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“If They Hand You a Paper, You Sign It”: A Call to End the Sterilization of Women in Prison

*Rachel Roth and Sara L. Ainsworth**

INTRODUCTION

There is no autonomy [in prison]. Your body is in effect ‘property
of state.’

- Misty Rojo

In the summer of 2013, amidst news reports of sterilizations of women in the California prison system, Misty Rojo testified about the problems inherent with sterilizing people in prison. As an advocate for incarcerated people who had spent years in a California prison herself, Rojo explained to the Legislature, “You can receive disciplinary action for getting a haircut too short . . . so the idea that you could make such a long-term permanent decision in that type of environment is ludicrous.”¹

More than 100 women incarcerated in California were sterilized by tubal ligation surgery between 2006 and 2010.² These procedures did not

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1. *California Department of Corrections and Rehabilitation: Female Inmate Sterilization: Informal Hearing Before the Cal. S. Pub. Safety Comm.* (Aug. 13, 2013) (testimony of Misty Rojo), available at http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=1546.

2. After revisiting the billing data and eliminating duplications, the Center for Investigative Reporting puts the number at 132 (based on calendar years). See Corey G. Johnson, *Bill Seeks New Restrictions on Sterilizations*, CTR. FOR INVESTIGATIVE REPORTING,

take place in a setting conducive to informed consent, although informed consent to any surgery is both ethically and legally required. Moreover, the procedures were not required for women's health: The primary purpose of tubal ligation is to eliminate the ability to have children, not to treat an illness.³ Despite this, women reported being pressured by doctors in the prison and in the hospital to undergo sterilization. Physicians and medical staff apparently targeted pregnant women who already had two or more children.⁴

Christina Cordero, now in her mid-thirties, described her experience with the obstetrician-gynecologist at California's Valley State Prison for Women: "As soon as he found out that I had five kids, he suggested that I look into getting it done. The closer I got to my due date, the more he talked about it. . . . He made me feel like a bad mother if I didn't do it."⁵ An African American woman named Kimberly Jeffrey told the prison obstetrician-gynecologist that she did not want to be sterilized. But the doctor who delivered her baby at the hospital brought it up anyway: "He said, 'So we're going to be doing this tubal ligation, right?' I'm like, 'Tubal ligation? What are you talking about? I don't want any procedure. I just want to have my baby.'"⁶

These stories are troubling for many reasons, not the least of which is the failure of law, medical ethics, and federal policy that ostensibly protect people in prison from such rights violations. California coercively

Feb. 20, 2014, available at <http://cironline.org/reports/bill-seeks-new-restrictions-sterilizations-california-prisons-5985>. The California State Auditor examined a longer time period and identified 144 cases (based on fiscal years). See CAL. STATE AUDITOR, REPORT 2013-120, STERILIZATION OF FEMALE INMATES: SOME INMATES WERE STERILIZED UNLAWFULLY, AND SAFEGUARDS DESIGNED TO LIMIT OCCURRENCES OF THE PROCEDURE FAILED 36 (June 2014), available at <https://www.auditor.ca.gov/reports/summary/2013-120>.

3. Tubal ligation is a surgery in which a physician closes the woman's Fallopian tubes for the purpose of rendering her permanently sterile. *Tubal Ligation*, U.S. NATIONAL LIBRARY OF MEDICINE, NATIONAL INSTITUTE OF HEALTH: MEDLINE PLUS (Oct. 9, 2014), <http://www.nlm.nih.gov/medlineplus/ency/article/002913.htm> [hereinafter *Tubal Ligation*]. Some women may have the procedure along with the removal of their ovaries to help prevent ovarian cancer. *Id.* However, there is no indication that the incarcerated women sterilized in California had the operation for that particular reason. Further, for women who may need to avoid pregnancy to protect their health, there are reversible methods of contraception with rates of efficacy comparable to sterilization. CENTERS FOR DISEASE CONTROL AND PREVENTION, PUB. NO. CS 242797, EFFECTIVENESS OF CONTRACEPTIVE METHODS (2011) available at http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/PDF/Contraceptive_methods_508.pdf (for example, the levonorgestrel, or LNG, IUD has a failure rate of 0.2%, as opposed to the higher 0.5% failure rate of female sterilization).

4. Of 144 women who underwent tubal ligation while incarcerated in California between fiscal years 2005 and 2013, all were in the hospital for childbirth and 115—almost eighty percent—had more than two children. CAL. STATE AUDITOR, *supra* note 2, at 36–38.

5. Corey G. Johnson, *Female Inmates Sterilized in California Prisons without Approval*, CTR. FOR INVESTIGATIVE REPORTING, July 7, 2013, <http://cironline.org/reports/female-inmates-sterilized-california-prisons-without-approval-4917>.

6. Johnson, *Female Inmates Sterilized*, *supra* note 5.

sterilized the largest number of people of any state during the eugenics era;⁷ that history led to state regulations that, along with state rules on prison medical care that expressly ban tubal ligation surgery absent state approval,⁸ should have prevented these sterilizations from taking place. Federal regulations prohibit the use of federal funds for the sterilization of people in prison, and establish a strong policy norm against any government involvement in sterilizing people who are institutionalized.⁹ And medical ethics flatly prohibit numerous practices that physicians engaged in when sterilizing women from prison in California, ranging from attempts to gain consent as women were about to give birth to apparently performing the surgery without consent.

In this article, we explore the problem of sterilizing incarcerated women in the United States, the history that led to the adoption of federal regulations against the practice, and the legal and systemic structures that foster the coercive sterilization of women in prison today. While the history of sterilization abuse in the United States has been thoroughly documented elsewhere,¹⁰ little has been written about the sterilization of women in prison outside of California,¹¹ or about the public debate that led to the federal ban on funding for such sterilizations. Despite the difficulty

7. Alexandra Minna Stern, *Sterilized in the Name of Public Health: Race, Immigration and Reproductive Control in Modern California*, 95 AM. J. OF PUB. HEALTH 1128, 1130 (2005) (“California carried out more than twice as many sterilizations as either of its nearest rivals, Virginia (approximately 8000) and North Carolina (approximately 7600)”).

8. Criteria for the Performance of Sterilization, Cal. Code Regs. tit. 22, § 70707.1-70707.7 (2014) (outlines the informed consent requirements for sterilization in acute care hospitals.) Further, under California regulations, tubal ligation is an “excluded service” for people in prison that may be provided only with prior approval from Institutional and Headquarters Utilization Management committees. CAL. STATE AUDITOR, *supra* note 2, at 9; Cal. Code Regs. tit. 15, §§ 3350.1(b)(4), 3352.1 (2014).

9. Specifically, federal regulations prohibit the Medicaid and Public Health Service programs from paying for or arranging for the sterilization of people who are incarcerated. *See infra*, Part 1B.

10. Many people who suffered eugenic sterilization, as well as legal and other scholars, have recounted the state and judicial role in forced and coerced sterilizations of people in the United States. *See, e.g.* DOROTHY ROBERTS, *KILLING THE BLACK BODY* 57–103 (1999); ELAINE TYLER MAY, *BARREN IN THE PROMISED LAND: CHILDLESS AMERICANS AND THE PURSUIT OF HAPPINESS* 95–125 (1995); RICKIE SOLINGER, *PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA 194–200* (2005); PAUL LOMBARDO, *THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND BUCK V. BELL* (2008). For an example of the efforts of involuntarily sterilized people to seek compensation, see Courtney Hutchison, *Sterilizing the Sick, Poor, to Cut Welfare Costs: North Carolina’s History of Eugenics*, ABC NEWS (Aug. 4, 2011), <http://abcnews.go.com/Health/WomensHealth/sterilizing-sick-poor-cut-welfare-costs-north-carolinas/story?id=14093458>.

11. Robin Levi, a human rights lawyer, and other staff members at Justice Now, the California human rights organization, have written extensively on coerced sterilization and other human rights abuses experienced by people in California prisons. *See, e.g.*, Robin Levi et al., *Prisons as a Tool of Reproductive Oppression*, 5 STAN. J.C.R. & C.L. 309 (2009) [hereinafter *Prisons as a Tool*]; Robin Levi et al., *Creating the Bad Mother: How the U.S. Approach to Pregnancy in Prisons Violates the Right to be a Mother*, 18 UCLA WOMEN’S L.J. 1 (2010) [hereinafter *Creating the Bad Mother*].

of obtaining information from the closed world of prisons, our research shows that a number of states allow the sterilization of incarcerated women—flouting important policy norms—and that medical providers and their professional organizations play key roles in sanctioning and carrying out these procedures. In short, we argue that the coercive nature of the prison environment undermines a person's ability to give meaningful consent to the irreversible destruction of fertility, and thus policymakers, prison authorities, and the medical profession must end their participation in sterilizing women in prison.

This argument is a controversial one, and as advocates for reproductive justice,¹² we must contend with the concern that our recommendations undermine the agency of women in prison, and deny them access to an important form of birth control. Sterilization is indeed a popular form of birth control in the United States, almost on par with hormonal birth control pills.¹³ Sterilization is more prevalent among women over 35, women who use public insurance or who lack insurance, women with less formal education, and women who are Latina or African American.¹⁴ A host of barriers may imperil women's access to the contraception that is best for them,¹⁵ and for many women, access to sterilization outside the prison

12. Reproductive justice is not a substitute term for abortion rights. Rather, it is both a much broader framework and also a social and political movement. As Loretta Ross, a founder of the movement, explains, reproductive justice encompasses "(1) 'the right to have a child; (2) the right not to have a child, and (3) the right to parent the children we have.'" Loretta Ross, *What is Reproductive Justice?*, in REPRODUCTIVE JUSTICE BRIEFING BOOK 4–5 (2007), available at <http://protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf>. The movement for reproductive justice was founded by and is led by women of color, and strives to promote the leadership of those most affected by law and social policies that undermine their health and wellbeing and the health of their families and communities. As the organization Forward Together explains, reproductive justice will be achieved when all people "have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives." ASIAN COMMUNITIES FOR REPRODUCTIVE JUSTICE (now Forward Together), A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS, AND REPRODUCTIVE JUSTICE 1 (2005), available at <http://forwardtogether.org/assets/docs/ACRJ-A-New-Vision.pdf>. Reproductive justice employs an intersectional analysis, understanding that each person's life is shaped by intersecting (and often socially constructed) identities such as race, class, immigration status, and gender. See e.g., Jael Silliman et al., UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE 4 (2004) (reproductive justice "recognize[s] that the control, regulation, and stigmatization of female fertility, bodies, and sexuality are connected to the regulation of the communities that are themselves based on race, class, gender, sexuality, and nationality"). It is, then, the leadership and insight of people with direct experience of incarceration that should guide resistance, advocacy, and policy considerations regarding the sterilization of people in prison.

13. GUTTMACHER INSTITUTE, CONTRACEPTIVE USE IN THE UNITED STATES, 2 (June 2014), http://www.guttmacher.org/pubs/fb_contr_use.pdf.

14. Jo Jones et al., *Current Contraceptive Use in the United States, 2006–2010, and Changes in Patterns of Use Since 1995*, 60 NATIONAL HEALTH STATISTICS REPORTS 1, 6–8 (Oct. 18, 2012), available at <http://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf>.

15. These barriers are many, and, for example, may include cost and availability. See, e.g., Kelly R. Culwell et al., *The Association of Health Insurance with Use of Prescription*

context is an important element of reproductive justice. Our argument is not with sterilization per se; rather, it is against the role of prisons and the medical profession in sterilizing women who are structurally vulnerable to coercion. Moreover, our claim is not a judgment on the capacity or agency of women in prison.¹⁶ We recognize people in prison as full human beings with decisional capacity, able to see beyond their immediate circumstances to a future life that may or may not include childbearing, and as capable of consenting to medical care that they need.

But the context in which the sterilization of incarcerated women¹⁷ takes place is a deeply coercive one. Very often, prisons are hostile to women's reproductive health and safety. Countless news reports, human rights investigations, and lawsuits document the depth of suffering experienced by women in prisons in the United States. Inadequate medical care is high on the list, demonstrated by the filing of formal grievances and litigation.¹⁸ Prisons are also sites of sexual violence. Incarcerated women report high levels of sexual assault, most often by the very people whose job it is to

Contraceptives, 39 PERSPECTIVES ON SEXUAL AND REPROD. HEALTH 226 (Dec. 2007) (women who lack health insurance are less likely to use prescription contraceptives); see also Judith C. Appelbaum & Jill C. Morrison, *Hospital Mergers and the Threat to Women's Reproductive Health Services: Applying the Antitrust Laws*, 26 N.Y.U. REV. L. & SOC. CHANGE 1, 7 (2001) (Catholic religious directives applied in Catholic hospitals limit access to tubal ligations).

16. On women's agency, see generally VICTORIA LAW, RESISTANCE BEHIND BARS: THE STRUGGLES OF INCARCERATED WOMEN (2d ed. 2009); Kathy Boudin & Judith Clark, *Struggles for Justice: Community for Women Organizing Themselves to Cope with the AIDS Crisis: A Case Study from Bedford Hills Correctional Facility*, 17 SOC. JUSTICE 90, 92 (1990) (discussing how "AIDS organizing can be accomplished in the prison context; and how mobilization around the AIDS crisis has significantly reduced stigma and fears among the women . . .").

17. We recognize that transgender people are confined in women's prisons throughout the United States, and are subject to interventions and deprivations that affect their health, safety, and fertility. Although not everyone who has the biological capacity to become pregnant identifies as a woman, and although not everyone who identifies as a woman becomes pregnant, we use the terms "woman" and "women" throughout this article because the people whose experiences with sterilization were reported and collected primarily identified as women and because it appears that they were targeted for sterilization based on their identities as women and mothers. Moreover, we recognize that men and transgender people incarcerated in men's prisons face threats to their health, bodily autonomy, and family decision-making. Although we have not seen reports that men in prison are being sterilized by vasectomy surgeries, our analysis would certainly apply to such situations. Our legal analysis, conclusions, and policy recommendations apply to all people, of all ages and genders, imprisoned in any prison, jail, youth detention center, or immigration detention center in the United States. *But see* Levi et al., *Creating the Bad Mother*, *supra* note 11, at 4.

18. See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (establishing that prisons have an Eighth Amendment obligation to meet incarcerated people's serious medical needs); on grievances, see TAMAR KRAFT-STOLAR, CORRECTIONAL ASSOCIATION OF NEW YORK, REPRODUCTIVE INJUSTICE: THE STATE OF REPRODUCTIVE HEALTH CARE FOR WOMEN IN NEW YORK STATE PRISONS 14 (Oct. 2, 2014) (forthcoming 2014, cited page numbers are provisional) (on file with authors) [hereinafter REPRODUCTIVE INJUSTICE]; on litigation, see Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555, 1570-71 (2003).

maintain safety in the prison.¹⁹ Routine pat searches and strip searches trigger memories of trauma and abuse.²⁰ Prison rules and personnel control most every aspect of women's lives and daily routines—from what to wear to what feminine hygiene products to use.²¹ Prisons are punitive, arbitrary, degrading places. In this environment, truly voluntary and informed consent to the irrevocable loss of procreative capacity is not realistic.

The best way to protect women and all people from the harms of imprisonment—including the permanent destruction of fertility—is to reduce the number of people in prison.²² As we work toward that goal, policymakers, health care providers, and advocates must take immediate steps to safeguard women who are incarcerated against the specific threat of sterilization abuse. These steps apply not only to departments of corrections and prisons, but also to the hospitals and individual physicians that contract with prisons to provide medical care to women in custody. The actions of physicians in sterilizing women from prison raise serious questions about medical ethics and professional responsibility and must be addressed as part of the solution.

The practice of sterilizing incarcerated women, whether intentionally coerced or not, takes place against a backdrop of mass incarceration and the long and ignominious history of forced and coerced sterilizations directed

19. Paul Guerino & Allen J. Beck, *Sexual Victimization Reported by Adult Correctional Authorities, 2007–2008*, U.S. DEP'T OF JUSTICE PRISON RAPE ELIMINATION ACT OF 2003 SPECIAL REPORT 8 (Jan. 2011), available at <http://www.bjs.gov/content/pub/pdf/svraca0708.pdf>. See also Jennifer Sullivan, *\$1M Awarded to 5 Washington Inmates in Sex-Assault Lawsuit*, SEATTLE TIMES, June 12, 2009, http://seattletimes.com/html/localnews/2009332905_webdocsettles12m.html (describing Washington State Department of Corrections' (DOC) settlement of lawsuit brought by women against corrections officers for sexual assaults in the state women's prison).

20. See, e.g., *Jordan v. Gardner*, 986 F.2d 1521, 1522–23 (9th Cir. 1993) (imprisoned women subjected to random pat searches by male guards stated an Eighth Amendment claim for cruel and unusual punishment because of the physical and psychological distress they suffered as a result of the searches).

21. See, e.g., Jorg Pont et al., *Dual Loyalty in Prison Health Care*, 102 AM. J. PUB. HEALTH 476 (2012) ("Prisons are totalitarian and repressive institutions"); Nancy Stoller, *Space, Place, and Movement as Aspects of Health Care in Three Women's Prisons*, 56 SOC. SCIENCE & MED. 2265 (2003) ("Movement control is an essential feature of prison life"); Maya Schwenar, *In Prison, Toilet Paper is the New Tampon*, MS. MAGAZINE BLOG (Apr. 12, 2010), <http://msmagazine.com/blog/2010/04/12/in-prison-toilet-paper-is-the-new-tampon/> (describing the lack and expense of adequate feminine hygiene products in women's prisons).

22. A full accounting of the growing movement to end mass incarceration in the United States is beyond the scope of this article. See, e.g., The New York Times Editorial Board, *End Mass Incarceration Now*, N.Y. TIMES SUNDAY REVIEW (May 24, 2014), at SR10. Scholars, activists, and people directly affected by incarceration have sparked this movement by documenting the structural racism inherent in drug policy, sentencing requirements, and the exercise of discretion by police, prosecutors, judges, and juries. See generally, MICHELLE ALEXANDER, *THE NEW JIM CROW* (2010); Dorothy E. Roberts, *The Social and Moral Cost of Mass Incarceration*, 56 STAN. L. REV. 1271 (2004); NATIONAL RESEARCH COUNCIL ET AL., *THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES* (2014).

at poor people and women of color in the United States. We explore this backdrop, and the federal sterilization regulations that arose from this history and from women's activism to change it, in Part I. In Part II, we explain how the appallingly bad and often unconstitutional state of medical care in prison forms the context for both indirect and direct forms of sterilization abuse in prison. We describe careless or aggressive medical treatment that results in infertility, present a case study of sterilizations in California, and analyze state prison policies that permit sterilization. Part III explores medical ethics and the lack of guidance from professional medical organizations on this issue. We conclude by addressing claims that access to sterilization is necessary for incarcerated women's reproductive autonomy, and making specific recommendations against the practice of sterilizing women in prison.

I. WOMEN, MASS INCARCERATION, AND THE EUGENICS LEGACY

Imprisonment and reproductive politics reflect the ongoing legacies of inequality and racial bias. Women from poor communities and communities of color disproportionately fill prison cells; these same women bear the brunt of public policies that regulate reproduction and punish women's reproductive decisions, including bans on public funding of abortion and the lack of support for single mothers.²³

Since 1980, the numbers of women in prison and jail have increased at least eightfold, to more than 200,000.²⁴ The United States incarcerates more people than any other country, including one-third of all women and girls in prison systems worldwide.²⁵ Harsh mandatory sentencing laws, especially for drug-related crimes, helped drive this upward trend.²⁶ Similarly, race bias at every stage of the criminal process—from arrest, to charging decisions, to jury selection, to sentencing recommendations—has resulted in a heightened risk of incarceration for African-American, Latina, and Native-American women.²⁷ In other words, the rising numbers of

23. See, e.g., SOLINGER, *supra* note 10; ROBERTS, *supra* note 10.

24. The United States Bureau of Justice Statistics estimated that, as of 2012, 108,866 women were incarcerated in federal and state prisons and 98,600 women were incarcerated in local jails. E. ANN CARSON & DANIELA GOLINELLI, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2012 - ADVANCE COUNTS 2 (July 2013), available at <http://www.bjs.gov/content/pub/pdf/p12ac.pdf>; TODD D. MINTON, BUREAU OF JUSTICE STATISTICS, JAIL INMATES AT MIDYEAR 2012 - STATISTICAL TABLES 5 (May 2013), available at <http://www.bjs.gov/content/pub/pdf/jim12st.pdf>.

25. ROY WALMSLEY, KING'S COLLEGE LONDON: INTERNATIONAL CENTRE FOR PRISON STUDIES, WORLD FEMALE IMPRISONMENT LIST 1 (2006), available at http://www.unodc.org/pdf/india/womens_corner/women_prison_list_2006.pdf.

26. MARC MAUER, THE SENTENCING PROJECT, THE CHANGING RACIAL DYNAMICS OF WOMEN'S INCARCERATION 9 (Feb. 2013), available at http://sentencingproject.org/doc/publications/rd_Changing%20Racial%20Dynamics%202013.pdf.

27. See generally ALEXANDER, *supra* note 22; JEROME G. MILLER, SEARCH AND DESTROY: AFRICAN-AMERICAN MALES IN THE CRIMINAL JUSTICE SYSTEM 12–55 (1996).

women in prison largely reflect policymakers' choice to treat drug use and addiction as a criminal matter instead of a public health matter, and the racial bias in the criminal system has made prisons an inverse reflection of the outside community.²⁸

Imprisonment is also a class issue. In Massachusetts, for example, fully half of those awaiting trial in the women's prison are behind bars because they cannot afford \$50 bail.²⁹ People who spend the pre-trial period in detention are more likely to get a jail or prison sentence than are people who can spend that period at home.³⁰ The criminal justice system thus perpetuates disadvantage, as those with the fewest resources to defend themselves from criminal charges end up serving more time, which in turn makes it even more difficult to find housing, secure employment, regain custody of children, and participate in civic life by voting once they return to the community.³¹

Policies that permanently penalize people with felony drug convictions are especially troubling. Federal and state policies impose years long or lifetime bans on public housing, public assistance, and food stamps.³² These policies hit women hard, because it is precisely low-income mothers, who are disproportionately women of color, who rely on these vital sources of assistance to take care of their families.³³ Excluded from these aid

28. The racial dynamics of women's incarceration have changed over the past decade. The number of African-American women in state or federal prison declined by 25%, while the number of white women rose by 48% and Latina women's incarceration rose by 75%. MAUER, *supra* note 26, at 6. To understand this change a different way, in 2000, African-American women were incarcerated at six times the rate of white women; by 2009, they were incarcerated at about three times the rate. MAUER, *supra* note 26, at 10. While the black-white disparity among women sentenced to prison is diminishing, racial disparities remain substantial.

29. ERIKA KATES, WELLESLEY CENTERS FOR WOMEN, MAKING WOMEN COUNT: WOMEN OFFENDERS IN MASSACHUSETTS 2 (May 2011), available at <http://www.wcwonline.org/pdf/ekates/MakingWomenCount.pdf>.

30. See, NAT'L LEGAL AID AND DEFENDER ASS'N, AMERICAN COUNCIL OF CHIEF DEFENDERS, POLICY STATEMENT ON FAIR AND EFFECTIVE PRETRIAL JUSTICE PRACTICES 6 (June 2011), available at <http://www.pretrial.org/download/policy-statements/ACCD%20Pretrial%20Release%20Policy%20Statement%20June%202011.pdf>.

31. See, generally, MARC MAUER & MEDA CHESNEY-LIND, EDs., INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT (2002).

32. Maggie McCarty, et al., *Drug Testing and Crime-Related Restrictions in TANF, SNAP, and Housing Assistance*, CONGRESSIONAL RESEARCH SERVICE 8 (2013), available at http://assets.opencrs.com/rpts/R42394_20120307.pdf.

33. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (better known as "welfare reform") includes a ban on certain public benefits, including cash and food assistance, for people convicted of drug-related felonies. 21 U.S.C.A. § 862(a) (West 2014). Over time many states have passed laws to opt out of or modify the ban because, as the Sentencing Project shows, it has had a damaging impact on the lives of women and families. MARC MAUER & VIRGINIA MCCALMONT, THE SENTENCING PROJECT, A LIFETIME OF PUNISHMENT: THE IMPACT OF THE FELONY DRUG BAN ON WELFARE BENEFITS 2, 4 (2014), available at http://sentencingproject.org/doc/publications/cc_A%20Lifetime%20of%20Punishment.pdf. See also PATRICIA ALLARD, THE SENTENCING PROJECT, LIFE SENTENCES: DENYING WELFARE BENEFITS TO WOMEN CONVICTED OF DRUG OFFENSES 2 (2002), available

programs, formerly incarcerated people must find work, but employment policies, both official and unofficial, that require disclosure of criminal records make it difficult to get and keep jobs.³⁴ Women from poor urban communities find themselves in a vicious cycle—they live in neighborhoods that are more heavily policed in the first place, subjecting them to greater risks of arrest than women in more affluent neighborhoods, and they face the greatest challenges to resuming life on the outside when they come home from prison.³⁵

They are also the most likely to feel the impact of punitive reproductive policies. Policymakers and the public single out certain women for coercive reproductive interventions, including sterilization. In 2008, for example, a Louisiana legislator suggested that the state pass a law allowing \$1,000 payments to every woman receiving public assistance who agreed to be sterilized.³⁶ An Arizona official with the state Republican party recently said, “You put me in charge of Medicaid [and] the first thing I’d do is get [female recipients] Norplant, birth-control implants, or tubal ligations.”³⁷ Women who use public assistance have long been demonized as “welfare queens” who engage in fraud to wrest undeserved support from the state.³⁸ This racialized demonization underlies a host of punitive measures to limit the scope of benefits and impose substantial requirements in return for assistance.³⁹

at http://www.sentencingproject.org/doc/publications/women_lifesentences.pdf. In addition, almost 20 states still automatically suspend people’s licenses to drive when they are convicted of drug offenses. LEAH SAKALA, PRISON POLICY INITIATIVE, SUSPENDING COMMON SENSE IN MASSACHUSETTS: DRIVER’S LICENSE SUSPENSION FOR DRUG OFFENSES UNRELATED TO DRIVING 1 (May 2014), available at <http://www.prisonpolicy.org/driving/report.pdf>.

34. MAUER & CHESNEY-LIND, *supra* note 31.

35. Beth Richie, *The Social Impact of Mass Incarceration on Women*, in *INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT*, 136–149 (Marc Mauer & Meda Chesney-Lind, eds., 2002).

36. Mark Woller, *LaBruzzo Considering Plan to Pay Poor Women \$1000 to Have Their Tubes Tied*, NOLA.COM/THE TIMES-PICAYUNE (Sept. 23, 2008, 10:40 PM), http://www.nola.com/news/index.ssf/2008/09/labruzzo_sterilization_plan_fi.html. While a “voluntary” program, similar rhetoric fuels “Project Prevention,” formerly known as CRACK (Children Require a Caring Kommunity (sic)), an organization that pays people with substance addictions to become sterilized. See Lynn M. Paltrow, *Why Caring Communities Must Oppose C.R.A.C.K./Project Prevention: How C.R.A.C.K. Promotes Dangerous Propaganda and Undermines the Health and Wellbeing of Children and Families*, 5 J. L. SOCIETY 11, 11–12, 16 (2003).

37. Stephen Lemons, *Russell Pearce Disses Government Programs for the Poor on His Radio Show, While Helping to Run One*, PHOENIX NEW TIMES, Sept. 10, 2014, http://blogs.phoenixnewtimes.com/valleyfever/2014/09/russell_pearce_denounces_government_programs_on_his_radio_show_while_helpin.php.

38. See, e.g. ROBERTS, *supra* note 10, at 207–208; Gary Delgado & Rebecca Gordon, *From Social Control to Social Control: Welfare Policy and Race*, in *FROM POVERTY TO PUNISHMENT: HOW WELFARE REFORM PUNISHES THE POOR* 28–33, (Gary Delgado ed., 2002); KAARYN S. GUSTAFSON, *CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF POVERTY* (2011).

39. See generally, GWENDOLYN MINK, *WELFARE’S END* (2d ed. 2002).

Attitudes toward women in prison are similarly disparaging. In response to a news story about a bill to establish a prison nursery in Connecticut, a commenter wrote on the newspaper's website, "Abortion is far cheaper . . . and more convenient," concluding, "Just tie the girl's tubes after the first free abortion."⁴⁰ An online essay about remembering imprisoned women on Mother's Day elicited this blanket statement: "All prisoners should be sterilized upon incarceration."⁴¹

It is not only people who spend their time commenting on websites who hold such dehumanizing opinions. A physician employed by a California prison felt no compunction justifying the sterilization of incarcerated women in economic terms. The obstetrician-gynecologist at Valley State Prison for Women stated that the amount of money the state prison system spent on sterilizations was small "compared to what you save in welfare paying for these unwanted children—as they procreated more."⁴² Not only did this physician assume (incorrectly) that mothers receiving public benefits have a higher than average number of children,⁴³ and that any children women might have in the future would be unwanted, but he apparently placed the state's alleged financial interests over his professional obligation to provide individualized care for his patients.

As these examples of public policy and attitudes demonstrate, women are disdained simply for being in prison, and imprisonment systematically erodes their reproductive autonomy. This stark reality demonstrates the need for legal protection of the reproductive health and rights of women in prison, as does the history of coercive sterilization, to which we now turn.

A. THE HISTORY OF STERILIZATION ABUSE IN THE UNITED STATES

The experiences of women sterilized while serving time in California evoke the long history of forced and coerced sterilization in the United States.⁴⁴ Women in prison in California and throughout the nation come from the same groups that have historically suffered sterilization abuse—poor women, women who receive public assistance, and women of color,

40. "My two sense," Comment to Joanne Somers, *Niantic Prison Would Get Nursery for Inmates' Infants Under Proposal*, THE DAY (May 20, 2013, 7:46 PM), <http://www.theday.com/article/20130520/NWS01/305209966/-1/nws>.

41. Molon Labe, Comment to Victoria Law & Tina Reynolds, *Birthing Behind Bars: Fighting for Reproductive Justice for Women in Prison*, ALTERNET (May 10, 2012), http://www.alternet.org/comments/story/155378/birthing_behind_bars%3A_fighting_for_reproductive_justice_for_women_in_prison#disqus_thread.

42. Johnson, *Female Inmates Sterilized*, *supra* note 5.

43. In fact, in California, the number of children in families receiving public assistance is no different than that of the average family in California – just over two children. Caroline Danielson, *California's Welfare Recipients: Family Circumstances, Income, and Time on Aid Among CalWork's Families*, PUB. POLICY INST. OF CAL. 11 (2012), available at http://www.ppic.org/content/pubs/report/R_512CDR.pdf.

44. See generally, MAY, *supra* note 10; SOLINGER, *supra* note 10; ROBERTS, *supra* note 10, at 4.

especially African-American, Latina, and Native-American women.⁴⁵ Their advocacy efforts led to the adoption of federal regulations that attempt to ban sterilization abuse, and parsing that history is critical to understanding the context in which sterilizations in prison take place today.

1. A brief history of eugenic and coercive sterilization policies and practices

In the beginning of the twentieth century, state governments singled out poor, usually white, women and men considered “feebleminded” or “promiscuous” and hence “unfit” to reproduce. Often institutionalized, those targeted were sterilized against their will, or without being told the true nature of the operation.⁴⁶ Indiana passed the nation’s first compulsory sterilization law in 1907.⁴⁷ Thirty states ultimately adopted such laws, and the Supreme Court upheld their constitutionality in 1927—a ruling that the Supreme Court has never expressly overturned.⁴⁸

These laws, and the thousands of people harmed by them, were the pinnacle achievement of the United States’ eugenics movement, which used pseudo-science on supposedly inheritable traits to justify the imposition of sterilization on people deemed inferior.⁴⁹ This movement was largely discredited in the United States after World War II, as people learned of the horrors of Nazi Germany,⁵⁰ but a eugenicist politics lingered, as policymakers and nongovernmental actors began to shift their focus to poor women outside of institutions, especially poor women of color.⁵¹

Under this new regime, welfare caseworkers threatened women with loss of their benefits if they did not submit to sterilization operations.⁵²

45. ROBERTS, *supra* note 10, at 97 (“The racial disparity in sterilization cuts across economic and educational lines.”).

46. *See generally*, ANGELA Y. DAVIS, *WOMEN, RACE, AND CLASS* 202–21 (1981).

47. J. H. LANDMAN, *HUMAN STERILIZATION: THE HISTORY OF THE SEXUAL STERILIZATION MOVEMENT* 291 (1932).

48. *Buck v. Bell*, 47 S.Ct. 584 (1927). Arguably, however, the Supreme Court’s opinion in *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (recognizing the right to procreate as “one of the basic civil rights of man”) and subsequent developments in the jurisprudence of the privacy right undercut the vitality of this infamous opinion.

49. *See* Paul A. Lombardo, *Medicine, Eugenics, and the Supreme Court: From Coercive Sterilization to Reproductive Freedom*, 13 J. CONTEMP. HEALTH L. & POL’Y 1 (1996) (“If we evaluate the eugenicists on their legislative accomplishments, and calculate the number of people affected by ‘eugenical’ laws, their success must be considered extraordinary.”)

50. MAY, *supra* note 10, at 116.

51. MAY, *supra* note 10, at 118–23; *See also* Dorothy E. Roberts, *Crime, Race, and Reproduction*, 67 TUL. L. REV. 1945, 1966–7 (1993).

52. *See, e.g.*, *Relf v. Weinberger*, 372 F.Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977).

[T]here is uncontroverted evidence in the record that minors and other incompetents have been sterilized with federal funds and that an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization. Patients receiving Medicaid assistance at childbirth are

Medical personnel thrust “consent” papers at women to sign when they were in the throes of labor, withheld pain medication or told women they would not deliver their babies if they did not sign, or sought signatures from women who could not read or understand English.⁵³ Some doctors destroyed women’s fertility when they were performing unrelated surgeries, without informing the women at all, let alone obtaining their consent.⁵⁴ Others lied to women and told them that the procedure was temporary. Government dollars were used to sterilize girls as young as 12.⁵⁵ Sterilization procedures were so common in some poor Southern African American communities that civil rights leader Fannie Lou Hamer famously referred to them as “Mississippi appendectomies.”⁵⁶ (Hamer had been subjected to involuntary sterilization herself.)

2. Women subjected to sterilization abuse fight back

In the 1970s, women of color and their allies brought lawsuits and organized campaigns to expose sterilization abuse.⁵⁷ Public health activist

evidently the most frequent targets of this pressure, as the experiences of plaintiffs Waters and Walker illustrate. Mrs. Waters was actually refused medical assistance by her attending physician unless she submitted to a tubal ligation after the birth.

Relf, 372 F. Supp. at 1199.

53. *Relf*, 372 F. Supp. at 1199; see also MAY, *supra* note 10; SOLINGER, *supra* note 10; ROBERTS, *supra* note 10.

54. See, e.g., DAVIS, *supra* note 46; Kim Severson, *Thousands Sterilized, A State Weighs Restitution*, N.Y. TIMES, Dec. 9, 2011, http://www.nytimes.com/2011/12/10/us/redress-weighed-for-forced-sterilizations-in-north-carolina.html?pagewanted=all&_r=0&pagewanted=print (describing the North Carolina legislature’s consideration of a bill that would require state funds to compensate the estimated 7,600 people subjected to eugenic sterilization in North Carolina, and noting the story of Elaine Riddick, who became pregnant at the age of 14 after a rape, and was sterilized without her knowledge or consent after giving birth.) As the article explains, North Carolina was particularly notorious because unlike other states that relied on judges to issue sterilization orders, North Carolina empowered its social workers to subject people to sterilizations. The same article recounts the story of a woman who was told she was having an appendectomy and only found out when she was having health problems at age 27 that she had been sterilized as a teenager. Her reflection as a woman in her 60’s shows what is at stake in destroying someone’s fertility: “I see people with babies and I think how much I would have loved to have a young one. It should have been my choice whether I wanted to have a baby or not. You just feel like you were held back, like you never had any say in your life.” In 2013, the legislature passed and the governor signed the bill establishing the compensation fund. See STATE OF NORTH CAROLINA: GOVERNOR PAT MCCRORY *Governor Pat McCrory Signs Fiscally Responsible Budget* (July 26, 2013), <http://www.governor.nc.gov/newsroom/press-releases/20130726/governor-pat-mccrory-signs-fiscally-responsible-budget>.

55. *Relf*, 372 F. Supp. at 1199; MAY, *supra* note 10, at 121–122.

56. MAY, *supra* note 10, at 121.

57. See JESSICA GONZALEZ-ROJAS & TAJA LINDLEY, NAT’L WOMEN’S HEALTH NETWORK, LATINAS AND STERILIZATION IN THE UNITED STATES (May/June 2008), <https://nwhn.org/latinas-and-sterilization-united-states> (describing activism against coercive sterilization, including a lawsuit, *Madrigal v. Quilligan*, brought by ten monolingual Spanish-speaking women against a Los Angeles hospital whose doctors had sterilized the women within hours of their giving birth).

Dr. Helen Rodriguez-Trias describes the story of a young woman detained by the New York City police who was pregnant and wanted to have an abortion. The employee at the public city hospital who “counseled” her about the abortion recommended sterilization as the best way to prevent future unintended pregnancies. “Uninformed and misled” about the procedure, the young woman agreed to the surgery.⁵⁸

In response to this activism and publicity, the federal health department issued regulations in 1974 to restrict the use of federal funds for sterilization.⁵⁹ Congress also acted, passing a law in 1975 making it a crime for people administering or working in federally funded programs to coerce any person to be sterilized or obtain an abortion by threatening the person with the loss of or disqualification from federal benefits.⁶⁰ Finding the 1974 regulations inadequate, individual women who had suffered sterilization abuse and the National Welfare Rights Organization challenged them in court,⁶¹ a suit that ultimately led to the adoption of the current federal regulations in 1979.⁶²

3. The federal government regulates sterilization and acts to protect people in prison

The sterilization regulations, essentially unchanged since their adoption, attempt to carefully guard the interests of people at risk for coercive sterilization. As explained below in section I.B, they prohibit federal Medicaid funding for sterilizations, unless the physician has

58. Kathryn Krase, *Sterilization Abuse: The Policies Behind the Practice*, 21 NETWORK NEWS: THE NEWSLETTER OF THE NATIONAL WOMEN’S HEALTH NETWORK 1 (1996).

59. Rulemaking was initiated in late 1973 after the Department of Health, Education and Welfare (HEW) issued a moratorium on federal funding for sterilization of legally incompetent people and young people under 21. As the Department later explained, the moratorium was initiated in response to “several tragic examples of sterilization abuse under the Federal programs.” Provision of Sterilization in Federally Assisted Programs of the Public Health Service, 43 C.F.R. § 52146-1(A)(1) (1978).

60. 42 U.S.C. § 300a-8 (2010) (passed in 1975 as part of a larger health care programs’ amendments bill, PL 94-63, July 29, 1975, 89 Stat 304).

61. *Relf v. Weinberger*, 372 F.Supp. 1196 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977).

62. Although the rules were designed to eliminate federal participation in coercive sterilization, they were highly contested by mainstream pro-choice activists, who saw the rules as a violation of the right to reproductive decision-making. *See, e.g.*, 43 C.F.R. § 52165 (1978) (“It was also suggested [during public hearings] that the proposed rules would . . . interfere with women’s rights to reproductive self-determination”); DAVIS, *supra* note 46, at 216–21. Such opposition demonstrated little understanding of the fact that women of color and low-income people had suffered forced and coercive sterilizations for decades leading up to the *Relf* litigation and the enactment of the sterilization regulations. As Dorothy Roberts explains,

[m]ost of the organizations that opposed sterilization reform had no eugenic motive; they simply failed to understand the concerns of the poor minority women. Focusing on the obstacle the regulations would pose to middle-class white women, they ignored the ravages on minority women’s bodies the new law would help to prevent.

ROBERTS, *supra* note 10, at 96.

obtained the patient's informed consent.⁶³ Further, programs funded "in whole or in part" through the federal Public Health Service may not arrange for or provide sterilizations without the patient's informed consent.⁶⁴ Most significantly, Medicaid and Public Health Service program funds may not be used to sterilize incarcerated and otherwise institutionalized people—under any circumstances, regardless of whether "consent" was obtained.⁶⁵

While it is the sterilization regulations that are most germane here, parallel developments involving medical experimentation on imprisoned people further illuminate the dehumanization that comes all too frequently with the prison setting. In the late 1960s and 1970s, people in prison, their allies, and dissenters in the medical profession fought to expose and end medical experimentation on people in prison.⁶⁶ Following Congressional hearings and investigations by special commissions, the federal government adopted regulations in 1978 to limit experimentation on human subjects in prison and jail.⁶⁷ The regulations limit the kinds of research that can be conducted in prison and designate prisoners as a "vulnerable population" for whom informed consent is problematic, given that people in prison may be induced to participate by the offer of even modest financial rewards and because people may seek to better their situation by winning the approval of prison administrators who have approved the research.⁶⁸

Sterilization is not experimental, but it is permanent. Women in prison by definition live in a hostile, coercive environment that limits their ability to make free decisions about a full range of reproductive options. This remains as true today as it was in 1979 when the federal sterilization regulations were adopted, and is even more pressing given how many more women are incarcerated today. As Misty Rojo explained in her testimony before a California legislative committee,

63. 42 C.F.R. § 441.253 (2013).

64. 42 C.F.R. §§ 50.201, 50.203 (2010).

65. 42 C.F.R. § 441.254 (2013); 42 C.F.R. § 50.206 (2013). The regulations define an "institutionalized" person as "an individual who is (1) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or (2) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness." 42 C.F.R. § 50.202 (2013).

66. *See generally*, ALLEN M. HORNBLUM, *ACRES OF SKIN: HUMAN EXPERIMENTS AT HOLMESBURG PRISON: A TRUE STORY OF ABUSE AND EXPLOITATION IN THE NAME OF MEDICAL SCIENCE* (1998).

67. *See, e.g.*, 45 C.F.R. § 46.301 *et seq.* (2014) (recognizing that the "constraints" of incarceration may affect an incarcerated person's "ability to make a truly voluntary and uncoerced decision whether or not to participate as [a subject] in research").

68. INST. OF MED. ET AL., *ETHICAL CONSIDERATIONS FOR RESEARCH INVOLVING PRISONERS* 73–108 (2007) (a patchwork of regulations apply to research conducted in prisons, depending on the funding source and institutional affiliation of the investigator).

When you are in prison, you do what you are told to do, to get out, period. So even in the idea of medical care, if a doctor tells you, you should do this. You are automatically inclined to feel like you should do it. Simply because of the environment you are in . . . if they hand you a paper, you sign it, that's it. Some people may be happy with that decision, but at the end of the day it is not informed consent, and it is coercive.⁶⁹

B. THE MEANING OF THE FEDERAL STERILIZATION REGULATIONS FOR PEOPLE IN PRISON

Eliminating coercion is the key attribute of the federal sterilization regulations (“the sterilization rules”).⁷⁰ As noted above, the sterilization rules affect both Medicaid and Public Health Service-funded projects.⁷¹ The regulatory scheme seeks to ensure that federal funds will not be used to sterilize anyone without that person's meaningful informed consent.⁷² The consent requirements are rigorous, and include the patient's signature on a federally prescribed form that expressly states that no federal benefits or services are conditioned on sterilization.⁷³ Given the social climate in which these rules were adopted, and the emphasis on informed consent, the flat prohibition on using federal monies to sterilize incarcerated people should be read as an assertion of the rights of incarcerated people to decisional autonomy in a context where most of that autonomy has been abridged (even if only temporarily), and meaningful consent to the permanent destruction of fertility is simply not realistic.⁷⁴

69. *Correctional Health Care Services: Sterilization of Female Inmates, Hearing Before Cal. Joint Leg. Audit Comm.* (Aug. 21, 2013), available at http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=1577.

70. We focus here on the sterilization regulations, not on a federal statute, 42 U.S.C. § 300a-8, that makes it a crime to coerce sterilization by threatening the loss of federal benefits. Our concern is with state, institutional, and medical policies and practices, rather than the possibly criminal actions of any individual actor.

71. The relevant programs—Medicaid and the Public Health Service—provide significant funding for health care services to qualified individuals, as well as health-related programs, health centers, and hospitals throughout the United States. In brief, Medicaid is a federal-state partnership, in which the federal government shares the cost of medical care for low-income people who qualify. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2581, 183 L. Ed. 2d 450 (2012), *citing* 42 U.S.C. § 1396a(a)(10).

72. 42 C.F.R. § 441.253 (2013) (prohibiting Medicaid reimbursement for sterilizations unless provided to a mentally competent patient age 21 or over, with that patient's informed consent); 42 C.F.R. § 50.203 (2013) (setting forth the same requirements of programs funded in whole or in part by the Public Health Service).

73. 42 C.F.R. § 441.257 (2013); 42 C.F.R. § 50.204 (2013). The regulations' requirements for informed consent are more stringent than those generally imposed by state law or medical ethics. Under the regulations, a provider must inform a prospective patient that eligibility for public benefits does not depend on sterilization. Further, the rules mandate a 30-day waiting period between the patient signing the consent form and having the surgery. In addition, federal financial participation (i.e., reimbursement) is only available for procedures performed on mentally competent adults over the age of 21. *Id.*

74. *See, e.g., N.C. DEP'T OF HUMAN RESOURCES, DEPARTMENTAL GRANT APPEALS BOARD*

1. The reach of the federal sterilization rules

The Center for Medicare & Medicaid Services requires, reviews, and approves state plans for the provision of Medicaid, to ensure state compliance with federal law.⁷⁵ Under the sterilization rules, states must assert in their Medicaid plans that they will not reimburse providers for sterilizations or hysterectomies unless all the informed consent requirements are met, and the provider abides by the prohibition on sterilizations of people who are under 21, mentally incompetent, or institutionalized.⁷⁶ Federal reimbursement is not available for sterilizations performed in violation of these rules.⁷⁷

In contrast to the singular Medicaid program, the federal Public Health Service supports a range of programs and health-related activities, including the Indian Health Service and the Health Resources and Services Administration (which distributes federal family planning funds).⁷⁸ Programs funded, “in whole or in part,” through the federal Public Health Service are prohibited from providing or arranging for the sterilization of any incarcerated or otherwise institutionalized person, and must comply with all the informed consent requirements for mentally competent adults over age 21.⁷⁹

2. The ban on federal involvement in the sterilization of people in prison

The first version of the proposed rules allowed for federal funding to sterilize incarcerated and institutionalized individuals under some circumstances.⁸⁰ But after reviewing the public comments, the Department of Health, Education and Welfare (HEW)⁸¹ ultimately decided to ban federal funding for “institutionalized persons,” including those who are incarcerated. Although compiled more than 30 years ago, the public comments raised the same kinds of concerns expressed by people in prison

DECISION NO. 285 (April 29, 1982) (“The legislative history of federal sterilization regulations reflects an underlying concern for the well being of those persons who might be sterilized.”)

75. 42 C.F.R. § 430.10 (2013).

76. 42 C.F.R. § 441.252 (2013).

77. 42 C.F.R. § 441.256 (2013).

78. See C. STEPHEN REDHEAD & PAMELA W. SMITH, CONGRESSIONAL RESEARCH SERVICE, PUBLIC HEALTH SERVICE (PHS) AGENCIES: OVERVIEW AND FUNDING, FY2010–FY2102 (Mar. 31, 2011), available at http://www.tennessee.edu/govrelations/docs/Public_health.pdf (explaining that three of the eight PHS agencies provide health care services or help fund systems that do so. [Indian Health Services] supports a health care delivery system for American Indians and Alaska Natives . . . [Health Resources Services Administration] funds programs and systems to improve access to health care among the uninsured and medically underserved . . . [the Substance Abuse and Mental Health Services Administration] funds mental health and substance abuse prevention and treatment services).

79. 42 C.F.R. § 50.201 (2013).

80. 43 C.F.R. § 52156 (1978).

81. This department is now known as Health and Human Services (HHS).

and their allies today, including the risk that the process of obtaining consent will be “manipulated by the conferring of rewards [to people who agree to be sterilized] or punishments [to those who do not].”⁸² The information about the public comment to the rules, while brief, supports the wholly logical conclusion that, in the context of responding to the outcry and lawsuits of people sterilized against their will, HEW included a ban on sterilizing incarcerated people because the “potentially coercive” prison environment undermines meaningful informed consent to a surgery that permanently ends a person’s ability to have children.⁸³

3. The federal ban’s application to people in state prisons

While the intent of the federal regulations to prohibit the sterilization of people in prison is clear,⁸⁴ its application to people in state prison is more complicated. First, Medicaid is generally not available to reimburse health care services to people who are incarcerated.⁸⁵ This is true even if a specific individual would be eligible for Medicaid if she were in the community instead of in prison. However, Medicaid will reimburse the costs of medical care for eligible incarcerated people who are hospitalized for 24 hours or more.⁸⁶ Since pregnant incarcerated women give birth—and are sometimes sterilized—in hospitals, and their care is costly, presumably state prisons would prefer that hospitals bill Medicaid instead of sending the bill to them.⁸⁷ But the sterilization rules do not contemplate that the ban on sterilizing incarcerated people with federal funds could be lifted simply by recasting the woman as a non-incarcerated patient. In short, providers will not—or should not—receive Medicaid reimbursement for a sterilization performed on a person who is incarcerated.

82. 43 C.F.R. § 52156 (1978).

83. 43 C.F.R. §§ 52146-52171 (1978) (noting at 52156 that “the intent of the definition [of institutionalized individuals] is to cover institutions which, because of the legal nature of the confinement or the mental disability of the person confined, constitute a potentially coercive environment”).

84. The ban on the use of federal funds is echoed in policy governing the federal Bureau of Prisons, which prohibits sterilization “as a form of birth control.” U.S. BUREAU OF PRISONS, HEALTH SERVICES MANUAL, CHAPTER XI: FEMALE HEALTH CARE, P.S. 6000.05 § 10–11 (Sept. 15, 1996) (on file with authors).

85. 42 U.S.C. § 1396d(a)(29)(A) (2010).

86. 45 C.F.R. §§ 435.1009, 435.1010 (2013).

87. *See, e.g.*, Letter from Richard Allen, Dep’t of Health & Human Services, Center for Medicare & Medicaid Services, Region VIII, to Colorado Attorney General John W. Suthers (Jan. 16, 2013), *available at* <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251848229033&ssbinary=true> (explaining that Colorado cannot get around the ban on Medicaid reimbursement for care to incarcerated people by claiming that people in privately-contracted community corrections facilities are not “inmates of a public institution,” and noting that pregnant women in such institutions would be eligible for federal reimbursement of medical care provided they are admitted to a hospital for 24 hours or more).

Unlike the Medicaid rules, the Public Health Service rules do not operate through a reimbursement per procedure method; they simply prohibit grantees from sterilizing people unless they follow the rules.⁸⁸ It is likely that most hospitals providing services to women brought from prison receive funding through the Public Health Service.⁸⁹ The question, then, is whether receipt of Public Health Service funding constrains only the program funded by the grant, or all of the actions of the grantee.⁹⁰ Given the plain meaning of the language “in whole or in part,” there is an argument to be made that the Public Health Service regulations would prohibit a hospital that received Public Health Service funding from “arranging for or providing” sterilization of incarcerated people with any of its funds. This argument is undercut, somewhat, by the federal agency’s 1978 response to public comments on the proposed regulations, explaining that the sterilization rules for the Medicaid program and the Public Health Service programs are “identical. The regulations differ only in the choice of regulatory mechanism, since the [Medicaid] programs regulate by restricting Federal financial participation if the Federal requirements are not followed, while PHS regulates primarily by making following the requirements a condition of the grant.”⁹¹

Case law does not answer the question, as few courts have had occasion to interpret *any* aspect of the sterilization rules, and no court has considered the meaning of the regulatory ban on sterilizing people in prison. Those courts that have considered the Medicaid sterilization rules in the context of patient lawsuits have interpreted the regulations narrowly.⁹² If the regulations apply to all the actions of a funded hospital –

88. 42 C.F.R. § 50.206 (2014).

89. In 2013, 48 states received Small Hospital Improvement Program grants through the federal Health Resources and Services Administration. These funds were distributed to multiple hospitals in each recipient state. *Active Grants for HRSA Program(s), Small Rural Hospital Improvement Program (H3H)*, HEALTH RES. AND SERV. ADMIN., http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=H3H&rs:Format=HTML4.0 (last visited Oct. 1, 2014). Hospitals are also funded through other Public Health Services programs. For example, according to the Department of Health and Human Services, at least some Title X-funded clinics are based in hospitals. *Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERV., <http://www.hhs.gov/opa/title-x-family-planning/index.html> (Sept. 26, 2013, 12:30 PM) (*citing* CI FOWLER ET AL., RTI INTERNATIONAL, FAMILY PLANNING ANNUAL REPORT: 2011 NATIONAL SUMMARY (Nov. 2012)).

90. This is in contrast to programs like the Indian Health Service, which, as an entity of the Public Health Service, is clearly banned from “arranging for or providing sterilization” for people who are incarcerated.

91. 43 Fed. Reg. 52148 (1978).

92. State court decisions suggest that the Medicaid sterilization rules do not create a duty to follow the consent standards for every patient in the hospital. *See, e.g., Isaac v. Jameson Memorial Hospital*, 932 A.2d 924, 929 (Pa. Super. Ct. 2007) (“the regulations cannot be read to place an independent duty on [a hospital] to obtain [the patient’s] informed consent”); *Hare v. Parsley*, 157 Misc. 2d 277, 280–81 (N.Y. S. Ct. 1993) (granting summary judgment to a patient on her negligence claim against a doctor and a hospital who violated the Medicaid sterilization rules when they sterilized her after caesarean surgery without

and not only Public Health Service programs within the hospital—then those hospitals are prohibited across the board from sterilizing incarcerated people, on pain of loss of those funds. If, however, courts interpret the Public Health Service regulations in the narrow fashion in which they view the Medicaid regulations, this argument is less promising. Until incarcerated people and their advocates seek agency guidance or file complaints with HHS arguing that hospitals receiving Public Health Service funds cannot permit any incarcerated people to be sterilized on the premises, even if other funding sources pay for the sterilization, the question will remain unanswered.⁹³

Despite the dearth of judicial interpretations, the rules evince strong federal policy against the sterilization of people in prison. They were adopted in a context of attempting to eliminate coercion⁹⁴ and recognizing that sterilization of institutionalized persons, including those who are incarcerated, is necessarily involuntary.⁹⁵ This principle is, unfortunately, ignored in some states, to the detriment of the reproductive health and wellbeing of women in prison.

II. STERILIZATION ABUSE IN PRISON TODAY

Understanding the conditions in which incarcerated women try to obtain treatment for their medical needs as well as the way those conditions may discourage women from seeking medical attention is critical to assessing whether meaningful consent to permanent sterilization is realistic in the prison context. In this Part, we explore these oppressive conditions,

obtaining her informed consent to the procedure more than 30 days prior). In *Hare*, the court based its decision on the fact that the patient was eligible for Medicaid. However, the judge also opined that even if the Medicaid regulations did not apply, the circumstances under which Hare's "consent" was obtained in this case—after her membranes had ruptured and prior to an emergency cesarean surgery—“deviated from accepted standards of medical care.” While this particular court decision honors patient autonomy, it suggests that the court viewed the Medicaid sterilization rules as applicable *only* to patients receiving Medicaid, and not as conferring on the hospital a broader duty toward all patients.

93. This is not to say that a woman sterilized against her will while incarcerated may not pursue other claims, such as negligence or lack of informed consent, against the surgeon or hospital. See *Morinaga v. Vue*, 935 P.2d 637, 643 (Wash. App. 1997) (the federal regulations are relevant to a negligence claim against a doctor for providing a sterilization without following the rules' consent procedures). However, as explained in Part II, incarcerated people face numerous challenges to litigating their rights in court, above and beyond the typical difficulties posed by medical malpractice or civil rights claims. See, e.g., *Thomas v. Hickman*, 2009 WL 1273190 (E.D. Cal. May 5, 2009) (woman incarcerated in California sued physicians, Madera Hospital, and medical staff at the prison for removing her ovary without her consent, denying for almost four years that they had removed it, and failing to treat her medical and psychological symptoms resulting from the surgery. After three years of litigation, which reduced the defendants down to just one doctor and eliminated her civil rights claim, a jury found in favor of the doctor, leaving the injured woman with nothing.)

94. See, e.g., *Relf v. Weinberger*, 372 F.Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977).

95. See 43 C.F.R. §§ 52146–52171 (1978). See, e.g., *Relf*, 372 F. Supp. at 1199.

offer a case study of the illegal sterilizations in California and analyze policies allowing sterilization in other state prison systems.

A. MEDICAL NEGLECT IN PRISON

Coercion is a fact of life in prison. And, unfortunately, so is poor medical care. People in prison are the only group in the United States with a constitutional right to medical care: in 1976, the Supreme Court held that depriving imprisoned people of adequate treatment for serious medical needs amounts to cruel and unusual punishment in violation of the Eighth Amendment.⁹⁶ And yet, the right to medical care is often stronger in theory than in practice.⁹⁷

California provides a particularly egregious example of prisons' failures to meet the medical needs of the people in their custody. As a three-judge panel of the federal district court of California explained, one person in a California prison was "dying needlessly *every six or seven days*."⁹⁸ Eight years later, a court-ordered review found that medical care for women incarcerated in California was still inadequate.⁹⁹ But medical neglect is not limited to California, or to state prison systems; investigative reports by human rights organizations expose severe health care shortcomings in, for example, immigration detention facilities.¹⁰⁰ And when governments privatize prison medical services, the profit motive can mean even worse access to care for people who are utterly dependent on the prison to meet their medical needs.¹⁰¹

People incarcerated in men's and women's prisons alike suffer from medical neglect and substandard medical services.¹⁰² But the circumstances of the majority of women in prison further limit their access to medical care. For women in prison, the majority of whom have experienced sexual or physical abuse,¹⁰³ the sometimes rough,

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

97. *See generally* Schlanger, *Inmate Litigation*, *supra* note 18.

98. *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 888 (E.D. Cal. 2009) (emphasis in original).

99. Victoria Law, Op-Ed., *California Turns to Private Prison to Address Overcrowding and Medical Care*, TRUTHOUT, June 10, 2014, <http://www.truth-out.org/opinion/item/24173>; JOE GOLDENSON, MADDIE LAMARRE & MIKE PUISIS, CENTRAL CALIFORNIA WOMEN'S FACILITY (CCWF) HEALTH CARE EVALUATION 5 (Dec. 11, 2013), *available at* <http://www.cphcs.ca.gov/docs/court/Plata-Expert-Report-CCWF.pdf>.

100. *See, e.g.*, HUMAN RIGHTS WATCH, *DETAINED AND DISMISSED: WOMEN'S STRUGGLES TO OBTAIN HEALTH CARE IN U.S. IMMIGRATION DETENTION 1* (Mar. 17, 2009).

101. *See, generally*, Paul von Zielbauer, *As Health Care in Jails Goes Private, 10 Days Can Be a Death Sentence*, N.Y. TIMES, Feb. 27, 2005, http://www.nytimes.com/2005/02/27/nyregion/27jail.html?_r=0; Mike Fuhrman, *Dying to Get Out*, COLUMBIA TRIBUNE, Sept. 29, 2002, <http://archive.columbiatribune.com/2002/sep/20020929feat007.asp>.

102. *See, e.g.*, Section 5, *Malign Neglect: Prison Medicine*, in *PRISON NATION: THE WAREHOUSING OF AMERICA'S POOR* 158–213 (Tara Herivel & Paul Wright eds. 2003).

103. AMERICAN CIVIL LIBERTIES UNION, *WORSE THAN SECOND CLASS: SOLITARY CONFINEMENT OF WOMEN IN THE UNITED STATES* 136 (2014), *available at* https://www.aclu.org/sites/default/files/assets/worse_than_second-class.pdf.

inappropriate, or even sexually abusive treatment they may receive from prison health providers can dissuade them from seeking medical care at all.¹⁰⁴

Pregnancy care is especially problematic, as demonstrated in numerous lawsuits brought by women whose experiences of substandard or total denial of care resulted in miscarriages, stillbirths, or the deaths of their newborn babies.¹⁰⁵ Prisons and jails frequently fail to meet the nutritional needs of pregnant women.¹⁰⁶ More than one incarcerated woman has given birth alone in a jail cell in the United States, as guards ignored her pleas for help.¹⁰⁷ Women suffering from postpartum depression—often exacerbated by the forced separation from their newborn babies—have been placed in solitary confinement,¹⁰⁸ a human rights violation.¹⁰⁹ Most states still permit

104. See Catherine G. Magee et al., *Preventive Care for Women in Prison: A Qualitative Community Health Assessment of the Papanicolaou Test and Follow-Up Treatment at a California State Women's Prison*, 95 AM. J. PUB. HEALTH 1712, 1712–1717 (2005) (women reported negative experiences with “unprofessional and sometimes rude” medical providers, as well as “an aversion to being examined by a male physician;” as a result of these conditions, “some women stated that they have avoided or even refused Pap testing” at the prison); see also, REPRODUCTIVE INJUSTICE, *supra* note 18, at 36 (“It’s so uncomfortable that lately I just sign refusals because I can’t take it,” explained a woman who refused to see the gynecologist in a New York prison).

105. See Rachel Roth, *Obstructing Justice: Prisons as Barriers to Medical Care for Pregnant Women*, 18 UCLA WOMEN’S L.J. 79 (2010). See also Diana Claitor & Burke Butler, *Pregnant Women in Texas County Jails Deserve Better Than This*, DALLAS MORNING NEWS, June 26, 2014, <http://www.dallasnews.com/opinion/latest-columns/20140626-pregnant-women-in-texas-county-jails-deserve-better-than-this.ece> (describing the story of Nicole Guerrero, who, while pregnant and incarcerated in the Wichita County Jail, was left alone in a “medical segregation cell” where she gave birth on a mat on the floor to a baby whose umbilical cord was wrapped around her neck. The baby died). See also *Boswell v. County of Sherburne*, 849 F.2d 1117, 1119 (8th Cir. 1988), *cert. denied*, *Witschen v. Boswell*, 488 U.S. 1010 (1989); *Boswell v. County of Sherburne*, 717 F. Supp. 686 (D. Minn. 1989); *Clifton v. Eubank*, No. 00-K-2555, 2007 U.S. Dist. LEXIS 9061, at *3 (D. Colo. Feb. 8, 2007).

106. Levi et al., *Creating the Bad Mother*, *supra* note 11, at 30–32 (describing how California prisons provided rotting food or not enough food to pregnant incarcerated people, and denying them legally mandated nutritional supplements); see also, REPRODUCTIVE INJUSTICE, *supra* note 18, at 81 (all incarcerated women interviewed and surveyed said they did not receive enough food when they were pregnant); Carole Schroeder & Janice Bell, *Doula Birth Support for Incarcerated Pregnant Women*, 22 PUBL. HEALTH NURSING 53, 55 (2005) (pregnant women in the King County Jail in Seattle, Washington said they were “constantly hungry”).

107. Claitor & Butler, *supra* note 105; see also RACHEL ROTH, CTR. FOR WOMEN POLICY STUDIES, “SHE DOESN’T DESERVE TO BE TREATED LIKE THIS”: PRISONS AS SITES OF REPRODUCTIVE INJUSTICE (July 2012), available at <http://www.centerwomenpolicy.org/news/newsletter/documents/RothCWPSUpdated13July2012FINAL.pdf>; Julie B. Ehrlich & Lynn Paltrow, *Jailing Pregnant Women Raises Health Risks*, WOMEN’S ENEWS, Sept. 20, 2006, <http://www.womensenews.org/article.cfm/dyn/aid/2894>.

108. See, e.g., MASS. GEN. LAWS ANN. ch. 127, § 118 (West 2014) (“A postpartum inmate shall not be subject to isolation absent an individualized, documented determination that the inmate poses a serious risk of harm to herself or others.”) The Massachusetts Legislature enacted this bill, in part, to address instances of placing postpartum women in isolation, a problem brought to light by the Prison Birth Project, based in Amherst, Massachusetts. Interview by Rachel Roth with Marianne Bullock (Aug. 8, 2014); Victoria Law, *The Untold*,

the shackling of pregnant, laboring, and postpartum women, a wholly unjustified¹¹⁰ and unconstitutional¹¹¹ practice that endangers women's safety and harms their dignity.¹¹²

Women trying to end a pregnancy are also at risk of being denied their right to abortion. Some jails and prisons have obscure, nonsensical, and unconstitutional policies that hinder or wholly deny women the ability to obtain a timely abortion procedure.¹¹³ Jurisprudential barriers, distance from an abortion provider, and cost also limit incarcerated women's access to abortion.¹¹⁴

Real-Life Story of the Prison in "Orange is the New Black" WAGING NONVIOLENCE, Apr. 23, 2014, <http://wagingnonviolence.org/feature/untold-real-life-story-behind-prison-orange-new-black/>. The problem is not limited to Massachusetts, according to correspondence between the Incarcerated Mothers Advocacy Project in Seattle, Washington; and the Prison Doula Project, Olympia, Washington; and Sara Ainsworth, in which advocates described working with women who had been placed in solitary confinement while suffering from postpartum depression.

109. See, e.g., Human Rights Comm., 87th Sess., July 10–28, 2006, Concluding Observations of the Human Rights Committee: United States of America, ¶ 32, U.N. Doc. CCPR/C/USA/CO/3/Rev. 1 (Dec. 18, 2006), available at <http://www1.umn.edu/humanrts/usdocs/hruscomments2.html> (expressing the Committee's concern with the practice in some U.S. prisons of detaining people in "cellular confinement" in a "depersonalized environment" in violation of the required respect for the inherent dignity of the person); see also, AMERICAN CIVIL LIBERTIES UNION, *supra* note 103, at 13.

110. Shackling is a practice generally decried by international human rights bodies regardless of the context or gender of the person upon which it is used. See, e.g., UNITED NATIONS COMMITTEE AGAINST TORTURE, *Observations of the Committee Against Torture on the Revision of the United Nations Standard Minimum Rules for the Treatment of Prisoners (SMR)* 9 (2013) ("the use of restraints should be avoided or applied as a measure of last resort, when all other alternatives for control have failed and for the shortest possible time, with a view to minimizing their use in all establishments and, ultimately, abandoning them.") Moreover, shackling a woman in the throes of childbirth advances no legitimate penological goal. See, e.g., *Brawley v. Washington*, 712 F.Supp.2d 1208, 1219–20 (W.D. Wash. 2010) (noting that there was no evidence that Ms. Brawley, a minimum security prisoner with no history of violence, posed any flight risk or likelihood of harming herself or others).

111. See *Villegas v. Metro. Gov't of Nashville*, 709 F.3d 563, 574 (6th Cir. 2013) ("The universal consensus from the courts to have addressed this issue as well as the chorus of prominent organizations condemning the practice demonstrates that, without any extenuating circumstances, shackling women during labor runs afoul of the protections of the Eighth Amendment").

112. See, e.g., THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE OPINION NO. 511: HEALTH CARE FOR PREGNANT AND POSTPARTUM INCARCERATED WOMEN AND ADOLESCENT FEMALES 2–3 (Nov. 2011), available at <https://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co511.pdf?dmc=1&ts=20140810T1315226147>.

113. See Diana Kasdan, *Abortion Access for Incarcerated Women: Are Correctional Health Practices in Conflict With Constitutional Standards?*, 40 PERSP. ON SEX. AND REPROD. HEALTH 59 (2009); Rachel Roth, *Do Prisoners Have Abortion Rights?*, 30 FEMINIST STUDIES 353 (2004).

114. See, e.g., *Roe v. Crawford*, 514 F.3d 789, 797 (8th Cir. 2008), reh'g en banc denied, No. 07-1491, 2008 U.S. LEXIS 6829 (Oct. 6, 2008) (while analyzing the constitutionality of a Missouri prison's policies prohibiting transporting an incarcerated woman out of the prison for an abortion, describing prison and jail administrative policies in other jurisdictions). All of the policies described in *Roe v. Crawford*, including those upheld by other courts, created unnecessary barriers to incarcerated women's access to abortion.

Yet, when imprisoned people attempt to assert their rights to medical care, they encounter significant procedural barriers. Since 1996, the Prison Litigation Reform Act has made it much more difficult for people in prison to bring claims of inadequate treatment to court.¹¹⁵ This, unfortunately, is the state of access to medical care for many incarcerated women and in many correctional institutions. Given this situation, it is not surprising that reports of sterilization in prisons reflect the same kinds of abuse, betrayal of patient decision-making and autonomy, and dehumanization of incarcerated women and their reproductive health needs.

B. INDIRECT FORMS OF STERILIZATION ABUSE IN PRISON

Tubal ligation surgeries are not the only way that women in prison lose their ability to have children. Prison practices that result in unnecessary hysterectomies or other operations that destroy fertility constitute indirect forms of sterilization abuse. Concerns about the high rates of hysterectomies in prisons in Ohio, for example, date back to the 1970s, when incarcerated women lodged complaints with the Ohio Advisory Committee of the U.S. Commission on Civil Rights that routine gynecological concerns were met with the prescription to have a hysterectomy.¹¹⁶ More recently, advocates for people incarcerated in New York, Missouri, and Arkansas have expressed concern about gratuitous hysterectomies and other forms of medical neglect and abuse that cause infertility.¹¹⁷ Women describe undergoing hysterectomies for fibroids or cysts, instead of receiving less drastic treatment.¹¹⁸

Advocates who work with women in prison in California have been concerned about assaults on women's fertility for many years. Because California has a well-established advocacy community, with strong connections to women inside prison and also to medical experts and

115. 42 U.S.C.A. § 1997e (West 2013); *see also* HUMAN RIGHTS WATCH, NO EQUAL JUSTICE: THE PRISON LITIGATION REFORM ACT IN THE UNITED STATES 1–3 (2009), available at <http://www.hrw.org/sites/default/files/reports/us0609web.pdf>.

116. Gerald Austin McHugh, *Protection of the Rights of Pregnant Women in Prisons and Detention Facilities*, 6 NEW ENG. J. ON PRISON LAW 231, 240 (1980).

117. Tina Reynolds, co-founder and chair of WORTH (Women on the Rise Telling HerStory) describes untreated cysts and fibroids leading to women being “sterilized” in the New York State prison system; Tina Reynolds, Panel Discussion at Hampshire College, *Interrupted Life: Incarcerated Mothers in the United States* (Feb. 13, 2007). Denise Lieberman recounted women's fear about needless hysterectomies, which deters women from going to the doctor. Interview by Rachel Roth with Denise Lieberman, Legal Director, ACLU of Eastern Missouri (July 17, 2003). Dee Ann Newell explained how hysterectomy patterns in Arkansas changed with the prison's contractor; as a cost saving measure, one contractor prescribed hysterectomies for women with cancer, even if the women were in their 20s and 30s. Personal Communication by Rachel Roth with Dee Ann Newell, founder of Arkansas Voices for the Children Left Behind (June 19, 2004).

118. In some cases, where pain and bleeding associated with fibroids are severe, a hysterectomy may be appropriate; however, it is not a first course of action. BOSTON WOMEN'S HEALTH COLLECTIVE & JUDY NORSIGIAN, OUR BODIES, OURSELVES 631–32, 638 (35th Anniversary ed. 2005).

researchers, more information is available about the situation in this state. Ellen Barry, who founded Legal Services for Prisoners with Children in San Francisco in 1978, has long heard from women in prison about “unauthorized” sterilization procedures.¹¹⁹

An African-American woman wrote to Legal Services for Prisoners with Children, sharing her experience of this phenomenon, and highlighting problems with informed consent in the prison context: “Time and again [the doctor] tried to convince me to have a hysterectomy, saying that the tumor could grow back, and I was 40 years old and wouldn’t have any children anyway. . . .”¹²⁰ Although she resisted the doctor’s urgings, in the end, her consent or lack thereof was meaningless. She had been diagnosed with an ovarian tumor and consented to surgery for the tumor but not to a hysterectomy. She was stunned to learn several months after the surgery that her uterus had been removed. An outside medical consultant who reviewed her file for Legal Services for Prisoners with Children concluded that a hysterectomy was appropriate because of the sum total of the woman’s gynecological problems, but also questioned whether the woman had consented to the surgery.¹²¹ It is clear from her description of events that she did not. As she said, “[t]hey destroyed all possibilities of me having children. . . . [w]hether I would or not, I should have been allowed the choice.”¹²²

This is a story of inexcusable oversights and omissions—omissions of information, proper procedures, and compassion. It is the story of a woman who was not told the extent of her medical diagnosis and why a particular course of treatment was recommended; she was not even told immediately after the surgery precisely what had been done to her body. The doctor met her concern about having children with callous comments about her age and also suggested that she should be grateful for getting an expensive surgery “for free.”¹²³

Other people’s experiences amplify the lack of meaningful consent to sterilization in the prison setting. A young African-American woman named Kelli Dillon sought treatment from the prison gynecologist when she was incarcerated at Central California Women’s Facility in 2001.¹²⁴ After surgery she suddenly found herself going through menopause at the

119. Ellen Barry, *Women Prisoners and Health Care: Locked Up and Locked Out*, in *MAN-MADE MEDICINE* (Kary Moss ed., 1996). Barry’s article drew on 19 years of experience interviewing imprisoned women about their experiences with medical care. *Id.*

120. Letter to Legal Services for Prisoners with Children (quoted with permission).

121. Prisoner complaint file, Legal Services for Prisoners with Children (reviewed with permission).

122. Letter to Legal Services for Prisoners with Children, *supra* note 120.

123. *Id.*

124. *Inmate Sterilization: Hearing on SB 1135 Before California Senate Health Comm.* (Apr. 2, 2014) (statement of Kelli Dillon) http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=1986 (Dillon was told she had endometriosis and cysts and should have a biopsy to check for pre-cancerous cells).

age of 24. As she explained: “I trusted the surgeon to respect and to acknowledge that I still had a future [and wanted to have children]. . . . I wasn’t given any other options of treatment, and because I was under the authority of the [prison system] at a very young age, I was uneducated and ignorant and I was conditioned to accept what my authorities was telling me.”¹²⁵ Dillon said, “I wanted a second chance at life and I wanted a second chance at being a mother.”¹²⁶ Not only was that chance extinguished, but no one explained to her what the surgeon had done; she had to file a grievance to find out why she was experiencing symptoms of menopause.

Incarcerated and formerly incarcerated people recount how prison medical staff aggressively pushed hysterectomies as a “first response” to fibroids, cysts, cervical abnormalities, human papilloma virus, and even stomach pain, in interviews with Oakland-based human rights organization Justice Now.¹²⁷ In two cases, women who underwent complete hysterectomies after diagnoses of cervical cancer found out later that they did not in fact have cancer.¹²⁸ In another case, the surgeon removed the wrong ovary.¹²⁹ In the course of documenting these incidents, Justice Now identified common themes: a general lack of informed consent to surgery, little or no information provided to women about the surgical procedures they underwent, and failures to provide information and support after the surgeries. In addition, the women and transgender men whose cases were documented tended to be people of color, and people as young as 22, with their whole adult lives ahead of them.¹³⁰

Shared knowledge of these experiences creates so much fear that some women decide to forego or delay needed care until they get out: “It’s not that I don’t want the surgery,” explained one woman who had been diagnosed with cervical cancer; “I don’t want it done here.”¹³¹ These situations also raise questions about the role of the medical staff at the hospital in the community where women have surgery. According to the woman quoted above, the surgeon she met with at the hospital never saw her pathology report or medical chart, and claimed “I’m just going on what [the doctor at the prison] told me” in recommending a radical hysterectomy. Ordinary standards of due diligence for diagnosing cancer and recommending a course of treatment, including physical examinations, conducting and interpreting biopsies and other tests, and discussing results

125. *Inmate Sterilization*, *supra* note 124.

126. *Id.*

127. *Prisons as a Tool*, *supra* note 11, at 312, 321–22.

128. *Id.* at 312, 321, 323.

129. *Id.* at 323.

130. *Id.*

131. Robin Levi, *Doing What Is Medically Necessary*, 36 OFF OUR BACKS 80 (2006). An advocate for women in prison in Missouri expressed similar concerns. Interview with Denise Lieberman, *supra* note 117.

and options with patients,¹³² are apparently violated by both prison and community-based medical organizations that have responsibility for providing women's care.

As these experiences illustrate, all the elements that make informed consent meaningful—such as being able to establish a trusting relationship with a health care provider, or getting a second opinion from an independent specialist¹³³—are either entirely lacking or severely curtailed by the way medical care is provided to people in prison in the United States. The problem only gets worse when prison officials and health care providers ignore policies designed to curb coercive or forced procedures.

C. STERILIZATIONS IN THE CALIFORNIA PRISON SYSTEM

Despite the history of sterilization abuse in California, for which both the Governor and the Attorney General have apologized,¹³⁴ the California Department of Corrections and Rehabilitation (CDCR) sterilized women in prison—contrary to explicit state policy—from at least 1997 until 2010. After seven years of investigation by Justice Now, the issue garnered significant media attention in the summer of 2013 with a series of articles by the Center for Investigative Reporting (CIR).

1. Women's experiences of coercive sterilization in the California prison system

Women report being pressured by doctors in prison and in the hospital to undergo sterilization, as well as cavalier attitudes about sterilizing women without ensuring their informed consent. Crystal Nguyen, who had worked in the infirmary at Valley State Prison for Women during her prison sentence, heard the medical staff asking women to agree to sterilization, especially women who had been incarcerated before. "I was like, 'Oh my God, that's not right.' Do they think they're animals, and they don't want them to breed anymore?"¹³⁵ As described above, a prison obstetrician told Christina Cordero she should be sterilized "as soon as" he found out she had five children. She had the operation. "I wish I would have never had it done."¹³⁶

Kimberly Jeffrey, who resisted the doctor's announcement that he was planning to sterilize her, was not "even quite sure if he was actually talking to me or if he was just making a general statement to all the medical staff," as she was being prepped for a cesarean surgery at the time—sedated and

132. See, e.g., Pont et al., *supra* note 21, at 476.

133. Stoller, *supra* note 21, at 2265 ("Consent for treatment, while technically available, is limited by the fact that prisoners have no choice in selection of care provider. It is either this one or none").

134. See Carl Ingram, *State Issues Apology for Policy of Sterilization*, L.A. TIMES, Mar. 12, 2003, <http://articles.latimes.com/2003/mar/12/local/me-sterile12>.

135. Johnson, *Female Inmates Sterilized*, *supra* note 5.

136. *Id.*

strapped to the operating table.¹³⁷ Although most known cases involve women who were in the hospital to give birth, at least one woman was approached about tubal sterilization when she was in the hospital for a different reason. A 34-year-old Latina woman told Justice Now that the doctor who performed hernia surgery told her that she had “enough” kids and should get her tubes tied. She does not know whether the surgeon did in fact perform a tubal ligation.¹³⁸ Perhaps not surprisingly given the all too common experiences of medical neglect in the prison setting, these sterilizations took place even though California prison officials were well aware that sterilization was not a permitted medical service for women in state custody under California law.

2. Subverting the ban on sterilization in the California prison system

In 2006, a California government commission on “gender responsive” prison strategies discussed the “cost effectiveness” of tubal ligations for women who give birth during their prison sentences.¹³⁹ If women were sterilized immediately following childbirth, the prison would not incur any additional expenses for transportation or hospital admission.¹⁴⁰ There was just one problem. Title 15 of the California Code of Regulations expressly prohibited prisons from paying for sterilization.¹⁴¹ But as the meeting minutes summarize, the commission decided to find a way to redefine tubal ligation as a “medically necessary” service in order to get around the prohibition.¹⁴²

137. See Pauline Bartolone, *California Seeks Answers On Questionable Prison Sterilizations*, NATIONAL PUBLIC RADIO (Sept. 20, 2013), <http://www.npr.org/2013/09/20/219366146/calif-seeks-answers-on-questionable-prison-sterilizations>; *Let Our Families Have a Future: “Sheri,”* JUSTICE NOW, <http://vimeo.com/70461530>. *Let Our Families Have a Future: “Sheri,”* is a video produced by Justice Now, in which “Sheri” (whose name has been changed and image obscured to protect her identity) testifies about the operation that left her sterile without her consent, saying

to know that what makes me a woman has been taken from me...that is a form of abuse, even though my time is done, this will follow me for the rest of my life...I wish to be a mother again and there is this realization, this pain, that physically I won't be able to do it.

Id.

138. See Letter from Cynthia Chandler, Exec. Dir. of JusticeNow, to Senator Loni Hancock, Chair of the Budget & Fiscal Review Subcomm. No. 5, 5 (Mar. 13, 2012), available at <http://www.jnow.org/downloads/JusticeNow.3.15.BudgetTestimony.FemaleOff.pdf> (regarding “Female Offenders Testimony of Justice Now Submitted to the California Budget and Fiscal Review Subcommittee No. 5 on Corrections, Public Safety, and the Judiciary”).

139. CAL. DEP'T OF CORR. AND REHAB., *Gender Responsive Strategies Comm'n Minutes*, 14 (July 18, 2006) (in letter from Cynthia Chandler to Senator Loni Hancock, attachment to Testimony of Justice Now, submitted to the Budget and Fiscal Rev. Subcomm. No. 5 on Corrections, Public Safety, and the Judiciary, March 13, 2012), available at <http://www.jnow.org/downloads/JusticeNow.3.15.BudgetTestimony.FemaleOff.pdf>.

140. *Id.*

141. Cal. Code of Reg. tit. 15, § 3350.1 (b) (2006) (defining vasectomy and tubal ligation as “surgery not medically necessary”).

142. CAL. DEP'T OF CORR. AND REHAB., *supra* note 139. The full passage reads:
The current contract language reads as, ‘Doing what is medically necessary.’

Justice Now quickly expressed concern about the proposal to sterilize women,¹⁴³ and sought information about whether women were being sterilized. Despite assurances from prison leadership that “the practice would never occur,”¹⁴⁴ in 2008, the Receiver appointed by a federal judge to overhaul the medical system confirmed that imprisoned women had indeed had post-partum tubal ligations.¹⁴⁵ Data received pursuant to Justice Now’s public disclosure request showed that hospitals were reimbursed for some 132 tubal ligation procedures on women in custody between 2006 and 2010 even though Title 15 had never been amended or revised to allow such payment.¹⁴⁶

Justice Now’s work informed a series of reports on the sterilization of women in the California prison system by the Center for Investigative Reporting. These articles convey the depth of disrespect that certain prison employees felt for state policies and for the women in their custody. In interviews with CIR, prison officials and physicians spoke candidly about their efforts to circumvent the state’s prohibition against sterilization. Equally remarkable, these officials were actively trying to subvert the state’s prohibition without any apparent knowledge that the state was already paying for sterilization operations, and had been since at least 1997.¹⁴⁷

This is derived from the Title 15, which states that sterilization is an elective surgery and the CDCR does not provide elective surgeries. To prevent amending Title 15, this language could be incorporated into the Inmate Medical Services Policies and Procedures (IMSP&P), Volume 4, Chapter 24. This could then be integrated into the contract in order to over [sic] the IMSP&P. T. Rougeux and J. Long will review this policy.

CAL. DEP’T OF CORR. AND REHAB., *supra* note 136. At the time, T. Rougeux was the Chief Operating Officer of the new California Prison Health Care Receivership Corporation and J. Long was the health care manager of the California Institution for Women. *Id.*

143. Robin Levi & Vanessa Huang, *A California Prison Proposal That is Disturbingly Akin to Eugenics*, DAILY JOURNAL, Jan. 15, 2007, <http://www.californiaprogressreport.com/site/california-prison-proposal-disturbingly-akin-eugenics>.

144. “[W]e were assured by CDCR leadership the practice would never occur.” *Testimony of Justice Now Submitted to the California Senate Public Safety Committee* 1 (Aug. 8, 2013), available at <http://www.jnow.org/downloads/JusticeNow.3.15.BudgetTestimony.FemaleOff.pdf>.

145. Letter from Tim Rougeux, COO, Medical Services, California Prison Health Care Receivership Corp., to Lynsay Skiba, JUSTICE NOW 5 (Sep. 10, 2008), available at <http://www.jnow.org/downloads/JusticeNow.3.15.BudgetTestimony.FemaleOff.pdf> (attached to *Testimony of Justice Now Submitted to the California Budget and Fiscal Review Subcommittee No. 5 on Corrections, Public Safety, and the Judiciary* (Mar. 13, 2012)).

146. Johnson, *Bill Seeks New Restrictions*, *supra* note 2; see Cal. Code of Reg. tit. 15.

147. For example, California Department of Corrections and Rehabilitation (CDCR) paid for tubal ligations on women from Valley State Prison for Women for nine years prior to the meeting of the Gender Responsive Strategies Commission where the topic of sterilization was discussed. Johnson, *Female Inmates Sterilized*, *supra* note 5; CAL. STATE AUDITOR, *supra* note 2; Letter from J. Clark Kelso, Receiver, to Assemblymember Bonnie Lowenthal & Senator Hannah-Beth Jackson, Chair and Vice Chair of the California Legislative Women’s Caucus (July 23, 2013) (on file with authors).

After the CIR news reports brought national attention, the Receiver produced a 1999 internal corrections memo announcing that “[p]ostpartum tubal ligation will be included as part of obstetrical care.”¹⁴⁸ Although he could not explain why a top prison official issued a memo clashing with state regulations, the Receiver said that the memo created a conflict in policy and that is why he decided not to discipline anyone for participating in the sterilization of women in custody.¹⁴⁹

The California State Auditor reached a different conclusion. At the Legislature’s behest, the Auditor investigated all known cases of tubal ligation over an eight-year period, finding systematic failures to secure advance approval¹⁵⁰ for the surgery and to document in women’s files that appropriate counseling had taken place.¹⁵¹ In addition to various training

Despite this history, the health care manager for Valley State told CIR that she did not approve the 60 surgeries performed on women during her tenure—with a couple of exceptions: “I’m sure that on a couple of occasions, [the prison ob/gyn] brought an issue to me saying, ‘Mary Smith is having a medical emergency’ kind of thing, ‘and we ought to have a tubal ligation. She’s got six kids. Can we do it? . . . And I said, ‘Well, if you document it as a medical emergency, perhaps.’” Johnson, *Female Inmates Sterilized*, *supra* note 5.

In another example, the health care manager at California Institution for Women, who was charged by the Gender Responsive Strategies Commission with reviewing the state’s sterilization policy, had already added tubal ligation to the prison’s contract with the local hospital the year before. *Id.*

Finally, doctors didn’t seem to think they “needed permission” to sterilize women. *Id.*

148. Memorandum from Susann J. Steinberg, Deputy Director, Health Care Services Division, California Department of Corrections, to Health Care Managers & Utilization Management Nurses (Oct. 4, 1999) (on file with authors) (concerning hernia and tubal ligation. The memo states that “Postpartum Tubal Ligations will be included as part of obstetrical care”); *see also* CAL. STATE AUDITOR, *supra* note 2, at 26.

149. Johnson, *Female Inmates Sterilized*, *supra* note 5; Corey G. Johnson, *Calif. lawmakers seek legislation to prevent prison sterilization abuse*, CTR. FOR INVESTIGATIVE REPORTING (Aug. 13, 2013), <http://cironline.org/reports/calif-lawmakers-see-legislation-prevent-prison-sterilization-abuse-5112> [hereinafter *Preventing Sterilization*]. Although the Receiver told legislators that “his office took swift action to stop the unauthorized sterilizations in 2010, after it realized they were occurring,” in fact, the Chief Operating Officer of the Receiver’s Office verified that sterilizations were being paid for in 2008 and was charged with reviewing the sterilization policy in 2006. *Id.*; *see also* CAL. DEP’T OF CORR. AND REHAB., *supra* note 139; Letter from Tim Rougeux, *supra* note 145.

150. CAL. CODE OF REG. tit. 15, § 3350.1 (d) (2006) (defining “Medically Necessary” Services as “Treatment for those conditions that are excluded within these regulations may be provided in cases where all of the following criteria are met,” including approval of the Institutional and Headquarters Utilization Management committees).

151. CAL. STATE AUDITOR, *supra* note 2, at 2–3. (“[A]ll but one” of the surgeries were done without the “necessary approvals,” and “in no instance” did women’s medical records reflect adequate counseling about the “sensitive and life-changing decision” to be sterilized). The report foregrounds the problems with lawful consent, at times seeming to gloss over the underlying question of whether women’s consent should have been sought in the first place—that is, whether the surgery was deemed “clinically necessary” and thus a legitimate exception to the ban on tubal ligation. *See* CAL. STATE AUDITOR, *supra* note 2, at 9. Because the prison doctors did not seek approval in 143 of 144 cases, there is no way to know whether that threshold was met. Moreover, the report says little about the coercive nature of prisons or the propriety of having prison doctors counsel women about sterilization. The section that does address these issues criticizes the prisons’ failure to

and procedural changes, the Auditor recommended that the Receiver report the physicians and hospitals that participated in the unlawful sterilizations to the state licensing boards for disciplinary action.¹⁵² As the Auditor's report shows, California prison officials and medical staff blatantly ignored the rules prohibiting sterilization, and medical providers in contract hospitals failed to comply with their ethical obligations to their patients. If these kinds of ethical (and legal) breaches are going on in a state that has rules against sterilizing incarcerated women, we are deeply concerned about the situation in other states, where prison policies permit sterilization or are silent on the issue, and there are no regulations or even any apparent oversight of these irreversible surgeries.

D. STATE PRISON POLICIES ALLOWING STERILIZATION

Although data on the incidence of sterilization is not readily available, incarcerated women have reported similar unethical treatment in states beyond California. In New York, for example, a woman in state custody told prison monitors that hospital staff gave her a form to sign after she gave birth. When she asked what the form was for, they explained that it was to have her "tubes tied." The woman was taken aback and clearly stated that she did not want to be sterilized.¹⁵³ In Montana, a nurse at the women's prison said that the prison had arranged for "high-risk" women to have tubal ligations when they were in the hospital.¹⁵⁴

A number of state departments of correction expressly permit sterilization procedures on women in their custody.¹⁵⁵ Depending on the state, the procedure is either at the woman's expense or the prison's expense. The nine states discussed here are those with official written policies that we were able to obtain. Other state corrections departments or individual prisons may also have policies permitting sterilization that are not available to the public. Although some states now post a variety of institutional policies and procedures on their websites, many do not, and many will not provide policies to people who ask for them. This withholding of information reflects pervasive problems with transparency

allow women to have a witness of their choice present when they sign the consent form, as required by state regulations, explaining that a witness who "presumably knows the patient well" "serves as a safeguard to help ensure that the patient understands the procedure and truly desires to be permanently sterilized." CAL. STATE AUDITOR, *supra* note 2, at 24. Most of the sterilizations were likely unlawful, not just the 39 for which the Auditor found problems with the consent paperwork. CAL. STATE AUDITOR, *supra* note 2, at 24.

152. CAL. STATE AUDITOR, *supra* note 2, at 3–4.

153. REPRODUCTIVE INJUSTICE, *supra* note 18, at 71.

154. Telephone Interview by Rachel Roth with medical staff member at the Montana Women's Prison (June 2, 2000).

155. See table, *infra* pp. 37–38; *infra* notes 157–168, 170. Rachel Roth originally obtained some of these policies when contacting state Departments of Correction for policies relating to the treatment of pregnant women. Some policies are now available online; others are still not readily available to the public.

and accountability in prison systems.¹⁵⁶ Because of the lack of transparency, there are significant roadblocks to collecting accurate information about prison policies and practices. Thus, this discussion cannot be an exhaustive review of such practices and policies, but represents perhaps the tip of the iceberg.

Five states have official policies specifying that women in prison may be sterilized if they pay for it: Idaho,¹⁵⁷ Oklahoma,¹⁵⁸ Oregon,¹⁵⁹ Rhode Island,¹⁶⁰ and South Carolina.¹⁶¹ Rhode Island permits the procedure only following childbirth; the other state policies are not so specific. Of the five, only Oklahoma includes a specific process or mentions counseling.¹⁶² The policies are excerpted in the table below.

STATE PRISON & DOC POLICIES PERMITTING STERILIZATION OF WOMEN

State	Written Policy
Georgia	“Tubal ligation will not be performed but at the inmate/probationer’s request can be considered if performed as part of another invasive procedure.”
Idaho	“Temporary and permanent sterilization procedures are considered elective and, if requested, must be paid for by the offender.”
Iowa	“Tubal ligation papers offered at UIHC [University of Iowa Hospitals and Clinics]” to pregnant women at 27-28 weeks
Missouri	“The department [of corrections] and CMS [private medical company] assume no financial responsibility for newborn care and treatment for tubal ligation following delivery.”

156. See Rachel Roth, *Searching for the State: Who Governs Prisoners’ Reproductive Rights?*, 11 SOC. POLITICS 411, 418–19 (2004); Michele Deitch, *The Need for Independent Prison Oversight in a Post-PRLA World*, 24 FED. SENTENCING REP. 236 (2012).

157. IDAHO DEP’T OF CORR. DIV. OF EDUC., TREATMENT AND REENTRY, STANDARD OPERATING PROCEDURE, CONTROL NO. 401.06.03.058 4 (2001–2015), available at <http://www.idoc.idaho.gov/content/policy/806>.

158. OKLA. DEP’T OF CORR., OP-140145, FEMALE OFFENDER HEALTH SERVICES 5 (June 25, 2014), available at <http://www.ok.gov/doc/documents/op140145.pdf>. [hereinafter Oklahoma OP-140145].

159. OR. DEP’T OF CORR., HEALTH SERVICES SECTION POLICY AND PROCEDURE NUMBER P-G-09: PREGNANCY COUNSELING 2 (Mar. 2012), available at http://www.oregon.gov/doc/OPS/HESVC/docs/policies_procedures/Section_G/PG09%20Pregnancy%20Counseling%202012.pdf.

160. R.I. DEP’T OF CORR., POLICY AND PROCEDURE NUMBER 18.53: GYNECOLOGICAL CARE, PREGNANCY COUNSELING AND PERINATAL CARE FOR WOMEN INMATES, III E (2000) (on file with authors).

161. S.C. DEP’T OF CORR., POLICY HS-18.15: LEVELS OF CARE 6, I (Mar. 30, 2000) (on file with authors).

162. Oklahoma OP-140145, *supra* note 158.

Oklahoma	<p>“Management of Pregnancy”:</p> <p>“Counseling/Education” in the first trimester includes “Options of sterilization if reached family size.”</p> <p>“Female Offender Health Services”:</p> <p>“Offenders desiring sterilization must submit their request in writing to a medical provider. This request will be scanned into the EHR [electronic healthcare record]. Medical staff will then refer the offender to an outside licensed facility for counseling about her options and her decision for sterilization. The referral agency will carry out any procedures agreed to by the offender and the referral agency’s health professional, who will also obtain the offender’s permission on the necessary consent forms. The offender or her family will be financially responsible for all costs related to the procedures. All payment will be completed prior to the procedure.”</p> <p>“Tubal sterilization following vaginal delivery or at the time of a C-section will be considered if the offender has attended tubal class at the OU Medical Center Department of Obstetrics and Gynecology, has signed the appropriate papers, and the delivering obstetrician concurs.”</p> <p>“Any decision regarding sterilization will be the sole responsibility of the offender.”</p>
Oregon	<p>“Temporary and permanent sterilization procedures are considered elective and although available, must be paid for by the inmate.”</p>
Rhode Island	<p>“Following childbirth, the patient may elect to have temporary or permanent sterilization procedures that are considered elective and, although available, must be paid for by the patient.”</p>
South Carolina	<p>“The Agency will not pay for either tubal ligations or elective abortions. An inmate wishing to have a tubal ligation in conjunction with her delivery or an elective abortion may apply in advance for elective outside medical care as per [Agency] Procedure.”</p>
Washington	<p>“Tubal ligation: at the time of cesarean section IF requested by patient in writing” is listed under “Medically Necessary Care Under Certain Circumstances” in the “Offender Health Plan.”</p>

In four other states (Georgia, Iowa, Missouri, and Washington State), corrections policies are ambiguous as to who pays for the procedure and under what conditions a prison would authorize tubal ligation surgery. In Washington State, for example, an overarching health policy describes what types of medical care the prison system will provide. This policy includes tubal ligation “at the time of cesarean section IF requested by patient in writing” in the category of “Medically Necessary Care Under Certain Circumstances.”¹⁶³

Georgia policy prohibits tubal ligation but immediately qualifies that declaration with the note that, at the woman’s request, the surgery “can be considered if performed as a part of another invasive procedure.”¹⁶⁴ The two provisions under the heading “Contraception and Sterilization” read: 1) “All other requests for sterilization of female inmate/probationers will be forwarded to the GDC Statewide Medical Director for consideration;” and 2) “Tubal ligation will not be performed but at the inmate/probationer’s request can be considered if performed as part of another invasive procedure.” These broad statements allow for the possibility of sterilization at the discretion of the medical director. The language provides no information about when a woman would have to request the procedure, who would pay for it, or what criteria the medical director would use to decide.

Missouri’s policy also lacks clarity. By stating that neither the corrections department nor the private medical company assumes financial responsibility for “treatment for tubal ligation following delivery,” it suggests that the corrections department may pay for the “treatment” itself—the tubal ligation—but not any follow-up care needed.¹⁶⁵ Most likely the ambiguity is simply a result of poor wording, but the policy implies that women may obtain tubal ligation surgery while in the hospital for childbirth.

In addition to its policy for women who request sterilization at any time, Oklahoma’s policy allows for sterilization after women give birth. The provision states: “Tubal ligation following vaginal delivery or at the time of a C-section will be considered if the offender has attended tubal class at the OU Medical Center Department of Obstetrics and Gynecology, has signed the appropriate papers, and the delivering obstetrician concurs.”¹⁶⁶ The wording suggests that the consent paperwork is the

163. WASH. DEP’T OF CORR., OFFENDER HEALTH PLAN, LEVEL 2: MEDICALLY NECESSARY CARE UNDER CERTAIN CIRCUMSTANCES 24 (Sept. 25, 2013), *available at* <http://www.doc.wa.gov/family/offenderlife/docs/OffenderHealthPlan.pdf>.

164. GA. DEP’T OF CORR., STANDARD OPERATING PROCEDURE, REFERENCE NUMBER VH 50-0001, WOMEN’S HEALTH SERVICES, VI, D. (May 1, 2000, rev. Mar. 1, 2004) (on file with authors).

165. MO. DEP’T OF CORR., INSTITUTIONAL SERVICES POLICY AND PROCEDURES MANUAL, NUMBER IS11-55: PERINATAL CARE, III.H. (Oct. 15, 1999) (on file with authors).

166. OU Medical Center in Oklahoma City is the contract hospital for labor and delivery. Oklahoma OP-140145, *supra* note 158.

responsibility of the hospital and that the prison might pay for the sterilization, as there is no mention of the woman's financial responsibility. A separate policy on pregnancy management lists discussion of sterilization as a routine part of early prenatal care: "Counseling/Education" in the first trimester includes "[o]ptions of sterilization if reached family size."¹⁶⁷ The Department of Corrections (DOC) does not charge women for prenatal care, perinatal care, or clinically indicated postpartum care.¹⁶⁸ Taking all three of these policies together, it appears that tubal ligation may be considered a part of prenatal care, in which case the prison would pay the cost.

A 2011 news story about pregnant women in the Iowa prison system profiled a woman who gave birth and "then asked doctors to tie her fallopian tubes, so she can't have any more children."¹⁶⁹ The reporter suggests that the woman asked physicians on the spot for a tubal ligation, although this may be artistic license. According to the policy on obstetrical services, "offering" tubal ligation is one of the routine elements of the 27-28 week prenatal visit, along with blood work and lab tests, at the University of Iowa Hospitals and Clinics where women get prenatal care.¹⁷⁰ The timeframe is well before a full-term birth; the policy, dating as far back as 1990, says nothing about informed consent, presumably leaving that to the hospital staff.

The Iowa news story did not make clear who paid for the sterilization procedure, and while disclosing such information about a specific individual would violate patient confidentiality, explaining responsibility for patient care in general does not. When asked if the Iowa Department of Corrections pays for sterilizations, a spokesperson said that the department does not pay for *any* hospital care; the hospital does.¹⁷¹ Another news story reported that the University of Iowa Hospitals and its clinics "dispensed" over \$5 million in medical services to incarcerated patients in the fiscal

167. OKLA. DEP'T OF CORR., MSRM-140145-01: MANAGEMENT OF PREGNANCY II(D) (Mar. 17, 2013), available at <http://www.ok.gov/doc/documents/140145-01.pdf>.

168. OKLA. DEP'T OF CORR., OP-140117: ACCESS TO HEALTH CARE III(F)4.i (Aug. 21, 2014), available at <http://www.ok.gov/doc/documents/op140117.pdf>.

169. Erin Jordan, *A Lifetime of Bad Choices Between This Mom and Her Baby Daughter*, THE GAZETTE (Jan. 30, 2011), <http://thegazette.com/2011/01/30/a-lifetime-of-bad-choices-between-this-mom-and-her-baby-daughter/>.

170. IOWA CORR. INST. FOR WOMEN, POLICY AND PROCEDURES MANUAL NO. 90.621: OBSTETRICAL SERVICES (March, 1990) (on file with authors). When author Rachel Roth requested a copy of this policy in 2011 (in order to compare to the one she had previously obtained), the Iowa Department of Corrections (DOC) spokesperson stated that the policy was confidential and he could not share it. Interview by Rachel Roth with Fred Scaletta, Iowa DOC Public and Media Relations (Jan. 12, 2012). That requests for information are granted or denied depending on the actor in the system demonstrates the arbitrariness and lack of transparency in prison administration.

171. Telephone interview by Rachel Roth with Fred Scaletta, Iowa DOC Public and Media Relations (Jan. 12, 2012).

year, without any reimbursement.¹⁷² There is no contract for services between the prisons and the University hospital; a spokesperson for the University said that the University simply absorbs the costs.¹⁷³ This seems surprising, given that Medicaid reimbursement is available for any eligible incarcerated person who is admitted to a hospital for inpatient treatment for 24 hours or more, as described above in Part I.¹⁷⁴ Although it is possible that the woman in the news story had private medical insurance, it appears that people in Iowa prisons may be sterilized at public expense.¹⁷⁵

All of these policies stand in sharp contrast to the federal Bureau of Prisons policy, which does not allow sterilization “as a form of birth control.” Women “shall not be sterilized, except for bona fide medical indications with their written consent.”¹⁷⁶ And unlike the federal regulations on sterilization, not one of the state policies analyzed here reflects or addresses the risks of coercion or the need for additional protections for people who are incarcerated. Given the lack of procedural safeguards and the ways that prison environments undermine meaningful consent—amply illustrated by the pressures reported by women in California—the possibility of sterilization abuse in prisons around the United States is a serious concern.

III. MEDICAL ETHICS

Prison policies on sterilization can be put into practice only if there are physicians willing to perform the surgery on women who are incarcerated.¹⁷⁷ Physicians should understand the strong norm in federal policy against such sterilizations and how that norm reflects broad concerns with the ethical provision of medical care to people in prison.

The experiences of California women described above expose this need. What was the role of doctors in local hospitals that contract with the prisons? Were some of these doctors, often meeting their patient for the

172. Erin Jordan, *Special Report: Pregnant Inmates Get Top Care and Two Days with Newborn*, THE GAZETTE, Jan. 30, 2011, <http://thegazette.com/2011/01/30/pregnant-inmates-get-top-notch-care-and-two-days-with-newborn/>.

173. Emails between Rachel Roth and Tom Moore, spokesperson, University of Iowa Hospitals and Clinics (Jan. 13, 2012) (on file with authors).

174. That is, Medicaid reimbursement is available for medical care other than sterilization, and presumably such reimbursement would save the hospital hundreds of thousands of dollars. See Section I(B)(3), *supra* p. 37; 45 C.F.R. §§ 435.1009, 435.1010.

175. When asked whether the hospital pays for tubal ligation, the spokesperson said, “I would assume so.” Telephone interview by Rachel Roth with Tom Moore, University of Iowa Hospitals and Clinics (Jan. 13, 2012).

176. U.S. BUREAU OF PRISONS HEALTH SERVICES MANUAL, *supra* note 84, at 3. It is not clear what would constitute a “bona fide medical indication,” given the availability of reversible methods of contraception; see *Tubal Ligation*, *supra* note 3.

177. As historian Rickie Solinger observes about the abuses of earlier eras, “In order for poor, vulnerable women to be sterilized against their own desires, members of the medical profession had to be willing to commit these outrages.” RICKIE SOLINGER, *PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA* 195 (2005).

first time when they deliver her baby, initiating discussions about tubal ligation? Accepting at face value that these doctors were not aware of the state regulations against sterilizing women in prison, standard notions of informed consent should have prevented them from asking women about sterilization when they were in labor or exhausted from giving birth.¹⁷⁸ In at least 27 cases, physicians sterilized women from prison without signing the required form to certify that the patient was mentally competent, understood the permanent nature of the operation, and had satisfied the waiting time mandated by state law.¹⁷⁹ This is a serious ethical breach, because “the physician is the last check in the informed consent process and provides the patient with the final opportunity to change her mind.”¹⁸⁰

Unfortunately, the guidance from leading professional organizations is not as clear as one would expect in this fraught context. The American Congress of Obstetricians and Gynecologists (ACOG) has published guidance for its members on caring for patients who are incarcerated. However, ACOG does not address the issue of sterilizing imprisoned women in its committee opinions on medical care for women in prison.¹⁸¹

In a recent committee opinion on access to post-partum sterilization, ACOG recommends revising the federal sterilization rules in the Medicaid program, arguing that signing a consent form 30 days in advance is a burden on access to sterilization for low-income women. The opinion consigns the deeply troubling history of coercive sterilization that gave rise to the rules to one subordinate clause about the rules’ original intent “to protect women from being sterilized against their will.”¹⁸² While the opinion reflects the profession’s interest in the important goal of helping patients to prevent unintended pregnancy, it also indicates a lack of consideration of the situations where women run the risk of being sterilized against their will; and, significantly, the opinion does not even mention

178. Indeed, state regulations governing the acute care hospitals in which they work prohibit seeking consent from any woman in labor. CAL. CODE REGS. tit. 22, §§ 70707.1–70707.7 (2011). These regulations are similar to federal sterilization regulations.

179. CAL. STATE AUDITOR, *supra* note 2, at 2, 19–24.

180. CAL. STATE AUDITOR, *supra* note 2, at 2.

181. ACOG OPINION NO. 511, *supra* note 112. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 535: REPRODUCTIVE HEALTH CARE FOR INCARCERATED WOMEN AND ADOLESCENT FEMALES (Aug. 2012), *available at* <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-Health-Care-for-Incarcerated-Women-and-Adolescent-Females>.

182. The full sentence reads: “Although the original intent was to protect women from being sterilized against their will, the lack of a timely signature on the federal consent form now interferes with patient autonomy because it has become a common reason for lack of provision of desired postpartum sterilization.” AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 530: ACCESS TO POSTPARTUM STERILIZATION 2 (July 2012), *available at* <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Postpartum-Sterilization>.

incarceration.¹⁸³ As the leading authority on pregnancy-related and reproductive health care, ACOG is tremendously influential, and should ensure that its goal of providing access to sterilization to those who want it does not justify eliminating protections for women who continue to need them.

The American Public Health Association (APHA), on the other hand, does address the issue of sterilizing incarcerated women in its 2003 standards for medical care in prison: “Sterilization must only be provided with voluntary written informed consent after counseling by an outside agency and consistent with state laws. Sterilization should not follow immediately upon giving birth.”¹⁸⁴ The standard tries to ensure voluntary informed consent by insisting on counseling by an agency outside the prison, but rests on the problematic assumption that such consent is feasible in the prison setting.

Moreover, in practice, prisons ignore these standards.¹⁸⁵ While the American Public Health Association states that sterilization should not immediately follow birth, the available evidence indicates that imprisoned women are almost always sterilized immediately after childbirth.¹⁸⁶ Indeed, the fact that women are in the hospital to give birth, perhaps already under anesthesia for a cesarean delivery, is part of the justification for the sterilization in the first place.¹⁸⁷

Medical professionals in prisons “face extraordinary ethical challenges: prisoners, who cannot choose their care provider and who are fully dependent on the health care provided to them, are a vulnerable population, as demonstrated by the many exploitations, abuses, and violations of their human rights in the past.”¹⁸⁸ The “walls, barbed wire, locks, and rules” that separate prison clinics “both literally and metaphorically from the wider medical community” exacerbate the challenges of providing care.¹⁸⁹ Those working in prisons also face the “omnipresent problem of dual loyalty”¹⁹⁰

183. ACOG OPINION NO. 530, *supra* note 182. The ACOG opinion is part of a renewed debate over the Medicaid sterilization rules. See, e.g., Sonya Borrero, et al., *Medicaid Policy on Sterilization - Anachronistic or Still Relevant?*, 370 NEW ENG. J. MED. 102 (Jan. 9, 2014); Deborah Reid, *Reproductive Justice Advocates: Don't Roll Back Sterilization Consent Rules*, RH REALITY CHECK, Apr. 2, 2014, <http://rhrealitycheck.org/article/2014/04/02/reproductive-justice-advocates-dont-roll-back-sterilization-consent-rules/>.

184. AMERICAN PUB. HEALTH ASS'N, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS 108 (3d ed. 2003).

185. For example, in California, at least 110 of 144 women sterilized signed the consent forms in prison, not at an outside agency, and “in no instance” did women’s medical records document sufficient counseling. CAL. STATE AUDITOR, *supra* note 2, at 2–3, 24.

186. See, e.g., CAL. STATE AUDITOR, *supra* note 2, at 37 (122 of the 144 women who were sterilized had the tubal ligation after cesarean surgery).

187. See CAL. DEP’T OF CORR. AND REHAB., *supra* note 139.

188. Pont et al., *supra* note 21, at 475.

189. Stoller, *supra* note 21, at 2265.

190. Ross MacDonald et al., *The Triple Aims of Correctional Health: Patient Safety, Population Health, and Human Rights*, 24 J. HEALTH CARE POOR UNDERSERVED 1226, 1229 (2013).

in which their allegiance is fragmented between their patients and the prison administration and staff.¹⁹¹ Medical staff may feel a loyalty to “the state,” evident in comments by a prison physician in California about how sterilization saves the state money in welfare payments.¹⁹² These conflicts extend to physicians who work under contract with prisons in hospital settings as well, especially when those physicians interact with their imprisoned patients in a locked ward that is segregated from the rest of the hospital and itself resembles a prison.

In short, medical ethics counsels an approach to providing tubal ligation that is unrealistic in the coercive, dehumanizing prison environment. This reality is borne out by the experiences recounted by women incarcerated in California (as well as the long history of sterilization abuse that came before). Because of the problems inherent with obtaining consent to the permanent destruction of fertility from people who are incarcerated, and the difficulties that dual loyalties present to providing strictly patient-centered care to people who are incarcerated, medical organizations should reconsider their positions and individual medical professionals should stop participating in the sterilization of imprisoned patients.

IV. STERILIZATION IN PRISON DOES NOT AFFIRM WOMEN'S REPRODUCTIVE AUTONOMY

Some may object that it discriminates against women in prison to prohibit sterilization when they might actually want the surgery, or find such a stance to be paternalistic.¹⁹³ The journalist who interviewed the top

191. Pont et al., *supra* note 21, at 476 (Quoting guidelines proposed by Physicians for Human Rights and the Health Sciences faculty of University of Cape Town, the authors spell out two ways that medical professionals become vulnerable to pressures: when they are “subject to employment arrangements that formally subordinate them to officials responsible for institutional operation,” and when “they become part of an institutional culture that subordinates patient interests to the financial, political, or administrative agendas of the institution.”)

192. Johnson, *Female Inmates Sterilized*, *supra* note 5.

193. Others may ask if the objections we raise to sterilization can be made to the provision of abortion to women who are incarcerated. After all, a woman's decision to have an abortion could be coerced by prison employees and medical staff, and an abortion permanently ends a pregnancy. While we agree that the risk of coercion to have an abortion is indeed present in prison, abortion ends a current pregnancy, but it does not end forever the possibility of becoming pregnant and having children in the future. See, e.g., Steven Holmes, *With More Women in Prison, Sexual Abuse by Guards Becomes Greater Concern*, N.Y. TIMES, Dec. 27, 1996, available at http://www.nytimes.com/1996/12/27/us/with-more-women-in-prison-sexual-abuse-by-guards-becomes-greater-concern.html?src=pm&page_wanted=1 (A woman in the Delaware prison who was raped by a guard and became pregnant said, “They were trying to get me to get an abortion. . . They said if my family couldn't pay for an abortion, they would pay for it.”).

And, significantly, the medical need for abortion is distinct from sterilization for the purpose of birth control. When a woman is pregnant, she has an immediate medical need – either for prenatal care to monitor her health and optimize the chances of healthy full-term birth, or for an abortion to terminate the pregnancy. The Third Circuit Court of Appeals

health care manager at Valley State Prison for Women reported that she “characterized the surgeries as an empowerment issue.”¹⁹⁴ The Receiver for the California prison system justified doctors’ actions by saying that doctors may believe in “good faith” that this is a matter of women’s “reproductive autonomy.”¹⁹⁵

We are deeply skeptical when prison officials claim that women’s autonomy and reproductive decision-making is an imperative. As explained above, in some states women in prison can get an abortion but in many state prisons they cannot, certainly not without a lawyer’s help.¹⁹⁶ As a general rule, women in prison have limited or no access to birth control—not even hormonal contraception to treat medical problems like endometriosis—because prisons consider all birth control off limits.¹⁹⁷ The lack of access to birth control also means that women cannot protect themselves from pregnancy in the all-too-common instance of sexual assault by officers or other prison employees.¹⁹⁸

adopted precisely this reasoning when recognizing abortion as a serious medical need. *Monmouth County Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 338 (3rd Cir. 1987). See also ACOG OPINION NO. 511, *supra* note 112. Thus, as the Third Circuit recognized in *Monmouth*, provision of either abortion or prenatal and, if all goes well, childbirth care to incarcerated pregnant women are the only possibilities when a woman is pregnant—and is mandated by the Constitution. In contrast to abortion, tubal ligation is not time-sensitive and is one of many available solutions to the medical need for pregnancy prevention.

194. Johnson, *Female Inmates Sterilized*, *supra* note 5. Johnson reports that, “After learning of the restrictions, [health care manager Daun] Martin told CIR that she and [ob-gyn James] Heinrich began to look for ways around them. Both believed the rules were unfair to women, she said;” and that Martin “characterized the tubal ligations as an empowerment issue for female inmates, providing them the same options as women on the outside.” Johnson, *supra* note 5.

195. *California Department of Corrections and Rehabilitation: Female Inmate Sterilization: Hearing Before the Cal. S. Public Safety Comm.* (Aug. 13, 2013) (testimony of J. Clark Kelso), available at http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=1546.

196. Even in states like California and New York, women have had difficulty obtaining abortion care when they are incarcerated in local jails. See, e.g., NEW YORK CIVIL LIBERTIES UNION, ACCESS TO REPRODUCTIVE HEALTH CARE IN NEW YORK STATE JAILS 18 (2008). For an analysis of state prison policies, see Roth, *supra* note 113. See also *Roe v. Crawford*, 514 F.3d 789 (8th Cir. 2008), *reh’g en banc denied* No. 07-1491, 2008 U.S. LEXIS 6829 (Oct. 6, 2008).

197. See, e.g., REPRODUCTIVE INJUSTICE, *supra* note 18, at 55. In a survey of correctional health providers around the country, 70% said that the prison or jail where they worked had no official policy on contraception; 55% said that women who were using birth control when they were brought to the prison or jail were not allowed to continue doing so (because of the way the results are reported, we do not know how many said that women were allowed to continue and how many said that they did not know). Carolyn B. Sufrin et al., *Contraception Services for Incarcerated Women: A National Survey of Correctional Health Providers*, 80 CONTRACEPTION 561, 562 (2009).

198. See, e.g., Jeff Seidel & Dawson Bell, *\$100 Million Ends Prisoner Sex-Abuse Suit*, DETROIT FREE PRESS, July 16, 2009, <http://www.freep.com/article/20090716/NEWS06/101250006/-100-million-ends-prisoner-sex-abuse-suit> (stating settlement reached in class action lawsuit brought by more than 500 women in the custody of the Michigan prison system).

If a woman in prison wants to get pregnant and asks to avail herself of insemination or in vitro fertilization, she would almost certainly be told no.¹⁹⁹ Very few prison systems permit private visits with a spouse (let alone a partner outside of marriage) and such visits are privileges, not rights.²⁰⁰ And as explained above, women who are pregnant frequently contend with inadequate prenatal care and unsafe, even dangerous, conditions for giving birth.²⁰¹ They have no say over who delivers their baby or who will be in the room when they give birth (that is, few prisons allow women to have a friend or relative there for support, and many post officers in the room).²⁰²

Incarceration also jeopardizes parent-child relationships.²⁰³ The majority of women in prison are mothers of children under age 18; many were primary caregivers before they were arrested and imprisoned.²⁰⁴ If a mother wants to see her children on a regular basis and her family does not own a car, the Department of Corrections is not likely to assign her to a prison close to home to make it easier for her family to visit. In fact, more than half of women in state prison never have a visit with their children, one reason being that prisons tend to be in remote locations inaccessible by public transportation.²⁰⁵ Staying in touch by phone is prohibitively expensive for many families.²⁰⁶

Not getting to see children in person has legal as well as emotional consequences. When a mother's children are placed in foster care and she

199. See, e.g., WASH. DEP'T OF CORR., OFFENDER HEALTH PLAN, *supra* note 163 at 23, 25 (defining "work up or treatment for infertility" as "Not Medically Necessary Care. Not authorized to be provided").

200. See, e.g., Kim Severson, *As Conjugal Visits Fade, A Lifeline to Inmates' Spouses is Lost*, N.Y. TIMES, Jan. 12, 2014, at A8, available at http://www.nytimes.com/2014/01/13/us/with-conjugal-visits-fading-a-lifeline-to-inmates-spouses-is-lost.html?_r=0.

201. See *supra* Part II(A), at p. 26; see generally, Roth, *Obstructing Justice*, *supra* note 105.

202. REPRODUCTIVE INJUSTICE, *supra* note 18, at 85 (New York); Liz Sawyer, *State Takes a Gentler Approach to Pregnant Women Behind Bars*, STAR TRIBUNE, Aug. 22, 2014, <http://www.startribune.com/lifestyle/health/272243761.html> (Minnesota).

203. JEANNE FLAVIN, "Bad Mothers": *Incarcerated Women's Ties to Their Children*, in OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN'S REPRODUCTION IN AMERICA, 139–163 (2009).

204. LAUREN E. GLAZE, & LAURA M. MARUSCHACK, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: PARENTS IN PRISON AND THEIR MINOR CHILDREN 1, 4 (Aug. 2008, rev. Mar. 30, 2010), available at <http://www.bjs.gov/content/pub/pdf/pptmc.pdf>.

205. FLAVIN, *supra* note 203, at 146.

206. Phone calls placed from prison can cost as much as one dollar per minute, thanks to monopoly contracts and kickbacks between phone companies and prisons. In 2013, spurred by a decade of activism and lawsuits, the Federal Communications Commission (FCC) voted on new rules to limit the cost of inter-state prison phone calls (but not calls within one state). Ian Simpson, *Regulators Vote to Reduce Rates for Prison Phone Calls*, REUTERS, Aug. 9, 2013, <http://www.reuters.com/article/2013/08/09/us-usa-fcc-idUSBRE9780TV20130809>; see also Jonathan Martin, *AT&T To Pay Washington Prisoners' Families \$45 Million In Telephone Class Action Settlement*, SEATTLE TIMES, Feb. 3, 2013, <http://blogs.seattletimes.com/opinionnw/2013/02/03/att-to-pay-washington-prisoners-families-45-million-in-telephone-class-action-settlement/>.

cannot see them, it is very difficult to demonstrate her ongoing involvement in their lives; perceived lack of involvement puts parents in jeopardy of having their parental rights terminated. Only a few states have changed their adoption and foster care laws so that parents in prison have a more realistic opportunity to protect their relationships with their children.²⁰⁷ Otherwise, termination of parental rights is all too common for parents who do not have anyone to care for their children and keep them out of the foster care system.

As this wealth of evidence demonstrates, prisons are not institutions that affirm reproductive autonomy. It should give pause when ending the ability to have children is the one area where prison officials invoke a concern for women's reproductive decision-making.²⁰⁸ The reality of the prison setting is such that sterilization takes place in a context of coercion, disrespect, and frequently substandard medical care. Given this reality, sterilizations should not be performed on people in prison. How to prevent that abuse is the subject of our conclusion.

V. CONCLUSION AND POLICY RECOMMENDATIONS

The inherently coercive nature of the prison environment works against meaningful informed consent to the permanent, irreversible termination of fertility. Public policies should promote the well-being and future life options of people in prison, rather than truncating those options. Therefore, prison administrations must end their involvement in authorizing or paying for sterilization and make clear to all prison employees and contractors that they are not to be involved with sterilizing people in their custody or care. To accomplish this, governors should place an immediate moratorium on the use of state funds to sterilize people who are incarcerated, while state legislatures act to adopt legislation with clear bans on sterilization mirroring those of the federal medical programs.

207. The Adoption and Safe Families Act of 1997, Pub. Law 105-89, set rigid time limits with no exception for parents in prison whose children are in foster care solely because of their parents' incarceration. The six states that have modified their laws to allow incarcerated parents more opportunity to maintain their family ties are California, Colorado, Nebraska, New Mexico, New York, and Washington. The New York and Washington laws afford families the most flexibility to protect parents' relationships with their children. On New York, see Tamar Kraft-Stolar, *A Fair Chance for Families Separated by Prison*, NORTH STAR FUND (June 30, 2010), <http://northstarfund.org/blog/2010/06/a-fair-chance-for-families-separated-by-prison.php>; On Washington, see Victoria Law, *New Law Gives Parents Behind Bars in Washington State a Way to Hold Onto Their Children*, TRUTHOUT (May 11, 2013), <http://truth-out.org/news/item/16312-new-law-gives-parents-behind-bars-in-washington-state-a-way-to-hold-onto-their-children/feed/>.

208. Concern for reproductive autonomy does not extend to men, apparently, as prison systems generally exclude vasectomies from their medical services. See, e.g., WASH. DEP'T OF CORR., OFFENDER HEALTH PLAN, *supra* note 163, at 26 (prohibiting the provision of sterilization "except as allowed under Tubal Ligation in Level 2 above" [referring to postpartum sterilization for women]).

Recognizing how difficult it is to achieve political change promoting the rights of people in prison, incarcerated people and their advocates may pursue alternative strategies to ensure that their rights are respected, including seeking federal guidance on the scope of the federal regulations, particularly the Public Health Service ban on the use of its program funds to sterilize people who are incarcerated. Finally—and perhaps most importantly—medical professionals should not participate in the sterilization of patients from prison, and their associations should stake out clear positions against sterilization of people in custody.

Under the glare of the national spotlight for the abuse of people in prison, the Legislative Women's Caucus in California introduced a bill that would clarify the prohibition on sterilizing incarcerated people for the purpose of birth control and ensure safeguards against unnecessary sterilization by hysterectomy or other surgery.²⁰⁹ As Justice Now staff told the California Senate's Public Safety Committee when testifying in support of the bill, "[v]erbal assurances that abuses have stopped are not sufficient. . . . There's an urgent need to clarify the legal obligations of medical and correctional staff as well as to strengthen oversight requirements."²¹⁰ Toward that end, the bill declares: "It is the intent of the Legislature in enacting this act to prevent sterilization abuse of vulnerable populations, to ensure safeguards against sterilization abuse within the coercive environment of prison and jail, and to positively affirm that all people should have the right to fully self-determine their reproductive lives free from coercion, violence, or threat of force."²¹¹ The governor signed the bill into law in September 2014.²¹²

While reducing the scale of incarceration is the most essential aspect of preventing prison abuses, our research underscores the need for immediate changes, including greater oversight of prisons. The story from California is one of officials actively seeking to subvert state regulations and doctors seemingly oblivious to all regulations.²¹³ As the California Legislature recognized, monitoring and oversight is critical to ensure that women in prison get the medical care they need and are not subjected to pressure to be sterilized. This monitoring and oversight is practically impossible when

209. Cal. S. Bill 1135 (2013–2014) (adding Chapter 6 (commencing with Section 3440) to Title 2 of Part 3 of the California Penal Code, relating to people in custody).

210. Johnson, *Female Inmates Sterilized*, *supra* note 5.

211. Cal. S. Bill 1135 (2013–2014). The bill correctly makes clear that individuals are "under the control of" the prisons, jails, and other correctional facilities in which they are "involuntarily confined or detained."

212. *Governor Signs Jackson Bill to Halt Forced or Coerced Sterilizations in Prisons*, Sept. 25, 2014 statement on Senator Hannah-Beth Jackson's website, available at <http://sd19.senate.ca.gov/news/2014-09-25-governor-signs-jackson-bill-halt-forced-or-coerced-sterilizations-prisons>.

213. Deitch, *supra* note 156.

prisons are privatized, and thus we also support an end to the privatization of jails and prisons, as well as an end to the privatization of medical services in jails and prisons.²¹⁴

In addition, our research underscores the need to connect people leaving prison with health care resources. In some states, prisons work with Planned Parenthood or Title X family planning centers to provide women with contraceptive counseling and methods before they go home.²¹⁵ These programs can include referrals to community-based providers of sterilization for women who want the information, and should be replicated broadly. The Affordable Care Act may improve access to care for people coming home from prison; however, not all states have opted to expand their Medicaid programs.²¹⁶ Given the poor health status of so many people in prison and their need for ongoing care for chronic illnesses, more needs to be done to give people returning to their communities a chance at a healthy life.

Women who were directly affected by sterilization abuse in the 1960s and 70s fought for their rights to make decisions about their own bodies and lives. The same women who were targeted for sterilization during that era—women of color and low-income women—are suffering those abuses in the prison system now. Once again, those who have been directly affected are calling on the government to stop the abuse. Women who spent time in prison successfully organized and testified on behalf of California legislation to ban sterilization in the prison system. Their experiences, including the permanent loss of their ability to have children, and their activism demonstrate the need for an immediate, multi-pronged approach in every state to ensure that people in prison are no longer subjected to this harm.

214. See generally CAPITALIST PUNISHMENT: PRISON PRIVATIZATION AND HUMAN RIGHTS 108 (Andrew Coyle et al., eds., 2003).

215. Prisons in New York and elsewhere have at times contracted with Planned Parenthood. Vanessa Cullins, Vice President for External Medical Affairs, Planned Parenthood Federation of America, personal communication with Rachel Roth, Oct. 13, 2014; See also Jennifer G. Clarke et al., *Improving Birth Control Service Utilization by Offering Services Prerelease vs. Postincarceration*, 96 AM. J. OF PUB. HEALTH 840 (2006).

216. Barbara DiPietro & Lisa Klingemaier, *Achieving Public Health Goals Through Medicaid Expansion: Opportunities in Criminal Justice, Homelessness, and Behavioral Health with the Patient Protection and Affordable Care Act*, 103 AM. J. PUB. HEALTH 840 e25–2e9 (2013); Erica Goode, *Little-Known Health Act Fact: Prison Inmates are Signing Up*, N.Y. TIMES, Mar. 9, 2014, at A1.

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