynecologic services in those facilities that may have the fewest resources to provide them.^{1,2}

Notably, people assigned as female at intake may identify as women, nonbinary, transgender men, or as other diverse gender identities. They have both female-specific and gender-specific health needs that correctional facilities must address. This position statement addresses some of the unique health care needs of people assigned female at intake in correctional settings. This document uses “women” and “female” when specific prior research used those terms and otherwise uses “people” as an umbrella term.

Trauma, Substance Use, and Mental Illness

Incarcerated women have high rates of mental illness and substance use disorders, which are often inadequately treated in the community. In prisons, 66% of females had a history of a mental health diagnosis compared to 35% of males.⁵ Similarly in jails, 68% of females had a history of a mental health diagnosis compared to 41% of males.⁵ In state prisons, 69% of females met criteria for drug dependence or abuse (using DSM-IV criteria).⁶

The prevalence of histories of sexual, physical, and emotional trauma, including intimate partner violence, among incarcerated women is also astoundingly high, as high as 90% in one study.⁷ Trauma and victimization may relate to women’s involvement in the criminal justice system, and incarceration itself retraumatizes some of these individuals. Such histories can lead to lifelong mental health issues, such as depressive disorders, stress disorders, anxiety disorders, learning problems, substance use disorders (with their attendant physical health problems), and behavioral problems. Screening for traumatic histories can help identify people who need treatment and other resources and should be done for all people entering correctional facilities. Correctional health staff should be trained in trauma-responsive care and be aware of appropriate referrals for those with a positive screen.

Importantly, pelvic and breast exams can be retraumatizing for people with a history of sexual trauma and should be done only when clinically indicated. The use of any restraint (e.g., handcuffs) during the performance of pelvic and breast exams is (re)traumatizing and must be avoided. Expert opinion supports trauma-responsive approaches to pelvic or breast exams to create a safe environment for all patients and to reduce risk of sexual

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misconduct in obstetric and gynecologic care.⁸ At a minimum, breast and pelvic exams should be explained, undertaken only with patient consent, performed with draping to minimize patient exposure, and be observed by a chaperone irrespective of the sex or gender of the person performing the exam. The American College of Obstetricians and Gynecologists defines a chaperone as a third party in the exam room present to provide reassurance to the patient about the professional context and content of the exam and the intent of the care provider and to serve as a witness should there be any misunderstanding or concern for misconduct. In a correctional setting, the chaperone should be a member of the health care staff. Chaperones are recommended for all exams performed in outpatient and inpatient settings.

Gynecological Care

Research has documented that people incarcerated tend to have higher rates of gynecologic conditions, such as irregular menstrual bleeding and vaginal discharge, than nonincarcerated people, and may have had limited access to gynecologic care prior to incarceration. For instance, the chronic stress from factors such as unstable housing, poverty, exposure to trauma and violence, addiction, and mental illness may influence menstrual bleeding. In one study, up to 40% of women incarcerated had abnormal menstrual bleeding.⁹ Although the majority of women incarcerated are young and therefore menstruating, their access to menstrual products is inconsistent and often inadequate.^{10,11}

To optimize care, a thorough gynecologic history should be collected at intake; standard elements should include menstrual history (e.g., last menstrual period, frequency, and whether periods are heavy), prior STIs, prior diagnoses of chronic pelvic pain or fibroids, prior breast and cervical cancer screening, current and past contraception use, and unprotected sex with a male in the past 5 to 7 days to assess the need for emergency contraception. It should also inquire about current symptoms such as vaginal discharge, bleeding, and pelvic pain. The U.S. Preventive Services Task Force (USPSTF) has determined that evidence is insufficient to recommend routine pelvic examinations on asymptomatic, nonpregnant people.¹² Therefore, pelvic exams must be done only when indicated, such as when a person has symptoms of pain, abnormal bleeding, or discharge, or when cervical cancer screening is due. If an exam is not indicated, performing one may cause additional trauma.

Breast and Cervical Cancer

Rates of cervical and breast cancer are higher among incarcerated women, likely related to underscreening and inadequate follow-up of abnormal screening tests both before incarceration and while in custody.^{13,14,15} Most cervical cancers are preventable with appropriate screening via Pap smears and HPV testing. ACOG recommends screening with HPV-based tests for all females ages 21 to 29 every 3 years, and those ages 30 to 65 every 3 to 5 years.¹⁶ Immunocompromised people and those with history of cervical dysplasia should have more frequent screening, per national guidelines. Importantly, abnormal Pap smear results and HPV testing must be followed up appropriately, which often means colposcopy. Correctional facilities should not routinely perform Pap smears upon intake nor annual Pap smears for people serving long sentences, unless these tests are indicated based on previous screening. The Centers for Disease Control and Prevention (CDC) recommends HPV vaccination through age 26 to reduce cervical cancer risk, and through age 45 for people at risk for new HPV infection. This vaccination series can be implemented in correctional settings.¹⁷

National guidelines for screening mammograms for people of average risk should be followed in correctional settings. ACOG, USPSTF, and the American Cancer Society (ACS) all have evidence-based guidelines that recommend initiation of screening between age 40-45 but differ based on screening intervals and the role of shared decision making.^{18,19,20} Correctional facilities should decide on one set of guidelines to follow.

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Recommendations on screening clinical breast exams also vary, with USPSTF and ACS recommending against it and ACOG recommending annual exams beginning at age 40. As with avoiding unindicated pelvic exams due to lack of benefit and potential to retraumatize women, breast exams for asymptomatic women should not be part of routine intake/exam procedures. Women with known personal or familial risk for breast cancer who are serving long sentences should also undergo screening and diagnostic imaging according to national guidelines.²¹

Follow-up of abnormal Pap smear or mammogram results may present challenges in short-stay facilities as people may be released before results are returned. Tracking systems, contact with community health providers, and notifying the patient of results by electronic or paper mail may facilitate postrelease cancer prevention and diagnosis.

Sexually Transmitted Infections (STIs)

A commonly reported symptom in custody is vaginal discharge, which may be related to higher rates of STIs, nonsexually transmitted bacterial vaginosis and yeast, or physiologic discharge that people may not be aware can be normal. To distinguish among these diagnoses, people with symptoms should undergo appropriate testing. People entering correctional facilities have high rates of STIs: A Rhode Island study found that 33% of women tested positive for an STI at admission, including 26% with trichomoniasis.²² Rates of gonorrhea as high as 3%²³ and chlamydia as high as 14%²² have been reported. The prevalence of HIV among incarcerated women was 1.3% in 2015.²⁴

Based on this high prevalence, the CDC recommends that all females age 35 or younger receive screening for gonorrhea and chlamydia at intake to a correctional facility.²⁵ Vaginal nucleic acid amplification testing (NAAT) has the highest accuracy and can be collected as a self-swab. Urine testing, while less accurate, is easier to collect and may be appropriate when vaginal self-swabs cannot be feasibly collected. Given the trauma that pelvic exams can cause, pelvic exams for the sole purpose of GC/CT testing should be avoided. People in custody should also be screened for HIV and other STIs in accordance with CDC guidelines.²⁵

Family Planning and Contraception

Incarcerated women generally have had limited access to contraceptive services in the community and have high rates of prior unintended pregnancy.^{26,27} A study in Rhode Island showed that only 28% of sexually active women had consistently used birth control in the 3 months prior to incarceration; 85% of these women planned to be sexually active upon release, yet only 9% reported wanting to be pregnant.²⁶ In this same setting, nearly half of those who were pregnant had become pregnant in between incarcerations.²⁸ Moreover, 60% of incarcerated women who could become pregnant upon release wanted to start a method of contraception while in jail.²⁷

Despite this need for contraception, in a national study of correctional health providers, only 38% reported that contraceptive methods were available on-site and 55% said that women could not continue using their current method of contraception.²⁹ In another study, nearly one-third of women entering jail had had unprotected sex within the last 5 days and could therefore be candidates for emergency contraception.³⁰ Correctional facilities should therefore provide access for people to continue any pre-incarceration method of contraception while in custody and to initiate all FDA-approved reversible contraceptive methods before release, if they desire to avoid pregnancy and start a method.

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Research has documented the feasibility in a variety of correctional settings of offering the full range of reversible contraceptive methods, including pills, injectable contraception, intrauterine devices, and subdermal contraceptive implants, either via on-site or off-site providers.³¹ However, given the potential for people to experience diminished autonomy and coercion in correctional settings, care should be taken when providing long-acting reversible contraceptive methods, which require a provider to insert and remove the device. Likewise, especially given documented recent abuses in prisons, and in accordance with ACOG guidelines, sterilization should generally not be performed on people incarcerated.³²

Incarceration is also a time to help people who want to become pregnant after release. Counseling about contraception should center future pregnancy desires and use a shared decision-making approach. Preconception counseling should focus on the risks of substance use and appropriate options for treatment of substance use disorders during pregnancy, improving nutritional status such as folate supplementation, and optimizing physical and mental health.³³ During intake, females who are identified as having had unprotected sex with a male in the last 5 to 7 days should be counseled about the chance of becoming pregnant and the option for oral or intrauterine emergency contraception.

Aging and Chronic Disease

Many prisons may be failing to recognize and prepare for the special physical, preventive health, social, and psychological needs of older females.³⁴ Hot flashes and other symptoms of menopause, such as sleep disturbance and irregular bleeding, can be challenging for women to manage in the correctional environment; for instance, they cannot regulate the ambient temperature and generally do not have access to ice to help with nonpharmacological means to manage hot flashes. Some women in custody may benefit from education and reassurance about the menopause transition.³⁵ Incarceration also has been linked to greater prevalence of hypertension, hepatitis, and cancer in women when compared to men, indicating both a need for better health care resources for older females and careful consideration of the risks of polypharmacy with managing symptoms of the menopause transition.^{36,37}

Nutrition and Diet

Correctional institutions should ensure that people across all life stages receive a healthy diet consistent with federal dietary and nutrient guidelines.³⁸ Obesity is more common among incarcerated females (37%-43%) compared to incarcerated males (20%-27%).³⁹ While the USPSTF has concluded that evidence is insufficient to recommend routine calcium and vitamin D supplementation to prevent fractures in community-dwelling women, they do not make recommendations for women in institutional settings; diets for people in correctional settings should have adequate calcium and vitamin D, following recommendations from the U.S. Department of Agriculture and the National Academies.⁴⁰

Pregnancy, Postpartum, and Parenting

Some people enter correctional settings pregnant. Sexually active females remain at risk for pregnancy until they go through menopause or have a tubal sterilization or hysterectomy. Correctional facilities should screen all females for pregnancy with verbal screening (“Are you currently pregnant?”) and offer urine testing to all females under age 50 within 48 hours of arrival. For people who decline pregnancy testing at intake, or who had a negative test at intake, requests at a later point should be accommodated. There is a dearth of data on pregnancy frequency and outcomes for people in custody, but the largest study to date reported that a total of 4% of women admitted to 22 state and all federal prisons and 3% of females admitted to six U.S. jails, including the five largest jails, were pregnant, and that nearly 900 people gave birth in custody in these facilities.^{41,42}

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Additionally, most incarcerated women are mothers and the primary caregivers to young children, ranging from 56% in federal prisons to 70% in local jails.⁴³ Correctional facilities are well-positioned to reduce maternal morbidity and mortality by training staff to conduct timely assessment and referral in response to urgent maternal warning signs.⁴⁴

The prevalence of people who enter correctional facilities postpartum (having given birth in the past 12 months) is unknown but is likely substantial. Because the postpartum period is one with specific health care needs, including lactation and mental health care, it is important for correctional facilities to verbally screen for postpartum status at intake. Facilities should support efforts for people to provide breast milk for their infants and to maintain contact with their children, and should recognize and treat the psychological difficulties that separation may cause.

Universal screening for postpartum depression and perinatal mood and anxiety disorders is recommended to identify mental health conditions with onset that may predate the perinatal period, may have occurred for the first time in pregnancy or the first year postpartum, or may have been exacerbated in that time.⁴⁵ Screening should be performed with a validated instrument such as the perinatal-specific Edinburgh Postnatal Depression Scale or more general instruments such as the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Scale-7 (GAS-7) at the initial prenatal visit, later in pregnancy, and postpartum. Health conditions and experiences common among people incarcerated have also been suggested as risk factors for self-harm during pregnancy and postpartum, including known mental health conditions, substance misuse, and stressful life events during pregnancy.⁴⁵

Correctional facilities must provide pregnancy and postpartum care in accordance with community standards of care and national guidelines, such as those issued by the American College of Obstetricians and Gynecologists. More information about pregnancy and postpartum care and nutrition in corrections, the nonuse of restraints in pregnancy, and promoting breastfeeding is available from NCCHC through the following resources:

- Pregnancy and Postpartum Care (white paper)
- [Nonuse of Restraints for Pregnant and Postpartum Incarcerated Individuals](#) (position statement)
- [Breastfeeding in Correctional Settings](#) (position statement)

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Note: An earlier version of this position statement was titled *Women’s Health Care in Correctional Settings*.

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POSITION STATEMENT

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