THE ESSENTIAL STRUCTURE
OF THE LIVED EXPERIENCE OF WOMEN OFFENDERS
ACCESSING HEALTH CARE IN A JAIL ENVIRONMENT

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Thank you to my ever-patient husband, Miles, without your understanding my lifelong goal would never have been achieved.
ABSTRACT

Evidence-based knowledge is minimal at best about women in jail yet the population is known to have difficulty accessing health care despite clear evidence the population suffers from a multitude of serious health conditions. Access to health care is important to attain and maintain good health yet we know little of the experiences of jailed women trying to access correctional health care services. The lack of knowledge prompted the phenomenological study to answer the research question, "What is the lived experience of women in a jail environment seeking access to jail health care services?" After the data were collected and analyzed two theme categories, seven theme clusters, and seventeen themes emerged. The first theme category, Expressing the Negative View, consisted of five theme clusters and thirteen themes. The second theme category, Expressing the Positive View, consisted of two theme clusters and four themes. The essential structure of the lived experience of women in jail trying to access health care services in a jail environment developed from the thematic findings is predominately negative describing a multitude of systemic, personnel, and quality of care issues.
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CHAPTER ONE
INTRODUCTION

Chapter one presents the background for the study that includes the philosophical orientation to research, the statement of the problem, the purpose for the study, and the research question. Chapter one concludes with the study assumptions and significance of the problem.

Women Offenders and Their Perceptions of Access to Correctional Health Care

The U. S. Department of Health and Human Services is the government organization that spearheads Healthy People 2010 (November 2000), an initiative that lists and tracks objectives identified to improve the health of Americans by the year 2010. Access to quality health care is but one of the objectives to be met if America is to achieve and maintain the end goal of good health. To determine whether or not the objective is being met, data are tracked primarily from National and State sources. It is important to note that the data excludes institutionalized populations, thereby excluding large numbers of incarcerated individuals. This segment of our population may very well be the most vulnerable and at highest of high risk to suffer ill health. The resulting picture of access to health painted by Healthy People 2010 may not be a true reflection of the health of America. So the question then becomes, “What is it like to access health care from the perspective of the incarcerated population, a vulnerable and needy segment of the American population?“

Philosophical Orientation to Research

How, then, can the true picture of health be represented and constructed? Using Occam’s razor, or the principle of parsimony, as a basis for explaining the philosophical
perspective of research methodology there are two basic approaches to understanding the complicated concept of health in relation to the incarcerated population, quantitatively and qualitatively. Quantitative methodology utilizes deductive reasoning, or a logical thought process moving from general to particular (LoBiondo-Wood & Haber, 1998). Existing theories are tested using a variety of techniques and statistical treatments to collected data in hopes of supporting or disputing the theory in question (Knapp, 1998). Ontologically, the true picture of health already exists; it just needs to be discovered (Knapp, 1998; Popkewitz, 1990; Salsberry, 1994). Given the complex nature of the incarcerated population and the lack of a theory to test their perspectives, the quantitative research approach may not be the best methodology to entertain.

The flip side of the philosophical coin, again, using Occam’s razor to explain the true picture of health, is through the qualitative lens using inductive reasoning, or reasoning that progresses from particular to general (LoBiondo-Wood & Haber, 1998). Ontologically, the truth is not “out there” to discover, but rather, is constantly being constructed from the consciousness of the individual experiencing and simultaneously assigning meaning to the phenomena (Cohen, Kahn, & Steeves, 2000; Denzin & Lincoln, 2000; Maxwell, 1996; McCutcheon, 1990). Meanings or making sense of our surroundings in the qualitative sense are constantly being constructed in past current and future interactions between individuals as they are exposed to social situations (Anderson, 1989). Meaning, then, is constructed continuously and when confronted with the task to understand the complexity of health, the search for meaning should begin from an individual’s perspective focusing on how meaning is assigned through their lens. The qualitative researcher can begin the complicated task of creating a true picture of health
from inmates’ perspectives and their assigned meaning to their experiences trying to access correctional health care services.

Statement of the Problem

The incarcerated population is the only group in America provided with mandated health care through the Eighth Amendment of the United States Constitution. The landmark legal case of Estelle versus Gamble ("Estelle v. Gamble," 1976) set the precedence by defining the government’s responsibility of assuring a spectrum of health care services to all detainees. Yet despite the constitutional right to health care, there have been numerous accounts of inmates challenging correctional systems claiming the inaccessibility of these services (Barry, 1996, 2001; Collins & Collins, 1996). Although men inmates have filed the majority of legal challenges, women offenders have also challenged correctional systems insisting barrier free access to health care services designed specifically for women be provided (Collins & Collins, 1996).

Nudged by legal challenges, correctional administrators faced with already shrinking resources developed health services systems to meet the needs of the majority in the correctional population, men. In doing so they inadvertently neglected one of the most vulnerable and fastest growing segments of the correctional population, women (A. J. Beck, Karberg, & Harrison, 2002; Collins & Collins, 1996; Fickenscher, Lapidus, Silk-Walker, & Becker, 2001; Freudenberg, 2002; Harlow, 1998; Teplin, Abram, & McClelland, 1996; Yasunaga, 2001). When women enter jail they require access to more than just the basics of health services as designed for men, they need expedited access to obstetrical and gynecological services as well as medical, dental, and mental health services (Alemagno, 2001; Barry, 1996, 2001; Fickenscher et al., 2001; Haywood,
Hawaii has not been immune to litigation involving the medical care of inmates. Prior to the Spear complaint ("Spear et al., versus Ariyoshi, et al," 1984; "Spear, et al versus Ariyoshi et al.," 1985), none of the correctional facilities housing women provided 24-hour health care services despite a population with serious medical conditions. Individuals with seizure disorders, diabetes and active tuberculosis were left without medical care and supervision. Of particular concern were the women with obstetrical and reproductive health needs; they had delayed or no access to health care services. The unresolved complaints by women initiated the Spear Consent Decree ("Spear, et al., versus Waihee, et al.," 1987) that forced improvements to correctional facilities in Hawaii through court mandated monitoring.

Yet despite Constitutional mandates and State assurances of barrier free access to quality health care inmates, specifically women inmates, continued to express their dissatisfaction with the manner in which services were provided while incarcerated. What is it that is not understood about their already complicated lives that lead women to perceive dissatisfaction or denial to health care services? What can the women themselves reveal that would broaden the narrow scope of knowledge about women trying to access health care services in a jail environment?

Statement of the Purpose and Research Question

The purpose of this qualitative phenomenological study was to examine the basis for the contradiction jailed women describe as they assign meaning to their lived experiences seeking access to correctional health care services. The goal of the research
study was to learn from women, who have been detained but were not currently in jail, what it is like to attempt access to health care services while they were incarcerated in jail. The research question to be answered was as follows, “What is the lived experience of women in jail seeking to access jail health care services?” Expansion questions were, “What are the universal themes that precipitate positive feelings and thoughts about the experience?” “What are the universal themes that precipitate negative feelings and thoughts about the experience?” “How does the correctional culture influence women’s perceptions of access to health care services?”

Assumptions

A major assumption of any seeker of health care services in the general community was that the seeker would have access to adequate, appropriate, acceptable and affordable care. So should it be for the inmate seeker of care in the correctional environment. Regardless of sex, ethnicity, or the nature of the crimes for which they are accused incarcerated individuals would also have access to adequate, appropriate, acceptable, and affordable correctional health care services that are comparable to those available in the community setting. The second assumption was that accessibility of these services would be barrier free; in fact, the assumption of barrier free access to care is even stronger in the correctional environment when compared to the general community given mandated assurances through the protective nature of the U. S. Constitution. The final assumption of the study was that services women received were perceived no different from men in the jail environment.
Significance of the Study

The significance of the study can be approached from the following standpoints, initial steps toward nursing theory development with expansion of nursing knowledge, provide the participant an opportunity to describe their experiences, and correctional policy development. From the theoretical perspective, although the development of a nursing theory is debatable with phenomenological inquiry (Haase, 1987; Rose, Beeby, & Parker, 1995; Walters, 1995), the important point is to begin the process of scientific examination toward identifying key constructs that would support the beginnings of a theoretical framework (Walker & Avant, 1995). Although only a beginning, the strength of the study lies in advancing the evidence based component of nursing by critically examining descriptions by jailed women of their experiences accessing health care. This research attempt is an important step closer toward theory development in understanding the complicated nature of and to attain positive health outcomes for incarcerated women.


The study can and will provide a mentally secure venue for jailed women to describe their experiences in a safe and confidential manner. They will be able to
wholeheartedly verbalize their thoughts and feelings about their experiences without the fear of retaliation and retribution. The women can expect a safe and secure environment, a situation these women would not normally enjoy in any connection to the jail culture.

Through the experiences of jailed women nurses may have the opportunity to apply evidence-based descriptive information to improve their professional practice in the care of incarcerated populations. Nurses, as well as other health care professionals, can benefit from the study by gaining a deeper and meaningful understanding of women in jail and develop and maintain a compassionate approach to care. It is hoped that the study will expand and deepen the current narrow and somewhat shallow knowledge base by providing an important and specialized facet to the nursing profession.

Summary

Successful legal challenges brought about on behalf of incarcerated individuals have forced correctional systems to provide health care services to the incarcerated population. Despite legal mandates the incarcerated population have had to continue to demand services comparable to what is available in the community to treat and manage serious medical conditions. Women inmates have been particularly vulnerable since the original health care delivery systems were designed for men, overlooking critically needed obstetrical and gynecological services. Only after successful litigation have correctional systems developed gender specific services to meet the needs of women. Yet despite constitutional and legal protection women continue to express dissatisfaction with the services provided.

The purpose of this study was to describe the essential structure of the lived experience of women in jail seeking access to jail health care services. The research
question was as follows, “What is the lived experience of women in jail seeking to access jail health care services? The assumptions of the study is that the woman seeker of care in the jail venue would have access to adequate, appropriate, acceptable, and affordable care and that the quality of services would be comparable to those available in the community setting. The second assumption is that the jailed woman’s access to these services would be barrier free and the last assumption is that the services received by jailed women were perceived not different from jailed men.

The significance of the study would be in the initial and critical steps of theory development and resulting expansion of nursing knowledge. The study would also provide an evidence based proactive approach to the development of correctional policy development with women and their health issues as opposed to a reactionary policy development resulting from litigation. And finally, the study would provide jailed women, who normally would remain silent, a safe and confidential avenue to describe their experiences of seeking correctional health care services.
CHAPTER TWO

CONCEPTUAL CONTEXT

Chapter two presents the conceptual context as it relates to women in jail. It describes the population, women in jail, and what is currently known about their health. Also presented is a description of the problems associated with access to correctional health care and a model of a correctional health care delivery system developed as a result of the problems and obstacles encountered by inmates trying to access care. Chapter two concludes with a description of jail culture as it relates to women and their access to correctional health care services and a personal interest viewpoint of jail experiences while caring for women inmates.

Conceptual Context

To proceed in an orderly manner and set the stage for academic inquiry the researcher must first determine and identify important concepts and place them into a context as they relate to the area of inquiry (Maxwell, 1996). For the study of women offenders seeking to access health care in a jail environment, a concept analysis was performed guided by the foundations, techniques and applications from Rogers and Knafl (2000). The four identified concepts listed below form the basis of the relevant literature review that follows and creates a framework for the academic inquiry.

1. Women in jail and their health,
2. Access to correctional health care,
3. Correctional health care delivery system,
4. Culture of jails.
A systematic review of the literature was conducted through a computerized data base retrieval system. For the concept, women in jail and their health, the following keywords were used: women inmates, inmate health, women in jail and prison, women inmate epidemiology. The keywords used to gather relevant literature for the concept access to correctional health care were access to correctional health care, and access to health care. Correctional health care delivery systems and models of correctional health systems were the keywords used to research the concept correctional health care delivery system. For the culture of jails the relevant literature was identified through discussions with the committee member familiar with the area and by using the following keywords: culture of jails and prisons, incarceration and culture.

The conceptual context is completed with the inclusion of the personal interest component described by Maxwell (1996). It contains the researcher's background and experience working with women in jail supporting the interest in the proposed research study.

**Women Offenders And Their Health**

*Demographics*

Several statistical reports obtained from the U. S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics were reviewed to develop the profile of the woman in jail. The report by Harlow (1998) is devoted to the profile of jail inmates, while the report by Greenfield and Snell (2000) is specifically about women offenders. The reports by Beck, Karberg & Harrison (2002) and Harrison & Beck (2002) combine information about both jail and prison inmates.
Although still small in numbers when compared to the numbers of men in jail, every statistical report highlights the growth of the female correctional population (A. J. Beck et al., 2002; Greenfield & Snell, 2000; Harlow, 1998; Harrison & Beck, 2002). In 2001, of the total number of 631,240 jail inmates, 72,621 were women. In 1990, women in jail comprised approximately nine percent of the jail population numbering 37,198, yet by 2001, the percent of women in jail rose to almost twelve percent numbering 72,621. This accounts for a 6.3% annual growth of women compared to an annual growth of 3.8% for men in jail. There was a 114% growth of women in prison accentuating the high index of certainty that the women in prison were either processed through the jail or had spent at least the initial pretrial period in a jail.

The ethnic background of the majority of women in jail has continued to be of color (A. J. Beck et al., 2002). Since 1990, in combination, Black, Hispanic, American Indian, Alaska Natives, Asians, and Pacific Islanders consistently account for more than half of the jail population. Of special note, in 1990, 41.8% of the incarcerated women’s population was white and 42.5% black however within the U. S. population white women comprise 82.6 % and black women only 12.7% (Greenfield & Snell, 2000; Harlow, 1998). Examining and comparing the two ethnic backgrounds found in 1995, 2000, and 2001, the percentage points between white and black women were separated by a range of 0.6 to 3.4 percentage points, which illustrates very little difference in the numbers of black and white women in jail but a large discrepancy between the two in the U. S. population. The percentage of Hispanic women has remained steady with a range from a low of 14.3 in 1990, to a high of 15.1 in 2000 (A. J. Beck et al., 2002). American Indians, Alaska Natives, Asians, and Pacific Islanders form a single ethnic category. They ranged
from a low of 1.3% in 1990, to a high of 1.7% in 1995, and have remained stable at 1.6% for the year 2000 and 2001 (A. J. Beck et al., 2002).

Greenfield & Snell (2000) and Harlow (1998) report on the following characteristics of the woman in jail. The median age of the woman in jail is 31 years compared to the median age in state prisons 33 years and Federal prisons 36 years. Twenty-one percent of the women in jail are less than 24 years of age with 73% ranging in age from 25 to 44 years. The remaining 6% are women 45 years or older. Married women comprise 15% of the jail population while 48% have never been married and the remaining 37% were divorced, separated, or widowed. Almost half of the women in jail have less than a high school education, 39% have a high school diploma or a GED and the remaining 11% of women have earned college credits or a college degree. In 1997, an estimated 2.8% of the population of minor children, or children under the age of 18, have at least one parent in jail or prison. Seventy percent of the women in jail report having one or more children under the age of 18. Jail inmates report low incomes with 45% earning less than $600 per month.

According to Greenfield and Snell (2000) jailed women were most likely to have committed a drug-related crime, accounting for 30% of the total offenses. Property offenses defined as fraud and larceny, account for 34% of the total offenses and may have been committed to support drug related behavior. These are followed by public-order and violent offenses, 24% and 12% respectively. Of the 12% of violent offenses approximately three fourths were simple assaults. The offense composition clearly demonstrates the drug-related problems of women in jail and all the potential health risks associated with drug addiction.
Health

The computerized database search yielded 203 journal articles. Many of the articles were health related however, excluded since the reported research was conducted in American or foreign based prisons, was not written in English or were from anecdotal and secondary sources. A total of eleven original research studies met the inclusion criteria (Beltrami, Cohen, Hamrick, & Farley, 1997; Bond & Semaan, 1996; Holmes et al., 1993; Lindquist & Lindquist, 1999; Magura, Kang, Shapiro, & O'Day, 1993; Mahon, 1996; Muzekari, Lonigan, Hattion, & Rowe, 1999; Ruiz et al., 1999; Shuter, Bell, Graham, Holbrook, & Bellin, 1998; Singer, Bussey, Song, & Lunghofer, 1995; Teplin et al., 1997). These studies could be organized into three health related categories: infectious disease, mental health issues, and health utilization. There were no studies on the status of chronic diseases found in the women jail population. The studies reviewed reported women in jail had higher incidences of untreated infectious diseases and serious mental illnesses requiring pharmacological intervention. Women utilized health care services more than men and reported difficulty assessing health services. There were several methods used to answer a variety of health related research questions but the major threads running through all the studies were two fold, that they were conducted to either initiate the development of a health care system, or justify and maintain, or recommend improvements to the current level of services available. The studies also seem to suggest women in jail do not receive the community standard of health care if they are able to access health care in jail at all (Yasunaga, 2001).
Access to Correctional Health Care

The literature search yielded very few sources of information. To augment the limited information letters of inquiry were sent to correctional health associations where books, pamphlets, journal articles, and legal documents were obtained and reviewed. The result of the search yielded fifteen journal articles, six legal documents, and two books.

Historically no formal organized system of health care existed in correctional facilities. Inmates with existing health conditions or health conditions contracted during incarceration were not provided medical, dental or mental health care (Cornelius, 1996; Freudenberg, 2002; Irwin, 1985; Lessenger, 1982). Over the years there have been improvements to correctional health care systems but the incentive to improve the system were initiated from successful legal challenges filed on behalf of inmates (Collins & Collins, 1996; Cornelius, 1996). The court systems mandated public safety departments to develop health care systems in order to meet the health needs of the inmates causing a rise in health care costs despite severe budget cuts (Acoca, 1998; Barry, 1996, 2001; Keamy, 1998; Pollack, Khoshnood, & Altice, 1999; Ross & Lawrence, 1998; Thorburn, 1995; Wilson & Leasure, 1991). Shrinking resources not only affected availability of services but directly impacted accessibility of services (Acoca, 1998; American College of Physicians, National Commission on Correctional Health Care, & American Correctional Health Services Association, 1992; Anno, 1993; Freudenberg, 2002; Hammett, Gaiter, & Crawford, 1998; Ross & Lawrence, 1998; Thorburn, 1995; Wilson & Leasure, 1991). Incarcerated women were especially affected by the failings of the correctional systems to provide barrier free access to health services.
Although correctional systems across the country are, first and foremost, entrusted to protect the public from their charges, just as important, these systems are obligated to provide necessary services to these individuals. When correctional systems fall short of their legal obligation, often the potential for major legal problems develop. Court systems of the 1970s and 1980s witnessed a surge of lawsuits exposing deplorable general and medical conditions behind bars. In the landmark case, Estelle versus Gamble ("Estelle v. Gamble," 1976), Mr. J. W. Gamble, claimed he was subjected to cruel and unusual punishment while incarcerated by the State of Texas. On November 9, 1973, the inmate requested medical services after being struck by a falling bail of hay that caused him back pain. Over a 3-month period he was evaluated 17 times by several members of the health care team. Despite a prescribed pharmacological regimen he refused to return to work because of poor back pain control. His refusal to work was interpreted as malingering by the prison disciplinary committee and on December 5, the inmate was sent to "administrative segregation." When he persisted in refusing to work because of unresolved back pain and newly diagnosed migraine headaches and high blood pressure he was sent to solitary confinement. While isolated he was not provided with his prescribed medication regimen on a timely basis. Finally on February 11, 1974, he filed a legal complaint.

Over the next several years the case spiraled through the judicial system reaching the United States Supreme Court in 1979. The final decision of the case resulted in the ruling that States cannot knowingly neglect the health care needs of inmates. It is the State's constitutional duty to provide all inmates with a health care delivery system with unimpeded access to medical care, competent, diligent personnel, and assurances that the
Correctional staff cannot deliberately delay or deny access to medical care or prescribed treatment.

Documents from Amnesty USA (2000) and Legal Services for Prisoners with Children ("Shumate v. Wilson," 1995; "Shumate v. Wilson," 1997) expose the failings of the California Department of Corrections in the class action lawsuit. The basis of the lawsuit stemmed from denying women access to health care at two California facilities, Central California Women’s Facility (CCWF) and the California Institute for Women (CIW) a violation of their constitutional rights. Sick call, the primary avenue women access health care, was held only once per week. Women did not receive the standard of care for routine gynecological examinations, waiting years for cervical cancer screenings and clinical breast examinations with lengthy delays in diagnostic follow up. It was not unusual to wait two years for dental care. Frequent interruptions in refilling prescription medications affected the outcome of chronic diseases. Of particular concern were for women taking HIV and tuberculosis medication. The California case continues to be monitored by the courts and it is not clear what changes have been made to improve the delivery of health care to women offenders.

Hawaii has not been immune to litigation involving the medical care of inmates. On September 14, 1984, Walter A. Y. H. Chinn, the United States District Court in the District of Hawaii clerk, accepted a class action complaint from lead attorneys Mary E. McClymont and Alvin J. Bronstein from the National Prison Project of the American Civil Liberties Union Foundation. None of the correctional facilities housing women provided 24-hour health care services despite a population of individuals with serious medical conditions. Individuals with seizure disorders, diabetes and active tuberculosis
were left without medical care and supervision. Of particular concern were the women with obstetrical and reproductive health needs; they had no access to health care services. The unresolved complaints by women ("Spear et al., versus Ariyoshi, et al," 1984; "Spear, et al versus Ariyoshi et al.," 1985) initiated the Spear Consent Decree ("Spear, et al., versus Waihee, et al.," 1987) that forced improvements to correctional facilities in Hawaii through court mandated monitoring.

**Correctional Health Care Delivery Model**

The literature review yielded no examples of correctional health care delivery models therefore the researcher observed and examined the model at her place of employment. Flow charts of the model were created that illustrate the services and the flow of patients through the health care system. The model was developed gradually over a period of fifteen years as services and personnel were added to meet the requirements of the Spear Consent Decree. It is described in detail below.

Figure 1, located below, is a schematic representation of the layers of health care services available to inmates from jail intake until release. The inmate is the central figure, or the bull’s eye, with all services represented by concentric circles revolving around the inmate. The first layer of services surrounding the central figure represents the immediate screening done during intake processing. The second layer consists of a battery of assessments offered to each offender within the first 14 days of admission to jail. The third layer represents the sick call system which is the main method used by inmates to access clinic services once routine screening assessments are completed. The fourth layer is the ambulatory clinic system consisting of medical, dental and psychiatric clinics. The final layer represents community services available to inmates while
detained. The health care personnel consist of a physician (MD), advance practice registered nurses (APRN), registered nurses (RN), license practical nurses (LPN), a psychiatrist (PMD), psychologist, psychiatric social workers (PSW), dentists, a dental hygienist and a dental assistant. The system does not utilize medical technical assistants as gatekeepers to the health care system.

_Layers Of Jail Health Services_

Figure 1.

**Model of Jail Health Services**

Intake screening (see Figure 2) is conducted on every inmate on the day of entry to jail. It consists of a cursory mental health interview by a PSW to determine appropriate housing placements. Most inmates are assigned to the general population; however, when men exhibit mental health concerns that require alternate housing accommodations they are assigned to special needs units. Unfortunately, women with mental health issues are
housed among women of the general population. Their small numbers discourage jail administrators from providing a special needs unit for mentally ill women.

*Intake Screening*

Figure 2.

**Intake Flow Chart**

Immediately following the initial mental health interview every inmate is directed to the health care unit where all inmates are screened for TB. A health-screening interview is conducted by an intake RN to confirm mental health concerns initially identified by the intake PSW and to identify physical and or medical conditions requiring alternate housing arrangements for the male offender. Men with physical or medical conditions not conducive for general population housing are sent to special needs units. Women, however, are sent to their general population despite having similar medical conditions and needs as men.
Inmates injured in the process of their arrest or with injuries prior to arrest are evaluated and treated with self-care counseling and sent to their housing units. There are two options available to the intake RN if the injuries require further evaluation or treatment. For less serious conditions, the inmate is referred to the next available ambulatory clinic. When the condition requires immediate attention, the nurse notifies the on-call MD for patient consultation. When chronic conditions are identified during the intake-screening interview, the inmate is referred to the next available ambulatory clinic depending on the condition for on-going care. The intake RN questions the inmate about drug and alcohol use to evaluate for withdrawal. If necessary the inmate is placed on medically approved withdrawal protocol immediately and referred to the ambulatory clinic system. Women who say they are pregnant have their pregnancies confirmed by fetal heart tone detection or urine or serum human chorionic gonadotropin testing. They are referred to the next ambulatory clinic sessions to initiate prenatal care.

*Multidisciplinary Health Assessments*

The next layer of health service is the battery of physical assessments offered to every inmate within the first 14 days of the intake process (see Figure 3). Professionals in conjunction with their area of expertise perform assessments to establish a health baseline and determine if there is a need for further care.

The three disciplines that perform inmate assessments are RNs, a dental hygienist, and PSWs. All inmates are encouraged to participate but if they are unwilling, the inmate signs a refusal form with non-participation consequences explained in detail. Each assessment component identifies inmate needs and each health professional has the flexibility to interface with and refer to any ambulatory clinic as determined by need. For
instance, the dental hygienist is free to refer to the APRN or MD for acute medical problems identified during the dental assessment or the RN is free to refer to the PMD for mental health issues identified during the course of the assessment phase.

*Nursing Assessment*

All participating inmates receive a detailed health history and a nursing physical assessment to establish a health baseline and to identify any nursing or medical needs (see Figure 4). If health needs are identified, the inmate is referred for further evaluation through the ambulatory clinic system. If there are no acute or chronic medical concerns identified by the assessment RN, the inmate is instructed to access the health care system via sick call should future health concerns arise. Women who are delinquent in routine gynecological examinations are automatically referred for cervical cancer and sexually transmitted disease screening.
Dental Hygiene Assessment

The dental hygienist performs a screening dental examination on every inmate to determine each individual's baseline dental condition and dental needs (see Figure 5). If there are dental concerns the inmate is referred to the dental ambulatory clinic for further evaluation and treatment by the dentist. If no needs are identified the inmate is instructed to self refer for future dental care via the sick call system.

Mental Health Assessment

PSWs interview every individual in the general population to establish a mental health baseline and evaluate the effect of incarceration (see Figure 6). If the inmate continues to be suitable for the general population access to mental health services can be initiated via the sick call system. If there is a pre-existing psychiatric history but no overt
Figure 5.

Dental Health Assessment Flow Chart

Entire Population → Dental Hygienist →

Return via Sick Call →

Ambulatory Clinic Referral

Figure 6.

Mental Health Assessment Flow Chart

General Population → Psychiatric Social Worker → Return via Sick Call

Psychiatric Population → Psychologist → Ambulatory Clinic Referral
RECEIVED
AS
FOLLOWS
Figure 5.

Dental Health Assessment Flow Chart

Entire Population

Dental Hygienist

- Return via Sick Call
- Ambulatory Clinic Referral

Figure 6.

Mental Health Assessment Flow Chart

General Population

Psychiatric Social Worker

- Return via Sick Call

Psychiatric Population

Psychologist

- Ambulatory Clinic Referral
signs of psychosis and there are no indications of mental decompensation, instructions are given for self-referral to mental health services needed in the future. If a male inmate exhibits signs of mental decompensation, a transfer to the psychiatric housing unit for further observation is arranged where a psychologist resumes the care of the inmate with collaboration with the psychiatrist as the need arises.

By contrast after being interviewed by a PSW, women known to have psychiatric problems are not isolated in separate housing units as are men. They are kept with the general population but when the women exhibit violent behavior or expresses suicidal thoughts they are confined to a limited number of isolation rooms. When all available rooms are exhausted, women can be transferred to another facility for continued care. The immediate goal is to preserve the safety and protection of the inmate and those around her. Although the numbers do not appear to justify a special needs unit for women, mentally ill women who enter jail are treated differently from men.

Sick Call System

The sick call component is the major method inmates use to access the health care system from their housing units once the routine multidisciplinary assessments are completed (see Figure 7). RNs visit each housing unit daily to interview and examine individuals who have health concerns. Depending on the inmate’s complaints, the sick call nurse has the flexibility to treat and provide health counseling immediately using a standardized medically approved nursing protocol or refer to the ambulatory clinic system. For example, if the inmate complains of a sore throat, the nursing protocol allows the nurse to provide salt for warm water gargles with instructions to return to sick call in five to seven days if there is no improvement. If an inmate has a condition not covered by
a standardized nursing protocol, the nurse refers to the ambulatory clinic system for further evaluation.

Figure 7.

**Sick Call Flow Chart**

The ambulatory clinic system provides three disciplines of service, medical, dental and psychiatric clinics (see Figure 8). Inmates are referred to the clinics through findings from sick call, intake screening, and routine assessments. The HIV clinic offering testing and counseling is a service provided by the Department of Health and conducted once per week. Since all results are confidential, individuals with positive results are counseled to seek medical attention as soon as possible. It is the decision of the inmate to have the HIV counselor facilitate a referral to the ambulatory clinic system or the inmate can access the clinic via the sick call system.
The medical ambulatory clinic has two levels of health care providers, a board certified MD and APRNs with national certification and prescriptive privileges (see Figure 9). The MD is medically responsible for the complicated acute and unstable chronic disease patients. If the inmate requires specialty care, the MD refers the patient to an approved community provider for off-site evaluation and treatment recommendations. The recommendations are reviewed by the MD and carried out as suggested by the specialist. If there are questions about the recommended plan of care the MD works with the consultant to modify the treatment to fit within the jail regimen.

Simple acute and stable chronic medical conditions are followed by the APRNs who work independently but collaboratively with the MD. When inmates' medical needs
Figure 9.

Medical Clinic Flow Chart

Sick Call/Intake/Assessment
Referrals

Physician

Unstable Chronic Disease Follow-up System
Specialty Care

Acute Condition

Return via Sick Call

Advance Practice Nurse

Stable Chronic Disease Follow-up System OB/GYN Clinic

Physician Referral

Figure 10.

Gynecological Services Flow Chart

Medical Clinic

Routine GYN

Abnormal Pap 2001 AMA Consensus Guidelines

Positive STD Single Dose Rx TOC

Breast Abnormalities Community Consultant

HIV Clinic

Return via sick call
exceed the scope of the APRN the inmate is triaged to the MD. Once the medical condition stabilizes, the patient returns to the APRN for continued care.

Routine gynecological services consist of clinical breast examinations, Pap smears, sexually transmitted disease testing and bimanual pelvic examinations (see Figure 10). They are performed exclusively by the APRN. If the examination reveals no problems, the women are counseled to repeat the examination in a year through sick call or with their private MD.

Suspicious findings on clinical breast examinations are referred for mammograms and if needed, referred to an approved community consultant for specialty care. Abnormal Pap smear results are reviewed and further testing is scheduled as determined by the American Medical Association’s Consensus Guidelines (2001). The APRN is notified of positive sexually diseases screening results and the women are treated with single dose antibiotic regimens as recommended by the Centers for Disease Control Guidelines (1998). Intensive safe sex counseling is provided with strong recommendations for HIV testing.

Confirmed pregnancies are referred to the APRN for prenatal care on the next clinic day (see Figure 11). The first visit is to determine her level of risk and whether or not to provide routine care on-site or to refer the woman for off-site specialty care. If the woman’s pregnancy is found to be of very high risk, care is transferred to an off-site community consultant. Care is routinely transferred to the community consultant at 36 weeks gestation or sooner if the woman’s pregnancy status changes. The delivery takes place at a local community hospital and the woman is discharged to the jail. There are no
services for parenting programs or facilities for an onsite nursery for women that deliver while detained.

Figure 11.

**Obstetric Services Flow Chart**

**Medical Clinic**

Initial Prenatal Risk Determination

Transfer of care to KMC OPD

Continuing Obstetric care

Parenting Program Nursery

Off site Delivery

Post natal

Return via Sick Call

**Dental Ambulatory Clinic**

A dentist and dental assistant provide dental care to inmates referred for service via the sick call, intake screenings, or assessment examinations (see Figure 12). Acute conditions are treated and the inmate returns in the future through the sick call system. Inmates with chronic dental diseases return to the clinic as instructed by the dentist. An approved community consultant provides specialty dental care as recommended by the correctional dentist.
Psychiatric Ambulatory Clinic

The psychiatric ambulatory clinic receives patient referrals through sick call, intake screenings, and nursing assessments. A PMD is responsible for the entire jail population's acute and chronic mental health needs. There is no APRN with a psychiatric focus and prescriptive privileges to monitor inmates with simple acute and stable chronic mental health needs as there is for the medical ambulatory clinic. This arrangement places the burden of seeing the entire mental health population in the ambulatory clinic on the PMD.

The model presented above is an example of a correctional health care delivery system illustrating a systematic approach to delivering inmate health care services. There are two ways inmates are able to access services. The first is through health screenings conducted during the admission process and through the determination of the inmates'
baseline health status. The second avenue inmates are able to access care is through the sick call system. Registered nurses visit each housing unit on a daily basis and examine those inmates with health concerns. The condition can be treated immediately through established nursing protocols or the nurse refers the inmate to the ambulatory clinic system for further examination. Although gender specific additions to the system have been made to meet gynecological and obstetrical needs of jailed women, there is a discrepancy in the facility’s ability to provide psychiatric and medical special needs care to women.

Culture of Jails

Understanding the culture of jails as it relates to women and their health is problematic since most of the studies of culture and incarcerated women reviewed were conducted in prison settings (Giallombardo, 1966; Heffernan, 1972; Owen, 1998; Ward & Kassebaum, 1966) and the single study of jail culture (Irwin, 1985) ignored women altogether. In all of the studies reviewed (Clemmer, 1940; Giallombardo, 1966; Heffernan, 1972; Irwin, 1985; Owen, 1998; Sykes, 1958; Ward & Kassebaum, 1966) there was very little information on access to health care services. Despite the scarcity of information an attempt will be made to begin to understand the relationship between the jail culture and women’s access to correctional health care with the available published information.

Within any correctional facility, whether jail or prison, the literature suggests the existence of two cultural components, a security component and an inmate component. The security component is comprised of a cohesive group of individuals or guards trained to maintain controls over the detained population (Irwin, 1985; Sykes, 1958). The level of
security risk for the day determines inmate activities, when and what to eat, where and how long to sleep, when to toilet, and recreation time. It is oppressive and can exert physical limitations on those who stray beyond the norms of acceptable correctional behavior.

The security component of the correctional culture supersedes but does not intend to minimize the diverse ethnic, religious, or personal cultures practiced in jails and prisons. Guards are tolerant of inmates practicing personal cultural beliefs and only when these practices interfere with maintaining controls over inmates, are they denied. The guards become deeply embedded into the culture of correctional security to ensure their lives in these facilities are as safe and tolerable as possible for themselves and to maintain their edge over the inmates (Clemmer, 1940; Giallombardo, 1966; Heffernan, 1972; Irwin, 1985; Owen, 1998; Sykes, 1958; Ward & Kassebaum, 1966).

The literature describes the second component of correctional culture. These academic views of human life focused on how men and women offenders adjusted to correctional cultures. Interestingly, the researchers found women and men adjust their lives differently (Clemmer, 1940; Giallombardo, 1966; Heffernan, 1972; Irwin, 1985; Owen, 1998; Sykes, 1958; Ward & Kassebaum, 1966). While men in prison organize into groups for solidarity and for protection against the security component (Clemmer, 1940; Sykes, 1958), women in prison organize into pseudo family units to mimic social contacts and intimate relationships from their non-incarcerated lives (Giallombardo, 1966; Heffernan, 1972; Owen, 1998; Ward & Kassebaum, 1966).

In Irwin’s (1985), study of jail culture, only men arrestees were examined. On arrest the men are confronted with an abrupt cessation of freedom coupled with strong
feelings of isolation and powerlessness. They are prevented from communicating with members of their family and persons with whom they have social ties unless permission is granted. Every move is watched with the threat of punishment if behavior strays beyond the expected, forcing jail inmates to learn the borders of acceptable behavior quickly, adding stress to an already stressful situation.

Irwin (1985) describes jail inmates abruptly deposited in a very negative environment. The inmates are immediately stripped of their independence and forced to submit to the degrading admission process giving the security staff a psychological advantage over the jail inmates. Clothing and personal property is confiscated and placed in a property room to be returned only upon release. Then comes identification of each offender by finger printing and picture taking. Ill-fitting prison uniforms are issued after the far from private bath. Then there is a long wait in rooms filled with other jail detainees for a cursory medical clinic visit and finally assignments to housing units are announced. The new detainees warily and hesitantly join the incarcerated population to live in and learn about the culture of the jail.

There are no published studies to document how women adjust to jail culture. Personal field observations during working hours, watching and talking to women on a daily basis in our jail health care unit, have contributed to understanding the experiences of jailed women. Since these personal observations and conversations were not undertaken in the academic research sense and took place only within the confines of the health care clinic, there are limitations to their trustworthiness, however they are included for they provide another facet of the conceptual context of the woman’s experience in jail.
Although women and men are subjected to identical jail processing procedures, from the interactions with women, I sense they appear more negatively affected than men by the processing of each inmate into the culture of the jail. When informally interviewed in the medical clinic, women express that the jail environment is the cause of and also increases their level of stress and anxiety. Other women complain of the inability to concentrate and focus during their clinic visit contributing to their difficulty in identifying medical needs. It is not unusual for women to seek pharmacological interventions to help with adjusting and learning the culture of the jail. Some women state they are preoccupied with thoughts about their children and do not have the inclination to learn the culture. Others are depressed and do not possess the mental energy to concentrate on their surroundings. And finally others are just rebellious by nature and refuse to conform.

When women do not learn the culture, the acceptable norms of jail behavior, they are labeled a problem and are seriously at risk for sanctions. It is interesting that some of the more experienced women help the less experienced learn and navigate the jail culture. Not in the sense that these “helper” women assume a mother role as in research studies reviewed (Giallombardo, 1966; Heffernan, 1972; Owen, 1998; Ward & Kassebaum, 1966) but more as an informal guide, teaching the ways of jail culture to get what is needed and avoid sanctions. The duration of jail detention, which is usually shorter than prison sentences, may be related to why women are not able to develop the supportive nature of the pseudo family units in jail as they commonly do in prison. The closest comparison is when jailed women refer to their close associations as a “bunkie” referring to the other woman assigned to their bunk bed. If they are compatible, they seem to rely on each other until they are separated by bunk bed reassignment or release.
Personal Interest

Being a masters prepared, nationally certified, advanced practice nurse employed by State Department of Health, I wanted to practice my level of skill in an appropriate position. With no positions available in the Department of Health, I was forced to expand my job search to other State departments. Fortunately an acquaintance found a position listed in a local newspaper and urged me to apply for a position in the local jail. I had my reservations since it was the Public Safety Department that was advertising for a nurse practitioner. When the position was offered to me the decision was to either decline the offer or overcome my unconfirmed fears and accept full-time work in the local jail. I could see myself continuing as a Department of Health nurse administrator when the State of Hawaii had invested time and resources to train me to become a nurse practitioner. After an agonizing period of soul searching, I accepted the position at the local jail with no expectations.

Knowing very little about the population when first hired, I attempted to locate evidence-based research studies to expand my knowledge base of the jail population. I wanted to learn more about their health needs and identify the most effective method for delivering health care to one of the most vulnerable segments of our population. The search uncovered a paucity of research-based articles regarding the health of the jail population and even less about women in jail, a group with the highest of high-risk health conditions. The readings revealed that nationally, from as early as the 1970s and extending on into the present, there have been serious legal complaints linked to the lack of or the limited access to health care services for women jail offenders resulting in consent decrees.
During the first two extremely stressful years of my employment at the jail, I learned that the Spear Consent Decree, a result of complaints brought about on behalf of a woman inmate, influenced almost every aspect of health care. The unit functioned under the scrutiny of a federal monitor who forced improvements to expand health care services and develop and institute a health care delivery system. Jail administrators in their attempt to assure the appropriateness of each improvement subjected the health care unit to a stringent accreditation process conducted by the National Commission on Correctional Health Care. In the year 2000, the consent decree was lifted and shortly thereafter, the National Commission on Correctional Health Care accredited the jail.

Yet, despite the lifting of the consent decree, continued national accreditation, and the development of a correctional health care delivery system designed with women in mind, why do women remark about poor or difficult access to health care services? What could account for the contradiction? It is clear that more research is needed to understand the meaning women in jail ascribe to their experiences trying to access health care services. It will serve to add another needed piece to the complex puzzle of women in jail.

Summary

The conceptual context set the stage of academic inquiry as it related to women in jail and their health, access to correctional health care, correctional health care delivery system, and the culture of jail. A review of the literature reveals essentially very little is known about the full spectrum of health as it relates to jailed women. Much of the available research based information centers around infectious disease, mental health issues and health utilization.
Historically health care services were virtually non-existent but a landmark legal case ("Estelle v. Gamble," 1976) resulted in a Supreme Court decision mandating public safety departments across the country to provide all inmates with access to a spectrum of health care services. Other lawsuits filed on behalf of women inmates ("Shumate v. Wilson," 1997; "Spear et al., versus Ariyoshi, et al," 1984) revealed women were denied access to health care or were delayed in receiving care resulting in negative health outcomes.

The literature review yielded no examples of models of correctional health care delivery systems. Because of this gap in the literature the system used by the researcher which was developed as a result of a consent decree ("Spear et al., versus Ariyoshi, et al," 1984) was examined and documented by the creation of health access and care flow charts. The model of jail health care illustrates a multidisciplinary approach to meeting the needs of inmates as well as specific attention paid to the gynecological and obstetrical needs of jailed women.

The literature review of jail culture as it relates to women in jail and their health was non-existent. The culture of jailed women has not been critically examined as a result personal field observations of the researcher were used to augment the limited knowledge base of jail culture.

Chapter two concludes with a personal reflection of the interest and desire to learn about women in jail. The section describes the effect of the consent decree on mandating health care services, attaining national accreditation and the need for further research because of the gaps in the literature and the complaints by women of access to health care.
CHAPTER THREE
PROPOSED RESEARCH

Chapter three presents the research methodology and method and arguments in support of selecting a qualitative methodology and the phenomenological method of research based on the research question. Also included are the sample selection and research sites, data collection, data management and data analysis and methods for ensuring trustworthiness. Chapter three concludes with a description of ethical issues and efforts to protect human subjects participating in the research study.

Research Methodology and Methods

Strauss and Corbin (1998) defined methodology as “a way of thinking about and studying social reality” and methods as “a set of procedures and techniques for gathering and analyzing data”. In deciding the methodology of research the differences between qualitative and quantitative research were reviewed. While both methods have their merits, methodological congruence was critical to maintain. Methodological congruence (Morse & Richards, 2002) or the best fit of methodology with method to answer the research question, “What is the lived experience of women in jail trying to access jail health care services?” was critically important to the validity and credibility of the research study.

The intent and strength of a qualitative study is to paint a critical picture of a phenomenon as seen through the descriptive lens of an individual who has experienced the phenomena being studied (Anderson, 1989; Cohen et al., 2000; Creswell, 1998; Devers, 1999; Lincoln & Guba, 1985; LoBiondo-Wood & Haber, 1998; Maxwell, 1996; Mayan, 2001; Morse & Richards, 2002). It is done inductively, by identifying specific
data from narrative information, analyzing the data, and thematically categorizing the
data to formulate meaningful commonalities related to the specific phenomena (Cohen et
al., 2000; Mayan, 2001; Miles & Huberman, 1994). The final product is a reduction of
the data describing experiential essences of the phenomenon of study.

In the case of women ascribing meaning to their experiences of trying to access
jail correctional health services, a qualitative approach was selected. Points to support the
selection were as follows. There is a paucity of knowledge surrounding the phenomena of
interest as supported by the contextual content. Participants could not be randomly
selected as in quantitative studies but, in fact, selected purposefully, meeting a set of
strict criteria. Data collection would occur in the natural setting with a minimum of
controls and the data, in the form of text, would then be analyzed to answer the research
question. Clearly the qualitative methodology was found to be the “best fit.”

The next critical decision to be made to select the qualitative method best suited
to answer the research question was considered. Creswell (1998) and Morse & Richards
(2002) discuss the congruence between the question asked and the method selected.
Although a number of qualitative methods are available, the three traditional methods
considered by the researcher were ethnography, grounded theory, and phenomenology.

**Ethnography**

The foundation of ethnography lies within the discipline of anthropology where
the researcher attempts to portray a portrait of a cultural group or people. The research is
conducted in a natural setting observing behavior patterns, customs, and ways of life
(Creswell, 1998; Roper & Shapira, 2000). Data is a collection of written field observation
notes and interview transcripts that are inductively analyzed using a series of steps to
make cultural meaning from the data (Roper & Shapira, 2000). Coding is conducted to identify domains, categories and subcategories and from each domain commonalities are sorted to identify patterns. The final abstraction examines the patterns from which emerge constructs supporting a theory that explains the culture in its totality. (Roper & Shapira, 2000). The ethnographic method described above focused on examining cultural aspects of groups and would not adequately answer the proposed research question regarding lived experiences.

**Grounded Theory**

The second qualitative method to be explored was grounded theory (Creswell, 1998; Strauss & Corbin, 1998) which has it’s foundations in sociology focusing on developing a theory grounded in data collected from the field. The data consists of multiple interviews with individuals selected through a process referred to as theoretical sampling (Strauss & Corbin, 1998) or selecting individuals with specific characteristics that have the potential to contribute to theory development. Data analysis proceeds systematically using open, axial, and selective coding. The data are fractured, conceptualized, and integrated to form the theory (Strauss & Corbin, 1998). Using grounded theory was not the best method to research the lived experience of women in jail trying to access health care.

**Phenomenology**

Phenomenology has it’s foundation in philosophy, sociology, and psychology focusing on understanding the essence of experiences about a phenomenon (Cohen et al., 2000; Creswell, 1998; van Manen, 1990). The researcher attempts to capture the description of the meaning of the lived experience as told by individuals who have
experienced the phenomena. Through descriptions the researcher learns the essence of how subjects attend to their world as it is lived (Creswell, 1998), develop relationships to other people, to things, to events, and to situations (Morse & Richards, 2002), and understand the fundamental nature of the subject’s reality (Walters, 1995). In the selected form of phenomenological inquiry, the researcher begins by bracketing all prior knowledge of the phenomenon to maintain objectivity by documenting assumptions, knowledge, and expectations so that the researcher enters the arena with a “clear slate” (Creswell, 1998; Morse & Richards, 2002; van Manen, 1990, 1997). It is the act of bracketing which lays a firm foundation to assure the researcher distance from the phenomenon, creating a thoughtless space, void of prior experiences enabling the researcher a fresh clear view of the phenomenon.

Sampling proceeds by selecting participants that meet a specific criteria relevant to the phenomenon of interest (Cohen et al., 2000). In depth interviews are conducted using the transcribed interview text as data to be analyzed. Data analysis begins with the researcher reading through each transcript isolating significant statements and categorizing their words into meaningful units or themes (Cohen et al., 2000). From the themes emerge a description of the overall picture, the essence or essential structure of the experience from individuals who have experienced the phenomena (Anderson, 1989; Cohen et al., 2000; Creswell, 1998; Omery & Mack, 1995; van Manen, 1990).

Phenomenology then, was the appropriate research method to answer the research question, “What is the lived experience of women in jail trying to access jail health care services?” With the important selections complete, the qualitative methodology and
phenomenological method, the foundations of the research study, the researcher was then able to proceed with the study.

Sample Selection and Site

The sample selection proceeded purposefully (Cohen et al., 2000; Creswell, 1998) to selectively recruit women who met the criteria of having been in jail and attempted to access health services. Women ex-jail offenders were recruited from two community based supervisory programs. The first program, T. J. Mahoney, agreed to post a flyer (see Appendix A) on their communications bulletin board seeking participates for the research study. The second program, Oahu Intake Service Center, agreed to have their supervisors recruit participants by passing out the research flyer to women after their appointments. The interested woman would contact the researcher through the telephone number provided on the flyer. Recruitment continued until all eligible participants had been contacted and when data analysis determined redundancy of categories had been achieved.

The criteria for participation were three fold. First, the participant must be female and detained in jail for a minimum of thirty days. During incarceration she must have attempted to access health services at least once. No more than three years must have passed between incarceration and recruitment for the study. It was made clear from the outset that participation was voluntary and the decision to participate would have no effect on their correctional status. If the woman met the criteria and chose to participate, she had to agree to the possibility of two audio taped interviews. The participants were compensated for their time and for the cost of transportation after each interview.
Data Collection

The interview was conducted at a negotiated location where there would be privacy and a minimum of distraction to the participant and researcher. The location was to be as quiet as possible to maximize the condition of audio taping the participant’s responses. Before the interview the researcher verbally explained the nature of the study and the demographic information. If the individual agreed to participate in the study the consent form (see Appendix B) was signed and the demographic sheet (see Appendix C) was completed. The data generating question to be asked was, “Tell me everything you remember, your thoughts and feelings, while at Oahu Community Correctional Center about having a dental, medical, psychiatric, or women’s health problem and what it was like to get to see a dentist, doctor, psychiatrist, or nurse practitioner for the problem.” If necessary the researcher asked the participant expansion questions such as “Could you tell me more about that?” or “What does that mean to you?”

Data Management

The researcher developed a system to manage data collected from the interviews to assure the data was easily accessible, organized and accurate. The researcher sought out, hired, and paid two transcriptionists to transcribe the data from the audiotapes. Communication between the researcher and the transcriptionists was facilitated by frequent e-mails via the Internet and by pager. When the document was completed, the transcriptionist contacted the researcher via pager to collect the document filed on a removable disc and the audiotapes. The researcher then reviewed the documents for accuracy making corrections as needed. The data was copied on to the researcher’s personal computer, personal data assistant, back up compact discs, and sheets of paper.
Data Analysis

After each audiotape interview was transcribed verbatim and checked for accuracy, the data was subjected to Colaizzi’s (1978) method of data analysis. Analysis was conducted with each protocol with continuous and repeated verification until redundancy was achieved and the maximum numbers of subjects were interviewed.

Critical analysis using Colaizzi’s (1978) method ensures a systematic and reliable method to verify the reliability of findings. The steps of data analysis are listed below.

1. Each subject’s descriptions, known as protocols, are read initially to acquire a general sense or feeling from the protocol.
2. Once the general sense of the protocol has been determined, significant statements are extracted.
3. Formulated meanings are derived from significant statements and are compiled into clusters of themes.
4. Returning to the protocols will validate the clusters of themes.
5. If the clusters of themes are not validated by the review of the protocols, then a re-evaluation of the protocols will be conducted to re-identify significant statements, formulated meanings, revealing clusters of themes and again returning to the protocols for validation.
6. The process will be repeated to develop a summary of clusters of themes leading to the formulation of an exhaustive description of the perceptions of women trying to access health care in jail.
7. Each participant will be subjected to a second interview to review and confirm the findings of the exhaustive description and any new data will be incorporated into the final product of the research.

Ensuring Trustworthiness

Strategies incorporated into the design of the study to ensure trustworthiness were synthesized from researchers experienced with the phenomenological method (Creswell, 1998; Lincoln & Guba, 1985; Morse & Richards, 2002). Bracketing, is the conscious effort to suspend the researcher’s biases to maintain objectivity during the research process (C. T. Beck, 1994; Caelli, 2001; Cohen et al., 2000; Colaizzi, 1978; Creswell, 1998; Drew, 2001; Hycner, 1985; Koch, 1995; Omery & Mack, 1995; van Manen, 1990). The researcher consciously identified and set aside prior knowledge and experiences with women in jail in an effort to prevent these thoughts from creating biases. Bracketing was begun by the researcher finding a measured amount of time asking, “Why do I want to do this research on women offenders? How does my experience as a nurse practitioner caring for women in jail bias my vision of their lived experience of trying to access health care in a jail environment? What information about jail health services will I gain from this research attempt? These questions increased the researcher’s self-awareness, clarifying biases, thereby increasing the possibility of objectivity. To assist with bracketing specific musical pieces were played to help the researcher with relaxation, concentration, and focus. The technique continued throughout the data analysis in an effort to assure an unbiased vision of the lived experience of women in jail.

Lincoln and Guba (1985) compared and converted the traditional notion of truth value, applicability, consistency, and neutrality in the quantitative paradigm into terms
they felt appropriate to qualitative paradigm. The quantitative criteria of internal validity, external validity, reliability and objectivity has been translated into the following qualitative terms, credibility, transferability, dependability, and confirmability, respectively (Lincoln & Guba, 1985).

Three techniques to improve credibility in qualitative research inquiry as described by Lincoln and Guba (1985) and are listed below and were incorporated into the research design. They are listed below.

1. Engaging in activities that increase credibility such as prolonged engagement, persistent observation, and triangulation.

2. Peer debriefing, and,

3. Member checks.

The following three activities prolonged engagement, persistent observation, and triangulation were reviewed. The first activity, prolonged engagement, is when the researcher has invested enough time at a site to have learned the culture and be able to detect falsehoods or misrepresentations in the data (Lincoln & Guba, 1985). In the case of the proposed research study, the researcher has been employed in a jail environment for several years and has working knowledge of the jail culture. She is trusted by the staff and is an accepted member of the Health Care Unit. Prolonged engagement was met by allowing a flexible frame of time to each participant to express her views and not be constrained by a specific frame of time. Although the drawback of prolonged engagement is the tendency of becoming so immersed in the group that the investigator “goes native” and loses objectivity (Lincoln & Guba, 1985), the researcher was consciously aware of
this tendency and vigilantly kept thoughts of “going native” continuously at the surface of the bracketing exercises.

While prolonged engagement provides the dimension of scope, persistent observation, the second activity to improve credibility, adds the depth that enables the investigator to identify relevant characteristics and elements in area of inquiry (Lincoln & Guba, 1985). The researcher feels that she has had the opportunity for persistent observations during her employment at the jail, which improves the probability that she may be prepared to identify relevant characteristics and elements as they relate to women in jail seeking health care.

Lincoln and Guba (1985) describe the third activity, triangulation, to improve the chance that the findings of a qualitative study is credible. Triangulation according to the authors can be multiple sources of data collection modes. In the phenomenological study of women in jail trying to access health care services there will be interview transcripts, demographic data, and field notes to meet the triangulation criteria.

The second technique to improve credibility is peer debriefing or having the researcher allow the scrutiny of feelings, thoughts, and biases by a disinterested peer in an effort to keep the researcher “honest” (Lincoln & Guba, 1985) and on track. The researcher consulted with her committee chair for likely disinterested peer candidates. When the individual was selected, understood and agreed to the role, meetings were set up periodically during the project to meet the criteria.

The third technique, member checking, provides the participants, from which the information was collected, the opportunity to review data, data analysis and the researcher’s conclusions to confirm their truthfulness, correct errors, and offer any
feedback (Hoffart, 1991; Lincoln & Guba, 1985). Member checking sessions were arranged by the researcher with the women participants to increase the probability that the findings are credible.

Operationalizing transferability is done from the thick descriptions of the participants that convince the reader that the conclusion of the researcher is a possibility (Creswell, 1998; Lincoln & Guba, 1985). The women participants will need to provide detailed descriptions relevant to the area of inquiry yet accompanied by a wide range of information that might enable readers to transfer information to other settings. With this research study, sampling was purposeful (Cohen et al., 2000; Lincoln & Guba, 1985) meaning only women ex-jail offenders who met specific criteria were included in the research study. The thirty day criterion was considered critical since the health care model indicates routine multidisciplinary health assessments are offered to all inmates during the first fourteen days of incarceration which guarantee automatic access to medical, dental, and mental health assessment services. The second criterion for sample selection was of those women detained in jail for thirty days or more; they must have attempted to access health care at least once. And lastly, the women needed to speak English and have to ability to express thoughts about their experiences without reserve.

Supporting thick description is the issue of data collection (Morse & Richards, 2002; Schwandt, 2001). All audiotape interviews were conducted by the researcher and transcribed verbatim to preserve every protocol. During the interview, the researcher was able to devote attention to note observable data not revealed by audio taping alone. This ensured an accurate and complete account of the participant’s perception of the phenomenon. The audiotape account allowed for the researcher to listen and recall the

An audit process and an audit trial are techniques suggested by Lincoln and Guba (1985) as a means toward operationalizing dependability and confirmability simultaneously. The selected auditor examined the record keeping process used by the researcher to authenticate adequate representation of the phenomenon of inquiry (Lincoln & Guba, 1985). Then the auditor assesses the accuracy of the data, findings, interpretation, and conclusions in an audit trail (Creswell, 1998; Lincoln & Guba, 1985). Lincoln and Guba credit the work of Edward S. Halpen for providing the direction to conducting both the audit process and the audit trail. For this research activity both the audit process and the audit trail were conducted according to Halpern and the potential auditor was selected with the help of the committee chair.

Ethical Issues and Protection of Human Subjects

The proposed study was submitted to the University of Hawaii Committee on Human Studies for review and did not commence until approval was confirmed. Because offender populations have been designated as vulnerable, it was made clear from the beginning participants of the study would be women ex-jail offenders and not detained in a jail environment at the time of the interview.

Every effort was made to protect participants from harm (Maeve, 1998; Munhall, 1988; Orb, Eisenhauer, & Wynaden, 2001). First, women were free to choose whether or not to participate in the study. If they refused to participate no harm came to them. If they chose to participate in the research study there was a face-to-face explanation of the study
and the consent form with opportunity to choose again whether or not to participate. There was no coercion to participate and the women were compensated monetarily for their time and transportation at the conclusion of the interview.

If the woman agreed to participate, the consent form was signed and kept under lock and key accessible only to the researcher and her committee members to protect the participant’s identity from being revealed. Confidentiality was maintained by giving the inmate the option of conducting the interview away from the jail at a mutually agreed upon location. All identifying information was stripped from transcribed text and any documents submitted for publication. Audiotapes and transcribed texts were destroyed at the conclusion of the research study.

Guided by the qualitative methodology, the phenomenological method, and Colaizzi’s data analysis procedure the researcher proceeded to begin recruiting women agreeable to participate in the study.

Summary

Arguments presented support a qualitative research methodology and the phenomenological method as the most appropriate approach in answering the research question, “What is the lived experience of women in jail seeking to access jail health care services?” The data collected were subjected to Colaizzi’s method of data analysis. Strategies to ensure trustworthiness were incorporated into the study’s design such as bracketing, prolonged engagement, persistent observation, triangulation, peer debriefing, and member checking. Particular attention was paid to ethical issues and the protection of human subjects since the incarcerated populations are particularly vulnerable. Every
effort was made to protect participants from harm. Only when all aspects of the approval process was obtained did recruitment of subjects begin.
CHAPTER FOUR

RESULTS

Chapter four presents the results of the study along with a description of the sample, sample size, and data collection sites. Included is the process used for computer-assisted qualitative data analysis as well as justification for NVivo software selection. The chapter concludes with the essential structure of the lived experience of women seeking to access health care services in a jail environment.

Gaining Research Approval

Research approval was impacted by the fact that the study was to be conducted with the incarcerated population. Because of past unethical research attempts the inmate population is considered to be very vulnerable, needing protection from unscrupulous researchers. Although qualitative research studies are less likely to be exploitive to study participants (LoBiondo-Wood & Haber, 1998), human subject protection is still applicable. Approval by the University of Hawaii Committee on Human Subjects took several telephone calls and a multitude of email messages since the target population would be women ex offenders. Once it was clear the research proposal was based on subjects not being currently incarcerated but rather released from detention and residing in the community the proposal was approved.

Once approval was obtained from the University of Hawaii, the proposal was submitted to the State of Hawaii Public Safety Department since the women would be recruited from community-based programs originating from the Public Safety Department. Another research application was submitted leading to another stringent
review. After three weeks of persistent communication research approval was granted and recruitment of subjects initiated.

Recruitment and Sample Size

Recruitment of participants through a purposive sampling model began on the day approval from Public Safety Department was received. The time span allotted for recruitment was from October 15, 2003, until March 31, 2004. Although a total of 20 women were recruited from the two programs, T. J. Mahoney and the Oahu Intake Service Center, not all met the inclusion criteria or attended the interview. Two women from T. J. Mahoney were recruited from the flyer posted on their communications bulletin board. Both women called the listed phone number to express their interest, however, one woman did not meet the criteria because too much time had passed from the time she was detained in jail until the time of recruitment. She believed her memory of her experiences in jail might be dimmed due to the passage of time. The second woman did meet the criteria and was interviewed as arranged.

At the Oahu Intake Service Center the supervisors passed out flyers to potential participants but the response was very poor. From October 15, 2004 to November 11, 2003 no calls from women were received, yet, 25 flyers were distributed. It was decided after discussing the problem with the program manager that recruitment might improve if the researcher could personally recruit participants from referrals by the supervisors. At the end of their intake appointments the women would be asked first by their supervisor if they were interested in participating in the study. If they expressed interest in participating they were introduced to the researcher. If they met the criteria for participation the study was explained and the forms completed.
Eighteen women were recruited in this manner from November 11, 2003 to March 31, 2004. Of the 18 women recruited, 3 women met the criteria but were not interviewed because they did not meet the appointment date. One woman was re-incarcerated shortly before the interview date and was therefore inaccessible to the researcher. Four women did not meet the criteria because they were detained for less than 30 days and found no need to access health care services. The data from one interview was not included in the final study because the session lasted three minutes and was not of sufficient length to be regarded as a phenomenological interview.

Out of a total of the 20 women recruited 19 met the study criteria and 11 were interviewed but as mentioned above 1 interview was not included because of the abbreviated interview length. The interviews considered for data analysis consisted of a single participant from T. J. Mahoney and 9 women from the Oahu Intake Services Center. The final sample size was a total of 10 participants.

Data Collection Sites

The first interview was conducted at T. J. Mahoney in a social worker's office on the second floor. It was comfortably equipped with a desk and two chairs and initially quiet. However, on two occasions as the interview progressed, workers needed to pass the office along an adjacent walkway while carrying on a rather loud conversation. The woman's concentration did not appear to be bothered by what the researcher considered to be a distraction. Shutting the windows and closing the sliding door was considered an option if the woman seemed bothered but the interview ended before any other distraction occurred. After the initial interview was completed, transcription service
difficulties led to the decision to move ahead with the remaining interviews as they became available rather than wait until the previous interviews were analyzed.

The next 9 initial interviews took place in the Oahu Intake Services Center Office. The manager of the center assigned an open cubicle with a desk and two chairs where the interviews could be conducted or arrangements made for off site interviews. The researcher felt the cubicle, which consisted of 7 feet high fabric and metal partitions, was too open and did not provide enough privacy. The women, however, when questioned, expressed feeling comfortable and unrestrained by the environmental arrangement. They did not feel being interviewed on site would interfere with expressing their thoughts and feelings. Eight women were then interviewed on site even though the researcher offered to meet them off site. The remaining woman would have agreed to the on site interview but had to leave for another appointment. She agreed to an interview time at a park located near her home later that day.

Computer-Assisted Qualitative Data Analysis Software

Colazzi's (1978) method provided structure and guidance to this phenomenological data analysis. It was very important to the researcher to learn not only how to perform traditional methods of qualitative data analysis, but just as important, to learn how to use computerized-assisted data analysis software program and incorporate the newly acquired skill while learning data analysis. It would mean simultaneously considering a parallel approach to data analysis, both traditional and computerized. The researcher felt the challenge would be worth the time and effort.

The use of computerized-assisted data analysis software is controversial (Miles & Huberman, 1994; St John & Johnson, 2000; Weitzman, 1999). Researchers utilizing
computerized qualitative data analysis software describe a distancing from the data that may affect analysis. Relying on concrete computerized pieces of coded data may cause a loss of the intimate relationship the qualitative researcher develops with data, a loss that may affect analysis. Yet other researchers suggest that with large amounts of data an intimate relationship is not possible no matter what data analysis method is selected and used.

What has been reported by research is that the particular software selected may affect analysis (St John & Johnson, 2000). The researcher who intends to employ computerized data analysis must understand the research methodology and select the software that has the best fit to the project. The requirements of the selected software need to be reviewed and tested prior to use to assure that it meets the needs of data analysis.

The researcher firmly believed the long-term benefits of learning these programs and incorporating their use in the research study would compliment the traditional hand analysis method of hard copies of data management. This exploration of both hand and computerized data analysis approaches would expand the options to the researcher. It was also thought that using and learning more than one type of data analysis program and finally selecting the software best suited to phenomenology would greatly expand the researcher’s knowledge base thereby setting a firm foundation for further qualitative research endeavors.

There were both pros and cons of using hand versus computerized data analysis. What did not work well was the time involved learning the program. It took approximately one month of daily use before the researcher felt confident enough to
actually perform analysis. Some of the tasks like “memoing” were never mastered but the future may further expand and improve the data analysis process.

What worked well for this project was a combination of both hand and computerized data analysis. Reading each protocol on the computer screen simultaneously while listening to the audio tape allowed the researcher to recall the richness of the interview which can be lost by coding just the hard copy. After the initial reading and listening computerized coding was done and the significant statements were extracted and transferred to a file. The significant statements were then reanalyzed and the formulated meanings were developed and separated into categories. When there was a question as to the significance of the statement the computer was able to locate the particular passages in the protocols quickly and effortlessly. There was no flipping though pages of protocols with visually scanning text to locate a particular passage. This helped with analysis because reflective thoughts were not lost while searching for text.

Several data analysis programs were available through the University of Hawaii School of Nursing and Dental Hygiene. The criteria for selection determined by the researcher were as follows, application to phenomenological data analysis procedures, ease of use, and support services. After stringent evaluation of the available software program, NVivo was selected for use.

NVivo, a qualitative research data analysis program, was originally developed to assist researchers with theory generation (Bazeley & Richards, 2000; Gibbs, 2002). Although the original intention was to provide data analysis for grounded theory, working with the software, the researcher was able to make alterations and adaptations to support the selected data analysis method (Colaizzi, 1978) for the proposed...
phenomenological research study. NVivo was by far the easiest to understand and manipulate using the available books and manuals. Support services were available via the Internet through email and response time was always one working day or less. Another advantage was the opportunity to attend several NVivo workshops conducted at the University of Hawaii and at Advances in Qualitative Methods Conference held in Banff Canada. Lyn Richards or Tom Richards, developers of the software program, facilitated all of the workshops attended by the researcher. Their advice and personal contact did not affect the selection process but rather it was the software’s ease of use, the ability to manipulate the analysis procedure to accommodate Colaizzi’s method, and readily available support services.

Description of the Sample

The ages of the 10 women ranged from 19 to 46 years with a mean of 33.60 years and a standard deviation of 6.16 years. Six were single, 2 were married but separated, and 2 divorced. All of the participants self reported their ethnicity, 5 as Hawaiian or part Hawaiian and 5 as Caucasian, dividing the sample population equally between the two ethnic groups (see Table 1). Although only two ethnic groups were represented in the study, Hawaiian or part Hawaiian and Caucasians are the two highest ethnic groups of women detained in Hawaii’s jail (State of Hawaii Department of Public Safety, 1998).

Collectively there were 17 admissions to jail (see Table 2). Eight women reported single admissions, one reported a total of 5 different admissions, and one reported a total of 4 different admissions in each of their lifetimes. Caucasian women listed nine different admissions and Hawaiian and Part Hawaiian women listed eight. Jail time reported by the
Table 1. Age and Ethnicity

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>43</td>
<td>Caucasian</td>
<td>Single</td>
</tr>
<tr>
<td>02</td>
<td>32</td>
<td>Caucasian</td>
<td>Single</td>
</tr>
<tr>
<td>03</td>
<td>33</td>
<td>Caucasian</td>
<td>Married but separated</td>
</tr>
<tr>
<td>04</td>
<td>46</td>
<td>Hawaiian/Part Hawaiian</td>
<td>Divorced</td>
</tr>
<tr>
<td>05</td>
<td>44</td>
<td>Caucasian</td>
<td>Divorced</td>
</tr>
<tr>
<td>06</td>
<td>19</td>
<td>Hawaiian/Part Hawaiian</td>
<td>Single</td>
</tr>
<tr>
<td>07</td>
<td>21</td>
<td>Caucasian</td>
<td>Single</td>
</tr>
<tr>
<td>08</td>
<td>31</td>
<td>Hawaiian/Part Hawaiian</td>
<td>Single</td>
</tr>
<tr>
<td>09</td>
<td>29</td>
<td>Hawaiian/Part Hawaiian</td>
<td>Single</td>
</tr>
<tr>
<td>10</td>
<td>38</td>
<td>Hawaiian/Part Hawaiian</td>
<td>Married but separated</td>
</tr>
</tbody>
</table>
Table 2. Number and Length of Detention

<table>
<thead>
<tr>
<th>Participant</th>
<th>Number of Detentions</th>
<th>Most Recent Detention in Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>02</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>03</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>04</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>05</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>06</td>
<td>1</td>
<td>1.25</td>
</tr>
<tr>
<td>07</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>08</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>09</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 3. Health Access Attempts, Conditions Seeking Care*, Conditions Not Receiving Care*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Health Access Attempts</th>
<th>Condition Seeking Care*</th>
<th>Conditions Not Receiving Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>5</td>
<td>GC</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>5</td>
<td>AM, MHC</td>
<td>AM, MHC</td>
</tr>
<tr>
<td>03</td>
<td>4</td>
<td>AM, MHC</td>
<td>MHC</td>
</tr>
<tr>
<td>04</td>
<td>20</td>
<td>AM, CM, DC, GC</td>
<td>AM, CM</td>
</tr>
<tr>
<td>05</td>
<td>4</td>
<td>AM, DC</td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>5</td>
<td>AM, GC, PC</td>
<td>AM</td>
</tr>
<tr>
<td>07</td>
<td>6</td>
<td>AM, DC, GC, PC</td>
<td>AM</td>
</tr>
<tr>
<td>08</td>
<td>4</td>
<td>GC</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>2</td>
<td>AM, DC, GC</td>
<td>AM, GC</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>CM, DC</td>
<td>DC</td>
</tr>
</tbody>
</table>

* Key to conditions

AM – Acute medical condition (ear ache, rash, cold/sore throat, boils, etc.)
CM – Chronic medical condition (diabetes, high blood pressure, asthma, etc.)
DC – Dental condition (tooth ache, tooth abscess, etc.)
GC – Gynecological condition (Vaginal discharge, yeast infection, sexually transmitted disease, etc.)
MHC – Mental health condition (depression, unable to sleep, anxiety, etc.)
PC – Pregnancy care (pregnancy testing, prenatal vitamins, special diet while pregnant, etc.)
women totaled 29.25 months or 29 months and one week. The average detention time amounted to 2.92 months. Hawaiian and Part Hawaiian women spent a total of 11.25 months in jail compared to a total of 18 months in jail for Caucasian women.

While detained, the women attempted to access health care 57 times, 33 times by the Hawaiian Part Hawaiian women and 24 times by Caucasian women for a mean of 5.7 times per woman (see Table 3). They sought care for acute medical conditions, dental needs, gynecological problems, mental health situations, and for pregnancy care. Three women reported success in receiving care but the remaining 7 women reported receiving no care for at least one of their conditions.

The Women

Understanding the lived experience of women in jail begins by knowing the women from field notes in conjunction with reading each of the protocols. To know the women is to accurately describe their lived experience and the meanings they attach to these experiences. The following paragraphs are descriptions of three women that represent the participants. One woman is a compilation of 8 participants and the other two were considered separate from the composite woman.

Eight of the women were so similar in their responses that it was as though they were a single person. Since these women shared so much in common a composite woman was created to paint the background of their lived experience and allow for a better understanding of the structure that appears on analysis of the textual data. Although they differed in age, ethnicity, number of incarcerations, and their health concerns, the
descriptions of self, sifted from the data and the researcher’s field notes, make them strikingly similar. The fictitious name of the composite woman will be Anna.

Anna believed she was desperately ill at the time of detention. Her certainty that she was ill stemmed from her high-risk behavior on the “outside” and felt she needed and deserved to have health care on the “inside”. Yet she described feeling as though the health care personnel did not believe that she was ill, just a suffering, complaining drug addict. When the sick call nurse came to her housing unit she felt pressure not to seek care since security personnel would badger her while she waited in line. She said that her greatest fear, if she did not receive attention for her health problem, was being found dead in her bunk by security personnel when she didn’t show up for the required head count. Should that have happened, she verbalized the deep sadness of never seeing her children and other family members again.

Sick call was supposed to be held everyday but there were days when the nurse did not show up. When sick call was held the line to see the nurse was long. Some times she just felt, “Why even bother to wait in line.” It cost Anna $3.00 each time she told the sick call nurse something was wrong and needed to see the doctor. She thought, “It didn’t seem right to have to pay for care. The State is supposed to be taking care of us and we deserve care, it is the law, it should be free.” Anna had only a few dollars in her jail account, yet she had to pay for each face-to-face sick call contact.

Anna was incarcerated because of addiction to drugs. In the past it was heroin, this time because of ICE. She was not gainfully employed at the time of arrest but shoplifted or wrote bad checks in order to pay for drugs. At one time she admitted to having sex in exchange for drugs or in exchange for money to purchase drugs. When
Anna was arrested and jailed her access to drugs ceased abruptly sending her body into withdrawal. When she withdrew from heroin she craved sugar and she expressed that she could not understand why something so innocuous as sugar packets would be considered contraband and confiscated by security personnel when found in her cubicle. Nor could she understand why health care providers refused to medically authorize sugar packets at the bedside. “It’s just a packet of sugar.” This time she was withdrawing from ICE causing her to have constant body aches and pains. She described, asking, for pain medication and the nurses told her to buy Tylenol from the store. By the time the store order medication arrived the withdrawal process was complete and the need for Tylenol had long passed. She wanted and needed pain relief at that time and could not understand why it was not provided when she expressed the need. She mentioned that she thought that it might be a form of punishment for taking drugs. She expressed feeling that she was not being treated as a human being and all she wanted was to feel healthy.

The second woman, whose name will be Malia, is nineteen years old, part Hawaiian, and incarcerated for the first time. She describes a teenage history of truancy and juvenile delinquency because no one understood what she was going through. She had no one who would listen to her talk about her problems. Then she found her boyfriend who she thought understood her feelings yet he was the individual who introduced her to drugs. Malia was arrested and incarcerated because she and her boyfriend were caught trying to purchase ICE from an undercover policeman. When she reached the jail she was subjected to an initial health assessment. The nurse asked many questions about her health but the one question she could not answer with certainty was
the date of her last period. The urine pregnancy test that she took turned out to be positive
diagnosing Malia’s first pregnancy on her first day in jail.

Malia expressed happiness when she found out she was pregnant but described
guilt when she realized that she had exposed the fetus to ICE, tobacco, and alcohol. This
made it even more urgent to her that she be seen quickly for prenatal care. She described
worrying about her pregnancy and was so afraid of losing her baby. She explained that
she expected prenatal care right away but after waiting three weeks for an appointment
she filed a complaint against the health care unit called a grievance. When she finally did
see someone, the experience itself was far from positive. She described the health care
provider as cold, distant, and automatic. Malia could not be sure but thought that her
treatment was retaliatory as a result of the grievance she had filed. She expressed wanting
to learn about being pregnant but instead felt again alone with no one to talk to. Above all
she was feeling guilty about exposing the baby to ICE and being labeled a jail pregnancy.

When she was younger, Malia fantasized her pregnancies would be the happiest
time in her life, instead, this pregnancy was all but happy. She recounts the jail
environment and the personnel causing her so much stress that she found herself crying
almost all of the time. But as she points out, when the other women in jail found out she
was pregnant they took her under their wing, protecting her from the jail predators, the
so-called “trouble makers” who could cause Malia physical harm. When she needed help,
Malia said she turned to these supportive women, describing them, “like a family.” She
explained that these nurturing women taught her what to expect and what was not normal
about pregnancy. She believed she was fortunate for they offered her choice portions
from their meal tray so that she would be sure to get enough to eat. Then at night they
took turns offering their pillows so Malia could sleep more comfortably. Because she had no money in her jail account and no family member who would deposit money into her account for her use, she could not buy extra personal hygiene products from the store. She explained that one woman shared her precious body lotion so that Malia could to rub the stretching skin on her growing stomach. Malia said, “Although food, extra pillows, and body lotion are considered simple things on the outside, in jail, they are highly valued commodities.” When given to Malia, to her, it meant these women going without until the next store order sometimes a month away. These sacrifices touched Malia making the jail pregnancy tolerable.

The last woman will be identified as Yvonne, a 40-year-old Caucasian woman who was jailed due to charges of domestic violence. She fought back when her abusive ex-husband attacked her and their 14-year-old son for the umpteenth time. She identified being arrested and charged because of her ex-husband as the source of incredible stress, however, she described feeling relief when she found out that their son was now safe and away from the father and ex-spouse who had beaten both of them so many times in the past.

She explained that her ex-husband beat her about the head so severely that she entered jail looking like a raccoon with two blackened eyes. She said she was immediately evaluated by the jail health care provider who determined she be sent the same day for diagnostic testing and further medical evaluations. According to Yvonne, the imaging studies found a blow out fracture of her orbit, which if not surgically addressed as soon as possible, would cause her to become blind. The surgical repair was performed and after a few days Yvonne returned to the jail. She explained that under
different circumstances she would have been embarrassed to walk around with two blackened eyes, but this time she said she wore them like a badge of courage having stood up for her rights as a woman, mother, and protector of her son.

Yvonne said she entered jail under difficult circumstances than most women she met while incarcerated. She described other women taking drugs and abusing alcohol but Yvonne did not take illegal drugs and drank alcohol once or twice a year. She described a violent out of control home environment then abruptly being transported to jail, a highly structured and tightly controlled environment. To Yvonne jail was a sanctuary, cloistered from the constant and persistent fear of battering and verbal abuse. She used the time of detention as an opportunity to collect her thoughts about life and what she planned for her future. Yvonne described her meaning assigned to jail as not positive nor punitive just a “time out.”

Yvonne verbalized that jail was better for her than for the other women, especially when asking for health care services. While there she explained that she watched women asking for help for what seemed to be legitimate health reasons and witnessed other women having to wait prolonged periods of time before being granted a visit to the clinic. In her case, she said she did not have to wait, when she asked for care she received it. It was learned much later that it was possible that she receive preferential treatment because she was the significant other of a prominent citizen.

The Exhaustive Description of the Results of the Analysis of Data

The exhaustive description of the of women's lived experiences seeking access to jail health care services is a collection of themes, theme clusters and theme categories derived from a compilation and integration of 41,211 data bytes or 194 significant
statements extracted from 10 protocols or interviews (see Table 4). The average length of the 10 protocols was 29.5 minutes. From the significant statements and the resultant formulated meanings two major theme categories, seven theme clusters, and seventeen themes emerged. Narrative descriptions follow each theme category, theme cluster and theme. Each theme is followed by direct quotes that serve to illustrate each thematic meaning.

Table 4. Theme Categories, Theme Clusters, Themes

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<tr>
<th>Theme Categories</th>
<th>Theme Clusters</th>
<th>Themes</th>
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<tr>
<td>Expressing the negative view</td>
<td>Delays in care</td>
<td>Wellness put on hold</td>
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<td>Waiting to be seen</td>
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<td>Paying to wait</td>
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<td>Challenges to the system</td>
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<td>Too many women and not enough resources</td>
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<td>Having to choose sick call or recreation</td>
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<td>Being denied my right to care</td>
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<td>Being shackled while pregnant</td>
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<td>Encountering the non-caring attitude</td>
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<td>Feeling degraded</td>
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<td>Being challenged by the staff</td>
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<td>Questioning the quality of care</td>
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<td>Receiving services less than the community standard</td>
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<td>Men come first</td>
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<td>“A man’s facility”</td>
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<td>Feeling second class</td>
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<td>Expressing the positive view</td>
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<td>Expressing no bad experiences with health care, but...</td>
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<td>Women helping women</td>
<td>Tended</td>
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<td>Befriended</td>
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Prior to each data analysis session, bracketing exercises were performed. It helped the researcher to start with a clear mind suppressing the natural thoughts and instincts developed over the prolonged engagement with women in jail. Bracketing consciously prevented invasions of thoughts during data analysis. After each analytic session entries were added to the researcher’s journal noting significant information, needed expansion of interview procedures, or just personal thoughts related to the study.

Each interview or protocol was read first to get a general feel of the data. Then the protocol was re-read simultaneously while listening to the audiotape to compare the feeling of the protocol with the tone of the conversation and field notes made during and after each participant was interviewed. Nine out of 10 interviews were profoundly negative correlating with negative vocal quality and depressed body language as described in the researcher’s field notes. At the start of each interview 8 of the 10 women were smiling while the remaining 2 women had a blank expressionless facial affect. Six cried while expressing their thoughts and feelings and 5 became angry as they relived their experiences. Every woman interviewed ended with either a sad or angry body language or voice quality.

The single interview with positive statements was expressed with vocal trepidation while the woman projected a body language of protection. She had her arms folded across her chest while slouched over the desk bobbing close to speak into the tape recorder. Before she spoke she would look around the office as if to confirm no one else was present. The researcher asked several times if she wanted to relocate but she assured me that she did not feel intimidated and the environment was not affecting her responses. Although what she verbalized did not correlate with her body language the veracity could
not be confirmed for attempts to contact her were unsuccessful. A general feeling of negativity blanketed all the interviews, even when positive statements were expressed.

Theme Category: Expressing the Negative View

From the theme category, Expressing the Negative View, the following theme clusters emerged, Delays in Care, Encountering the Non Caring Attitude, Challenges to the System, Questioning the Quality of Care, and Men Come First.

Theme Cluster: Delays in Care

This theme cluster was developed from all the statements describing delays in care. Nine out of 10 women described delays in care with 7 of the women being released before ever having at least one of their conditions addressed. These women delivered their statements with a bitter tone, emphasizing having to wait for services, yet feeling the system designed for them should address their conditions in a timely manner no matter how trivial or serious. Women’s voices expressed anger and disappointment at having to pay to wait prolonged periods of time for needed care, claiming the delays negatively affected their health and/or compounded their existing conditions. Some were resigned to the wait; saying they had no other choice but to wait. And others just chose not to access the system at all, knowing full well they would have to wait for services, despite having what they felt to be a valid medical condition.

Theme – Wellness put on hold.

Preventive health services such as routine women’s health examinations, dental examinations and mental health evaluations are offered to all inmates to ensure wellness in a population known to have neglected health conditions. Women are encouraged to not only seek care for existing medical conditions, but to be proactive in remaining healthy.
Even beyond the benefits to individual women, a policy of preventive care to maintain wellness is cost effective to the State. However, *Anna* found that although she received preventive health services the follow up care was significantly delayed possibly causing her harm. She found out months after her gynecological examination that she had an abnormal Pap smear result then waited months for an off site surgical consultation. Her story painted a picture of delays in care that she feels had serious implications to her health status.

- “I went down for a Pap smear, that’s the normal thing you do. I get called from the medical unit, I think, it was, three months later and tell me I have an abnormal Pap smear. Two months later, they call me back down to medical unit, they misplaced my papers. So I get it (appointment with a gynecologist) postponed again. (Participant 01)

*Anna* has a diagnosis of a serious psychiatric disorder which requires medication to normalize her behavior. She waited weeks to see a psychiatrist in order to get the medications restarted putting her return to normalcy on hold.

- So I had to go to, my body had to go through all withdrawals for at least two weeks, two and a half weeks. And it takes thirty days for the medication to work, so I had to start all over again. (Participant 02)

*Theme: Waiting to be seen.*

In addition to emphasizing preventive health maintenance, correctional health care personnel encourage the jail population to seek care for acute or chronic conditions or conditions that occur while in jail. The women are instructed to seek care through the sick call system. *Anna* wanted to see the dentist for a toothache that had been bothering her for weeks. It was so painful that she needed something for the pain. When *Anna* finally accessed the system she was told she would have to wait to be seen.

- So when I got in, I had that, abscess up on my, um, in my gums, and I was telling them for weeks and weeks, you know, for the whole month, that this teeth, they (a
dentist in the community) was goin' to pull it out. And they (jail dentist) never give me anything (for the pain) but after a month and a half they finally came out with some Motrin. (Participant 04)

Malia discovered she was pregnant for the first time on the day she was admitted to jail and could not understand why she had to wait for prenatal care.

• This is my first pregnancy and I didn’t know what to expect and that’s what my grievance was for, the delay…it took them (medical unit) about maybe two to three weeks, um, for them to give me their attention as far as my pregnancy. (Participant 06)

Theme: Paying to wait.

In addition to having to wait for health care services, the inmate is charged $3.00 for every health care service request made via the sick call system. Each inmate has a financial account where family members or friends are able to deposit a limited amount of money. Working inmates deposit their paychecks into their account for personal use. Since most of the work assignments are for slotted for men, the income generating capacity for women is quite limited. Although $3.00 does not seem to be extraordinarily high, every sick call visit costs $3.00 and the sick call bill for women inmates can add up quickly. Anna was not able to get a job in jail and verbalized the feeling that she is actually paying to wait for health care.

• When you go to sick call you pay $3, but like most the time that you go sick call they never, they never like got back to me on it. And I paid the $3, yeah. (Participant 07)

• You have to wait, if you're sick you have to wait in the morning to sign a paper in order to see the doctor or the nurse and they charge you 3 dollars, which they take off your store order. And sometimes you gotta wait a week or 2 weeks before you can see them. (Participant 02)
Theme Cluster: Challenges to the System

*Anna* and Malia identified instances where the correctional system failed to provide basic services or created barriers to positive health outcomes. They felt that while detained they were not provided with basic necessities for living like adequate housing, food, clothing, and health care services. They also described instances when the numbers of women in the system forced rationing or a suspension of services. They could not understand why the system forced them to choose between sick call and recreation two highly desired basic services. Malia verbalized poor correctional procedures and policies requiring pregnant women to be shackled for off site appointments and court appearances.

*Theme – Too many women and not enough resources.*

*Anna* expressed frustration with a system ill prepared to handle large numbers of detained women. As a result she felt she could not receive the basic services at the time they were needed. The long sick call line left *Anna* feeling defeated and this contributed to her decision not to access the system. She observed that the system could not provide enough supplies to everyone, meaning going without could contribute to the development of new medical conditions or make existing conditions worse. *Anna* felt caught in a Catch 22 basic hygiene prevents certain illnesses but the system is unable to provide these supplies therefore she ends up sick or needing health care.

- ...but when you feeling sick and you got twenty, thirty, people standing in (in line in front of you) for medical (for acute care conditions), medications, I didn’t want to go. (Participant 01)

- ...knowing that they had to take out that cracked tooth and they (the dental unit) were having so many people, so many... I just handled it myself. (Participant 01)
• Sometimes they run out of soap (bathing) and they tell you to buy. Or toilet paper, they don’t have. (Participant 02)

• I broke out when I came in here with so much acne. I mean it was everywhere, it was all over my face, my arms. It’s from the water cause they don’t supply you with soap. When you come in they might give you a half a bar of hotel soap. They don’t give you shampoo. They don’t give you deodorant. They don’t give you no hygienes at all, maybe a little toothbrush like this (indicating with index fingers three inches apart). (Participant 02)

Theme – Having to choose sick call or recreation.

Anna could not understand why the system was designed to conduct sick call and recreation concurrently. She was frustrated when the system forced her to choose, causing them to feel as though they were denying themselves one service when choosing the other. She verbalized the importance of both sick call and recreation to attain and maintain wellness and that the system was creating barriers to positive health outcomes.

• Um, ‘cause they say we cannot go in (to sick call) because if we sick, why we go outside (for recreation)? It’s not about being sick, you know, if we sick, we sick, But when we hurting ... we have no other choice but ... that’s the only way we can breathe fresh air is going outside there... so that never make sense. That was frustrating. (Participant 04)

• If you not gonna go rec, if you gonna go sick call you gotta stay back (from participating in recreation). ‘Cause when they call sick call that’s when you get rec, yeah. I never know that. (Participant 10)

Theme – Being denied my right to care.

Anna and Malia could not understand why they were denied care or medicines when the system was designed to provide services to everyone. Anna verbalized only the critically ill received health care leaving other requests for health care ignored.

• …the medical unit is for us, you know, no matter if it’s not a life and death thing. …shouldn’t be denying us or we should have, medical attention is, um, ah, priority. You know, at least have it (any medical condition) checked out, you know, but not put us on one run (being ignored) or put us on one hold. (Participant 04)
Theme – Being shackled while pregnant.

Malia sobbed as she described feeling frustrated and scared because of the system’s shackling policy. She was shackled when she was transported off site for medical care. With her hands cuffed and her ankles shackled she was afraid of tripping and not being able to protect her unborn child from harm. She had a difficult time understanding why the system would deliberately place her and her baby in such an unsafe situation. Although she understood the need to use restraints when inmates travel in the community, she strongly suggested a new policy that any pregnant woman during any stage of pregnancy be provided a medical exemption from shackling.

Theme Cluster: Encountering the Non-caring Attitude

The theme cluster focused on statements identifying instances where women were either the recipients of, or observed non-caring attitudes and behaviors from correctional and medical personnel. Anna and Malia both described instances when they were frustrated and appalled by the treatment they received, being ordered about in a nasty tone of voice by correctional officers as well as medical personnel. Both felt even though they were in jail they did not deserve to be treated as though their feelings did not matter. It was especially hurtful when Anna received such treatment from medical personnel, who she felt needed to be caring and helpful instead of judgmental. She verbalized that her requests for health care services were dismissed as lies or exaggerations just because
she was an inmate. She also felt that correctional staff should not interfere with sick call by systematically denying certain women from accessing care.

Theme – Feeling degraded.

Anna and Malia felt, despite their prior indiscretions that caused them to be detained, being verbally abused by correctional and medical staff served no merit or purpose. They are forced to follow directions whether instructed pleasantly or unpleasantly for fear of punishment but would have preferred a softer, more pleasant, and caring approach. Anna could not understand why she had to be treated in such non-caring, brutal fashion. Anna, faced with having to undergo a painful gynecological procedure was relieved to have a female correctional officer transport and escort her to an off site medical appointment. She found, however, no difference in the treatment of women by either sex of correctional officers when Anna became the target of unpleasant remarks from another woman.

• I didn’t want no male staff there, you know (tearing), um (voice wavering) I think they are very inconsiderate when it comes to females’, um, feelings...so the little remarks coming from the ACOs (adult correctional officers), you know the males, and um, made me very uncomfortable. „,so I had a female ACO take me. And that’s kinda degrading, because, she’s behind the curtain while I’m doing the surgery, making remarks. (Participant 01)

• I’m still in pain after (gynecological surgical procedure) after this treatment, I get stripped searched, I gotta bend, see how squat through this whole nine yards. Yeah, I put myself here but it’s also degrading at the same time. (Participant 01)

• She said, “Come here!” You know the kind like, “Sit over here!” “Do this!” you know the kind. They’re the ones supposed to be taking our blood not ourselves. But she was so mean... (crying). (Participant 10)

Theme – Being challenged by the staff.

Anna and Malia did not feel that the medical staff took them seriously or believed that they were experiencing a legitimate medical condition. Perhaps the feeling stems
from being inmates known to employ manipulative behaviors. The women suspected the correctional staff and medical personnel were working together to systematically target certain women to prevent them from accessing sick call, verbally taunting them to withdraw.

- Adult Correctional Officer to inmate standing in sick call line: “Don’t come in the line unless you’re sick. You no look sick.” Inmate replies, “So you gotta be looking sick? You cannot see my pain. OK? If you could feel um, I would give um to you, but you know what you cannot feel my pain.” (Participant 04)

- They don’t care. Oh, I had my period once, I woke up with it, and I was bleeding everywhere and they would not let me take a shower to wash. They said I had to wait till the showers open. (Participant 02)

- I don’t think they take it (medical requests from women) serious, because we’re, people here are prisoners. (Participant 09)

**Theme Cluster: Questioning the Quality of Care**

Anna felt the quality of care and the ability of the medical and nursing personnel were less than the community standard. She felt the care received was substandard simply because inmates were viewed as inmates and not as regular people. She verbalized that the economic requirements of the system fostered an environment that was based on cutting quality in an effort to meet the demands of the population. She felt like a hostage, not at liberty to choose another provider or service delivery system and forced to accept what was provided or go without.

*Theme – Feeling suspicious of the care giver.*

Anna expressed fear and concern for her health while in the hands of someone that may not possess medical and nursing expertise to provide appropriate, acceptable, and safe care. She verbalized that medical personnel were probably less qualified and forced to practice in the correctional environment because they either could not function
in any other practice venue or because the correctional environment was not subject to stringent standards. She did not trust that the giver of care could possibly prescribe correct medications nor be certain that she would receive the correct medication that was prescribed. She perceived the jail medical and nursing staff were forced to work only with inmates and were not capable of working anywhere else.

- It was in a 2 minute interview that he (psychiatrist) thought he knew me and what (psychiatric medications) I should be taking. (Participant 02)

- You just stand in the line and go up, tell them (the medication nurse) your name. Lotta times people accidentally get the wrong medication, though. (Participant 03)

- The medical unit, they don't. They're I don't know. I just keep, I think that they're people who got rejected from excelling in their career, you know, and they're left here (in the correctional health care delivery system). (Participant 09)

Theme - Receiving less than the community standard.

Anna and Malia verbalized that they would have been treated differently if they had the same complaints out in the community. They believed that because they were incarcerated they were not entitled to they kind of care available out in the community and did not feel comfortable with the medical decisions made for them. They expressed feeling afraid that their health was in jeopardy.

- ...to me they don’t give proper medical attention, yeah. If you tell somebody you’re going to hurt yourself, and you, they (medical personnel) put you in a room with all types, all kinds of things. I could hang myself with a telephone cord, you know, like. And, um, it’s just I dunno, I guess it’s really not proper. (Participant 09)

- It was just the medical attention you can get here compared to the medial attention you get out there is totally different. I feel like no matter if you’re incarcerated or if your on the outside, each person should get treated the same. (Participant 06)

- And then the nurse told the doctor, whoever treated me, told me, that, um, I’m cured of my diabetes, I don’t need diabetes pills... That’s why I was tripping out, like, how come they don’t want to give me my pills? (Participant 10)
Theme Cluster: Men Come First

Anna described instances when her medical needs were considered only after the needs of the men were met, provided the men did not deplete the all of the resources. She believed she was resigned to accept anything provided, which in her perception was probably not consumed by the men so therefore provided as an afterthought to women. She verbalized being at a disadvantage feeling that the facility’s design priority was for men and housing women a major nuisance. She had no choice but to be housed in what they refer to as a man’s facility and feeling victimized by the system. She was not happy being housed in a facility meant only for men and did not deserve to be treated as though they were a burden to the system. Nor did she feel safe being housed with women suffering from unstable psychiatric conditions. She preferred housing assignments similar to that provided to men, segregation by security level and psychiatric and medical conditions. Male misdemeanants are separated from felons by housing unit assignments and men with medical and psychiatric conditions are segregated from the non-psychiatric population also by housing unit assignments. She felt that all women inmates deserved treatment and services equal to men.

Theme – “A man’s facility.”

These women came to believe very soon that they were not wanted in a man’s facility. They felt as though they were a bother to the system and that the facility was not able or not wanting to provide services exclusively for women that they certainly were entitled to receive.

- It’s like they care more for the men than the women as it’s a men’s facility. (Participant 02)
• Well this is a man’s facility….that is intended for men. Um, and so they’re not geared towards women’s’ needs. (Participant 05)

• …here they focus on the men before the women, because it is their facility. (Participant 09)

• Um, being that this is, is mainly a male correctional unit, um, everything, everything the men has priority first... (Participant 08)

_Theme – Feeling second class._

Jailed women perceive themselves as second-class citizens when they compare themselves to jailed men. They are not happy with this distinction but again feel victimized by the system and therefore are powerless to change their view.

• So the women are always second, you know. We get the leftovers, whatever they have…. (Participant 02)

• Because women get the second of everything… (Participant 09)

• ...and so we’re more or less stuck with the hand-me-downs whether it’s, um, food, medical, or whatnot, because their (the men’s) population is larger. So, you know, we rank second, and it’s like if there’s a large number of men that have to go to the medical unit first, then we get prolonged. And there is only so much time in the day, you know. So it’s first come first serve more or less. (Participant 08)

_Theme Category – Expressing the Positive View_

From the theme category, Expressing the Positive view, 2 theme clusters emerged Receiving Health Care and Women Helping Women. Yvonne who observed other women treated disrespectfully cried because she felt fortunate yet isolated that she did not have to endure the kind of treatment she witnessed. She questioned if she was special among the women since she received care without having to ask and was never a recipient of verbal abuse from correctional or health care personnel. Malia described positive situations when she felt joy and pleasure because of what the women that offered
to her because of her pregnancy. They were willing to sacrifice their comforts depriving
themselves of things they needed for Malia.

Theme Cluster: Receiving Health Care

This theme cluster focuses on significant statements from Yvonne. Of all the
protocols reviewed she was the only participant that described ease in getting care and
civil treatment from correctional staff and medical personnel. She describes what she felt
to be acceptable health care services also expressing being aware that she had received
extraordinary care. She did not express gratefulness but rather wonder at her care since
she observed women around her being treated so disrespectfully. Her body language at
times during the interview would change as though she was afraid of saying other than
pleasant statements. It seems as though she said what she thought the researcher wanted
to hear.

Theme – Feeling somewhat special.

Yvonne described receiving appropriate and adequate care without delays or
ridicule although she had witnessed other women treated otherwise. When the medical
personnel and correctional staff addressed her they were civil and of a helping rather then
of a hindering nature. She felt as though she was being treated differently, special, and
could not imagine why she was treated so differently.

- Cause I, I can’t read very well without glasses (inmates are issued glasses to read
  legal documents). These are prescription right here, too, (lifting up her glasses) so,
  um, at the time I told them I needed glasses, they were able to give me the glasses
  right there. Which was unusual. (Participant 05)

- I didn’t have to go through sick call...they were nice enough to let me come down
  there (to the medical unit)... (Participant 05)
• Uh, I would say that they weren’t disrespectful because you were an inmate (pause) ... I’ve heard and seen (long pause) ... problems (turning head away). (Participant 05)

Theme – Expressing no bad experiences with health care but...

Yvonne said that she had no bad experiences with seeking health care but she acknowledged hearing about bad experiences. The field notes at the time of her interview describe her sitting in a chair opposite from the interviewer in the open air office cubical. Initially she described no bad experiences but as she recounted only having heard of bad experiences. At that point the notes describe her looking around the cubicle, develop a flat facial affect, round her shoulders with loosely crossing her arms over her chest, she bent at the waist to get closer to the microphone and said in a lowered tone of voice but matter of factly how she had heard of bad experiences twice. Then she sat up immediately.

• (Looking around first) I had no bad experiences, (bends over to the microphone) but I have heard of some. I’ve heard of some. (Back to sitting) But personally, I didn’t have any bad experiences. (Participant 05)

• But for me, um, I felt, you know, like I didn’t feel threatened by not being able to receive the care that I might need if I had incurred any injuries or become sick. (Participant 05)

Theme Cluster: Women Helping Women

These are statements made by Anna and Malia who identified instances when women banded together to provide support to other women in need. The differences between the 2 themes are subtle but significant. The Tending theme emerges from statements that describe direct hands-on treatment like tending to the plants in a garden. The Befriending theme differs in that a family like closeness develops as other women gave helpful advice to Malia, the young first time pregnant woman.
**Theme – Tending.**

*Anna* described being unable to walk after injuring her ankle and needing help with activities of daily living and to go to sick call to report her injury. Women joined together and came to her aid carrying her in a chair to and from the bathroom and from the dormitory to where sick call was being conducted. *Anna* expressed gratitude that she was able to call upon the help of other women and their hands on care to help her when she could not do for herself.

- Well I got help (from) the inmates, you know….and I had the inmate girls carrying me around, you, know to the bathroom and back and forth and getting’ my food and stuff for me. They carried me to sick call….sitting in the chair waiting (for sick call). (Participant 03)

**Theme – Befriending.**

Malia found that she felt more comfortable receiving pregnancy advice from the other women rather than medical personnel. She was upset and cried out of frustration that she did not receive simple information from the medical staff; information that she thought would be expected and automatically given to all pregnant women. She felt confused about how to handle morning sickness or when to take her prenatal vitamins. What she found two very helpful situations from the actions of other women. One was when other women formed a protective family-like closeness for her sake and the other was being able to depend on these pseudo family members for help and advice.

- They (other women inmates) just knew I was pregnant. I didn’t know how far along I was. I didn’t know what kind of symptoms to expect, morning sickness. I didn’t know when to take my prenatal vitamins. They don’t tell you. I had to ask other women inside the module…no information like that came from the doctor…(crying). (Participant 06)

- They (other women inmates) were telling me what to expect (about being pregnant). (Participant 06)
• And while you are in, a lotta people, become like your family, you know. You need them, and they’re there to help you. (Participant 06)

Essential Structure

The essential structure is a compilation of common elements extracted from experiences described by study participants. The general sense from 9 out of 10 interviews of women about their lived experience of trying to access jail health care services was primarily negative. Women met a multitude of procedural, systemic, behavioral, and attitudinal obstacles in their attempts to access services.

The negative perceptions of women originate first from the social sigma of incarceration and second from having the perception that their needs are considered second to men. Women take responsibility for their detention but perceive themselves as second-class inmates, second behind men inmates. The resources and services offered to women are perceived as being “the leftovers” seen as both insufficient and not specific to meet the needs of women. Men as the priority negatively interfered with women in their attempt to maintain and attain wellness and develop positive health attitudes.

The demands on the correctional health care system cause women to expect delays in care. Knowing they would have to wait for care contributed to their defeatist attitude making women think twice before accessing jail health care services. To add insult to injury, the women have to pay for these unwanted delays. Women feel that the system is not prepared to handle the needs of women. The numbers of women needing care puts a strain on correctional resources leading to shortages of resources, causing women to go without. The system’s basic policies also affect women and their health. They feel that current policies create unnecessary tension and stress having to choose between two highly desirable services, sick call and recreation time. The policy for
shackling pregnant women is viewed by the women as a disaster waiting to happen. It is thought among the women that the policy should be changed to consider a pregnant woman’s safety.

Women consistently are recipients of non-caring attitudes from the correctional staff and medical personnel. When they want and need health care services they have nowhere else to go but through the existing correctional system. As such, they have no other choice but to bear the ridicule and verbal abuse from correctional and medical staff. This kind of treatment fuels their perceptions that health care providers who choose to be employed in a correctional environment must be less qualified than providers out in the community or they wouldn’t be working in a jail.

Despite the negativity surrounding these women, there are rare glimmers of less than negative experiences. Some women managed to get the care they needed but knew this was out of the ordinary and felt a tinge of fear for they had witnessed other women around them that were not as fortunate. Out of adversity, women found they could depend on other women developing pseudo family units turning to them for support and nurturance.

Summary

This chapter presented the results from the analysis from interviews with 10 women who experienced seeking health care in a jail environment from which 17 themes, 7 theme clusters and 2 theme categories were identified. An exhaustive description of each theme category, theme cluster and theme was supported by quotes from the 10 interviews.
The two theme categories were: Expressing the Negative View and Expressing the Positive View. The first theme category, Expressing the Negative View, has 5 theme clusters and 13 themes. The second theme category has 2 theme clusters and 4 themes.

The essential structure of the lived experience of women seeking access to health care in a jail environment is a description of the participants experience and was developed from the synthesis of the components identified through the phenomenological study. The lived experience by the majority of jailed women seeking access to health care was shaped and shrouded by negative behavior from correctional as well as health care personnel that deeply affected the women. They also described their experiences with a delivery system that prevented access to health care because of the increasing numbers of women and limited resources. Access to care was restricted by the practice of making women choose between two highly desirable services, or by deliberately ignoring the health care requests of some women, and by supporting restraints during pregnancy, a vulnerable time in a woman’s life.

There was a single woman that described a positive experience despite being surrounded by overwhelming negativity. She received medical care that she thought was adequate but found that women around her were not treated equally so. Another positive experience came from the pregnant participant who described other women tending to her and befriending her during her time of need.

The women in jail expect correctional health care services to which they are entitled. They do not accept having to overcome systemic barriers or having to endure unnecessary abuse from correctional or health care personnel.
Chapter five presents the relationships of the study results (of the lived experience of women seeking access to jail health care) to the 4 components of the conceptual context. Other sections of the chapter discuss the study limitations, the contribution to the fund of knowledge related to the incarcerated population, and the implications to the practice of nursing.

Evidence based foundations are built as each qualitative research study contributes to the body of knowledge. The qualitative methodology is an ideal way to understand deeply and completely a single facet of a multifaceted humanistic problem occurring in the natural setting of life. As more and more information is generated and added to the fund of scientific knowledge, the conceptual framework for theory generation is developed and tested. The evidence based foundation related to women in jail is shallow and needs to be developed by qualitative contributions. Much of the information that exists about women in jail is anecdotal rather than research based; therefore, selecting the qualitative research approach was well suited to answer the research question, “What is the lived experience of women in jail seeking to access jail health care services?”

Relationships of Results to Conceptual Context

Although there is a paucity of research concerning women in jail, a comparison of the results of the perceptions of women seeking access to jail health care services to the conceptual context was conducted to determine the relationships and linkages that either support or refute the existing body of knowledge. It was found that the concept, Access to
Correctional Health Care served as the prominent thread through the three concepts, Health of Jailed Women, Correctional Health Care Delivery Model, and Culture of Jails.

Access to Correctional Health Care

The literature related to access to correctional health care is grounded in litigation brought on behalf of the incarcerated population. Because no formal system of health care existed prior to the landmark case of Estelle versus Gamble ("Estelle v. Gamble," 1976) correctional systems fell short of providing basic health care services (Cornelius, 1996; Kearny, 1998; Schiff & Shansky, 1998). Yet despite the decision by the U. S. Supreme Court that correctional facilities were bound by the 8th Amendment of the U. S. Constitution to provide health care ("Estelle v. Gamble," 1976), the incarcerated population found they were consistently denied these mandated services and were compelled to seek legal action (Collins & Collins, 1996). However, even after protective constitutional mandates the provision of a spectrum of health services to jailed women remained lacking causing another round of legal challenges ("Shumate v. Wilson," 1995; "Shumate v. Wilson," 1997; "Spear, et al. versus Ariyoshi, et al," 1984; "Spear, et al. versus Ariyoshi et al," 1985; "Spear, et al., versus Waihee, et al.," 1987) which forced further adjustments to correctional systems. Despite gender specific changes to the health care delivery system, women still perceived correctional health care negatively.

The theme category, Expressing the Negative View, strongly supports the problems women face while seeking and finally gaining access to correctional health care. The 5 theme clusters and their associated themes within this category are descriptions by jailed women recounting their difficult decisions and experiences faced with access to care while trying to either address or improve their state of the health, or
having to overcome systemic obstacles, or endure the negativities fueled by jail culture. Unfortunately, jailed women have no other avenue but to seek health care services from the health care units within their respective correctional facilities.

*Seeking Access to Health Care and the Health of Jailed Women*

According to Greenfield and Snell (2000), women enter jail after committing a drug related crime 30% of the time. The next most common offenses that account for 34% of arrest data being fraud and larceny, offenses highly suspicious of actions necessary to support drug related behaviors. Drug use and related activities interfere with seeking health care in the community (Cotten-Oldenburg, Jordan, Martin, & Kupper, 1999; Fogel, 1992; Huffit, Fawkes, & Lawson, 1993; Poland, Dombrowski, Ager, & Sokol, 1993; Ryan & Grassano, 1993; Terk, Martens, & Williamson, 1994) and use of drugs are related to negative health outcomes (Bond & Semaan, 1996; Magura, Kang, Shapiro, & O'Day, 1993; Maruschak, 1999). Much of the literature accentuates the need for expedited health care services for jailed women, women that may likely suffer from serious health conditions from high risk behaviors prior to detention (Alemagno, 2001; Amnesty International, 2000; Baillargeon, Black, Pulvino, & Dunn, 2000; Baldwin & Jones, 2000; Barry, 1996, 2001; Beltrami, Cohen, Hamrick, & Farley, 1997; Bond & Semaan, 1996; Conklin, Lincoln, & Tuthill, 2000; Cotten-Oldenburg et al., 1999; Fickenscher, Lapidus, Silk-Walker, & Becker, 2001; Freudenberg, 2002; Lessenger, 1982; Lindquist & Lindquist, 1999).

All of the participants in this study described wanting to address their health concerns and begin a regimen of positive health behaviors. They were anxious to know the results of their health screening activities, wanting to find out if they had any medical
condition that required attention. However, when they found that to address their health concerns and conditions, they were met with access difficulties, they verbalized dissatisfaction knowing that their health could or would be affected.

In the theme cluster, Delays in Care, the women described routine, acute and chronic medical and psychological conditions that they felt needed to be addressed on a timely basis, but were not able to do so because of the delays encountered. The three examples provided by the women were, weeks of delays for routine prenatal care of drug exposed fetus, a delay in follow up appointments for abnormal Pap smears and delays in starting a psychotherapeutic medication regimen.

The theme cluster, Questioning the Quality of Care, has access linkages to the health of women in jail. Women described feeling uncomfortable with the quality of care and were not confident that the care they received in jail would be comparable to the quality of care available in the community. Nor did they feel that the provider of care, nurse, physician, or psychiatrist was qualified to deliver adequate and appropriate health, medical, and psychiatric services. They perceived that the providers of care were forced to work in the jail environment because they were not qualified to work in the community. These perceptions of substandard care and substandard health care personnel affect their decisions not to access care, possibly contributing to poor health outcomes.

Women in jail have no income generating capacity, consequently, because of the cost, the participants described choosing to wait until their medical condition reached a point where it became an absolute necessity for medical intervention. The care, then, was prolonged, more than likely necessitating a more costly therapeutic plan of care. This
situation could have been avoided if the condition was addressed earlier and not dependent on a co-payment.

The participants in the study believed these access problems negatively affected their physical and mental health conditions as well as compounding the already high levels of stress incurred as a result of detention. The only recourse that was left to them was to wait, knowing that delays to care could possibly affect their health outcomes negatively.

Seeking Access to Health Care and the Correctional Health Care Delivery Model

As mentioned previously there have been no published models of jail health care delivery. As a result of this study the researcher was able to add to the existing literature by documenting an existing delivery model from the facility where the study was conducted. The model of health care delivery serves as a foundation from which administrators are able to examine the positive and challenging aspects of health care delivery. This study was not intended to evaluate the health care delivery model, however, the study results seem to support a need to re-examine the health care delivery model in the theme cluster, Challenges to the System.

The systemic problems perceived by women in the theme cluster, Challenges to the System, underscore the need for an awareness of women’s perceptions of the system developed specifically for their benefit. Women feel that the system denies their right to health care by addressing only the more critically ill women thereby denying care to those with less urgent health issues and concerns. They expressed their belief that care should be provided to all. As one participant aptly described the systemic inadequacy, “the medical unit is for us, you know, no matter if it’s not a life and death
thing...shouldn’t be denying us.” They feel it is the health care delivery system that selects who is sick enough to access care.

Long sick call lines, a result of a system lacking in resources, cause women with legitimate health problems to turn away from seeking health. Participant 01 stated it well, “...but when you feeling sick and you got twenty, thirty, people standing (in line), I just didn’t want to go.” The correctional system then inadvertently becomes a conduit to poor health outcomes.

Women described being forced to choose between attendance at sick call and participation in recreation. They described feeling frustrated with the system and could not understand the reasons for having to choose between the two services when both are important to maintain and attain health.

*Seeking Access to Health Care and the Culture of Jails*

The security system of any correctional facility controls every aspect of the inmates life as reflected in the studies related to the incarcerated population whether conducted in jails or prisons (Clemmer, 1940; Giallombardo, 1966; Heffernan, 1972; Irwin, 1985; Owen, 1998; Sykes, 1958; Ward & Kassebaum, 1966). External controls pervade correctional environments to maintain order and safety. When breeches in security occur, inmate access to services ceases and facility activity is kept to a minimum. It is a culture in which any and all services are second to security and only when there is a medical emergency will the need for health care ever rise above the needs of maintaining the safety and well being of all individuals within a correctional facility, employees and inmates alike. Knowing and understanding the priorities of correctional environments, it is easy to understand how access to health care can be affected by jail
culture. Jailed women are bound to conform to the stringent rules of life within the jail and if they do not there is the specter of punishment.

The study results are supportive of and additive to the information related to jail culture extending the information beyond security and into the daily activities of women. In the study women describe obstacles to health care simply because they are women housed in what they perceive as a culture that focuses strictly on the needs of men. In the theme cluster, Men Come First, the women verbalized having a “rank second” to men in many of the aspects of daily living and to health issues. The participants talked about men having better housing units, with individual cell assignments as opposed to dormitory style living arrangements. The men had more food to eat when compared to the portions given to women. Even if the women considered their health conditions to be more of a medical urgency, they reported that men were seen first in the clinics. Often if there were more men to be transported off site for medical conditions, the women were left for another day, causing a cascade of re-scheduling activity between off site provider and the facilities’ transportation and housing units. Women attribute the cause of their delays in access to care and missed health opportunities to a culture that caters first to the needs of men. This culturally influenced perception of inferiority negatively affects the health seeking behavior of jailed women, fueling the defeatist attitude preventing attempts by women to enter into the health care arena. The culture of the jails is then a contributing factor to missed health opportunities.

Women felt they were “stuck with the hand-me-downs” and the “leftovers” from the men. Women go on to describe health care services that they had received for an illness as actually a resource intended for men but at that particular time was not needed
for men. These perceptions undermine women's confidence in accessing care in a cultural environment when men are viewed as the priority.

The adjustment to jail culture is difficult and forces inmates to seek any means to secure feelings of safety and positivity. It is known that women in prison create pseudo families to help with the adjustment factor (Giallombardo, 1966; Heffernan, 1972; Owen, 1998; Ward & Kassebaum, 1966) and until now there has been no evidence of how women in jail adjust culturally to the stresses of jail. A finding in this study supports the reality of a type of family connection among women in their adjustment to jail. In the theme cluster, Women Helping Women, a woman described a family like bond with other jailed women not unlike the pseudo families created by women in prison. It supports family bonding of jailed women to escape the negativity of the jail culture. This allows them to emerge with the ability to face and solve some of the problems encountered in the environment. Seeking health advice or being the recipient of material goods and food from other women in the same situation is similar to the actions of members of a family. As one participant said "...while you are in (jail), a lotta people, become like your family...you need them and they're there to help you." The jail cultural can have a positive effect when it forces women to turn toward their peers for family-like support and guidance.

Irwin (1985), clearly describes and discusses an unrelenting oppressiveness that negatively affects the psyche of jailed individuals. The theme cluster, Encountering the Non-Caring Attitude is supportive and additive of the information on culture within jails in that the women frequently describe being the recipients of negative verbal taunting and abuse. One participant was ordered by a correctional officer to step out of the sick call
line since she did not appear to be ailing. The woman retorted that she may not look ill but the officer had no medical training to determine the level of her illness. The woman did not comply knowing she risked punishment for disobeying a correctional officer. Women cannot escape the negative cultural aspect of the jail and are forced to endure for fear of retribution or punishment and question the reasons for being treated with such disrespect.

The Ideal Health Care Delivery Model For Jailed Women

The ideal correctional health care delivery model would allow women to perceive their health care in a jail environment to be accessible, acceptable, adequate, affordable, and appropriate. It should focus on what is known about the state of the science of the health status of jailed women. More importantly the model should incorporate evidence based information regarding the essential structure of women seeking access to health care in a jail environment. This information was developed from descriptions of the cultural and systemic obstacles affecting jailed women's access to health care and their desire for positive health outcomes.

The cultural component of the ideal model would need to focus on reducing or eliminating the association of punishment with health seeking behaviors. It is understandable that individuals in jail have some reason for incarceration, however, denying access to health care as a means of discipline is far from appropriate. Nor is it acceptable for the security staff to make judgments about the state of the health of women seeking care. Although challenging, implementation of sensitivity training to correctional personnel, security as well as health care staff, who have shown callous behavior with ill women should be considered. Nurses who are not able to connect therapeutically may
need a refresher course on how to deal with the difficulties in caring for the correctional population. If they are not able to provide appropriate and acceptable care to this difficult population seeking another venue for nursing care may need to be considered.

The current model of health care delivery was developed as a result of a consent decree and addresses much of the health care needs of jailed individuals. However, the second look at the model is necessary to address the mainly negative descriptions by jailed women. Women strongly perceive that they are at a disadvantage because the are certainly the minority among jailed men. The best way to address these concerns is to have a system exclusively for and about women. The women need to be separated from men, in a separate facility, where there would be no sharing of or competing for health care services. The clinic facility would handle the needs of women only. When women require gynecological or obstetrical care they would not have to fear that a male inmate would inadvertently find his way into the examination room. There would be not have to be decisions about which sex would be the more fortunate to be transported for service for that day. All transportation would be to address the needs of women.

The payment for sick call should be eliminated. The income generating capacity for women in jail is almost nil, therefore, to expect them to pay for health care that is constitutionally mandated is incomprehensible. If women desire services over and above what is deemed medically necessary then exceptions should be made for women to purchase these services at a cost consistent with community prices. For instance if a women wants a second opinion of a medical or psychiatric condition, she can petition for an off-site visit provided at her expense.
The reality that, without the infusion of additional resources, having separate sick
call and recreation time may increase the already long lines for sick call. One solution
may be to provide specific days for sick call for different letters of the alphabet. For
instance, the following schedule could be used for sick call, Monday A-E, Tuesday F-J,
Wednesday K-O, Thursday P-T, and Friday U-Z, with Saturday, Sunday and holidays,
when the clinics have less staff, reserved for emergency situations. When women require
care on other than their scheduled day their health care need and priority should be
assessed by the staff at hand. At times, a nursing shortage causes sick call to be cancelled,
women should have the option of completing a written sick call sheet and have their
concerns triaged by the available nursing staff.

To address the concern that the health care professional responsible for their care
is incompetent jailed women should be provided with information about the staff that
care for them. Printed information should include statements that these professionals
work with the incarcerated populations by choice and are required to be credentialed just
as stringently as their community counterparts. Basic information about each provider to
be included would be educational preparation and any certification or special training
received. Correctional health professionals are required to maintain credentials specific to
their discipline as well as those required for facility accreditation. Correctional nurses are
required to complete more than 20 hours of continuing education credits. The facility
accreditation would be in jeopardy if there was no documentation that the required hours
of continuing education has been met by all the nursing staff. Advanced practice nurses
are required to maintain state licensure to practice and prescribe as well as national
certification. Registered nurses, whether staff or advance practice are not allowed to provide nursing services to the jailed population without the appropriate credentials. The ideal model of health care delivery would be changed to accommodate what is currently known about the health of jailed women and the results of this study. Although the changes do not need to be structural (the flow charts of the model would not change), having an exclusive clinic for women might create and foster perceptions of accessible, acceptable, adequate, affordable, and appropriate health care while incarcerated.

Contributions of the Study

The entire study is viewed as a contribution to the nascent fund of evidence based knowledge of women in jail. It is the first qualitative phenomenological study of women and their descriptions of seeking access to jail health care services and serves as a scientific foundation for subsequent qualitative studies for women in jail, giving voice to women who ordinarily would otherwise remain silent.

A major contribution is the theme cluster, Women helping Women. Taylor et al (2000) describe women functioning differently under stress by tending and befriending as opposed to men who fight or flight. Women in jail are under considerable stress. They lack personal privacy and are separated from their children and extended families with infrequent family visitations. They are forced to exist under the most stringent of environments, not being allowed to come and go as they choose but to function within the confines of schedules and the constant observations by security personnel. Women turn to their best resources, themselves by tending and befriending, in an attempt to make their existence tolerable.
Limitations of the Study

A limitation of this study is the difficulty with validation and member checking. There were multiple attempts by the researcher to contact every participant, however, the contact information provided by the women did not meet with the researcher's expectation. Telephone numbers were disconnected or when the numbers were correct it was found that the participant had moved and their whereabouts were unknown. Several of the participants were inaccessible to the researcher either through re-incarceration locally or extradition to another state for re-incarceration. Only 4 out of the 10 participants were contacted and their feedback was very valuable and confirmed the negative results of the study. The positive view of accessing health care could not be confirmed since the participant was extradited becoming inaccessible to the researcher.

A second limitation to the study was 9 out of 10 interviews were conducted after supervisory sessions, sessions when the women were given positive as well as negative feedback on their supervisory plans. It is not certain if these sessions had any effect on the emotional state of the participant thereby affecting their responses during the interview. However, all were exposed to this same supervisory session.

A third limitation is the physical layout of the interview site. As mentioned above the interview took place in an open office juxtaposed to the three program supervisors who conducted the counseling sessions and were the source of referrals. The office was not sound proof and while the interview was being conducted, individuals passing in the hallway or in front of the doorway could be privy to what the participant was saying. Although every participant was given the option of selecting another interview site, the only participant who agreed to another location was because she had to return home to
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care for her children and not because she felt uncomfortable with the interview site. If not for her childcare concerns, she too would have found no reason for another interview site.

The fourth and perhaps the most important limitation is one that all qualitative and naturalistic researchers must accept is the complicated issue of generalizability (Lincoln & Guba, 1985). Steeves' (1994) commentary supported by Lincoln and Guba (1985) contends findings from qualitative studies are used to "gain understanding" and should be applied to practice by the reader. The clinician in similar settings would be the best judge of the applicability of the study findings. In support of this study's findings, it was certainly known from the beginning that the findings would not fit the accepted generalizability criteria but rather would bring about a deep and thorough understanding of the lived experiences of jailed women when accessing health care services. From the lack of generalizability has emerged a stronger possibility of application of the study findings to positively change the clinical practice of correctional nursing in small but significant ways. Despite the limited nature of the study findings, the personal growth of the researcher as a provider of clinical services has allowed thoughtful changes in which health care is delivered to jailed women.

Recommendations for Further Research

The population of jailed women is unique and cannot be compared to women in prison. However, by all accounts much more research has been conducted with women in prison. Unfortunately, the more extensive research findings from prison populations cannot be extrapolated to the population of jailed women. Women in jail are more like the population of marginalized women existing in the community, probably with similar health needs of their community counter parts. What sets jailed women apart from the
often vaporous community based women is detention and accessibility to the researcher. More needs to be known about the health of jailed women not only in the hope of improving jail health outcomes but in the hope that what is learned in jail can be applied to high-risk women in the community.

The literature discusses the known health status of jailed women in relation to sexually transmitted diseases, mental health issues, and utilization of health care services (Yasunaga, 2001) but discusses very little of the chronic conditions of jailed women. Information regarding the incidences or rates of heart disease, asthma, diabetes types I and 2, obesity, metabolic syndromes, and other chronic diseases is essentially non-existent. This lack of evidence based information makes it difficult to justify program planning and budget allocations if we do not have data supporting the extent of these conditions and their effect on the health care delivery system.

Nursing Implications

Nurses and advance practice nurses need to know as much as possible about the populations to which they provide services. The information needs to be evidence based in order to support the development of functional plans of care that will lead to the end result of positive health outcomes. Nurses caring for women in jail have at best a shallow foundation of evidence based studies from which to develop nursing care plans. How can direct care nurses know that the care they deliver will indeed contribute to positive health outcomes without a firm foundation? Advanced practice registered nurses need to systematically develop research plans seeking to expand the fund of evidence based knowledge surrounding women in jail with the goal of improving health outcomes, outcomes which are not well researched at this time.
Because nurses are the first responders within the correctional health care system, their behaviors can create a positive or negative perception of health for their patients. Correctional nurses need to be acutely aware that they are the inmates' first encounter with the health care system and will set the tone for further access attempts. Creation of a positive encounter is difficult and challenging because of the nature of the clientele and the oppressive culture of jails. Nurses must remain non-judgmental and provide medical and nursing services that are medically indicated and warranted as opposed to those services merely wanted by inmates. Despite the negative environment of jails, nurses are in a powerful position to introduce positive health attitudes and assist with the maintenance of positive health behaviors for vulnerable women.

Women in jail do not always have the strength or the reserve to create positive health changes. Their energies are diverted to handle the daily stresses and strains of jail life. Nurses can provide vulnerable women with the tools and courage necessary to break the cycle of jail negativity in seeking health care services. Breaking the cycle may result in positive changes that might extend beyond the confines of the jail and into the community when the woman is released. What better way than to initiate a positive attitude toward a healthy lifestyle and adopt healthy habits while in jail and all because of a nurse.

Summary

Jails are a microcosm of individuals with the highest of high-risk health care issues. An estimated 60% of jailed individuals return to the community after serving 14 or less days of detention. Whether they return to the community with a health status that is improved, unchanged or worsened is not able to be determined, but the strength and
contribution of this study is from descriptions of jailed women's lived experiences as they sought health care services while detained in jail. From the results of this study 9 out of 10 women who sought access to jail health care described a negative perception of their experiences thematically clustered as Delays in Care, Challenges to the System, Encountering the Non-caring Attitude, Questioning the Quality of Care, and Men come First.

Although uncommon, positive situations did occur as a result of seeking health care in jail. A sole woman in the theme, Feeling Somewhat Special, described a positive experience when she sought care while detained, but went on to describe how uncomfortable she felt witnessing another woman was made to endure ridicule from the correctional staff. A pregnant woman described weeks of delays waiting for prenatal care, found support from other jailed women and looked to these women as her pseudo family as they tended and befriended her by providing material goods and giving what she felt was helpful pregnancy advice. Another woman with an injured foot who was unable to walk, described hands on care from other women detainees.

When women are forced into a negative cultural environment, it can affect their view of the world. This negatively colored lens of the world fuels a negative perception of health care that is compounded by unsolicited negative behavior from security and health care personnel directed at them when seeking health care in jail. The most qualified health care personnel or the best health care delivery model will not change a woman’s perception of their lived experience of seeking health care if they observe non-caring attitudes form the very individual from there is an expectation of caring. As a result this encourages women to delay addressing their health concerns contributing to missed
health opportunities and possibly increasing the cost of care for jailed women. Nurses have the opportunity and the obligation to use the study findings to improve their professional practice and address the health needs of jailed women and thus begin to change negative perceptions to positive perceptions.

If there is any population worthy of research it is women in jail. The study examined the lived experiences of women seeking access to health care in a jail environment. The results suggest that women have a negative perception of the correctional health care processes. These negative perceptions are influenced by women’s need for health care because of their behaviors prior to detention, the health care delivery system that considers them to be inferior to men, and the negative culture of jails. The study can serve as a foundation for further evidence based knowledge to examine and improve the health and well-being of jailed women.
Appendix A: Consent Form

Title:

AGREEMENT TO PARTICIPATE IN
THE ESSENTIAL STRUCTURE OF THE LIVED EXPERIENCE OF WOMEN
OFFENDERS ACCESSING HEALTH CARE IN A JAIL ENVIRONMENT

(Title of Project)

Amy Yasunaga, 2520 The Mall, Webster, Honolulu, HI 96822, 686.0737
(Principal Investigator’s name, address, and phone number)

Project Description:

Purpose:
The purpose of this study is to describe women offender’s experiences trying to access health care in a jail.

Procedures:
I agree to participate in two interviews conducted by the principal investigator at a mutually agreed upon time and location. The first interview will be to complete a questionnaire then talk about my experiences trying to access health care in jail. The second interview will be to review the results of the study and provide any necessary feedback. The interviews are expected to last approximately one hour. After each meeting I will receive $20.

I agree to the audio taping of the interview so that the principal investigator is able to transcribe my responses accurately. Only the principal investigator and members of the research committee will have access to the interview notes, transcripts, and audiotapes.

Confidentiality
I understand that my name will not be used in the publication or report generated from this study in any way. The interview notes, transcripts and the audiotapes will not have my name on them and will be kept in a locked office. They will be destroyed after the research project is finished.

Risks:
I understand the interview process may be upsetting to me but I can stop the interview at any time.

Benefits:
The benefit to me will be my opportunity to verbalize my feelings about access to health care in a jail and I will be contributing to the principal investigator and other’s increased knowledge of the access to health care in jail.

Certification:
I certify that I have read and that I understand the contents of the consent, I have been given satisfactory answers to my questions concerning project procedures and that I have been advised that I am free to withdraw my consent and discontinue participation in the project without prejudice.

I hereby give my consent to participate in this project with the understanding that such consent does not waive any of my legal right, nor does it release the principal investigator or institution or any employee or agent from liability or negligence.

Signatures:

Signature ___________________________ Date ____________

Print Name ______________________________

c: Signed copy to subject
(If you cannot obtain satisfactory answers to your questions or have comments or complaints about your treatment in this study, contact: Committee on Human Studies, University of Hawaii, 2540 Maile Way, Honolulu, Hawaii, 96822. Phone (808) 956-5007).
Appendix B: Unstructured Interview Question

Please tell me everything you remember, your thoughts and feelings, while at Oahu Community Correctional Center about having a dental, medical, psychiatric, or women’s health problem and what it was like to get to see a dentist, doctor, psychiatrist, or nurse practitioner for the problem.
Appendix C: Demographic Information Sheet

1. Age today________.

2. Age during the most recent stay at Oahu Community Correctional Center (OCCC)

3. Marital Status
   ____ Single
   ____ Married
   ____ Divorced
   ____ Widowed

4. Ethnicity with which you most identify:
   ____ African-American
   ____ Asian American
   ____ Latino/Hispanic
   ____ Native American
   ____ Hawaiian/Part Hawaiian
   ____ Other

5. I have been in OCCC _____ time(s).

6. For the most recent stay, I spent_____ month(s) in OCCC.

7. I tried to get care for a health condition _____ amount of times while in jail.

8. I tried to get the following conditions treated while in jail.
   ____ Acute medical condition (rash, ear ache, cold/sore throat, boils,)
   ____ Chronic medical condition (diabetes, high blood pressure, asthma, etc.)
   ____ Dental condition (tooth ache, tooth abscess, etc.
   ____ Gynecological condition (vaginal discharge, yeast infection, etc.)
   ____ Mental health condition (depression, unable to sleep, etc.)
   ____ Pregnancy care (prenatal vitamins, special diet, etc.)

9. I was not able to receive care for the following conditions while at OCCC:
   ____ Acute medical condition (rash, ear ache, cold/sore throat, boils,)
   ____ Chronic medical condition (diabetes, high blood pressure, asthma, etc.)
   ____ Dental condition (tooth ache, tooth abscess, etc.
   ____ Gynecological condition (vaginal discharge, yeast infection, etc.)
   ____ Mental health condition (depression, unable to sleep, etc.)
   ____ Pregnancy care (prenatal vitamins, special diet, etc.)

   Thank you!

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