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# Justice for Incarcerated Moms Act of 2021: Reflections and recommendations

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**Abstract**

In the last five decades, the number of women behind bars in the United States has risen exponentially. It is now estimated that there are nearly 58,000 admissions of pregnant people—disproportionately women of color—to jails and prisons each year. Recognizing the urgency and consequences of mass incarceration on pregnant people, their families, and communities, House Resolution 948: Justice for Incarcerated Moms Act of 2021 was introduced to Congress as a part of the Black Maternal Health Momnibus. The Justice for Incarcerated Moms Act aims to improve health care and promote dignity for incarcerated pregnant and parenting people through an array of policies and oversight. In this article, we review and reflect on the components of this bill within their broader public health and reproductive justice contexts. We close with recommendations for policymakers and professionals committed to promoting equity and justice for pregnant and postpartum incarcerated people.

**Keywords**

jail, maternal health, policy, postpartum, pregnant, prison

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## Introduction

Since the 1970s, the number of people behind bars in the United States (U.S.) has risen exponentially, from a little over 500,000 in 1979 to nearly 1.7 million in 2020.[1,2] It's estimated that there are nearly 58,000 admissions of pregnant people to jails and prisons each year—a number that only begins to reflect the ripple effect of mass incarceration on parents, children, and communities of harmful policies toward pregnant and parenting people.[3,4] The ballooning of the incarcerated population has disproportionately affected poor people and communities of color, especially Black individuals, whose imprisonment rates are five times that of white individuals.[2] Amid this racially-grounded expansion, women have been the fastest growing group, with a nearly 800% increase from 1978 to 2018. In 2020, there were nearly 1 million arrests of females, and nearly 153,000 women incarcerated on any given day.[1,2,5,6] The majority of imprisoned women are younger than 45 and are mothers and the primary caregivers to young children.[2,7] Although we know less about maternal incarceration in rural areas, children living in rural areas are nearly twice as likely to experience the incarceration of a parent than children living in urban areas,[8] where there are notable gaps in services and resources to support families affected by incarceration.

These statistical descriptors of what is known as "mass incarceration" represent the convergence of policies rooted in structural racism, manifesting in the U.S. reliance on confinement and punishment as a means of social, economic, and racial control.[9,10] Such policies include, but are not limited to, disproportionate policing of communities of color, discriminatory policies of the so-called "war on drugs," and harsh, and racially disparate sentencing

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practices.[9,10] Mass incarceration is deeply tied to other upstream policies, such as divestment from robust and equitable social and medical safety net services that have perpetuated poverty, lack of access to quality education, unstable housing, and limited access to medical and mental health care, among others.[11,12]

All of these structural factors have distinctly affected women in the U.S., though the effects are often overlooked because women represent a smaller proportion of the incarcerated population than men. Yet we cannot afford to ignore the experiences of this group, nor the broad repercussions of incarcerating mothers and non-parenting women alike. Recognizing the urgency of the extensive web of etiologies and consequences of mass incarceration on pregnant people and their families, House Resolution (H.R.) 948: Justice for Incarcerated Moms Act of 2021 was introduced to Congress.[13] The bill aims to improve health care and promote dignity for incarcerated pregnant and parenting people through an array of policies and oversight. In this article, we describe the components of this bill within their broader public health and reproductive justice contexts.

Punitive policies have been particularly harsh for pregnant people who use drugs, with laws and sentencing practices in many states punishing these individuals with incarceration rather than treatment and structural support.[14,15] Punitive approaches to certain pregnancy conditions have disproportionately vilified Black women, with the paradigmatic example being the myth of the "crack baby." In the 1980s and 1990s, as crack-cocaine use increased across the U.S., researchers and healthcare providers claimed that babies who had been exposed to the substance in utero were born with short and long term physical and behavioral disabilities. However, these causal claims were based on faulty research methods and have since been disproven.[15] However, the "crack baby" claims received much media attention, and, since crack-cocaine use was understood to be a problem of Black communities (though it was also widely used among white and other racial groups), the false assumptions about the "crack baby" became tied to Black mothers. This led to enhanced vilification of Black motherhood, differential prosecution, and criminalization of Black mothers who used drugs in pregnancy, family separation, and enduring discriminatory policies.[15]

Incarceration exposure during pregnancy (maternal exposure and/or romantic partners' exposure) has been found to be associated with reductions in maternal and newborn health, including higher rates of preterm and low birthweight in infants.[16] For children with incarcerated mothers, the short and long term consequences can be devastating—research demonstrates that they are at increased risk for insecure attachment and developmental delays, and a growing body of evidence demonstrates the risks of maternal incarceration for children's other social, emotional, educational, and cognitive outcomes.[17–19] Beyond these increased developmental risks, children of incarcerated parents are also exposed to other adverse childhood experiences[20] and an increased likelihood of being incarcerated as adults themselves.[21]

As for people who are pregnant while incarcerated, they must endure isolation from their families, variable access to quality medical and mental health care, and uncertainty about what will happen to them and, if they give birth in custody, their newborns.[11] While institutions of incarceration are constitutionally mandated to provide access to health care,[22] there are no required health care standards or oversight systems that they must follow. As a result, the care that pregnant people experiencing incarceration receive varies wildly from jail-to-jail, prison-to-prison, between, and within states. Pregnant people experiencing incarceration have been denied access to their constitutional right to abortion; housed in solitary confinement; ignored when in need of emergent medical attention; forced to go through opioid withdrawal despite known risks; shackled throughout pregnancy, labor, delivery, and the postpartum period; prevented from providing breastmilk to their infants; and separated from their newborns hours after birth.[23] In a study of 22 state prison systems and all federal prisons, there were nearly 800 births in one year; only 15% of these postpartum people were breastfeeding.[3] While the preterm birth rate of 6% in this study was lower than national rates, similar to a systematic review that also reported lower rates of low birth weight,[24] these metrics do not reflect the variability in pregnancy care that women are exposed to, nor the lack of dignity they experience being pregnant and birthing in custody.

Several policy and advocacy efforts, often led by previously incarcerated people, have sought to disrupt the neglectful and dangerous treatment of pregnant people behind bars. Legislation to ban the use of restraints or shackling of pregnant, birthing, and postpartum people has, to date, received the most attention. In 2000, Illinois became the first state to pass an anti-shackling statute, followed by California in 2006. As of October 2021, shackling during labor is prohibited in 35 states, the District of Columbia, and the Federal Bureau of Prisons. While these legislative victories are significant, they are only the tip of the iceberg of the work that needs to be done to advance dignity, safety, and justice for pregnant people experiencing incarceration. Not only do 15 states still permit the unsafe practice, but illegal restraints are still used even in states with anti-shackling laws. This may be due to many factors, including limited oversight for officers' training and implementation, hospital staff not knowing the laws and ethical practices, and shackling law loopholes.[25,26] In some instances, anti-shackling bills have included other policy changes—though often without funding—affecting pregnant individuals, such as requiring access to doulas (e.g. Minnesota, Oklahoma). In 2018, California

passed a law requiring county jails to facilitate access to lactation (i.e. pumping breast milk or breastfeeding through direct contact) for postpartum people in custody.[27] In 2021, Minnesota's legislature passed a landmark bill, the Healthy Start Act, that will permit the Commissioner of Corrections to divert pregnant and postpartum people sentenced to prison into community-based alternatives for up to 12 months.

These state policies reflect a patchwork approach to addressing a complex issue that impacts pregnant and postpartum people in prisons and jails across the country. We urgently need local, state, and federal policymakers to recognize the devastating consequences mass incarceration has had and continues to have on pregnant people, parents, families, children, and communities. H.R.948 provides a starting point for addressing the unique needs of pregnant and postpartum incarcerated people at the federal level. In this article, we briefly review the key elements of H.R.948 and our reflections on this historical bill. We close by outlining seven recommendations that we have for envisioning a different future for pregnant and postpartum people in the U.S.

## Summary of House Resolution 948: justice for Incarcerated Moms Act of 2021

H.R.948—the Justice for Incarcerated Moms Act of 2021 was introduced on February 8th, 2021. It is sponsored by Representative Ayanna Pressley, a Democrat from Massachusetts, and co-sponsored by 34 Democratic Representatives. Its Senate equivalent S.341 was introduced by Senator Cory Booker on February 22nd, 2021, with two Democratic co-sponsors. These bills are related to the Black Maternal Health Momnibus Act of 2021, which was introduced to the legislature in February 2021.[28] This "Momnibus" was proposed to "end preventable maternal mortality and severe maternal morbidity in the United States and close disparities in maternal health outcomes." Indeed, during 2007–2016, Black and American Indian/Alaska Native women had significantly more pregnancy-related deaths per 100,000 births than did white, Hispanic, and Asian/Pacific Islander women. These disparities persisted over time and across age groups (See Petersen et al., 2019)

All of these proposed bills have the potential to improve the health and well-being of mothers and children across the U.S. The first part of H.R.948 addresses the effort to end the shackling of pregnant individuals. If this legislation were passed, states that receive federal grants from the Omnibus Crime Control Act of 1968[29] —and do not have laws restricting use of shackles on pregnant people in prison—will lose 25% of their grant funding the following year. Funds diverted from states without such restrictions will be directed toward states that do have them in place. This aspect of the bill aims to provide a fiscal incentive to reduce or eliminate the use of restraints on pregnant people in prisons and jails.

Next, Section 4 of the proposed legislation identifies a major goal: "Creating model programs for the care of incarcerated individuals in the prenatal and postpartum periods." Within one year of the enactment of this Act, maternal health optimization programs must be established in at least six Bureau of Prisons (BOP) facilities. In order to construct effective programs, the Attorney General will consult with relevant stakeholders including community-based organizations, patient representatives, maternity care and maternal health education providers, perinatal health workers, researchers, and policy experts. These programs will begin within 18 months of the Act's enactment and will last five years. The Act proposes 10 directions that these pilot programs address, such as providing healthy food for pregnant people, improving access to prenatal care, offering counseling and treatment for mental health issues and trauma, and more.

In terms of reporting, the six facilities will be responsible for recording and reporting program outcomes. This will certainly promote more accountability in the criminal legal system and inform the development and implementation of subsequent programs. The Act also includes a subsection requiring the Attorney General to hire an independent organization to conduct oversight of the new programs, another important step toward government and facility accountability. Finally, this section ends with an authorization to spend $10,000,000 for each of the fiscal years 2022–2026 on this programming.

The following section of the bill (Section 5) outlines a grant program proposed to improve maternal health outcomes in state and local prisons and jails. This distinction between federal facilities and state and local facilities is an important one to make; without this section of the legislation only those people who are pregnant or postpartum in BOP facilities would be able to benefit from this Act, leaving out thousands of mothers and infants impacted by various state and local correctional systems. The intention of this grant funding is very similar to that of the model programs described in Section 4 pertaining to BOP facilities. The funds are to be used to "establish or expand" programs with the same outlines and sample policies as the model programs being created in the BOP facilities. Section 5 also requires reporting and oversight, with the same guidelines as those specified for BOP facilities.

In the interest of accountability, Section 6 of H.R.948 outlines the requirements for a Government Accountability Office (GAO) Report, which the Comptroller General must submit to Congress within the first two years of enactment. This report must include the number of pregnant individuals who are incarcerated in BOP facilities, statistics on racial and ethnic disparities in maternal/infant health outcomes for incarcerated people, and totals for

each of the following categories (for incarcerated individuals in all U.S. carceral facilities in the past 10 years): number of people who have experienced a pregnancy-related death or the death of an infant, number of severe maternal morbidity cases, and number of preterm and low-birthweight births. The Act includes a provision that if the Comptroller General is unable to determine the required information, there must be a comprehensive assessment of the barriers that prevent information from being collected and saved appropriately, and recommendations for how best to eliminate those barriers. It also requires that the GAO report address causes of adverse health outcomes and maternal morbidity that are unique to incarcerated people, and emphasizes the difference in impact for racial and ethnic minority groups. Finally, the report must make recommendations to reduce maternal mortality and address the racial and ethnic disparities in maternal health outcomes among incarcerated individuals in federal, state, and local facilities.

The final requirement of this legislation is a report about the implications of pregnant and postpartum incarcerated people being ineligible for State medical assistance. This report will be compiled and published by the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission, and will be required no later than two years after the enactment of the Act. The report must include the following information: effects of ineligibility for incarcerated people on maternal health outcomes and potential implications on maternal health outcomes if this ineligibility was suspended when a pregnant or postpartum person is incarcerated. This section also identifies the importance of acknowledging disparities in health outcomes between white individuals and those from other racial and ethnic minority groups, and maintains the focus on race, poverty, pregnancy, and incarceration — a recognition of the profound racialized disparities in maternal morbidity and mortality in the U.S.

## Reflections on the proposed legislation

For more than a decade, members of our team have worked individually and collectively on issues related to the health and well-being of incarcerated pregnant people. Our team reflects expertise in obstetrics and gynecology, medical anthropology, developmental psychology, maternal and child public health, doula care, lactation support, perinatal mental health, and parenting education. It is through these lenses that we reflect on H.R.948. The proposed legislation reflects an urgent and imperative goal—that all birthing people are treated with dignity.

As we reflect on H.R.948, we want to recognize Representative Pressley and Senator Booker for their leadership and attention to these critical issues—issues that have been long-ignored as the number of women behind bars has skyrocketed in this country. To our knowledge, this is the first bill in U.S. history that directly considers the health and wellbeing of incarcerated pregnant people. We consider our reflections in the context of this historical legislation, highlighting aspects of the bill that are particularly strong while identifying parts of the bill that could do more to promote health equity and justice for pregnant and postpartum incarcerated people.

As summarized above, the first part of H.R.948 seeks to identify a financial incentive for all states to pass anti-shackling legislation. As proposed, states that do not have laws restricting use of shackles on pregnant people in prison would lose 25% of their funding from the Omnibus Crime Control Act the following year. This is a creative strategy for encouraging the 15 states that do not currently have laws restricting the use of restraints on pregnant incarcerated women to enact similar legislation. And yet, even in the 35 states where such laws do exist, few have reporting requirements. We also know that implementation of these laws is complicated and compliance is rarely monitored.[30] Even in states like Minnesota where reporting requirements are included in the law, there are known violations and documented concerns about lack of compliance.[31] In order for these laws to truly protect pregnant and birthing people, there must be intentional oversight of the laws and consequences for jails and prisons that fail to comply. In this way, H.R.948 could be strengthened by creating a grant mechanism that provides technical assistance to states without anti-shackling laws in order to develop comprehensive policies and data collection systems for monitoring the use of restraints, as well as training for officers and staff.

Section 4 of the bill outlines a major goal related to the creation of model programs for the care of pregnant and postpartum people in six BOP facilities, with parallel goals for programs in state prisons and local jails detailed in Section 5. What's most exciting about these sections of the legislation is their inclusion of currently and formerly incarcerated people's voices in the development of these programs. The bill states that programs should be developed "in consultation with stakeholders such as relevant community-based organizations, particularly organizations that represent incarcerated and formerly incarcerated individuals." Organizations like RestoreHER and the National Council for Incarcerated and Formerly Incarcerated Women and Girls are led by individuals who are directly impacted by incarceration—many formerly incarcerated mothers, some of whom were pregnant and gave birth while in custody. In addition, the bill authors recognize the importance of engaging individuals from diverse professional backgrounds, including maternity care providers, perinatal health workers, along with research and policy experts. In order for substantial, lasting change to happen, we believe legislators, practitioners, and researchers must follow the lead of individuals directly

impacted by incarceration. The authors' attention to prioritizing the voices of formerly incarcerated people is a model for others.

The bill outlines several aspects of care and support that programs may provide to pregnant and postpartum people, including access to perinatal health care workers, access to nutritious foods and recommended activity levels, among others. While we commend the bill's authors for recognizing these important determinants of maternal health, we strongly believe that many of the things outlined in the bill are essential aspects of maternal care that should be available to all pregnant people, not just those in the selected pilot facilities or grantees. The bill could be strengthened by outlining guidance on minimum policies and practices that prisons and jails must follow in order to meet the needs of pregnant and postpartum people, following the recommendations by relevant professional organizations, including the National Commission on Correctional Health Care, the American College of Obstetricians and Gynecologists, the American Public Health Association, and the United Nations' Bangkok Rules (or Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders). From there, the bill could require that all BOP facilities and states that receive funding from the Omnibus Crime Control Act follow this guidance or be subject to financial penalties. Such mandates—in conjunction with pilot programs that aim to implement enhanced programming—would go farther to support the health and wellbeing of pregnant and postpartum people and their infants.

We appreciate the bill authors' attention to both federal and state systems of incarceration, but find it imperative to note that some aspects of the proposed legislation are likely infeasible in the absence of other major shifts in BOP policies and procedures. For example, offering "opportunities for postpartum individuals to maintain contact with (their) newborn child to promote bonding, access to prison nursery programs, or breastfeeding support" require that the infant co-reside with the mother inside the prison or that the infant is in close geographic proximity to the facility in which the mother is imprisoned. The BOP was only recently required to ensure that all incarcerated people are within 500 miles from home with the passage of the First Step Act.[32] Even still, limitations in facilities' bed capacity, and the incarcerated persons' security designations, programming needs, and health needs leave most people who are incarcerated in federal facilities thousands of miles away from their children and families.

And while the BOP offers two programs for pregnant and postpartum people—Mothers and Infants Together (MINT) and the Residential Parenting Program (RPP)—these programs have strict eligibility criteria that drastically limit the number of people who could benefit from participation, and evaluation on the effectiveness of these programs is sorely lacking. MINT is a community residential program that aims to assist offenders during the last two months of pregnancy by transferring them to a Residential Reentry Center, where they are able to stay for up to three months post-birth. Although this is a well-intentioned release program, it is only available for mothers in five of the 28 federal facilities that house women. And RPP, a program allowing minimum security federal inmates to live in supervised custody with their babies for up to 30 months, is only available to mothers in Washington. We encourage Representative Pressley, Senator Booker, and their co-authors to advocate for greater transparency in existing BOP programs targeting this population, expand programming to meet the needs of all the pregnant and postpartum people who could benefit from services, and—most importantly—support legislative efforts aimed at decreasing the use of incarceration among pregnant and parenting people more broadly.

We commend the authors for prioritizing applications (Section 5, Subpart d) from states that have "demonstrated a commitment to developing exemplary programs for pregnant and postpartum individuals in prison and jails." In recent years, several states—most in partnership with community-based organizations—have implemented innovative programs to address the unique and complex needs of pregnant and postpartum people in prisons and jails. Our authorship team includes the founder and executive director (EG) and the research director (RS) for the Minnesota Prison Doula Project, which has provided group-based and one-on-one support to pregnant and postpartum people in Minnesota for more than a decade. We have demonstrated that doula support is feasible in this population[33,34] and preliminary evidence indicates that program participation is associated with positive outcomes, including high levels of participant satisfaction[35] and high rates of breastfeeding initiation.[36]

The Minnesota Prison Doula Project has set a model for programs in states, including the Alabama Prison Birth Project. Alabama is leading the way in regards to lactation and incarceration. In its program at Julia Tutwiler Prison for Women, pregnant participants meet prenatally with a lactation counselor from the Alabama Prison Birth Project. Seventy percent of pregnant people choose to participate. Through the project, milk is expressed, stored, and shipped frozen to the infant. This is a relatively simple process with immeasurable benefits to parent and child, and significant financial savings for the caregiving family. Together, we're just beginning to learn about the facilitators and barriers to these programs' success and document participants' outcomes through a five-year, multi-site study funded by the National Institutes of Child Health and Human Development. We have much to learn about the existing programs supporting pregnant and postpartum people in state prisons.

House Resolution 948 signals the timeliness and significance of the work that is happening within state

prisons, but also reflects the limitations of what can be done to support pregnant and postpartum incarcerated people through federal legislation. Indeed, a relatively small proportion (less than 10%) of the corrections population is housed within the BOP. H.R.948 could be strengthened by including additional funding and support for states to implement programs and services to support this population and to coordinate across states. Further, additional legislative efforts will need to be made at the state and local levels to pass bills to support pregnant and postpartum people in local jails and state prisons. H.R.948 is a start, but state legislatures will need to do more to address the needs of this population in order to have the greatest impact.

H.R.948 also outlines data collection and reporting requirements for the pilot BOP facilities and grantees from state prisons and local jails, including key indicators related to maternal and child health, such as pregnancy-associated deaths, rates of preterm births, and low-birthweight births. In addition, Section 6 outlines requirements for a Government Accountability Office (GAO) report. These aspects of program evaluation, data collection, and ongoing research are essential and will significantly inform known gaps in our understanding of the outcomes of pregnant and postpartum incarcerated people.[37]

In addition, the bill specifies a required report on the implications of pregnant and postpartum incarcerated people being ineligible for State medical assistance. While the Affordable Care Act had important implications for pregnant incarcerated people,[38] we know that critical gaps in coverage remain and that as more states look to alternatives to incarceration for pregnant and postpartum people,[39,40] adequate health insurance coverage will be a key determinant of maternal and child health. This is an important aspect of the bill and is aligned with other key legislative efforts that recognize the importance of adequate health insurance coverage and access to health services in reducing maternal morbidity and mortality.[41,42]

There are other aspects of the bill that, while seemingly narrow, have the potential for meaningful shifts in the care and treatment of pregnant and postpartum people in prisons and jails. For example, under Sections 4 and 5, pilot BOP facilities and Justice for Incarcerated Moms grantees could "train medical personnel to ensure that pregnant incarcerated individuals receive. . .care that promotes (their) health and safety." Evidence from reviews of prison policies, as well as from lawsuits where pregnant people's labor symptoms were flagrantly ignored, leading to jail cell births, demonstrate inconsistency in quality of pregnancy care provided.[43,44]

Another provision would "provide clinical educational opportunities to maternity care providers in training to expand pathways into maternal health care careers serving incarcerated individuals." There is growing recognition among health professionals that medical, nursing, and dental students should be adequately trained to provide quality care to incarcerated populations, yet a majority of health care trainees are not exposed to issues of mass incarceration and health.[45] And while some U.S. medical schools offer training at the intersection of health and criminal justice, there is considerable variation in this curricula[46] and few focus on women' health, specifically.[47] Venters has argued that recruiting and retaining healthcare providers to work in prisons and jails remains "a core barrier to improving correctional health care."[48] Preparing a mission-driven workforce that is highly qualified to provide excellent care to pregnant and postpartum people in prisons and jails will require meaningful training opportunities, like what is proposed in H.R.948. While academic-correctional health partnerships exist and we support calls for expanding partnerships between academic health centers and prisons,[49,50] such partnerships must attend to the deep history of structural racism embedded in the healthcare system,[51–54] especially as it relates to the care and treatment of Black and Ingenious pregnant people.[52,55] Giftos et al.[56] have emphasized the important role that health care providers have in transforming the criminal legal system and ending mass incarceration. We recognize the great potential that health care providers can have in improving the quality of care for pregnant and postpartum people during periods of incarceration and we urge them to see their essential role in collaborating with directly impacted people to support advocacy efforts aimed at transforming the system altogether.

## Current & future recommendations

If passed, H.R.948 would signal critical attention to the needs of pregnant and postpartum people in prisons and jails in the U.S. While the bill is historic and important, we believe it reflects only a starting point for the radical shifts that need to occur at the local, state, and federal levels in order to fully promote justice and dignity for all incarcerated birthing people. The recommendations that follow originate from the place of lived experiences, from directly impacted people, and frontline prison and jail perinatal health workers. These recommendations provide a summary of the first action steps health care professionals, policy makers, prison and jail leaders, and others can take to end harmful practices and promote health equity and dignity for incarcerated birthing people.

### *Listen to incarcerated and formerly incarcerated birthing people*

The best change begins at the source, right at the root of inequality, despair, or harm. Incarcerated birthing people know their needs, and if asked, they will tell us what one needs to know to create necessary change. Their ideas should be at the heart of all of our efforts, because they are

the ones who have to shoulder the consequences of our collective actions. In visioning sessions, program and policy development, and legislative planning, center their voices. Call them to the front of the conversation, listen, empower, believe, and follow their leads.

### *Support the passage and implementation of evidence-based policies to promote the health of pregnant and postpartum people in prison*

Pregnant incarcerated people are not receiving adequate physical and mental health care.[11] Pregnant incarcerated people are at risk of hunger and poor nutrition[57,58] and have high rates of postpartum depression.[59] The continued incarceration of pregnant people makes it imperative that their needs are acknowledged and that the system is reimagined to be better positioned to care for them. Transparency has previously been scarce, and this lack of awareness of what happens to pregnant people behind bars has hidden tortuous realities, creating environments of gross injustice. The Justice for Incarcerated Moms Act of 2021 would create opportunities for new programming, data collection, and leverage the end to harmful practices. Our expertise and the current evidence support the goals of H.R.948 and we encourage States and the Federal government to implement evidence-based policies to promote the health of this population.

### *Humanize people experiencing poverty, addiction, mental illness, and incarceration*

When we see people as meaningful members of our communities, with real needs that can and should be addressed, we recognize their humanity. Many times, this population is dehumanized and reduced to nothing more than the mistakes they might have made. We must acknowledge that they are parents, and in nearly every instance will be released from prison and rejoin society. There are many pathways to incarceration. For women, these pathways to prison are most often tied to mental illness, trauma, addiction, poverty, and structural racism.[60–63] If women and birthing people with complex risks for adverse outcomes are better supported in our communities, and allowed access to the resources they need, we have the potential to interrupt pathways to prison and significant harm. Humanizing them thus means changing policies and services to address the underlying causes of their criminalization, so that they can thrive in their communities.

### *Increase knowledge and awareness among perinatal healthcare workers*

Healthcare professionals in both carceral and community settings can better support these complex care situations and improve health outcomes. This may look like getting clients an extra sandwich in prison and giving flexible eating times because they live in a perpetual state of hunger; making sure that patients are informed about their pregnancy care and expectations for birthing while in custody; or a perinatal nurse in the hospital asking custody officers, especially male officers, to leave the room while performing exams to preserve the pregnant person's dignity. These are all small things—that can't be legislated—that make a world of difference to the person going through the experience.

Most of the things that happen to pregnant incarcerated individuals happen in darkness. There is little to no oversight on how they are treated. Doctors, nurses, midwives, doulas, and other health care professionals are in unique positions to shine some light on these practices. We encourage them to ask probing questions. What is happening at your local prison or jail? Are the incarcerated people being treated humanely? Are pregnant people receiving the vital care that they need? What about nutrition? Are they being shackled? Can pregnant people access pregnancy-related programming? How can I make sure my hospital or clinic's policies and practices promote dignified and safe care for this population? When we ask hard questions, we can be an agent of change. We encourage others to be prepared to be uncomfortable, and then take action to do what one can to reduce harmful practices in their communities.

### *Provide universal access to lactation resources for postpartum incarcerated people*

Breast milk has countless benefits for the birthing parent and child.[64,65] For the child, some of the benefits include fewer ear infections, reduced risk of obesity, Type 2 diabetes, and infant mortality.[66–68] For mothers, breastfeeding helps with postpartum blood loss, reduces risk for postpartum depression, and reduces risk for the development of breast and ovarian cancers.[69–71] Breastfeeding/chestfeeding/pumping helps maintain maternal and child bonds which promotes mental and child health. The American College of Obstetricians and Gynecologists[72,73] recommends exclusive breastfeeding for the first six months of an infant's life, and specifically recommends that incarcerated individuals be able to breastfeed or express milk. Likewise, the National Commission on Correctional Health Care[74] also recommends "making accommodations for nursing women in custody, including at short-stay facilities, that will enable them to maintain their breast milk supply." We agree with ACOG's and NCCHC's positions on this topic and advocate for postpartum incarcerated people to have universal access to lactation support. This will require prisons and jails to implement new policies (e.g. allowing more frequent contact visits) and invest in resources (e.g. breast pump and milk storage equipment, systems for transporting milk to caregivers) to fully support the lactation needs of postpartum incarcerated people and their infants.

### *Provide funding and other resources to implement new and expand existing programs that support pregnant and postpartum incarcerated people*

In the past decade, several states have begun implementing enhanced perinatal programs for incarcerated women through partnerships with community-based organizations. The Alabama Prison Birth Project, Michigan Prison Doula Initiative, and Minnesota Prison Doula Project, are just a few. Funding is needed to support these existing programs which provide a variety of evidence-based services to meet this population's needs, including group-based education, labor and delivery support with a trained doula, lactation counseling, and postpartum support. Ongoing evaluation of these existing programs can inform the implementation of similar programs in other states and in the BOP. In addition, the BOP's MINT and RPP programs are available to some pregnant people, but strict inclusion criteria and limited availability mean that most of the pregnant and postpartum people who could benefit from services do not have an opportunity to receive them. We must work to improve the care and treatment for all pregnant and postpartum people in state and federal prisons and local jails, while simultaneously working to identify ways to end this practice entirely.

### *End prison and jail birth in the United States*

Some practices are associated with enough harm that we simply must consider ending them. The spirit of Minnesota's Healthy Start Act, to end prison birth, is a model that other state and federal legislation should follow. This law permits the Commissioner of Corrections to conditionally release pregnant people and those who have given birth within the previous eight months to community-based programs, with the goal of keeping mothers and their infants together and meeting mothers' individualized needs (e.g. substance abuse treatment, housing) out of the carceral environment. The Healthy Start Act offers an innovative approach to addressing the complex needs of pregnant women and mothers in prison that warrants ongoing evaluation.

In cases where the biological mother and infant must be separated, supporting alternative caregivers is integral in ensuring the wellbeing of the infant, caregiver, and family system. Caregivers of infants born to mothers in prison report experiencing considerable stress that impacts their own mental and physical health.[75] Identifying ways to reduce caregiver stress through material, emotional, and informational support is important to supporting stable and safe homes for infants. In addition, when mother-infant reunification is the goal, prison policies and programs should provide mothers with opportunities to develop their parenting skills; have frequent, developmentally appropriate, family-friendly visits; and support communication and collaboration with co-parents. Prisons and community-based programs should also provide intentional support for the mother-infant-caregiver triad to promote healthy transitions when mothers are released from prison and resume caregiving responsibilities.

## Limitations

Our review of H.R. 948 and recommendations are not without limitations. First, although our authorship team reflects decades of experience working with pregnant and postpartum people, our perspectives are subject to potential bias. As researchers and health professionals, we can offer our critical analysis of the bill, but additional review and analysis from other experts—particularly those directly impacted—is critically important. We did not collect primary data to systematically assess the perspectives of people with lived experience on the bill's components and potential impact, though as we note our recommendations originate from our extensive work with this population. Finally, in our review of proposed legislation, we did not systematically review the scientific literature to support our reflections of the bill.

## Conclusions

In 2010, the United Nations passed a resolution to adopt the Bangkok Rules, which encouraged states to adopt legislation to establish alternatives to incarceration. While this international agreement to improve prison conditions for women and seek more humane alternatives to incarceration was groundbreaking, the United States notably abstains from following the Bangkok Rules. Changing our conceptions of punishment to acknowledge the trauma, pain, and suffering that incarceration causes to women and their children would be a crucial step toward justice.

The time has come to start collectively questioning if pregnancy in the absence of proper basic resources, birthing in chains, birthing alone, and forced infant-parent separation with no risk of imminent harm, fits the criteria for inhumane treatment. There is no science to support these current practices. People who perpetuate harm, and are rightfully convicted, can pay their debt to society and can also be supported in being healthy parents to their children. There can be an experience of justice and accountability, and children do not have to lose their parents. Our systems can—and must—evolve.

### Author contribution(s)

**Rebecca J Shlafer:** Conceptualization; Writing—original draft; Writing—review & editing.
**Erica Gerrity:** Conceptualization; Writing—original draft; Writing—review & editing.

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## References

1. Minton TD and Zeng Z. Jail inmates in 2020—statistical tables. Bureau of Justice Statistics, U.S. Department of Justice, 2021, https://bjs.ojp.gov/library/publications/jail-inmates-2020-statistical-tables
2. Carson EA. Prisoners in 2020—statistical tables. Bureau of Justice Statistics, U.S. Department of Justice, 2021, https://bjs.ojp.gov/library/publications/prisoners-2020-statistical-tables
3. Sufrin C, Beal L, Clarke J, et al. Pregnancy outcomes in US prisons, 2016-2017. *Am J Public Health* 2019; 109(5): 799–805.
4. Sufrin C, Jones RK, Mosher WD, et al. Pregnancy prevalence and outcomes in U.S. *Obstet Gynecol* 2020; 135(5): 1177–1183.
5. Sawyer W. The gender divide: tracking women's state prison growth. Prison Policy Initiative, 2018, https://www.prisonpolicy.org/reports/women_overtime.html
6. Federal Bureau of Investigation. Uniform crime reporting program, 2021, https://www.fbi.gov/services/cjis/ucr (accessed 28 December 2021).
7. Maruschak LM, Bronson J and Alper M. Parents in prison and their minor children: survey of prison inmates, 2016. Bureau of Justice Statistics, U.S. Department of Justice, 2021, https://bjs.ojp.gov/library/publications/parents-prison-and-their-minor-children-survey-prison-inmates-2016
8. Murphey D and Cooper PM. *Parents behind bars*. Bethesda, MD: Child Trends, 2015.
9. Alexander M. *The new Jim Crow: mass incarceration in the age of colorblindness*. New York: The New Press, 2010.
10. Davis A. *Race and criminalization: black Americans and the punishment industry*. New York: Pantheon Books, 1997.
11. Sufrin C. *Jailcare: finding the safety net for women behind bars*. Berkeley, CA: University of California Press, 2017.
12. Wacquant L. Class, race, and hyperincarceration in revanchist America. *Soc Democr* 2014; 28(3): 35–56.
13. Pressley A. *Justice for Incarcerated Moms Act of 2021*, 2021. https://www.congress.gov/bill/117th-congress/house-bill/948/text?q=%7B%22search%22%3A%5B%22hr+9%22%5D%7D&r=9&s=1
14. Paltrow LM and Flavin J. Arrests of and forced interventions on pregnant women in the United States, 1973–2005: implications for women's legal status and public health. *J Health Polit Policy Law* 2013; 38(2): 299–343.
15. Goodwin M. *Policing the womb: invisible women and the criminalization of motherhood*. Cambridge: Cambridge University Press, 2020.
16. Testa A, Jackson DB, Vaughn MG, et al. Incarceration as a unique social stressor during pregnancy: implications for maternal and newborn health. *Soc Sci Med* 2020; 246: 112777.
17. Poehlmann J. Representations of attachment relationships in children of incarcerated mothers. *Child Dev* 2005; 76(3): 679–696.
18. Poehlmann J. Children's family environments and intellectual outcomes during maternal incarceration. *J Marr Fam* 2005; 67: 1275–1285.
19. Dallaire DH, Zeman JL and Thrash TM. Children's experiences of maternal incarceration-specific risks: predictions to psychological maladaptation. *J Clin Child Adolesc Psychol* 2015; 44(1): 109–122.
20. Turney K. Adverse childhood experiences among children of incarcerated parents. *Child Youth Serv Rev* 2018; 89: 218–225.
21. The Annie E. Casey Foundation. A shared sentence: the devastating toll of parental incarceration on kids, families shared-sentence/
22. Estelle v. Gamble, 1976, https://tile.loc.gov/storage-services/service/ll/usrep/usrep429/usrep429097/usrep429097.pdf
23. Hayes CM, Sufrin C and Perritt JB. Reproductive justice disrupted: mass incarceration as a driver of reproductive oppression. *Am J Public Health* 2020; 110(S1): S21–S24.
24. Knight M and Plugge E. The outcomes of pregnancy among imprisoned women: a systematic review. *BJOG* 2005; 112(11): 1467–1474.
25. DiNardo C. Pregnancy in confinement, anti-shackling laws and the "extraordinary circumstances" loophole. *Duke J Gend Law Policy* 2018; 25: 271–295.
26. Goshin LS, Sissoko DRG, Neumann G, et al. Perinatal nurses' experiences with and knowledge of the care of incarcerated women during pregnancy and the postpartum period. *J Obstet Gynecol Neonatal Nurs* 2019; 48(1): 27–36.

27. Jones-Sawyer. County jails: infant and toddler breast milk feeding policy, 2018, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2507 (accessed 30 December 2021).
28. Booker SC. Black Maternal Health Momnibus Act of 2021, 2021, https://alliancetoendhunger.org/wp-content/uploads/2021/05/Black-Maternal-Health-Momnibus-Act-of-2021.pdf
29. Omnibus Crime Control and Safe Streets Act of 1968, 1968, https://www.govinfo.gov/content/pkg/COMPS-1696/pdf/COMPS-1696.pdf
30. Yearwood LT. Pregnant and shackled: why inmates are still giving birth cuffed and bound. The Guardian, 2020, https://www.theguardian.com/us-news/2020/jan/24/shackled-pregnant-women-prisoners-birth (accessed 30 December 2021).
31. KARE11.com. KARE 11 investigates: DOC and jails fail to report pregnant inmates shackled, https://www.kare11.com/article/news/investigations/cruel-and-unusual/kare-11-investigates-doc-and-jails-fail-to-report-pregnant-inmates-shackled/89-7f4099e7-8078-4bb6-871c-3ad72776ce39 (accessed 30 December 2021).
32. First Step Act, 2018, https://www.govtrack.us/congress/bills/115/s756/text
33. Shlafer RJ, Gerrity E and Duwe G. Pregnancy and parenting support for incarcerated women: lessons learned. *Prog Community Health Partnersh* 2015; 9(3): 371–378.
34. Shlafer RJ, Hellerstedt WL, Secor-Turner M, et al. Doulas' perspectives about providing support to incarcerated women: a feasibility study. *Public Health Nurs* 2015; 32(4): 316–326.
35. Shlafer RJ, Davis L, Hindt L, et al. The benefits of doula support for women who are pregnant in prison and their newborns. In: Poehlmann-Tynan J and Dallaire D (eds) *Children with incarcerated mothers*. Cham: Springer, 2021, pp. 33–48.
36. Shlafer RJ, Davis L, Hindt LA, et al. Intention and initiation of breastfeeding among women who are incarcerated. *Nurs Womens Health* 2018; 22(1): 64–78.
37. Bronson J and Sufrin C. Pregnant women in prison and jail don't count: data gaps on maternal health and incarceration. *Public Health Rep* 2019; 134(suppl. 1): 57S–62S.
38. Shlafer RJ and Kozhimannil KB. What the affordable care act means for pregnant inmates, 2014, http://healthaffairs.org/blog/2014/04/04/what-the-affordable-care-act-means-for-pregnant-inmates/
39. The Healthy Start Act, 2021, https://www.revisor.mn.gov/laws/2021/0/Session+Law/Chapter/17/ (accessed 30 December 2021).
40. Pregnant in prison: MD and legislation proposes alternatives, https://www.publicnewsservice.org/index.php?/content/article/77053-1 (accessed 30 December 2021).
41. Adams EK, Dunlop AL, Strahan AE, et al. Prepregnancy insurance and timely prenatal care for Medicaid births: before and after the Affordable Care Act in Ohio. *J Womens Health* 2019; 28(5): 654–664.
42. Eliason EL. Adoption of Medicaid expansion is associated with lower maternal mortality. *Womens Health Issues* 2020; 30(3): 147–152.
43. Chiu A. Diana Sanchez gave birth in Denver jail cell alone, lawsuit says. The Washington Post, 2019, https://www.washingtonpost.com/nation/2019/08/29/pregnant-woman-diana-sanchez-birth-alone-jail-cell-denver/ (accessed 30 December 2021).
44. Daniel R. Prisons neglect pregnant women in their healthcare policies, 2019, https://www.prisonpolicy.org/blog/2019/12/05/pregnancy/ (accessed 30 December 2021).
45. Simon LE, Williams RE, Cohen MJ, et al. Training the next generation of medical providers in the era of mass incarceration. Health Affairs, 2017, https://www.healthaffairs.org/do/10.1377/forefront.20171219.421701/abs/ (accessed 30 December 2021).
46. Simon L and Tobey M. A national survey of medical school curricula on criminal justice and health. *J Correct Health Care* 2019; 25(1): 37–44.
47. Sufrin CB, Autry AM, Harris KL, et al. County jail as a novel site for obstetrics and gynecology resident education. *J Grad Med Educ* 2012; 4(3): 346–350.
48. Venters H. A three-dimensional action plan to raise the quality of care of US correctional health and promote alternatives to incarceration. *Am J Public Health* 2016; 106(4): 613–614.
49. Trestman RL, Ferguson W and Dickert J. Behind bars: the compelling case for academic health centers partnering with correctional facilities. *Acad Med* 2015; 90(1): 16–19.
50. Pelletier SG. Unlikely partners: how academic medicine and correctional facilities can forge progress together. *AAMC*, 2016, https://www.aamc.org/news-insights/unlikely-partners-how-academic-medicine-and-correctional-facilities-can-forge-progress-together (accessed 30 December 2021).
51. Bailey ZD, Krieger N, Agénor M, et al. Structural racism and health inequities in the USA: evidence and interventions. *Lancet* 2017; 389(10077): 1453–1463.
52. Owens DC. *Medical bondage: race, gender, and the origins of American gynecology*. Athens: University of Georgia Press, 2017.
53. Amutah C, Greenidge K, Mante A, et al. Misrepresenting race—the role of medical schools in propagating physician bias. *N Engl J Med* 2021; 384(9): 872–878.
54. Feagin J and Bennefield Z. Systemic racism and U.S. health care. *Soc Sci Med* 2014; 103: 7–14.
55. Washington HA. Medical Apartheid: the dark history of medical experimentation on black Americans from colonial times to the present. Harlem Moon, 2006, https://www.penguinrandomhouse.com/books/185986/medical-apartheid-by-harriet-a-washington/ (accessed 30 December 2021).
56. Giftos J, Mitchell A and MacDonald R. Medicine and mass incarceration: education and advocacy in the New York city jail system. *AMA J Ethics* 2017; 19(9): 913–921.
57. Shlafer RJ, Stang J, Dallaire D, et al. Best practices for nutrition care of pregnant women in prison. *J Correct Health Care* 2017; 23(3): 297–304.
58. Prison Voice Washington. Correcting food policy in Washington prisons: how the DOC makes healthy food choices impossible for incarcerated people & what can be done, 2016, https://static.prisonpolicy.org/scans/Correcting%20Food%20Policy%20in%20WA%20Prisons_Prison%20Voice%20WA.pdf
59. Howland MA, Kotlar B, Davis L, et al. Depressive symptoms among pregnant and postpartum women in prison. *J Midwifery Womens Health* 2021; 66(4): 494–502.

60. Asberg K and Renk K. Substance use coping as a mediator of the relationship between trauma symptoms and substance use consequences among incarcerated females with childhood sexual abuse histories. *Subst Use Misuse* 2012; 47(7): 799–808.
61. DeHart DD. Pathways to prison: impact of victimization in the lives of incarcerated women. *Violence Against Women* 2008; 14(12): 1362–1381.
62. DeHart DD, Lynch SM, Belknap J, et al. Life history models of female offending: the roles of serious mental illness and trauma in women's pathways to jail. *Psychol Women Q* 2014; 38(1): 138–151.
63. Grella CE, Stein JA and Greenwell L. Associations among childhood trauma, adolescent problem behaviors, and adverse adult outcomes in substance-abusing women offenders. *Psychol Addict Behav* 2005; 19(1): 43–53.
64. The American College of Obstetricians and Gynecologists. Optimizing support for breastfeeding as part of obstetric practice, 2018, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/10/optimizing-support-for-breastfeeding-as-part-of-obstetric-practice
65. Eidelman AI, Schanler RJ, Johnston M, et al. Breastfeeding and the use of human milk (policy statement). *Pediatrics* 2012; 129(3): e827–e841.
66. Scariati PD, Grummer-Strawn LM and Fein SB. A longitudinal analysis of infant morbidity and the extent of breastfeeding in the United States. *Pediatrics* 1997; 99(6): E5.
67. Yan J, Liu L, Zhu Y, et al. The association between breastfeeding and childhood obesity: a meta-analysis. *BMC Public Health* 2014; 14(1): 1267.
68. Owen CG, Martin RM, Whincup PH, et al. Does breastfeeding influence risk of type 2 diabetes in later life? A quantitative analysis of published evidence. *Am J Clin Nutr* 2006; 84(5): 1043–1054.
69. Labbok MH. Health sequelae of breastfeeding for the mother. *Clin Perinatol* 1999; 26(2): 491–503.
70. Stuebe AM, Willett WC, Xue F, et al. Lactation and incidence of premenopausal breast cancer: a longitudinal study. *Arch Intern Med* 2009; 169(15): 1364–1371.
71. Hamdan A and Tamim H. The relationship between postpartum depression and breastfeeding. *Int J Psychiatry Med* 2012; 43(3): 243–259.
72. The American College of Obstetricians and Gynecologists. Committee opinion: health care for pregnant and postpartum incarcerated women and adolescent females. *Obstet Gynecol* 2011; 118(511): 1–5.
73. The American College of Obstetricians and Gynecologists. Barriers to breastfeeding: supporting initiation and continuation of breastfeeding, 2021, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/barriers-to-breastfeeding-supporting-initiation-and-continuation-of-breastfeeding (accessed 30 December 2021).
74. National Commission on Correctional Health Care. Breastfeeding in correctional settings, 2018, https://www.ncchc.org/breastfeeding-in-correctional-settings (accessed 30 December 2021).
75. Pendleton VE, Schmitgen EM, Davis L, et al. Caregiving arrangements and caregiver well-being when infants are born to mothers in prison. *J Child Fam Stud*. Epub ahead of print 12 October 2021. DOI: 10.1007/s10826-021-02089-w.