What Women Want: A Qualitative Study of Contraception in Jail

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Objectives. We undertook this study to understand women's perceptions of receiving contraception at Rikers Island Jail.

Methods. We conducted semi-structured in-depth interviews in 2011 to 2012 with 32 women incarcerated at Rikers Island Jail. We analyzed the data using standard qualitative techniques.

Results. Almost all participants believed that contraception should be provided at the jail. However, many said they would hesitate to use these services themselves. Reservations were caused in part by women's negative views of health care services at the jail. Fears about the safety of birth control, difficulties associated with follow-up in the community, and desire for pregnancy were other factors that influenced interest in accepting contraception.

Conclusions. Contraception at the jail must be provided by trusted medical providers delivering high quality care with the goal of allowing women to control their own fertility; this would ensure that women could access birth control and cease using birth control when desired. (*Am J Public Health.* 2015;105: 2269–2274. doi:10.2105/AJPH.2015.302765)

The number of women incarcerated in the United States has tripled over the past 10 years; there are currently more than 1 million women who are incarcerated, under parole, or on probation.[1] However, medical services in correctional facilities have failed to meet the needs of this growing population.[2,3] Among some of the more salient unmet medical needs is reproductive health care. This is of special concern because most women in correctional facilities are of reproductive age.[4] More than 80% of incarcerated women have reported a history of unintended pregnancy.[5] Incarcerated women interested in contraceptive care have reported barriers to care before incarceration, including difficulties with payment, finding a clinic, and transportation.[6] Previous surveys have found that most incarcerated women are interested in starting birth control either while incarcerated or soon after release (60%–77.9%).[5–7] Unfortunately, contraception is not routinely available. In one study, only 38% of correctional health providers indicated that their facilities provided birth control.[8]

Evidence suggests that women will use contraceptive services if they are offered in a correctional facility. When contraceptive services were introduced at a facility in Rhode Island, initiation of a method increased from 4% to 47%.[9] Women who did not want to become pregnant were more likely to want to start a form of birth control compared with women with ambivalent attitudes.[10] However, the preferences for and perceived barriers to receiving contraceptive services while incarcerated or upon release remain otherwise unknown.

Previous studies of contraceptive services for incarcerated women used surveys to examine women's preferences and provider practices. We used qualitative interviews to explore this topic. Qualitative methods are useful for exploring topics about which little is known. We conducted this research to understand women's contraceptive needs as they prepare to re-enter their communities and to learn about their perceptions of receiving contraception at Rikers Island.

METHODS

We conducted this study at the women's facility of Rikers Island Jail Complex, the Rose M. Singer Center (RMSC). Rikers Island is New York City's (NYC's) main jail, run by the NYC Department of Correction (DOC) with health services provided by a private contractor that is overseen by the NYC Department of Health and Mental Hygiene (DOHMH). RMSC has a daily average population of approximately 900 women. The average length of stay varies widely, with many released within 1 week to 1 year (H. Venters, personal communication, 2010).[11–13] Although at the time of data collection, DOHMH policy required that all women be offered family planning services, women rarely received contraceptive counseling or services while incarcerated or before release unless medically indicated (H. Venters, personal communication, 2010). Our study was approved by the institutional review boards at Albert Einstein College of Medicine and the NYC DOHMH.

Sample and Data Collections

We conducted interviews using a convenience sample of women incarcerated at Rikers Island; we offered the interviews in both English and Spanish. We recruited women from several settings, including a walk-in clinic, an "Inmates' Council," a group preparing to re-enter the community, and a group of women with babies in the jail's on-site mother–infant nursery program. Women aged between 18 and 45 years who were sexually active with men before incarceration were eligible to participate. We excluded pregnant women and women unable to become pregnant.

We conducted the semi-structured interviews in a private room in the jail from October 2011 to March 2012. Interviews lasted approximately 1 hour, and were audio recorded and transcribed verbatim. The interviewer (A. B.) had training in public health and extensive experience conducting qualitative interviews. The interviews focused on experiences with health care and birth control, preferences for contraceptive services, and attitudes toward pregnancy (see the box on the next page for sample questions). Consent

was obtained from all participants. The incentive for participation was a clothing package, as recommended by the DOHMH.

Data Analysis

We analyzed the data using modified grounded theory. Members of the research team (D. S., A. B., M. G.) independently read through the initial transcripts and created a list of preliminary codes. We applied this codebook to the next set of transcripts and revised them accordingly. This process continued in an iterative fashion until the coding list was judged to be comprehensive and accurate. The entire data set was then coded by 2 authors (D. S., A. B.). We resolved discrepancies through discussion until consensus was achieved. We uploaded the coded data into NVivo version 10 (QSR International, Doncaster, Victoria, Australia), which is a qualitative data analysis software that facilitates the organization and retrieval of thematically related data. Recruitment was concluded when thematic saturation was reached.

RESULTS

We conducted 32 interviews. The median age of the women was 28.5 years (range = 18–44). Most women were from minority groups, and one third did not have a high school diploma or general equivalency diploma. All but 6 of the women were mothers. The majority mentioned a history of substance use. Table 1 lists the demographic characteristic information. We created a conceptual framework using the ecological model (Figure 1) in which factors acted on numerous levels to both promote and decrease interest in contraception at the jail.

Attitudes Toward Availability of Contraceptive Services at Rikers Island

When asked, all but 1 participant believed that birth control services should be available at the jail. One woman said, "(Birth control's) part of health care. It's a woman's choice, and it's an option that should be there." When asked what services would be useful, women had a variety of suggestions. These included educational classes, counseling, and printed materials, as well as access to contraception itself. Most felt that all forms of birth control should be available at the jail. A few proposed that contraceptive services could be offered as part of discharge planning either via onsite services or as a referral to care in the community. Women suggested that contraception be provided in advance of release so that their bodies would have time to adapt to the method.

Participants stated that offering contraception at the jail was important because many women wanted to avoid pregnancy immediately upon returning home to pursue goals and get their lives back in order without worrying about a new child. One woman explained:

> I don't want to get pregnant when I get home because I want to get my life together first. Like I told you, I been drugging and everything, and I need treatment. I need help for myself right now. I can't really think about any kids right now.

Another said,

> I want no kids right now. . . Because like I said, I have a plan to go home and get focused. . . . I want to go back to school. I want to get my money up, like I want to dedicate myself more to my kids, like I still owe them a lot.

Jail as an "Opportunity" for Contraceptive Services

Some women viewed time in jail as an opportunity for getting needed medical services. Many women noted that life "on the street" made access to care difficult. They identified substance use as a major barrier to care. According to one woman,

> I didn't ever go back or get a chance to go back (to the outside clinic) because I was up there drugging. That's why I didn't go back and get a (Depo-Provera) shot again. I was too busy out there chasing after drugs.

Many women described other barriers to accessing medical care, including lack of time, lack of money, and competing priorities. Participants stated that receiving birth control at the jail would provide them with a "head start," giving them time to find a doctor and get to an appointment. One woman said, "I think they should give (birth control) to them here to prepare them just in case they can't get on their feet as fast or get to the place as fast, at least they have some type of protection."

Concerns About Barriers to Care in the Community

A few women expressed that offering birth control at the jail was pointless because of barriers to follow-up care. One woman said,

> If there's a facility that some women can go to follow-up on the birth control, that would be great. But if they can't, then what's the point? You're setting them up for a fall. You're going to give them birth control while they're in jail with a bunch of other women, and it's not going to work when they're outside in the real world with the men.

Concerns about follow-up were especially prevalent regarding long-acting reversible

Sample Questions from Interview Guide: A Qualitative Study of Contraception in Jail, New York City, 2011–2012

- Sometimes people need or want to see a doctor but can't for different reasons. Tell me about the last time you wanted to see the doctor but could not go.
- I want to talk a little bit about your experience with health care here at Rikers. What is it like to get health care here?
- The women we've talked to have had a lot of different thoughts about getting pregnant. . .What do you think it would be like if you got pregnant when you return home?
- Can you share with me some of your thoughts on birth control?
- Tell me about your experiences with birth control in the past.
- Thinking about women who are leaving Rikers, what would be the best way for them to get birth control?
- Some people we've talked to have thought you should be able to get birth control at Rikers and other people haven't. What do you think?

  What would be good about getting birth control from here?

  What would be bad about it?

TABLE 1—Study Participants' Characteristics: A Qualitative Study of Contraception in Jail, New York City, 2011–2012

Characteristics	Median (Range) or No. (%)
Age, y	28.5 (18–44)
Race/ethnicity[a]	
Black	22 (59.5)
Hispanic	8 (21.6)
White	6 (16.2)
Native American	1 (2.7)
Born outside the United States	2 (6.3)
Educational attainment	
< high school graduate	10 (31.3)
High school graduate or GED	16 (50.0)
Some college	5 (15.6)
College	1 (3.1)
Employment before incarceration	
Working	14 (43.8)
Not working	18 (56.3)
Insurance coverage	
Uninsured	10 (31.3)
Public insurance	19 (59.4)
Private insurance	2 (6.3)
Unspecified insurance	1 (3.1)
Pregnancy history	
Women who have been pregnant	29 (90.6)
Women with children	26 (81.3)
Women with at least 1 abortion	18 (56.3)
No. of pregnancies	3 (0–12)
No. of children	2 (0–7)
History of contraceptive use[a]	
Condoms	32 (100.0)
Oral contraceptive pills	20 (62.5)
Depot medroxyprogesterone acetate injection	16 (50.0)
Withdrawal	8 (25.0)
Patch	4 (12.5)
Ring	4 (12.5)
Copper IUD	2 (6.3)
Levonorgestrel IUD	2 (6.3)
Mentioned history of substance use	21 (65.6)

Note. GED = general equivalency diploma; IUD = intrauterine device. The sample size was n = 32.
[a]Number is higher than total number of participants to account for women who reported > 1 identification or contraceptive method.

contraception (LARC), like the intrauterine device (IUD) or a subdermal contraceptive implant. One woman said, "Really, what do you do if you get something in here, and there's no facility outside to help you with the aftercare? Now you're stuck." Another said, "Because let's say I get (the IUD) here, and then where am I going to go to take it out?"

Factors Affecting Interest in Contraceptive Services in Jail

Stigma and mistrust of contraception. Although almost all participants felt that birth control services should be offered, many stated that they would not use those services themselves.

For a few women, stigma was a concern. Some thought that taking contraceptives in jail could imply that women were having sex with correctional officers. One participant said, "If I see you on the birth control pill, and there's only girls here, you have to be doing it with one of the officers." Women did not want to be seen using contraception too far in advance of their release because of this concern.

A more common concern was fear about the safety of contraceptives. One woman said, "I want to know the side effects. I want to know what can happen. I don't want to die." Another noted, "It can affect your long-term health."

For some, concerns reflected broader mistrust of the health care system regarding birth control. One woman who had previously sought contraceptive services from a community clinic noted:

> Sometimes I feel like—excuse my language—they're bullshitting half of the time because I'm like, you're telling me this, but when I got (the birth control), it was a whole different story, . . . but they don't warn you before it happens. They are all advocating. It's like a hustle. "It's the greatest thing ever. Take this—Great! Great! Great!" No matter how many people have complained about it.

Many women lacked trust in the jail in particular as a source for birth control. One woman said,

> I have a girlfriend, she's a fellow inmate. She, a few years ago, got some type of experimental birth control (in jail). She's back in prison, and they won't take it out. No one wants to cut her open and take it out. It's in her arm. . . . She was part of the experiment. Now she can't get it out. So I don't recommend anything experimental in jail.

Distrust of jail-provided medical care. The more common barrier to interest in receiving birth control at Rikers was related to perceptions of the quality of medical care offered at the jail. Participants were highly dissatisfied. As one noted, "How do I know my medication is new? When is it going to expire? Is it properly sealed or wrapped? Am I getting a generic?" Another said, "They get hand me downs, expired. . . . I wouldn't want anything here, because they get so much generic stuff. It wouldn't be effective."

In addition, women viewed the medical providers at Rikers as substandard. One woman stated, "They don't go the extra mile, and even though we're in jail (and) we are labeled in society, we are still human, and you should care about us." Another said, "It's the

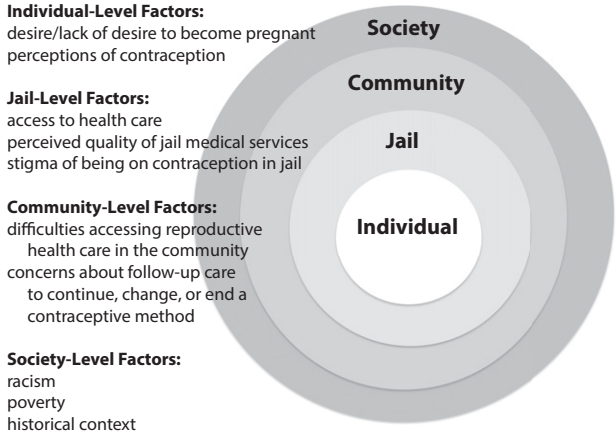

FIGURE 1—Attitudes towards contraception in jail: conceptual framework.

bedside manner, the gentleness. . . . Some of these nurses and doctors in jail just don't have it." Participants felt judged and disrespected by medical staff: "I understand we're inmates. . . . We got a bad break; we're here. They're demeaning. They don't care. . . . I might as well stay in bed and die. . . . They can't do anything for me."

Women also worried that medical providers at the jail were poorly trained. One woman said, "Sometimes I feel like these doctors graduated from (an online university), and I'm not even kidding when I say that. Sometimes I feel like they have no idea what they're talking about." Another woman agreed:

> They're like . . . people who just got out of med school or like people who's been doing internships. . . . They're not highly trained in certain things, or they don't know a lot of information about (birth control).

Because of concerns about low-quality services, many women expressed concern about receiving LARC at the jail. As one participant noted: "These are not highly trained specialists . . . [An IUD insertion] is a procedure. That means you have to trust people for that." Others said,

> Their performance and things is not really good, so you really wouldn't want to do [a contraceptive implant insertion]. . . . I'd rather . . . get a referral to a professional doctor that really cares and wants to help you . . . than somebody in here to do it 'cause you might lose your arm.

> If you leave something like that up to these doctors in here, and he's already put 40 IUDs in this morning, he's not going to feel like putting 41 in. He's just going to throw that thing in and he doesn't care if he hurts you or not.

Positive views of pregnancy and parenting. A final influence on interest in contraceptive uptake in jail was that many women had positive thoughts about pregnancy, and some hoped to become pregnant soon after release. For many, a new baby represented hope. These women stated that a new child would motivate them to remain off drugs, finish school, and stay on track. One woman said,

> If I would get pregnant when I got home, my life would be totally different. . . . I would go back to school . . . would do the right thing with my baby in my stomach. . . . It would be much more better for me because I wouldn't want to use.

Others said, "And if I had a girl. . . . I'd be so overprotective. . . . I would quit partying, the drugs like the marijuana, and the liquor and stuff, I'd change that 'because that's a little girl,'" and,

> A baby's a blessing. It's like something to look forward to, somebody to fight for. . . . I got to find food. I've got to find a job. I've got to get home to my kids. I can't be hanging out. . . . I've got to take them to the doctor and stuff.

For some women who already had children, there was hope that a new baby would be an opportunity to be a better parent—to be present in their child's life, to have custody of their children, and to experience parts of parenthood that jail or drug use had taken away from them. One woman said, "There's a lot of other ways (having a baby would) be good. I'll be home. I'll be able to have them. I'd be able to raise them on my own, you know." Another stated,

> I gave birth inside of jail . . . so I really only spent 2 full days with my son as far as holding him and sleeping with him so, and to this day. . . . I've always been in jail. So having a (new) baby when I go home, the good thing would be I would be able to experience the things I've missed with my son.

Many women expressed ambivalence about pregnancy. For some, a desire for children was constrained by current financial and social circumstances. Many women were optimistic about being in a better position to raise a child in the near future; for this reason, LARC was unpopular. One woman explained, "Because that's 5 years. You understand? And in 5 years, you could meet somebody, get married, whatever. So that's something you really have to think about before you get that." Another woman expressed:

> Because that's for like long term, and some people just, they don't want to get pregnant at the moment, but they want to get pregnant later. . . . I guess 3 months would be a good enough time for you to be like okay, after this 3 months are up, I'm going to try to get pregnant.

DISCUSSION

The 1976 Supreme Court decision in *Estelle v. Gamble* established a right to health care for prisoners by deeming "the deliberate indifference to the serious medical needs" of incarcerated people to be unconstitutional.[14] However, contraception has typically not been considered a serious medical need. Nonetheless, almost all participants in this study expressed that contraception should be provided at Rikers Island. Although almost all thought birth control should be offered, women identified many factors that influenced the uptake of these services.

Some women were uncertain about their ability to follow-up in the community after release to start, continue, change, or end a contraceptive method, and especially to remove LARC devices. This was a realistic concern because cost, lack of insurance, long wait times, and stigma are some of the barriers to health care faced by people on parole.[15,16] For women to feel comfortable receiving services at Rikers, and for services to have continued impact upon return to the community, the ability to access follow-up care must be guaranteed.

Another concern that affected the interest in contraceptive services was fear about the safety of birth control and suspicions about the health care system in general, a finding seen in much other research,[17–22] and which was not surprising because of the long history of coercive family planning programs in this country. Sterilization of prisoners without consent[23–25] and the use of LARC devices to control the fertility of low-income women[26,27] affected thousands throughout the 20th century, and reports of its use on incarcerated women have continued in recent times.[28–31] Furthermore, studies showed that low-income women of color were more likely to be advised by medical providers to limit their childbearing.[32,33] Some of the women's concerns pertained to misperceptions about side effects, which could be addressed by education. A more significant problem was the lack of trust in the medical profession and concerns about coercion regarding contraception, a much larger issue that was related to the coercive nature of incarceration.

Another key influence on willingness to use birth control was the desire for pregnancy. Many women had positive thoughts about pregnancy and believed a new baby would bring a new beginning. Although many women identified the major social and financial ramifications of a new baby, they spoke of a moral transformation that would occur, allowing them to become a new and better person, a concept seen in previous literature.[34–37] Although not stated explicitly, it appeared that for many, ambivalence contributed to low intentions to use contraception. Poor and minority women are often discussed in public health literature as being far less likely to use an effective method of birth control[38,39] and far more likely to experience "unintended" pregnancy.[40] However, it was clear from our interviews that these statistics must be viewed within the context of history and women's experiences. It is important that providers not pathologize a desire for pregnancy among low-income men and women, and even more, should recognize the important meaning that pregnancy might represent. This could ensure that family planning services are truly patient-centered and delivered in a way in which the patient's reproductive desires and goals are respected.

Finally, an influence on interest in contraceptive uptake unique to our study and of critical concern was that women believed the health care providers at Rikers were providing substandard care. Women perceived the services to be of poor quality and the providers to be untrained and uncaring. Although we did not examine the quality of services directly, evidence suggested that these perceptions of substandard care might be accurate because the private contractor of health services at Rikers is currently facing numerous charges for poor care, including wrongful death[41–43] and fines for failing to meet Occupational Safety and Health Administration regulations.[44] For women to feel comfortable accessing contraceptive care at Rikers, the jail must ensure that they are providing medical services that meet appropriate standards of care, and women must feel that they can trust the providers and care received there.

Limitations

The use of a convenience sample was necessary because recruitment was restricted by the jail setting. In addition, NYC has a strong network of social services, and it was possible that our results were not generalizable. Furthermore, interviews in a jail setting might be biased by a power differential. That being said, this was the first qualitative study that we know of to use in-depth interviews with incarcerated women to learn about their contraceptive needs and perceptions.

Conclusions

Our results suggest a number of implications for providing contraceptive services in jails. First, for women to feel confident in their ability to follow-up in the community, a network of affordable and accessible clinics must be made available and a referral process put in place. Second, women expressed mistrust of birth control; therefore, they should be provided with accurate information on the benefits and risks of contraception. Furthermore, medical providers must acknowledge the long history of reproductive coercion that has existed in this country, and work toward improving trust. One critical step is to not assume that all women want or "need" birth control. Desire for pregnancy must be respected, and preconception counseling should be offered alongside contraceptive services. Lastly, and most importantly, for women to feel comfortable accepting contraceptive services at the jail, immediate priority must be given to improving the quality of health care provided there. Our results could help to inform public health programs, both inside and outside of jail, to best meet the needs of this marginalized population. Further research should explore how best to provide patient-centered reproductive health care in an inherently coercive setting. ■

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Contributors

D. Schonberg originated the study and led all aspects of implementation, data analysis, and writing. A. H. Bennett contributed to study design, interviewed all participants, and contributed to data analysis and writing of the article. C. Sufrin contributed to study design and writing of the article. A. Karasz contributed to data analysis and writing of the article. M. Gold supervised all aspects of study implementation, data analysis, and writing.

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Human Participant Protection

This study was approved by the institutional review boards at Albert Einstein College of Medicine and the New York City Department of Health and Mental Hygiene.

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