How to Improve Prenatal Care in U.S. Prisons

Amber Fischer

Sacred Heart University

Honors Capstone

Dr. Rober & Dr. Loris

March 31, 2022

Amber Fischer

Dr. Rober & Dr. Loris

Honors Capstone

31 March 2022

How to Improve Prenatal Care in the U.S. Prisons

Prisons are reserved for those who have committed serious crimes or are serving long sentences (Rose & LeBel, 2020). They are home to 10.2 million people worldwide (Franco et al., 2020). The United States has the highest incarceration rate globally, with 22 state and federal prisons (Franco et al., 2020). Women's imprisonment in the United States is rising (Paynter et al., 2019). Since the 1980s, women's incarceration has increased by 750%. The U.S. has incarcerated 30% of the world's incarcerated females worldwide (Paynter et al., 2019) but is only home to 4% of the world's female population (Jensen, 2021). In 2019, there were 222,455 women prisoners (The Sentencing Project, 2022). As the number of incarcerated women has grown, there has been an increase in pregnant women in prison (Bard & Plugge, 2016). A study found that 5 to 10% of pregnant women got admitted, and other women got pregnant in prison (Saraiva et al., 2010). These women need prenatal care to ensure the safety and health and the baby (Paynter et al., 2019). But women are often the ‘forgotten inmates,’ and the prenatal care provided in prison is inconsistent and inadequate. Changes in prison practices, legislation, and prenatal care need to occur in prison to match the growing need for prenatal care in incarcerated pregnant women.

Prenatal Care for Incarcerated Women

Outcomes of Pregnancy in Incarcerated Women

The research on the outcomes of these pregnancies is not clear (Paynter et al., 2019). Prisons are not required to report data on their pregnant prisoners, so there is a gap in the

research. The research on the perinatal period focuses on infant outcomes like birth weight, premature birth, and other birth outcomes (Paynter et al., 2019). This is a serious concern because infants born in prison are more likely to be premature, have low birth weight, and experience withdrawal syndrome (Rose & LeBel, 2020). In 2018, 27% of women incarcerated experienced complications like preterm birth. Five studies from 2015 found that low birth weight ranged from 6 to 17% (Bard & Plugge, 2016). According to Paynter et al. (2019), .4%-7% of incarcerated pregnant prisoners had pregnancy-induced hypertension. Paynter et al. (2019) also found levels of moderate depression in incarcerated women. These women reported depression, anger, and regret after giving birth. 58% of incarcerated women are afraid to be separated from their children or lack attachment. 71% of incarcerated women are confident in their mothering ability. 79% think of their infant all the time. Sufrin et al. (2019) presented further statistics on pregnancy outcomes in prison. One thousand three hundred ninety-six women were sampled from the 22 state and federal prisons in the United States from 2016 to 2017. This study collected data on births, miscarriages, abortions, and other health outcomes. They found that 92% of the sample had live births, 6% had miscarriages,1% had abortions, and .5% had stillbirths. There were three newborn deaths but no maternal deaths. 6% of the live births were preterm, and 30% of the deliveries were C-sections. These outcomes give an insight into the outcomes of prenatal care in prisons, but the data is limited and often outdated. Hence, it is challenging to develop an idea of pregnancy outcomes.

Legislation

Federal. According to Yunus (2021), the Eighth Amendment of the United States Constitution applies to the treatment of prisoners. This amendment states that the federal government cannot inflict cruel and unusual punishment on prisoners. “Cruel and unusual

punishment is defined as ‘punishment that is torturous, degrading, inhuman, grossly disproportionate to the crime in question, or otherwise shocking to the moral sense of the community” (Yunus, 2021). So, under this definition, all U.S. prisons need to provide medical care, including prenatal care (Jensen, 2021). Incarcerated pregnant women can bring claims against the prisons for not providing adequate medical care (Yunus, 2021). The case of *Estelle v Gamble* in 1976 took this idea a step further (Saraiva et al., 2010). It was further established that under the Eighth amendment, prisons are required to provide medical care to inmates. Still, plaintiffs must show that the penitentiary staff showed deliberate indifference to their serious medical needs (Saraiva et al., 2010).

In 1986, in the case of *Harris v. McCarthy*, the prison was brought to court because it did not provide quality prenatal or postpartum care (Yunus, 2021). The court found that this violated the Eighth Amendment and *Estelle v Gamble* (Yunus, 2021). It resulted in a settlement where qualified OB-GYNs and a healthcare team were available to address the needs of pregnant incarcerated women in California (Yunus, 2021). Yunus (2021) warns that there are two barriers to using the eighth amendment to encourage the development of prenatal care. Pregnancy is not a severe medical need, so some courts do not consider it cruel and unusual punishment when prenatal care is not provided. The Eighth Amendment also goes beyond negligence, so it is challenging to decide what is deemed to be cruel and unusual punishment. As a result, the courts usually side with the prison.

More recently, on October 1, 2020, the House of Representatives passed The Pregnant Women in Custody Act (Yunus, 2021). The Pregnant Women in Custody Act establishes healthcare standards for pregnant women and prohibits the use of shackles and solitary confinement (Yunus, 2021). The federal government will also collect data on pregnant

incarcerated women and report it annually to the Committee on the Judiciary of the Senate and the House of Representatives (Yunus, 2021). Even though the Eighth Amendment, *Estelle v Gamble*, and The Pregnant Women in Custody Act establish standards for prenatal care, they are often not upheld by prisons.

State. State prisons have different policies to follow or no policy because there are no nationwide mandatory health standards for state prisons (Jensen, 2021). Each state develops different regulations and policies that its prisons must follow (Jensen, 2021). As a result, the policies between state prisons vary drastically. In 2019, Jensen (2021) reviewed the state policies and found varying results regarding prenatal care, delivery, special care, nutrition, and medical examinations. They found that 12 states had policies about prenatal care that should be offered in prisons. Twenty-four states also did not have policies about making delivery arrangements. Twenty-two states had no guidance for care needed for high-risk pregnancies. Thirty-one states had no rules about nutrition provided to incarcerated pregnant women. Only "12 states had policies explicitly stating that medical examinations were a requirement for prenatal care" (Jensen, 2021). Though a Jensen (2021) review revealed that some states have some guidance and policy for certain aspects of prenatal care, the prisons often do not follow these policies (Yunus, 2021). They are sometimes not enforced by the states (Jensen, 2021). For example, Arizona has established specific guidelines about the nutrition provided to incarcerated pregnant women. But a Tucson state prison tour revealed that pregnant inmates were not provided adequate fruits and vegetables.

Prenatal Care Provided

The amount of prenatal care offered in prisons is not well understood (Rose & LeBel, 2020). Since federal regulation only applies to federal prisons and each state differs in

established policies, prenatal care in prison is inconsistent and difficult to quantify. Saraiva et al. (2010) found that in 2010 only 49% of prisons offered prenatal care. Even fewer prisons offered prenatal counseling, at 21% of prisons, and only 15% of prisons had policies for light workload for pregnant inmates. In comparison, Yunus (2021) found that in 2004 94% of incarcerated pregnant women reported receiving an obstetric exam upon admittance to state prison, and 54% received prenatal care. Jensen (2021) found that 53.9% of pregnant incarcerated received prenatal care. At the same time, Bard & Plugge (2016) and Yunus (2021) found that 46% of incarcerated pregnant women in 2008 did not receive prenatal care. Considering these results, it is unsure how much prenatal care is offered to incarcerated pregnant women.

These results also show that prisons have some form of prenatal care (Jensen, 2021). Most prenatal care is provided by a qualified healthcare professional of imprisonment (Franco et al., 2020). High-risk pregnancies or emergency health difficulties are transferred to a local hospital (Franco et al., 2020). If there are no apparent complications, many prisons wait till active labor before transporting to a local hospital (Saraiva et al., 2010). After giving birth, the inmate is given 24-48 hours in the hospital to recover (Jensen, 2021). They often allow the mother to stay with the infant during that 24–48-hour period, but then the child is placed in foster care or given to a family member.

It is not clear and varies drastically between prisons, but this is the general practice of prisons. There is not a lot of recent research on the impact that COVID-19 had on prison prenatal care. Hutinson-Colas & Sachdev (2021) discuss some of the effects. They state that there are more barriers for incarcerated pregnant women to receive adequate care. It has become difficult to attend prenatal appointments. There is a delayed diagnosis of pregnancy due to the inability to receive medical care. Pregnant women are also more likely to develop a severe case of COVID-

19, resulting in an admission to the ICU. Incarcerated pregnant women are forced to live in tight quarters without any protective equipment, making them more likely to develop the disease. Pregnant women also have more comorbid illnesses that can make them susceptible to COVID-19. The combination of comorbid diseases and tight living quarters has put pregnant incarcerated people at a higher risk of developing COVID-19 resulting in a severe case of COVID-19. For example, Andrea Circle Bear, a 30-year-old that had just given birth, died from COVID-19 28 days later. The added number of pregnant incarcerated women put added pressure on the limited prenatal care that the prison provides.

Different Harmful Practices in Prison

Shackling. Shackling is used in prison on inmates to keep them under control (Jensen, 2021). Prisons have used shackling on incarcerated pregnant women during transportation to the hospital, throughout labor and delivery, and post-delivery (Jensen, 2021). They use this because they are worried that the pregnant incarcerated women are a danger to others or are a risk of fleeing (Jensen, 2021). But pregnant women will not be running during or after labor and delivery. They are not healthy enough to escape (Jensen, 2021). Most of these women are also non-violent offenders, so they would not be a danger to anybody (Jensen, 2021). Yunus (2021) noted that in 2019, President Trump passed the First Step Act. This act prohibits restraints during pregnancy "unless the inmate is considered a flight risk or an immediate threat to themselves or others" (Yunus, 2021). Only federal prisons must follow this law, again leaving an inconsistency of care in state prisons. Jensen (2021) found that 37 states passed policies limiting the use of restraints in 2019. Only 13 states restrict shackling beyond labor and delivery. In 21 states, medical personnel are allowed to remove shackles during delivery. Twenty-seven states require documentation for using restraints. Thirteen states have no policies or legislation about

shackling. Shackling is still practiced on pregnant women in some prisons, and even those with established policies against it shackle pregnant inmates. For example, New York state passed an anti-shackling policy, but shortly after, 23 out of the 27 women who gave birth were shackled throughout labor and delivery.

Solitary confinement. Solitary confinement is placing an inmate in a cell by themselves for 22-24 hours a day (Yunus, 2021). Solitary confinement can last for days or even years (Yunus, 2021). Like shackling, it is used as a control strategy. It is used as a disciplinary action or for inmates that pose a threat (Yunus, 2021). This practice is used on all inmates, including pregnant women (Yunus, 2021). In 2015, President Barack Obama suggested that the use of solitary confinement becomes limited (Jensen, 2021). The Department of Justice (DOJ) then prohibited solitary confinement for pregnant women, postpartum inmates, and those inmates that had had miscarriages (Jensen, 2021). The DOJ's decision only applied to federal prisons, so many state prisons still use solitary confinement on pregnant women (Jensen, 2021). In 2019, only 12 states passed legislation on solitary confinement (Jensen, 2021). Furthermore, prisons have changed the phrase of solitary confinement to 'medical' or 'protective isolation' or 'restrictive housing' (Jensen, 2021), so they can still practice solitary confinement, but it does not break any regulations.

Improvements for Prenatal Care in Prison

Data collection & Reporting

Prenatal care in prisons is not regulated well, and there is not much existing or recent research on the pregnancy outcomes in those incarcerated women in prison (Sufrin et al., 2019). Documenting these outcomes and providing prenatal care can reduce maternal health disparities between the general pregnant and the incarcerated pregnant populations. By reporting the data,

prisons can be held accountable for the outcomes, and it can ensure that they are following current legislation (Jensen, 2021). Yunus (2021) notes that with more data collection and reporting, the impact of new policies can be reviewed and changed to result in better outcomes. The Pregnant Women in Custody Act has taken a significant step toward this goal by requiring the federal government to collect data on federal prisons and reports. But this should apply to all prisons. State prisons should also report pregnancy outcomes and other prenatal care provided to their state governments. The Pregnancy in Prison Statistics was developed in 2016 to collect data on the "number of pregnant women, stillbirths, miscarriages, maternal and neonatal deaths, and other pregnancy-related issues" (Jensen, 2021). The data would be collected while considering demographics and prenatal care provided by the prison (Yunus, 2021). If this system could be set up in state and federal correctional facilities throughout the United States, it would increase the data on prenatal care and pregnancy outcomes in prison and help develop policies to improve prenatal care.

Prenatal care

Medical care

Medical care is a crucial component of prenatal care, but the available medical care in prisons is not clear. So, guidelines need to be set for prisons to follow. Yunus (2021) states that the most essential medical care component for pregnant incarcerated women is regular prenatal visits. This allows the doctor to have time to discuss any pre-existing conditions and how to address them. They can also monitor the infant's growth and detect issues early on. They can test for different health issues like STI and HIV in the mother. Doctors can also suggest changes in lifestyle like exercise or nutrition that could benefit the mother and infant's health. The incarcerated pregnant woman should also be provided education on keeping her infant healthy,

signs that something might be wrong, and developing and developing a birth plan. The incarcerated mother should also receive the appropriate nutrition. According to the Office of Disease Prevention and Health Promotion (2022), pregnant women should eat vegetables, fruits, whole grains, and protein foods. In their second trimester, incarcerated pregnant women should get an extra 340 calories. Those incarcerated women in their third trimester should receive an additional 450 calories a day. But, if the mother is still hungry, they should be provided more nutritious food. One program that could be implemented in all prisons is the Live-In Nurseries (Bard & Plugge, 2016). Incarcerated pregnant women would be moved to a nursery two months before giving birth (Bard & Plugge, 2016). While there, they learn prenatal parenting and infant care, receive hands-on training and child development training, and have coordinated community services (Bard & Plugge, 2016). Implementing this program can strengthen the prenatal care received by incarcerated pregnant women (Bard & Plugge, 2016).

Therapy

There is a higher prevalence of mental disorders in incarcerated women (Paynter et al., 2019). They are more likely to have higher stress levels due to life events than the general population (Paynter et al., 2019). They are more likely to experience violence, abuse, and poverty (Paynter et al., 2019). A study found that 57% of incarcerated women reported a history of abuse before incarceration, but others believe that percentage is closer to 64-98% (Jensen, 2021). With such a high level of experience with stressful and traumatizing events, it is more common to see mental illnesses in incarcerated women than in the general population before admittance (Rose & LeBel, 2020). One study found that 65.8% of incarcerated women had a history of mental illness (Jensen, 2021), and 48.5% of incarcerated women had received mental health treatment (Rose & LeBel, 2020). Prison can only heighten the mental health issues an

incarcerated woman is already experiencing (Paynter et al., 2019). Being a pregnant incarcerated woman can lead to feelings of depression, anxiety, loneliness, and pain (Paynter et al., 2019). Poor mental health can lead to difficulty with prenatal care, preterm delivery, low birth weight, and miscarriage (Rose & LeBel, 2020). To avoid this, weekly therapy sessions for pregnant incarcerated women should follow their prenatal care visits (Rose & LeBel, 2020). This can ensure that they receive the proper treatment for their mental health to avoid adverse outcomes in the pregnancy (Rose & LeBel, 2020).

Substance Abuse Treatment

Mental illness is often comorbid with substance abuse, especially among pregnant incarcerated women (Rose & LeBel, 2020). Rose & LeBel (2020) reports that 18.5% of incarcerated women had reported being treated for substance abuse in the last year. 62 to 75% of incarcerated women had a mental health disorder, and 82% reported being dependent on a substance. Substance abuse in pregnancy can result in adverse pregnancy outcomes, including preterm labor, infant and maternal mortality, low birth weight, and addiction in the infant. Substance abuse treatment must also be incorporated into the prenatal care provided to incarcerated women in jail to avoid these negative outcomes. Substance abuse treatment should include any necessary drugs and therapy to ensure the health of the mother and child (Jensen, 2021). For example, opioid use disorder is a common disorder in the United States during pregnancy. According to Sufrin et al. (2020), opioid use is associated with 10% of pregnancy-related deaths from 2007 to 2016. Treatment for opioid use disorder needs to occur in prenatal care to reduce the risk of preterm labor and other negative health outcomes. The recommended care for opioid use disorder is a medication that can optimize pregnancy outcomes. It can lower the impact of withdrawal on the mother and fetus. So, this medication would be available at all

prisons so that those with an opioid use disorder can be treated in the safest way possible. Prisons should also offer the Women's Infants at Risk program. This program places incarcerated pregnant women with substance abuse in an outside facility that can support the women through pregnancy and provide needed resources.

Shackling

Shackling is a continued practice in prisons despite some legislation against it (Jensen, 2021). Shackling can negatively impact the health of the infant and mother (Yunus, 2021). It can make it difficult for medical professionals to provide the appropriate medical care and detect issues like hypertension, preterm labor, and hemorrhaging (Yunus, 2021). It can cause extreme pain and trauma in the mother because it can be difficult to move during labor and increases the mother's fall risk (Jensen, 2021). For example, Shawanna Nelson had her legs shackled during childbirth in 2003. Due to the shackles, she developed mental health problems and back issues that later had to be addressed through surgery (Yunus, 2021). The restraints are unnecessary during labor (Yunus, 2021). They can endanger the mother and fetus so incarcerated pregnant women should no longer be shackled during transportation to the hospital and labor and delivery (Yunus, 2021). There is legislation prohibiting this practice through the First Step Act, but it does not apply to state prisons and only prohibits shackling during labor (Yunus, 2021). Shackling should be banned in state and federal prisons to avoid adverse pregnancy outcomes (Yunus, 2021).

Solitary Confinement

Solitary confinement is another practice in prisons that pregnant mothers should not have to endure (Yunus, 2021). Although there is federal regulation against it, this regulation does not apply to state prisons, and federal prisons can get around the regulation by calling it 'restrictive

housing' (Jensen, 2021). Solitary confinement can negatively impact the mother's health by limiting her access to medical care, especially if there is a medical emergency (Jensen, 2021). It also limits her physical activity, which can negatively affect her health (Jensen, 2021). Furthermore, solitary confinement can impact mental health. It can cause depression, anxiety, and paranoia (Jensen, 2021). With deterioration in a pregnant incarcerated woman's physical and psychological health, the infant's health will deteriorate, resulting in poor pregnancy outcomes. Considering the effect solitary confinement can have, pregnant incarcerated women should not be allowed to be placed in solitary confinement or 'restrictive housing.'

Legislation

Implementing these changes would rely entirely on legislation at both the federal and state level (Jensen, 2021). The federal government needs to adjust ensure that these policies are consistent and enforced on both the state and federal levels (Jensen, 2021). They must create a set of steps that each prison should follow to provide the best prenatal care (Jensen, 2021). These steps should include medical care, therapy, and substance abuse treatment (Jensen, 2021). As well as prohibiting shackling and solitary confinement for incarcerated pregnant women (Jensen, 2021). Then the federal government should further ensure that all federal prisons follow The Pregnant Women in Custody Act to collect data on the pregnancy outcomes and levels of prenatal care offered (Yunus, 2021). Although the federal government cannot enact binding legislation on state prisons, the federal government should provide incentives for each to follow the guidelines and legislation set about prenatal care (Yunus, 2021). There should then be an external review committee that analyzes the data and adjusts. This review committee will also hold each prison accountable to follow the state and federal governments (Yunus, 2021).

Conclusion

Incarcerated pregnant women seem to be a population that often gets overlooked. But as the number of women being incarcerated continues to grow, the lack of adequate prenatal care in prisons will be more jarring. Federal legislation has tried to address the need for prenatal care, and states have passed some legislation to attempt to improve prenatal care in prisons. Still, often, these legislations are not enforced or clear. But because of the lack of organization, not much is known about pregnancy outcomes and prenatal care provided in prisons. This problem needs to be addressed by setting specific guidelines and legislation, prohibiting shackling and solitary confinement, and providing treatment for substance abuse and psychological disorders. These changes will take time to develop, but steps need to be made to ensure the health and safety of mothers and their unborn infants.

References

Bard, E., Knight, M., & Plugge, E. (2016). Perinatal health care services for imprisoned pregnant women and associated outcomes: A systematic review. *BMC Pregnancy and Childbirth, 16*(1). 10.1186/s12884-016-1080-z

Franco, C., Mowers, E., & Lewis, D. L. (2020). Equitable care for pregnant incarcerated women: Infant contact after birth- A human right. *Perspectives on Sexual & Reproductive Health, 52*(4), 211-215. 10.1363/psrh.12166

Hutchinson-Colas, J. & Sachdev, D. (2021). COVID-19 and pregnancy care for incarcerated women. *Case Reports in Women's Health, 30*. 10.1016/j.crwh.2021.e00296

Jensen, R. (2021). Pregnancy during incarceration: A "serious" medical need. *Brigham Young University Law Review, 46*(2), 529-570.

Office of Disease Prevention and Health Promotion. (2022). *Eat healthy during pregnancy: Quick tips.* MyHealthfinder.https://health.gov/myhealthfinder/ topics /pregnancy/nutrition-and-physical-activity/eat-healthy-during-pregnancy -quick-tips#:~:text=Eat%20a%20variety%20of%20vegetables,bread%2C%20and%20some%20snack%20foods.

Paynter, M. J., Drake, E. K., Cassidy, C., & Snelgrove-Clarke, E. (2019). Maternal health outcomes for incarcerated women: A scoping review. *Journal of Clinical Nursing, 28*(11-12), 2046-2061. 10.1111/jocn.14837

Rose, S. J., & LeBel, T. P. (2020). Confined to obscurity: Health challenges of pregnant women in jail. *Health & Social Work, 45*(3), 177-185. 10.1093/hsw/hlaa015

Saraiva Felix, R., Rodrigues de Franca, D. J., Targino Nunes, J., Braga Coutinho Cunha, I. C.,

Barbosa Tapia, N. D., & Vaughn, M. S. Legal issues regarding medical care for pregnant inmates. *Prison Journal, 90*(4), 417-446.

Sufrin, C., Beal, L., Clarke, J., Jones, R., & Mosher W.D. (2019). Pregnancy outcomes in US prisons, 2016-2017. *American Journal of Public Health, 109*(5), 799-805. 10.2105/AJPH.2019.305006

Sufrin, C., Sutherland, L., Beal, L., Terplan, M., Latkin, C., & Clarke, J.G. (2020). Opioid use disorder incidence and treatment among incarcerated pregnant women in the United States: Results from a national surveillance study. *Addiction, 115*(11), 2057-2065. 10.1111/add.15030

The Sentencing Project. (2022). *Incarcerated Women and Girls.* The Sentencing Project. https://www.sentencingproject.org/publications/incarcerated-women-and-girls/#:~:text=Washington%2C%20D.C.%3A%20Bureau%20of%20Justice,1980%20to%20222%2C455%20in%202019

Yunus, M. (2021). The challenges in health care for pregnant women in U.S. correctional institutions. *Hastings Race and Poverty Law Journal, 19*(1), 125-150.