



# Reproductive Health Care in Carceral Facilities

## Identifying What We Know and Opportunities for Further Research

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With increased attention on and awareness about the rights of incarcerated people, their reproductive rights and other health issues are also gaining traction in national discourse. Reproductive health care is critical for incarcerated people, especially as approximately half are parents of minor children (Ghandnoosh, Stammen, and Muhitch 2021) and 3 to 4 percent of women have been reported to be pregnant upon admission to state and federal prisons (Maruschak 2008). Furthermore, prisons have violated people’s reproductive freedom and physical autonomy with inhumane practices such as forced sterilization and the restraining of pregnant people\* during labor. Despite its importance, research on reproductive health care access in prisons is limited. In this brief, we provide an overview of what is known about reproductive health care in carceral settings and explore opportunities for further research.

## Problem Statement

Reproductive health care for incarcerated people continues to be understudied, with limited research available on access to preventive care and menstrual hygiene products, abortions, and prenatal care.

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\* In this brief, we often use “pregnant people” rather than “pregnant woman” because not all people who are pregnant identify as women, and people of all gender identities can become pregnant. In some places, however, we use “pregnant women” or “incarcerated pregnant women” to accurately reflect the research we are citing.

Moreover, coerced sterilization of incarcerated people and shackling during pregnancies are particularly concerning; sterilization abuses have been well documented, even in the past two decades.<sup>1</sup>

In addition, research has demonstrated that people entering prison are likely to have more significant health care needs than the general population, underscoring the importance of providing for their reproductive health needs. Incarcerated people are more likely than the general population to have HIV, sexually transmitted diseases, hepatitis B and C, hypertension, asthma, arthritis, and diabetes (Hotelling 2008; Maruschak 2008). Furthermore, the very experiences that often result in women's criminalization and legal system involvement, including poverty, addiction, domestic violence, sexual violence, and sex work, also put them at risk of contracting HIV (Kraft-Stolar, Vasandani, and Williams 2015). Incarcerated women experience gynecological conditions at higher rates than nonincarcerated women, including irregular menstrual bleeding and vaginal discharge that is worsened by limited access to basic preventive health and gynecological care (Allsworth et al. 2007). Rates of cervical and breast cancer are also higher among incarcerated women (Brousseau, Ahn, and Matteson 2019; Pickett et al. 2018).

Further, incarcerated pregnant people have been identified as a high-risk group for poor perinatal outcomes including poor maternal mental health well-being and low birth weights (Knight and Plugge 2005). Studies also show that common complications for incarcerated pregnant people include miscarriages, preterm deliveries, spontaneous abortions, low-birth-weight infants, and preeclampsia (Fogel 1993; Kyei-Aboagye, Vragovic, and Chong 2000). Importantly, many incarcerated people's pregnancies may be unplanned and may also be exacerbated by mental health issues, substance use, sexually transmitted diseases and infections, poor and unsafe conditions in carceral facilities, and limited access to medical care (Braithwaite, Treadwell, and Arriola 2011; Fogel and Belyea 2001; Girsheck 2003; Maruschak 2008).

Despite incarcerated people's greater need for comprehensive health care, particularly reproductive health care, health care for incarcerated people across the United States has gaps and is not standardized. This, coupled with historical and contemporary examples of how prisons and jails have harmed the bodily autonomy of incarcerated people, exemplifies the need for more research on reproductive health care for incarcerated people and for policies that prevent reproductive health abuses and increase access to care.

## **Reproductive Justice**

Reproductive health care for incarcerated people can be reviewed through the framework of reproductive justice. Reproductive justice reframes reproductive rights as rights to bodily autonomy (including the right to have or not have children) and to parenting children in safe and sustainable communities. This framework also acknowledges the social, political, and economic inequalities that impact a person's access to reproductive health care services.<sup>2</sup> It involves addressing issues of autonomy, access to essential health care, and protections from harm. People who are incarcerated face unique challenges and barriers to receiving adequate health care and maintaining bodily autonomy because of the very nature of incarceration.

As a strict system of physical confinement and punishment, imprisonment in the United States has unique institutional characteristics, and yet it is a microcosm of reproductive politics. Nowhere is race and class stratification more evident than in the criminal legal and prison systems, where people of color, particularly Black people, are vastly overrepresented (Nellis 2021). And prisons present symbolic and literal restrictions on bodily and reproductive autonomy. Every dimension of reproductive justice is affected by imprisonment—from access to abortion and the basic medical care needed to maintain one’s health and fertility to the ability to form and maintain relationships with one’s children. Medical neglect in prisons and the erosion of parental rights both fit into a long history of reproductive oppression experienced by people of color and people experiencing poverty; that history has included the sale of children under slavery, the forced removal of Indigenous children to government boarding schools, restrictive immigration policies, sterilization abuse, bans on public funding for abortion, and punitive welfare policies.

Though options for furthering reproductive justice may be limited in, or even incompatible with, carceral systems, access to reproductive health care can be improved for people who are incarcerated. For this brief, we use this framework as a guide as we identify research in key areas related to reproductive rights and bodily autonomy, opportunities for meeting the reproductive health needs of people who are incarcerated, and considerations for future research.

## What We Know about Reproductive Health Care for Incarcerated People

The bodily autonomy of and health care access among incarcerated people are growing areas of research. Areas of inquiry include access to preventive health care, menstrual hygiene products, abortions, prenatal care, and lactation, as well as inhumane practices, such as coerced sterilization and the restraining of pregnant people during labor. In this section, we present information about these areas of inquiry gathered from reviews of journal articles and other research, case law, policies, and contemporary news sources to shed light on the wide array of reproductive health issues people incarcerated in state and federal prisons are facing.

### Access to Preventive Health Care and Menstrual Hygiene Products

Gaining access to medical care while incarcerated can be a complicated process. Though health care varies across carceral facilities, typically medical care in those facilities is reactive, meaning it is delivered in response to a specific medical need (e.g., someone may request medical attention for a condition). For example, the Federal Bureau of Prisons does not require that incarcerated people receive yearly preventive-care visits.<sup>3</sup> Primary or preventive care is often not prioritized in this reactive care model.

Access to medical professionals is integral for quality reproductive health care. Routine care provided by gynecologists and other practitioners includes checkups, pelvic exams, Pap tests, and

mammograms, yet research shows that incarcerated people often do not get access to this routine care or additional care they require for specific needs. Access to gynecological services and ob-gyns (obstetrician-gynecologists) proves more difficult to provide in some prisons—particularly if on site there are no gynecologists or trained medical personnel, such as a physician’s assistant to handle reproductive health issues including mammograms and cervical cancer screenings. In a survey of incarcerated women in the New York State Department of Corrections and Community Supervision, 54 percent of respondents reported they could not see a gynecologist when necessary; in one prison, as many as 65 percent of respondents reported this outcome (Kraft-Stolar 2015). Access to ob-gyns, who often perform critical screenings, may be limited in prisons across the United States, meaning many treatable conditions are going undetected and untreated.

In terms of preventive care, emergency contraceptives are not widely available in prisons, which is a critical gap in part because sexual violence is a significant problem in those facilities (Beck 2014). Further, evidence shows that offering contraceptive services in carceral settings can lead people who are released to initiate contraceptives at higher rates than when these services are only provided in the community (Clarke et al. 2006). According to Smith and coauthors (2019), however, research on the community health delivery system for system-involved women is very limited, meaning we know little about the services provided to incarcerated women upon release, gaps in those services, challenges and barriers in accessing them, and outcomes for those who receive them.

Moreover, menstrual products in jails and prisons around the country are limited and expensive, which exacerbates menstrual inequity, or disparate access to hygiene products. An incarcerated person may spend a significant portion of their income on hygiene products in addition to other expenses like phone calls or legal fees. In Colorado, the “high” daily wage for an incarcerated person is approximately 38 cents; it would take a person earning that wage there two weeks to afford a box of tampons.<sup>4</sup> This is all especially critical as the majority of incarcerated people are young and at menstrual age.<sup>5</sup>

Legislation is slowly expanding access to hygiene products in prisons. Through the First Step Act in 2018, Congress mandated that federal prisons housing women provide them free tampons, pads, and pantyliners.<sup>6</sup> But fewer than a third of US states have laws stating that state carceral facilities must provide menstrual products at no cost,<sup>7</sup> and even when laws do state as such, carceral staff may have discretion over what products and how many are provided, leaving an incomplete picture of what access actually looks like even when legislation for free menstrual products exists.

## Abortion Access

Although the Supreme Court recognized abortion as a constitutional right in the 1973 decision *Roe v. Wade*, access to abortions continued to be challenged and restricted across the country, including by state legislation (box 1). The court’s overturning of *Roe v. Wade* in June 2022 has already exacerbated such challenges and restrictions. The decision allows states to pass and enforce strict restrictions on abortions, including full prohibitions. Restrictions on abortion fall especially heavily on poor people and people of color—particularly Black women, who are overrepresented in prison and, reflecting national

trends in racial disparities in access to preventive health care, are more likely to experience unintended pregnancies (Finer and Zolna 2016) and are disproportionately burdened by barriers to abortion.

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## BOX 1

### Abortion Restrictions across the United States

There are many abortion restrictions in the United States, and potentially more to come. These include waiting periods; requirements for multiple trips (e.g., needing to visit a clinic twice before being able to receive abortion services); requirements for parental involvement for people younger than 18; limited insurance coverage; and outright bans on abortions and laws which ban them after a certain number of weeks with limited exceptions (for instance, many states have 20-week bans, and three have passed 6-week bans).

Before the Supreme Court overturned *Roe v. Wade*, Planned Parenthood's national tracker of abortion access rated 19 out of 50 states as "severely restricted" and 9 as "restricted."<sup>a</sup> And as of 2017, as many as 89 percent of US counties did not have a clinic providing abortions (Jones, Witwer, and Jerman 2019). Consequently, travel to clinics providing abortion services is a major challenge. A 2019 study found that nearly one-fifth of abortion patients in 2014 traveled more than 50 miles to visit the closest clinic available (Fuentes and Jerman 2019). With the reversal of *Roe v. Wade*, access will become even more limited and travel distances for people seeking abortions will increase in many states.

<sup>a</sup> The tracker is available at <https://www.plannedparenthoodaction.org/abortion-access-tool/US>.

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Obtaining abortions is even more difficult for incarcerated people. Although professional organizations, such as the American Congress of Obstetricians and Gynecologists in 2011, have created standards for what practices and services should be provided to incarcerated women that include access to abortion services and counseling, national laws do not reflect these standards.<sup>8</sup> And according to the American Civil Liberties Union, several state systems do not have pregnancy-specific policies for incarcerated people in their custody, and only 23 jurisdictions have standards addressing abortion access.<sup>9</sup> In New York State, a systematic 2008 review of county jail policies found that fewer than half of the 52 counties with incarcerated women in their custody had an abortion policy, and only 23 percent of those counties unambiguously guaranteed access to abortion services (NYCLU 2008). Many US carceral facilities have no official written policies informing people of how to request an abortion or instructing staff on how to meet those requests.

Although federal and state courts have upheld incarcerated people's right to abortion access (Kasdan 2009), significant barriers have persisted. In a study of abortion policies in US jails and prisons, researchers found that only half of the 22 state prisons they sampled allowed abortions in both the first and second trimesters, and that two-thirds of those that allowed abortions required incarcerated women to pay for them (Sufirin et al. 2021).

That the majority of women's prisons appear to require that people seeking abortions pay for them is a significant barrier to access. In 2017, the national average cost of a surgical abortion was \$549 at 10

weeks and the median cost at 20 weeks was triple the cost at \$1,670; the cost of the procedure varies significantly by state, ranging between \$410 and \$5,386 (Witwer et al. 2020). People who are incarcerated make an average minimum daily wage of \$0.86 and an average maximum of \$3.45.<sup>10</sup> In addition, incarcerated people who get abortions may have to pay for other things including gas, tolls, other transportation fees, the time of officers who transport them to clinics, and even wear and tear on the vehicles they use for transportation (Gips, Psoter, and Sufrin 2020; Roth 2011). The costs of transportation and staff time are significant barriers for incarcerated people given that facilities are often located far from abortion clinics, especially in rural regions. The average distance from a federal prison to the closest abortion clinic ranges from under a mile (for example, in Illinois and Pennsylvania) to over 100 miles in West Virginia (Gips, Psoter, and Sufrin 2020). This barrier is exacerbated in the 14 states that require a person to visit a clinic twice before they can receive an abortion,<sup>11</sup> meaning an incarcerated person may be made to pay for transportation, officer time, medical consultation, and any other fees more than once.

Moreover, in most cases, incarcerated people must identify abortion providers themselves without assistance from carceral staff, but they may not have consistent or stable internet access in their facility. On a survey of correctional health providers conducted in 2006–07, 68 percent of respondents indicated that incarcerated people could obtain elective abortions, but only 54 percent affirmed that correctional health providers helped arrange appointments whereas the remainder reported that people had to schedule their own appointments (Sufrin, Chang, and Creinin 2009). Furthermore, prisons and abortion services providers may have multiple layers of paperwork an incarcerated person may find cumbersome to fill out because of their literacy level, limited access to personal identification documents during incarceration, and/or a lack of money for stamps to mail paperwork (Roth 2011). Such bureaucratic requirements can put abortions out of reach for incarcerated people without their rights ever being explicitly denied and can contribute to misconceptions among incarcerated people about whether they can access abortions. A 2009 study found that only 68 percent of incarcerated people in women’s prisons believed their facility permitted people to obtain elective abortions, despite the absence of actual legal bans (Kasdan 2009). This suggests many facilities deny access to abortions formally, through written policy, or informally, via the barriers that make abortions nearly impossible to access.

Courts have repeatedly ruled that prisons and jails must accommodate incarcerated people’s decisions to have abortions—in 1987, for instance, the US Court of Appeals held in *Monmouth County Correctional Institution Inmates v. Lanzaro* that an abortion constitutes a “serious medical need” and is therefore not elective. However, carceral staff have routinely exercised their own discretion to refuse people’s requests for abortion services (Kasdan 2009). Incarcerated people seeking abortions depend on the willingness and availability of facility staff, but staff may only be available to assist people outside their standard shift hours, thus requiring overtime pay.

Even where abortion is legally permitted, the barriers outlined here—costs, logistics, limits on the agency of incarcerated people—severely restrict access to abortion services and violate people’s

reproductive rights (Kasdan 2009).<sup>12</sup> This represents a major incongruity between an incarcerated person's reproductive rights and their ability to actually assert those rights during incarceration.

## Sterilization

Forced sterilization has a long history in the United States. Eugenic policies in the 1920s and 1930s promoted the sterilization of individuals and communities viewed as inferior for reasons including race and ability, particularly targeting people in the custody of state facilities. In *Buck v. Bell* (1927), for instance, the Supreme Court upheld a Virginia law permitting the compulsory sterilization of people incarcerated in prisons or medical facilities when the state deemed it in society's or the person's best interests. Men were sterilized at higher rates than women until 1920, when women institutionalized for psychiatric disorders and disabilities began to be sterilized at higher rates (Kluchin 2009). Eugenic policies persisted in the decades that followed, primarily targeting women of color (particularly Black and Indigenous/Native American women; box 2) through misinformation and coercion.<sup>13</sup>

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### BOX 2

#### Forced Sterilization, Racism, and the Reproductive Rights Movement

Throughout the 1960s and 1970s, as many as 25 percent of Indigenous/Native American women are believed to have been sterilized by the Indian Health Service, a branch of the US Department of Health, Education, and Welfare (now the Department of Health and Human Services) (Lawrence 2000). In the southern United States, forced sterilization of Black women was such a common occurrence between the 1920s and 1980s, it was referred to as a "Mississippi appendectomy." Leader of the Mississippi Freedom Democratic Party Fannie Lou Hamer brought awareness to these forced sterilizations of Black women in the 1960s.<sup>a</sup>

After *Roe v. Wade*, mainstream white-led, pro-choice organizations were focused on abortion rights, and either failed to address forced sterilizations or even opposed guidelines to regulate these abuses (Fried 2013). The Committee for Abortion Rights and Against Sterilization Abuse, founded in 1977, followed the lead of activist women of color in actively opposing sterilization abuse while affirming the need for abortion rights (Silliman et al. 2016). Rather than focusing on abortion as a single issue, it aimed to include a broader range of issues with an intersectional approach including race and class.

<sup>a</sup> Debra Michals, "Fannie Lou Hamer," National Women's History Museum, 2017, <https://www.womenshistory.org/education-resources/biographies/fannie-lou-hamer>.

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Today, certain prison practices result in unnecessary vasectomies, hysterectomies, and other operations that destroy fertility; these constitute sterilization abuse, and forced and coerced sterilization practices often impact vulnerable populations—particularly Black, Latine, and Native American people, who are overrepresented in prisons and other types of detention facilities. In 2013, the Center for Investigative Reporting released a report disclosing that from 2006 to 2010, the California Department of Corrections and Rehabilitation paid for over 130 incarcerated women to receive tubal ligations without gaining proper consent or state approval.<sup>14</sup> In interviews, some of those

women described the pressure they received from medical staff to get those procedures, particularly those who had already had children or whom staff perceived as likely to become incarcerated again. More recently, a whistleblower complaint from an Immigration and Customs Enforcement detention center in Georgia drew attention to several women who underwent invasive gynecological procedures, including hysterectomies, without their full consent.<sup>15</sup>

Certain federal and state programs have policies and guidelines for getting informed consent from incarcerated people undergoing sterilization procedures, such as guidelines for procedures funded by Medicaid.<sup>16</sup> But such policies and guidelines have not necessarily protected incarcerated people. Scholars such as Jess Whatcott use the “social death” thesis to assert that noncoercive consent is unattainable in situations where someone’s personhood and agency is not fully realized (as is the case for incarcerated people) and that normalizing informed consent in carceral settings is a continuation of “state biopolitical violence” (Whatcott 2018). Further, although there are protections against sterilization abuses at the federal level, states have to pass their own laws to provide such protections. In the case of California, after the release of the Center for Investigative Reporting’s 2013 report citing forced sterilizations, the state passed Senate Bill 1135 (2014) to prohibit sterilization except in emergency medical situations. As evidenced above, however, prison staff have circumvented laws and processes for sterilization procedures.

## **Prenatal Care and Delivery**

Health organizations including the American Congress of Obstetricians and Gynecologists, the American Public Health Association, and the National Commission on Correctional Health Care have created standards on prenatal health care, yet there is significant inconsistency between recommended standards and the reality incarcerated pregnant people face. Research demonstrates that prenatal care for incarcerated pregnant people is of poor quality and insufficient for meeting their needs. One survey of incarcerated people found that only about half of pregnant women in state prisons received some type of care for their pregnancy (Maruschak 2008). A national scan of policies for incarcerated pregnant women found that most states do not have policies for adequate prenatal care for incarcerated people (Rebecca Project for Human Rights and NWLC 2010), despite evidence that incarcerated women have higher-risk pregnancies (Hotelling 2008). That scan found that 43 states do not require medical examinations as a component of prenatal care, 34 do not screen people for high-risk pregnancies, and 41 do not have policies requiring prenatal nutrition or prenatal nutrition counseling for incarcerated pregnant women (Rebecca Project for Human Rights and NWLC 2010). And a study of health care practices for pregnant people incarcerated in 19 state prisons indicated that health care, living conditions, and counseling failed to meet pregnant people’s basic needs; it also found that state prisons did not provide nutritionally adequate meals, appropriate clothing, educational programming, or psychosocial support services for pregnant people (Ferszt and Clarke 2012).

The American Public Health Association recommends that mothers have ongoing contact with their children after delivery,<sup>17</sup> but the vast majority of pregnant people incarcerated in prisons are separated from their children within 48 hours after birth (eight US prisons have residential or nursery programs



where eligible incarcerated mothers can live with their newborn babies) (Goshin and Byrne 2009). Research indicates prison nurseries carry long-term positive childhood outcomes, including increased attachment between parent and child and lower anxiety and depression (Byrne 2019; Byrne, Goshin, and Joestl 2010; Goshin, Byrne, and Blanchard-Lewis 2014). Further, the National Commission on Correctional Health Care indicates that carceral facilities with pregnant and postpartum people should enable either direct breastfeeding or expression of breastmilk for newborns, given the medical and social importance breastfeeding has on both parents and newborns.<sup>18</sup> Despite this recommendation, many facilities implement breastfeeding policies inconsistently. Even at places that have policies focused on lactation, few people in prison breastfeed or pump breastmilk (Asiodu, Beal, and Sufrin 2021).<sup>19</sup>

## Shackling

The practice of restraining pregnant people during labor, during transportation to prenatal care, and in other situations—also known as “shackling”—has been widespread in carceral institutions across the country. According to McCoy and coauthors (2020), restraints can include “any mechanical device made from metal, natural materials, plastic, or other materials to control movement” and are used with the purpose of controlling or limiting a person’s movement; different types of restraints include flex cuffs, soft restraints, metal handcuffs, leg irons, and belly/waist chains. In 2018, the Federal Bureau of Prisons and the US Marshals Service, under the First Step Act, changed their policies to prohibit the shackling or use of restraints (terms used interchangeably) on incarcerated people who are pregnant or in labor, unless the circumstances require it (box 3). There are a few exceptions, including when someone is an immediate and credible flight risk, when someone poses an immediate and serious threat of harm to themselves or others that cannot be prevented by other means, and when a health care professional determines restraints are necessary for medical safety (Congressional Research Service 2019). The American Medical Association reports that the use of restraints during or after childbirth can aggravate pregnancy-related mental health problems, such as depression and post-traumatic stress disorder, and notes that incarcerated women already experience mental health problems at higher rates than the general population (AMA 2015; Harner et al. 2015).

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### BOX 3

#### Legislation Against Using Restraints on Pregnant People

In recent years, federal legislation has been enacted to restrict shackling. The First Step Act (passed in December 2018) prohibits federal correctional institutions from shackling incarcerated people during the duration of their pregnancy. But that act only applies to federal facilities, which house approximately 11 percent of the total incarcerated population in the United States.<sup>a</sup> Twenty-six states and the District of Columbia have legislation that restricts the use of shackles on people during pregnancy (Goshin et al. 2019).

Professional health associations including the American College of Obstetricians and Gynecologists, the American College of Nurse Midwives, the American Medical Association, the American Public Health Association, and the Association of Women’s Health, Obstetric and Neonatal

Nurses have spoken out against the practice of shackling. In testimony supporting antishackling legislation in California, District IX of the American College of Obstetricians and Gynecologists stated that “physical restraints have interfered with the ability of physicians to safely practice medicine.”<sup>b</sup> The American Correctional Association, the oldest association developed for corrections professionals, is also not in favor of shackling, though its standards are not mandatory.<sup>c</sup>

<sup>a</sup> Wendy Sawyer and Peter Wagner, “Mass Incarceration: The Whole Pie 2022,” Prison Policy Initiative, March 14, 2022, <https://www.prisonpolicy.org/reports/pie2022.html>.

<sup>b</sup> “Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals,” American College of Obstetricians and Gynecologists, July 2021, <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/07/reproductive-health-care-for-incarcerated-pregnant-postpartum-and-nonpregnant-individuals>.

<sup>c</sup> Bell v. Wolfish, 441 U.S. 520, 543 n.27 (1979); Grenning v. Miller-Stout, 739 F.3d 1235, 1241 (9th Cir. 2014) (finding that the Court could not determine the significance of ACA accreditation).

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In a 2020 national study, McCoy and coauthors found that 39 percent of state departments of corrections indicated that shackling is not used on pregnant people at any point during pregnancy in women’s prisons, while 24 percent reported that shackling is prohibited at some point during pregnancy; whether shackling is prohibited during the first or third trimesters or during labor varies. Furthermore, on a survey of Association of Women’s Health, Obstetric and Neonatal Nurses members who self-identified as nurses focused on mothers, babies, and pregnancy, 83 percent reported that shackles were used on their incarcerated women patients; frequency of use ranged from *sometimes* to *all of the time* (Goshin et al. 2019).

Evidence shows that restraining a person during their pregnancy, and especially during labor and delivery, can lead to injuries for the parent and infant. For example, shackling may negatively impact medical staff’s ability to assess and treat a patient or cause unnecessary delays in situations such as maternal hemorrhages that require rapid emergency care to ensure the health of the pregnant person and fetus (AWHONN 2012; Sufrin 2014). Shackling also exposes pregnant people to increased medical risks, such as for blood clots. Furthermore, the birthing process is made more onerous with shackles as the ability to move during labor increases the likelihood for a shorter and less painful labor, reduces the need for medication, and promotes successful cervical dilation and delivery (ACOG 2011; AWHONN 2012; Goshin et al. 2019). Although corrections professionals may support shackles for preventing pregnant incarcerated people from escaping, there is no evidence demonstrating escape as a risk during childbirth (Feinauer et al. 2013).

## Opportunities for Knowledge Development and Policy Change

Reproductive health care for incarcerated people continues to be an overlooked area for knowledge development, research, and policy change, yet this population experiences significant reproductive health care needs before, during, and after incarceration. Based on our review of current research, policies, and practices, we recommend four areas of focus for knowledge development and policy

change: increased data collection and analysis; improved service delivery in the community, and prenatal and postpartum care; enhanced prenatal support; and research on intersectionality in reproductive health care.

### **Increased Data Collection and Analysis**

As a first step, data can be a useful tool for measuring access and identifying gaps for policy innovations. For example, in a 2019 study of state and federal prisons that reported nearly 1,400 admissions of pregnant people, Sufrin and coauthors found that more than 750 live births, almost 50 miscarriages, and 11 abortions occurred in one year. As they discussed, there has never been a systematic assessment of pregnancy outcomes in prisons, including abortions, stillbirths, miscarriages, and neonatal and maternal deaths. Moreover, prisons continue to struggle with transparency, data collection, and data sharing. Increased data collection and transparency can enable the needs of people newly incarcerated in jails and prisons to be identified and addressed from the outset.

### **Improved Service Delivery in the Community, and Prenatal and Postpartum Care**

Research shows that community-based care is essential to addressing behavioral health needs, and particularly to ensuring a continuum of care for people who are incarcerated (SAMHSA 2019). A continuum-of-care model can be extended to reproductive health care by connecting people to clinics and community-based organizations providing care and working on reproductive health issues before their release from prisons and jails.

### **Enhanced Prenatal Support**

Doula programs can improve birth outcomes and experiences for pregnant people in prison, and community-based organizations have started doula programs in carceral facilities to provide incarcerated pregnant people physical, emotional, and informational prenatal and postpartum support. Programs such as the [Alabama Prison Birth Project](#) and the [Minnesota Prison Doula Project](#) provide support throughout people's pregnancies with counseling, group education, and physical support during the birthing process. Although one study comparing birth outcomes for incarcerated women who did and did not receive enhanced pregnancy support in one state prison showed no differences in outcomes (Shlafer et al. 2021), further research is needed to understand the well-being outcomes of prison doula programs. There are also opportunities to consider the impacts of release options, such as expedited parole, on birth outcomes for pregnant people incarcerated in prisons.

### **Research on Intersectionality in Reproductive Health Care**

The available literature does not shed much light on the nuanced experiences of women of color, particularly Black, Latine, and Indigenous women, in accessing reproductive health care while incarcerated. Understanding the social conditions impacting people's reproductive health—including the role of mass incarceration—is key (Hayes, Sufrin, and Perritt 2020). When examining different

aspects of reproductive health care in carceral settings, researchers should use an intersectional approach and recognize the specific needs of women of color and LGBTQ+ people (including gender nonconforming people), as well as the pathways that may have lead people to incarceration.

## Conclusion and Considerations for Future Research

Researchers should continue examining the reproductive health needs of incarcerated people and identifying areas of improvement. Questions that could guide further research include the following:

- To what extent does a lack of menstrual and sanitation products contribute to negative health outcomes for incarcerated people? How can unlimited and free access to those products improve those outcomes?
- How has legislation impacted the provision of reproductive health services in prisons and jails?
- How will the reversal of *Roe v. Wade* impact (and how has it already impacted) abortion access for incarcerated people?
- To what extent are incarcerated people able to receive care in the community, if they choose to do so, rather than inside prisons or jails? How does this care vary, and does it affect health outcomes?
- What policies and procedures can hold prisons more accountable for negative reproductive health care outcomes and harm done to incarcerated people?

Opportunities for improving care for incarcerated people include providing access to preventive health care and menstrual products, access to abortions without additional burdens, quality prenatal care and care during delivery, and ending forced and coerced sterilization. More can also be done to hold prisons and jails more accountable for negative reproductive health outcomes, failing to provide adequate care, and practices around reproductive coercion and abuse. Researchers and decisionmakers need to reckon with the long history of abuse, violence, and lack of care in carceral facilities in order to address the present needs of people incarcerated in prisons, particularly women, people of color, and LGBTQ+ people. Reproductive justice cannot be fully realized in carceral systems, but it can be a powerful framework for examining mass incarceration and the needs of people who are incarcerated.

## Notes

- <sup>1</sup> David M. Perry, “Our Long, Troubling History of Sterilizing the Incarcerated,” Marshall Project, July 26, 2017, <https://www.themarshallproject.org/2017/07/26/our-long-troubling-history-of-sterilizing-the-incarcerated>.
- <sup>2</sup> “Reproductive Justice,” SisterSong Women of Color Reproductive Justice Collective, accessed July 25, 2022, <https://www.sistersong.net/reproductive-justice/>; “Reproductive Justice,” In Our Own Voice: National Black Women’s Reproductive Justice Agenda, accessed July 25, 2022, <https://blackrj.org/our-issues/reproductive-justice/>.

- 3 Federal Bureau of Prisons preventive health care screening guidance, June 2018, available at <https://www.bop.gov/resources/pdfs/phc.pdf>.
- 4 Wendy Sawyer, “How Much Do Incarcerated People Earn in Each State?” Prison Policy Initiative, April 10, 2017, <https://www.prisonpolicy.org/blog/2017/04/10/wages/>.
- 5 Robert Kravitz, “Correctional Facilities and the Menstrual Equity Movement,” Corrections.com, February 18, 2019, <http://www.corrections.com/news/article/49956-correctional-facilities-and-the-menstrual-equity-movement>.
- 6 Federal Bureau of Prisons Operations Memorandum, “Provision of Feminine Hygiene Products,” August 1, 2017, [https://www.bop.gov/policy/om/001\\_2017.pdf](https://www.bop.gov/policy/om/001_2017.pdf).
- 7 “The Unequal Price of Periods: Menstrual Equity in the United States,” American Civil Liberties Union, accessed August 23, 2022, [https://www.aclu.org/sites/default/files/field\\_document/111219-sj-periodequity.pdf](https://www.aclu.org/sites/default/files/field_document/111219-sj-periodequity.pdf).
- 8 “State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison,” American Civil Liberties Union, accessed July 26, 2022, <https://www.aclu.org/state-standards-pregnancy-related-health-care-and-abortion-women-prison-0#hd1>.
- 9 “State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison,” American Civil Liberties Union.
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