



# The Perinatal Period in U.S. Jails and Prisons

A Look at Health Care & Legal Protections

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Children of  
Incarcerated  
Caregivers

October 2025

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Children of Incarcerated Caregivers (CIC) produced this report in anticipation of our 3rd Annual Global Prison Nursery Network symposium in October 2025, to familiarize our organization and event participants with the existing research on the perinatal period in custody, existing medical guidelines, and laws, policies and practices around the United States. It began as a graduate-student capstone project in partnership with University of Minnesota's Hubert H. Humphrey School of Public Affairs.

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## Summary

Pregnancy in custody is an overlooked public health and human rights issue in the United States. Incarcerated pregnant people are one of the most vulnerable groups in the country. They are high-risk for adverse birth outcomes and require accommodations and regular, specialized health care to ensure their well-being, as well as the health of their fetus or child. However, access to perinatal care in jails and prisons appears to be inconsistent, often inadequate, and, at times, seriously harmful. As female incarceration rates rebound to pre-pandemic levels, more pregnant people will likely be incarcerated in the coming years, resulting in more births in custody and more children with incarcerated parents. This issue demands urgent attention. To promote maternal health equity, reforms are needed to divert pregnant people from incarceration and improve care in custody.

To help inform and inspire action, this report provides a primer on the perinatal period in U.S. jails and prisons. It compiles the latest research, medical guidance, and laws and policies related to incarcerated pregnant people to provide:

- An overview of female incarceration, including the prevalence of pregnancy in jails and prisons, birth outcomes, and overlapping risk factors for pregnant people
- Domestic laws and international norms related to pregnant people in custody
- Analyses of kinds of care and accommodations pregnant people should receive while incarcerated, which includes recommended medical guidance and research examining the reality of care
- Examples of promising policies and practices that provide support and care to pregnant people in local, state, and federal facilities.

## Overview

The perinatal period, spanning from the start of pregnancy to a year postpartum, is a critical time for a pregnant person's physical and mental health. For those in U.S. prisons and jails, perinatal health changes and challenges can be further compounded by the experience of incarceration. Each year, an estimated 58,000 pregnant people enter jails and prisons,<sup>1</sup> and about 2,000 babies are born to incarcerated people annually.<sup>2</sup> They require regular, specialized health care to ensure their well-being, as pregnancies in custody are often considered high-risk.<sup>3</sup> Though the U.S. Constitution guarantees incarcerated people the right to health care,<sup>4</sup> correctional facilities are said to be “ill-equipped” to provide basic reproductive care<sup>5</sup> and “fail to address unique health needs” of women.<sup>6</sup> Perinatal care specifically appears to be inconsistent, often inadequate, and, at times, seriously harmful. Access seems to depend on someone's circumstances, like which type of facility or state they are held in<sup>7</sup> and whether they can afford care.<sup>8</sup> Limited research shows pregnancy outcomes –both maternal and neonatal– for people in custody are mixed; some studies indicate better outcomes, others suggest worse.<sup>9</sup> To improve maternal health, this overlooked issue needs urgent attention.

Medical experts say perinatal care should begin when a pregnancy is positively identified and continue through the year after birth. Both physical and mental health should be provided for, and care should be safe, effective, timely, efficient, equitable and people-centered, according to the World Health Organization (WHO).<sup>10</sup> National medical organizations, including the American College of Obstetricians and Gynecologists (ACOG), have issued guidelines for evidence-based care in correctional settings.<sup>11</sup> Broadly, ACOG recommendations comport with U.S. Supreme Court decisions and international norms, i.e. The Bangkok and Nelson Mandela Rules, in stating that health care, including reproductive care, for incarcerated people should be comparable to what is available in the community. “Ensuring that incarcerated individuals receive respectful, consistent, high-quality reproductive health, pregnancy, and postpartum care is essential for ameliorating inequities and affirming these individuals' dignity,” ACOG states.

However, the “widespread pattern of poor reproductive health outcomes among incarcerated and previously incarcerated women suggests that these standards are not consistently adhered to and simply having published standards is not enough,” one research team asserts. “It is imperative to establish policies and programs that recognize and address the unique reproductive health concerns of incarcerated women and provide gender-responsive, trauma-informed care.”<sup>12</sup>

Some states do have laws on the books regarding aspects of perinatal care,<sup>13</sup> and various correctional facilities have incorporated certain medical guidelines into their laws and policies. Facilities can seek voluntary accreditation from corrections organizations that have adopted some of them.<sup>14</sup> The Federal Bureau of Prisons (BOP) and all state prison systems reported to the federal Bureau of Justice Statistics (BJS) in 2024 that they have the infrastructure to care for pregnant women either from an on-site infirmary or on-call care.<sup>15</sup> Each prison system also reported it provides routine medical appointments to pregnant women in their custody.<sup>16</sup> There is no comparable study of jail facilities.

But more uniformity of health services and protections is needed; great differences in care from state to state, facility to facility creates inequity.<sup>17</sup> And whether care is actually accessible and utilized is

unclear.<sup>18</sup> A 2021 Government Accountability Office (GAO) report found that policies for federal prisons don't always align with national guidance.<sup>19</sup> In a 2019 review of all 50 states' prison health care policies, most failed to meet the most basic standards of care for pregnant women.<sup>20</sup> Health care in jails is particularly poor, as there are typically fewer services.<sup>21</sup> Even when care is available to incarcerated pregnant people, it can be inadequate and even harmful. Numerous lawsuits against corrections systems and staff allege negligence or worse, and practices like forced inductions and shackling still occur in some jurisdictions despite widespread condemnation. News stories also paint a "haunting" and "horrific" reality of care.<sup>22</sup> Some medical organizations consider a lack of comprehensive, quality health care to be a violation of basic human rights.<sup>23</sup> Other experts say the U.S. carceral system violates the core principles of reproductive justice, which assert people have "the right to have children, the right not to have children, and the right to parent with dignity and safety."<sup>24</sup>

Conversely, for some incarcerated people, jail or prison may be the only place where they receive consistent food, shelter, and medical care during pregnancy.<sup>25</sup> This positively benefits some pregnant people's health and emphasizes the barriers to care outside of prison.

Experts say this issue has received limited attention, leaving pregnant, incarcerated people neglected.<sup>26</sup> Incarcerated people in the perinatal period remain a largely invisible population, whose "complex and unique needs are rarely met in prison."<sup>27</sup> As abortion rights are being further restricted across the country<sup>28</sup> and female incarceration rates rebound to pre-pandemic levels,<sup>29</sup> the situation will likely worsen. Women who are entering or in the system will be forced to carry pregnancies they may have otherwise terminated, likely leading to more pregnancies and births in custody. This issue also has intergenerational consequences, as children and their health are impacted and influenced by their parents' incarceration.<sup>30</sup>

Yet, there is promise. Research on the perinatal period is growing, and new programs and policies to divert pregnant people from incarceration and improve perinatal care in correctional facilities have emerged at the local, state, and federal levels. They include community-based sentencing alternatives and doula and lactation support programs.

But far more must be done. Pregnant people should not be incarcerated except in the most extreme circumstances. International human rights instruments express such a preference for alternatives to incarceration, and a few U.S. cities and states have already created diversion programs and sentencing alternatives that offer promising examples. For those who remain in custody, correctional facilities that house pregnant or postpartum individuals must improve perinatal care, and reproductive care generally. "Policies that standardize and regulate carceral health care services according to existing recommended (but currently optional) guidance could improve pregnancy care in carceral settings," wrote expert Dr. Carolyn Sufrin et al.<sup>31</sup> Corrections departments should adopt policies that align with expert medical guidelines,<sup>32</sup> and facilities should ensure their implementation. New federal and state laws are needed to mandate action and establish oversight.<sup>33</sup> Through collaboration rooted in evidence and lived experience, the U.S. can greatly reduce the number of pregnant people in jails and prisons and improve perinatal care for those who remain in custody.

# Chapter 1: Background

## 1.1 Women & Pregnancy in Jails and Prisons

A lack of gender-appropriate health infrastructure in carceral facilities is significant, given that 75 percent of incarcerated women in the U.S. are of childbearing age and require reproductive health care.<sup>34</sup> The United States incarcerates more women than any other country in the world,<sup>35</sup> and women are the fastest growing incarcerated population in the country.<sup>36</sup> In 2024, 190,600 women were incarcerated in jails, state and federal prisons, and other facilities<sup>37</sup> –accounting for 15 percent of the local jail population and 8 to 9 percent of the state prison population.<sup>38</sup>

In 2023, 2 percent of women admitted in nearly all state prison systems and federal prisons had positive pregnancy tests, according to a BJS survey of corrections facilities.<sup>39</sup> On a single day, 328 pregnant women (0.5 percent of all incarcerated women) were housed in these facilities –mostly in state prisons.<sup>40</sup> Additionally, 665 babies were born to women who were incarcerated.<sup>41</sup> The Pregnancy in Prison Statistics (PIPS) project, led by Dr. Carolyn Sufirin, estimated many more pregnancies based on its sampling of 22 state prison systems and the federal BOP from 2016–17; it estimated 3 to 4 percent of women in prison are pregnant (about 3,000 in prisons and 55,000 in jails).<sup>42</sup> It is unclear why the discrepancy between the BJS and PIPS studies exists.<sup>43</sup> Importantly, Sufirin’s research notes significant differences in the number of pregnant women from state to state too.<sup>44</sup> She points to factors like differences in sentencing laws, prison health care policies, general health care access and differences between individual women.

## 1.2 Overlapping Risk Factors

Pregnancy in custody cannot be understood in isolation from the broader context of who is incarcerated and their experiences prior to incarceration. “Structural inequities, including racism, adversely affect the reproductive health outcomes, autonomy, and access to care that people in custody face,” writes one research team.<sup>45</sup> Black and American Indian and Alaska Native people have long been overrepresented in state and federal prisons.<sup>46</sup>

A significant number of incarcerated women are criminalized survivors of gender-based violence whose pathways to prison are shaped by trauma.<sup>47</sup> Women report experiences of physical or sexual abuse, or violence, often at the hands of intimate partners or family members.<sup>48</sup> These histories are frequently ignored or dismissed by courts during sentencing.<sup>49</sup> In some cases, courts judge women not only for their crimes, but for their perceived failure to conform to gender roles such as being a “caring mother” or “loyal wife,” with such perceived moral failings influencing harsher outcomes.<sup>50</sup>

Pregnant women in custody are also more likely to have risk factors like poverty, experiences of domestic violence, mental illness, and substance use than non-incarcerated pregnant people.<sup>51</sup> Prior to prison, many incarcerated women have limited access to health care,<sup>52</sup> and there are few programs for mental health and substance use treatment available inside.<sup>53</sup> This may, in part, be why incarcerated women have high rates of chronic disease; about half have a history of a chronic medical condition.<sup>54</sup> Incarceration can worsen poor health because of stress, violence, communicable diseases, and poor nutrition and environment.<sup>55</sup>

Many incarcerated women enter prison with “significant mental health care needs,” and incarceration can exacerbate or create new issues.<sup>56</sup> Substance use disorder (SUD) is also common among incarcerated pregnant people.<sup>57</sup> Many pregnant people in jails are forced to go through withdrawal rather than provided recommended treatment<sup>58</sup> and sometimes even placed in solitary confinement, which can exacerbate symptoms or create new mental health issues.<sup>59</sup>

These overlapping risk factors predispose pregnant people in prison to having high-risk pregnancies,<sup>67</sup> the effects of which can include preterm labor, low birth weight, stillbirth, maternal mortality, and other adverse outcomes.<sup>68</sup>

### 1.3 Pregnancy & Birth Outcomes

Limited research shows pregnant incarcerated women are at high risk for poor perinatal outcomes,<sup>69</sup> yet it “remains difficult to draw definitive conclusions about the impact of incarceration on birth outcomes.”<sup>70</sup> Two recent studies –one from PIPS project and another from BJS– provide the most comprehensive data on birth outcomes in state and federal prisons to date.<sup>71</sup> They both found most pregnancies that ended in custody resulted in live births.<sup>72</sup> Outcomes in jails were more varied, with higher percentages of abortions and miscarriages than in prisons, according to another survey of a few large jail systems.<sup>73</sup> No maternal deaths were reported in these studies covering the years 2016 to 2017 and 2023, but at least four newborns died.<sup>74</sup>

Smaller, more localized studies provide mixed results about birth outcomes in custody. A study of maternal and infant health outcomes of incarcerated women in an Arkansas prison between 2014 and 2019 found that obstetrical complications were common and NICU admission rates were high, though few babies needed extensive treatment.<sup>75</sup> A 2024 study of pregnant people in California state prisons found women who were incarcerated had significantly higher rates of severe maternal morbidity than nonincarcerated women.<sup>76</sup> Their babies also had significantly higher odds of prematurity and admittance to the NICU and were more likely to be small for gestational size. A much earlier study found that women through age 39 who were incarcerated at some point during their pregnancy had greater likelihood of low birthweight and preterm birth compared to non-incarcerated women on Medicaid.<sup>77</sup> Conversely, a 1997 study of pregnant women in North Carolina who were incarcerated during one of their pregnancies and not in custody for another found that more days spent in custody was associated with higher baby birth weight.<sup>78</sup> The authors noted this may suggest that greater

#### **The Cost of Care**

Though incarcerated people are constitutionally guaranteed health care, it isn’t always free. Corrections departments and the private companies that run carceral facilities provide or facilitate care. Many shift costs onto incarcerated people in the form of medical copayments, or out-of-pocket fees, for health services like doctor’s visits and medication.<sup>60</sup> All federal prisons and 40 states charge “copays,” which typically range from two to five dollars.<sup>61</sup> This is unaffordable for many people in custody. Most incarcerated workers make low wages, and some don’t get paid for their labor; others can’t work.<sup>62</sup> A 2024 report found these copays limit access to care in prisons.<sup>63</sup>

Almost all state prisons have copay exemptions for certain services or populations.<sup>64</sup> Thirteen states have copay waivers for pregnancy-related care; though a review of these policies determined that exemptions are “so limited, ill-defined and inconsistent that they fail to make the copay system fairer and less harmful for incarcerated people.”<sup>65</sup> Some corrections and health care organizations recommend outlawing copays altogether.<sup>66</sup>

access to shelter and regular food, restricting alcohol and drug use, and access to health care could improve outcomes for high risk women. A more recent study of birth outcomes of pregnant women in a Minnesota state prison found no difference in rates of preterm births for incarcerated pregnant women compared to national estimates, as well as cesarean rates consistent with Minnesota’s average rate.<sup>79</sup>

## 1.4 Lack of Data

Accurate and comprehensive data on the perinatal period in carceral settings –from prevalence and birth outcomes to the availability and utilization of health services – is essential to achieve health equity for incarcerated pregnant people.<sup>80</sup> Data can be collected and used to understand health care needs; identify inequities and gaps in care; and improve maternal and infant outcomes by informing intervention programs and policies. Once reforms are implemented, data can provide insight into their efficacy over time, as well as the compliance of corrections agencies and facilities, potentially reducing future instances of abuse and neglect of care.<sup>81</sup>

Despite its importance, there has been a severe lack of data related to pregnancy in custody, especially jails, until recently.<sup>82</sup> Data on the prevalence of pregnancy in custody hadn’t been published by the federal government for more than a decade,<sup>83</sup> and national health surveys don’t inquire about maternal incarceration status when compiling pregnancy-related outcomes.<sup>84</sup> The PIPS study filled that gap in 2018.<sup>85</sup> Since, a few federal agencies –including the BJS and GAO– have provided more information about the number of pregnant women admitted to jails and prisons and how many reported receiving prenatal care,<sup>86</sup> as well as data on pregnancy outcomes and use of restraints.<sup>87</sup> More recently, following a congressional directive,<sup>88</sup> BJS administered a Maternal Health supplement with their annual National Prison Statistics collection for the first time in 2024, releasing their report in April 2025.<sup>89</sup> It surveyed all 50 state departments of corrections and the federal BOP.

While the BJS survey is a much-needed step in the right direction, it still has limitations and illustrates barriers to data collection that need to be addressed. BJS did not request information from respondents on several key indicators typically included in pregnancy outcome metrics for the general population, such as birth setting, outcomes of live births (preterm, c-sections or low birthweight), and neonatal and maternal death.<sup>90</sup> It also provides no mechanism for looking at the quality and sufficiency of the corrections agencies’ pregnancy-related training, care, and services, nor for their actual utilization and enforcement.<sup>91</sup>

BJS cites a lack of standardized reporting across state departments of corrections (DOCs) and individual facilities as a contributing factor for how they structured the supplement, finding that many facilities didn’t have access to key metrics on pregnancy outcomes.<sup>92</sup> In scoping feasibility for the supplement, BJS discovered many facilities store relevant data in electronic medical records, separate from the case management systems that correctional staff have access to, while some DOCs lack control over the transfer of medical records of individuals in their facilities, creating gaps in reporting due to delayed and missing files.<sup>93</sup> Other researchers describe similar challenges.<sup>94</sup>

To better understand the relationships between incarceration and pregnancy, experts detail a variety of data and research needs, including calls to expand pregnancy in prison research beyond the public health lens.<sup>95</sup> This includes calls for data and research on:

- Pregnancy prevalence and pregnancy and birth outcomes in *all* prisons and jails
- The health status of pregnant people in custody

- Racial and ethnic disparities in maternal health
- Root causes of women's justice involvement
- Health services and accommodations provided in carceral facilities and their utilization
- Policies and programs related to pregnancy and childbirth and their utilization
- Community based alternatives to incarceration
- Custody and reunification outcomes of infants born to an incarcerated parent

Researchers suggest providing technical assistance and training to correctional systems to establish or improve data collection on the perinatal period.<sup>96</sup> Another way to increase reporting and data collection is through legislation mandating it, thereby forcing states to address the barriers to data collection they currently face. While certain states require reporting of specific instances involving incarcerated pregnant people, such as the use of restraints or isolated housing, there is no federal oversight requiring any regular reporting metrics around populations and care.<sup>97</sup> There have been a few efforts to create reporting mandates and strengthen oversight through federal legislation in recent years, including the Pregnant Women in Custody Act<sup>98</sup> and the Births in Custody Reporting Act.<sup>99</sup> The former would require BJS to survey and collect detailed information about pregnant people in custody, the provision of pregnancy care and services, facility policies, pregnancy outcomes and more from federal, state and local correctional facilities.<sup>100</sup> The latter would require states to report information about pregnancy care and outcomes to the U.S. Attorney General or risk funding cuts.<sup>101</sup>

## Chapter 2: Relevant Laws

### 2.1 Constitutional Right to Health Care

*Estelle v. Gamble* establishes that incarcerated individuals in the U.S have a constitutional right to adequate medical care, but it does not mandate any specific services and standards, enabling variability in availability and access to care.<sup>102</sup> *Estelle* justifies a cause of action under the Eighth Amendment through 42 U.S.C. § 1983, when a “serious medical need” fails to be addressed due to “deliberate indifference” of that need.<sup>103</sup>

### 2.2 Federal Laws & Regulations

Legislation has been enacted or proposed signaling growing recognition of the critical need to improve healthcare for incarcerated pregnant people. While federal laws only apply to federal prisons and immigration detention facilities—which detain only about 12 percent of incarcerated women in the U.S.<sup>104</sup>—the federal government can and does influence local and state policy through funding incentives. It also operates federal grant programs to support maternal health care in federal, state, and local prisons.<sup>105</sup>

Enacted in 2003, the Prison Rape Elimination Act (PREA) requires correctional facilities to provide access to reproductive health care, including contraception, as part of efforts to prevent and respond to sexual abuse.<sup>106</sup> However, PREA does not establish binding health care standards or mandate uniform compliance across facilities. Implementation varies widely; some jurisdictions interpret “access” narrowly, offering emergency contraception only in the aftermath of assault, while others provide more comprehensive reproductive services.<sup>107</sup> Moreover, PREA’s enforcement mechanisms are indirect. Compliance is tied to federal funding incentives and periodic audits, but the standards themselves are not legally binding for local jails, immigration detention centers, or privately operated facilities that are not under Department of Justice contracts.<sup>108</sup> As a result, reproductive health care access has remained highly inconsistent across the carceral landscape.

In 2018, the First Step Act was created to offer more specific protections by prohibiting the use of restraints on individuals in federal custody who are pregnant, in labor, or in postpartum recovery, except in limited circumstances.<sup>109</sup> Shackling is not banned outright at the federal level. Instead, the use of restraints in correctional settings continues to be evaluated under the deferential “reasonableness” test set forth in *Turner v. Safley*, which permits restrictions so long as they are reasonably related to legitimate penological objectives.<sup>110</sup> This standard allows broad discretion by correctional staff.

Since the First Step Act, a handful of bills have been introduced in Congress to limit other harmful practices such as solitary confinement and improve prenatal and postpartum care. None have been adopted by Congress to date.

- The Dignity for Incarcerated Women Act of 2019 would have required the BOP—which manages federal prisons—to allow pregnant people in custody to participate in residential substance abuse

treatment even if they didn't disclose a substance abuse problem.<sup>111</sup> State versions of the same name have focused on banning shackling and solitary confinement for pregnant people.<sup>112</sup>

- The Justice for Incarcerated Moms Act of 2021 would have provided funding for federal, state and local corrections facilities to establish programs for pregnant and postpartum women; cut funding for states that receive certain federal grants and have yet to prohibit shackling; and commission a study on maternal mortality and morbidity in custody.<sup>113</sup> A team of researchers and practitioners including Sufrin and Dr. Rebecca Shlafer says the bill could be improved by outlining existing health guidelines (see 2.5 Professional Guidelines & Standards) and requiring that all BOP facilities and states that receive certain funding follow the guidance or face cuts, among other amendments.<sup>114</sup>
- The Pregnant Women in Custody Act of 2023 would have required BOP to provide appropriate services and programs for pregnant and birthing people; limit the use of solitary confinement for people who are pregnant or postpartum and prohibit it for women in their third trimester; and report annual data on the number of administrative claims and appeals filed by pregnant people.<sup>115</sup> Other versions of this act have been introduced in the last few years.

In addition to federal law, the BOP Female Offender Manual sets out policies that mandate certain practices in federal facilities.<sup>116</sup> However, these policies lack specific guidance; for example, the requirement of providing prenatal care is expressed simply as: “[t]he Warden shall ensure that each pregnant inmate is provided medical, case management, and counseling services.”<sup>117</sup>

## 2.3 State Laws

States and local jurisdictions overwhelmingly incarcerate the most people, including 84 percent of female prisoners.<sup>118</sup> Many states have passed laws regarding pregnant people in custody; they vary in focus and comprehensiveness.<sup>119</sup> For example, some states, like California, set criteria for perinatal care, creating a standard of care across facilities.<sup>120</sup> At least 40 states restrict shackling and/or isolation (See 4.3), and at least eight states allow new parents more time with their newborns after birth (See 5.4).<sup>121</sup> Only six states require carceral facilities to have lactation policies (See 5.2).<sup>122</sup> A handful of states allow a pregnant person's sentence to be delayed and/or establish community-based alternatives to incarceration (See Appendix B).<sup>123</sup>

However, state laws are only as good as their enforcement power, and to be effective, it is important that lawmakers include mechanisms for compliance. For example, Nebraska's Healthy Pregnancies for Incarcerated Women Act includes a civil cause of action for violations.<sup>124</sup>

States' DOCs may also have perinatal care policies; though these policies offer weaker protection to incarcerated pregnant people and do not apply to local and regional jails, which typically have their own policies. Often, DOC policies do not allow for public accountability or legal recourse if violated, and can be easily altered or eliminated following events such as a change in commissioner or gubernatorial leadership.<sup>125</sup> See examples of laws and policies throughout Chapters 3, 4, and 5.

## 2.4 International Human Rights Standards

International human rights norms recognize the unique needs and vulnerabilities of pregnant women and mothers in detention, as well as the rights of their children. While the United States has not ratified relevant core treaties—the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)—these instruments, along with authoritative United Nations rules and soft law, help set persuasive international benchmarks.

The CRC (a core treaty ratified by every UN member state except the U.S.) emphasizes that in all actions concerning children, including those undertaken by courts or administrative authorities, “the best interests of the child shall be a primary consideration.”<sup>126</sup> This principle has direct implications for policies regarding childbirth, separation of an infant from an incarcerated parent, conditions of confinement when children remain in prison with a parent, visitation, and communication between the incarcerated parent and a child.<sup>127</sup> Similarly, CEDAW obliges states to ensure access to appropriate services for those confined during pregnancy and postpartum.<sup>128</sup>

While non-binding, the Mandela and Bangkok Rules also speak to standards of treatment and are widely recognized as an authoritative articulation of international standards. The UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) affirm the need for “special accommodation for all pregnant women in prison, including prenatal and postnatal care and treatment.”<sup>129</sup> The UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) provide specific guidance on how states should treat incarcerated women. Rule 64 states that “non-custodial sentences for pregnant women and women with dependent children shall be preferred where possible and appropriate,” and where imprisonment is unavoidable, governments must ensure that the “best interests of the child” are taken into account.<sup>130</sup> The Bangkok Rules also recognize the importance of maintaining family ties: Rule 26 affirms that “contact between women prisoners and their children shall be encouraged and facilitated by all reasonable means.”<sup>131</sup>

Together, these international standards underscore a clear expectation: governments must avoid the incarceration of pregnant women and mothers of dependent children wherever possible, and when detention is necessary, they must ensure humane treatment, continuity of care, and preservation of the mother-child relationship.

## 2.5 Professional Guidelines

Medical and academic experts have developed guidelines for perinatal care in correctional settings. Leading organizations like ACOG<sup>132</sup> and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) have issued comprehensive recommendations covering pregnancy through the postpartum period.<sup>133</sup> They are not mandated by the federal government and are only required by some states, such as California, which mandates that its county jails and state prisons follow certain ACOG standards.<sup>134</sup> In other states, they may be incorporated into internal corrections policies.

Other corrections-focused organizations, such as the National Commission on Correctional Health Care (NCCHC),<sup>135</sup> have also developed health care standards, including some specific to the perinatal period.<sup>136</sup> Public and private correctional facilities, including county jails, prisons and immigration

detention centers, can seek voluntary accreditation from these agencies. Some of the standards are mandatory for their accredited facilities, while others are optional. According to the NCCHC, accreditation offers several benefits, including public recognition for standards-based care, greater efficiency, reduced costs, and a lower risk of “adverse events” and litigation.<sup>137</sup>

To ensure consistent and equitable care, experts recommend instituting uniform standards for correctional facilities based on these guidelines, along with oversight mechanisms to monitor compliance.<sup>138</sup>

## Chapter 3: Reproductive & Prenatal Health Care

The prenatal stage covers pregnancy up to birth. Quality care during this time can help ensure the health and well-being of pregnant people and their fetuses. Reproductive and prenatal health care should include pregnancy testing, health screenings, proper nutrition, and treatment for sexually transmitted diseases and opioid use disorders, among other care.

### 3.1 Pregnancy Tests

Pregnancy tests, with urine or blood, are the standard method for determining whether a person is pregnant. Despite clear guidelines, jails and prisons across the U.S. do not consistently follow them. “Pregnancy testing is not routine in correctional settings,” notes one group of researchers.<sup>139</sup> In the BJS survey of all 50 state corrections departments and the federal BOP, all but one reported having pregnancy testing at intake.<sup>140</sup> The departments reported that most women (88 percent) who entered their facilities were tested for pregnancy. A 2017 survey of 53 U.S. jails revealed far lower compliance in regional facilities: only 38 percent of facilities reported performing pregnancy tests on all women upon entry and 45 percent relied on women to self report.<sup>141</sup>

ACOG recommends that every person of childbearing age be assessed for pregnancy and offered testing.<sup>142</sup> AWHONN says that incarcerated women should have access to pregnancy testing, counseling and, if requested, a referral for abortion or adoption services.<sup>143</sup> The NCCHC recommends that all women under age 50 be offered a urine test within 48 hours of entering a correctional facility.<sup>144</sup> Dr. Carolyn Sufrin also advises that individuals who report unprotected sex in the month before incarceration receive a follow-up test after two weeks.<sup>145</sup> At the federal level, BOP instructs medical staff at federal prisons to screen for pregnancy during intake and physicals.<sup>146</sup> California recently mandated such policies. Its county jails must offer voluntary pregnancy tests within 72 hours of entry and by request at any time, and state prisons must offer it during intake and by request.<sup>147</sup>

Failure to identify a pregnancy early delays prenatal care and the detection of health risks.<sup>148</sup> It also postpones access to critical information, such as which foods, medications and behaviors may be harmful.

### 3.2 Prenatal Care & Appointments

Many jails and prisons report offering prenatal care, but the extent to which it is accessible or utilized is unclear. In a 2017 survey of 53 jail facilities, all reported having onsite medical care, and the majority did not charge for OB-GYN medical services.<sup>149</sup> The BJS survey of all 50 state corrections departments and the federal BOP found that 83 percent of these agencies (45) train staff to care for pregnant people. All agencies reported that they have the infrastructure to care for pregnant people via an on-site infirmary and/or on-call care and that they provide medical appointments routinely throughout pregnancy.<sup>150</sup> Nearly all (96 percent) reported that they provide medical appointments within two weeks of a positive pregnancy test. However, the report did not assess whether these services are actually utilized nor their quality.<sup>151</sup> In some prisons, additional trips to the infirmary between scheduled prenatal appointments are only permitted at the discretion of corrections staff, potentially delaying care.<sup>152</sup> In the federal prison system, BOP gives wardens the responsibility to ensure pregnant inmates receive medical care, case management, and counseling, potentially creating variability and inconsistency between facilities.<sup>153</sup>

ACOG recommends that incarcerated people have readily available, regularly scheduled obstetric care, beginning in early pregnancy and aligned with ACOG’s clinical guidelines.<sup>154</sup> Similarly, AWHONN supports “comprehensive, high quality” perinatal care for pregnant people in custody, including regular visits with clinicians trained in obstetrics.<sup>155</sup> For facilities accredited by NCCHC, prenatal care should include medical examinations, lab and diagnostic testing, counseling and vaccinations in accordance with national guidelines.<sup>156</sup> International standards also affirm the right of incarcerated individuals to receive prenatal care. The Bangkok Rules and Mandela Rules assert that women in prisons must receive all necessary care, including prenatal care, which should be equivalent to what is available in the community.<sup>157</sup>

Consistent, high-quality prenatal care promotes the health and well-being of both pregnant people and their fetuses. It can reduce the risk of complications and increase the likelihood of a healthy pregnancy and positive birth outcomes.<sup>158</sup> Standard prenatal care includes physical exams, weight monitoring, blood tests, ultrasounds, and health screenings. Prenatal visits also provide opportunities for providers to share important health information and answer questions about pregnancy and birth. Some corrections officials say transporting pregnant individuals to and from appointments can be hindered by staffing shortages and coordination difficulties.<sup>159</sup>

### 3.3 Nutrition, Exercise & Other Basic Needs

Proper nutrition is essential for a healthy pregnancy. Deficiencies can increase risks for poor outcomes like low birth weight, neural tube defects and impaired brain development.<sup>161</sup> Nutrition is recognized as a key social determinant of health that may have long-lasting effects across generations.<sup>162</sup> Exercise also has many health benefits during pregnancy. It can help reduce discomfort and treat prenatal health conditions like gestational diabetes.<sup>163</sup>

The **Alabama Prison Birth Project** serves a weekly meal to its pregnant clients in Julia Tutwiler Prison for Women, including vegetables, fruit, proteins and more.<sup>160</sup>

Nutrition policies vary across state prisons and local jails. No federal statutes require prenatal nutrition for incarcerated, pregnant people.<sup>164</sup> In federal prisons, medical staff can authorize additional food for pregnant women.<sup>165</sup> Medical staff in state prisons typically oversee the nutritional value of meals and special diets for pregnant people.<sup>166</sup> As of March 2024, only 16 states had statutes regarding nutrition for incarcerated pregnant people. None include a requirement to meet national recommendations for proper nutrition for pregnant people, most are vague, and all lack a mechanism for enforcement.<sup>167</sup> Many facilities do provide “pregnancy snack packs” to pregnant inmates, but there has been no systematic assessment of their nutritional content and whether they are sufficient to meet the dietary needs of pregnancy.<sup>168</sup> In a 2017 survey of 53 jail facilities, 25 reported offering healthier food options to pregnant women and 50 reportedly offered prenatal vitamins.<sup>169</sup>

International standards promote proper nutrition and exercise. The Bangkok Rules declares pregnant and breastfeeding women should receive advice on their health and diet from a “qualified health practitioner,” as well as adequate, timely food, healthy environment and the opportunity for exercise, free of charge.<sup>170</sup>

Medical organizations and health experts have issued detailed guidance about nutrition for incarcerated pregnant people. ACOG and AWHONN recommend that pregnant people in custody receive adequate nutrition.<sup>171</sup> ACOG specifically advises that diets should include folic acid, calcium and other important nutrients, and recommends providing snacks between meals.<sup>172</sup> A team of health experts, including Dr. Rebecca Shlafer, concur, recommending that facilities provide incarcerated pregnant people with meals that adhere to nutrition guidelines issued by respected experts, as well as daily prenatal vitamins, additional food, regular access to water, and education and information on healthy diets.<sup>173</sup>

ACOG also says it is important that pregnant people have ample opportunity for moderate exercise, and they should not be required to stand or participate in strenuous activity.<sup>174</sup> AWHONN agrees women should be able to exercise in custody.<sup>175</sup>

### 3.4 STI Testing

Sexually transmitted infections (STIs) are becoming increasingly common in the U.S.,<sup>176</sup> with the exception of HIV, which has steadily declined year over year.<sup>177</sup> People in custody are disproportionately affected by STIs, with greater prevalence of chlamydia, gonorrhea, syphilis, HIV, trichomonas vaginalis, and viral hepatitis than nonincarcerated people.<sup>178</sup> Incarcerated women specifically have higher rates of certain infections compared to incarcerated men and nonincarcerated women.<sup>179</sup> Infections typically occur prior to incarceration.<sup>180</sup>

Like other care policies, testing and treatment vary greatly across jails and prisons.<sup>181</sup> Some corrections agencies mandate testing if there is concern for transmission; others either provide tests upon request or after a medical evaluation, or they offer everyone a test and they can decline. When testing does occur, it is typically done at intake, and sometimes before release to the community. The BOP has issued comprehensive clinical guidance for federal facilities that include preventive care and screenings for various STIs.<sup>182</sup> Its facilities only offer testing by request or if there is a potential exposure incident.<sup>183</sup> Tennessee, in 2020, required regular prenatal care that includes STI and HIV testing.<sup>184</sup> Alabama requires STI testing at intake for all people detained in city and county jails or state correctional facilities for 30 or more days, as well as an examination for STIs prior to release for anyone imprisoned for more than 90 days.<sup>185</sup> The facility should provide treatment if the person is not able to pay. Regarding treatment, at the local level, a 2022 study of Midwest jails found that only 23 percent of the nearly 200 surveyed facilities offered STI treatment.<sup>186</sup> A 2020 study in Los Angeles County Jail showed low treatment rates too; 56 percent of 151 women diagnosed with gonorrhea and chlamydia were treated.<sup>187</sup> The rest were released before their results were available.<sup>188</sup>

Both international law and medical organizations promote prevention and care. The Bangkok Rules prescribe that women in custody receive comprehensive health screenings and should receive education and information about preventive healthcare measures, including about HIV and other sexually transmitted diseases.<sup>189</sup> The Center of Disease Control and Prevention (CDC) and ACOG emphasize the importance of routine STI testing in correctional facilities.<sup>190</sup> They specifically recommend testing for chlamydia, gonorrhea, trichomonas, syphilis, viral hepatitis, cervical cancer, and HIV.

The consequences of untreated STIs during pregnancy can be severe and harm maternal and fetal health. Infections like gonorrhea, syphilis, and chlamydia can cause premature labor and infection of the

uterus.<sup>191</sup> Some STIs, including HIV, syphilis, and genital herpes can be passed from mother to baby too.<sup>192</sup> If a fetus or newborn contracts an STI during pregnancy or birth, it can have a variety of harmful effects, like low birth weight, infections, brain damage, deafness, or even death.<sup>193</sup>

### 3.5 Access to Abortion

Following the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization* in 2022, abortion access has been totally banned or restricted in most states.<sup>194</sup> These laws disproportionately impact incarcerated people, creating “formidable, if not insurmountable barriers to accessing care.”<sup>195</sup> Nine of the 10 states with the highest rates of incarcerated women have highly restrictive abortion laws, some of which provide no exceptions for rape, forcing survivors in carceral settings to carry their pregnancies to term.<sup>196</sup> Even where abortion remains legal, facilities frequently enforce stricter internal rules like earlier gestational cutoffs, additional approvals, or mandatory waiting periods, and staff have reportedly imposed anti-abortion beliefs, coerced women to continue their pregnancies and pressured them to consider adoption.<sup>197</sup> Corrections officials and staff sometimes deny or deliberately delay or deter care, including providing misinformation.<sup>198</sup> The cost of abortion also creates a financial burden, as only some facilities cover the cost.<sup>199</sup> Further, in one study of pregnant women’s experiences in custody, the nature and circumstances of incarceration “shaped [their] abilities to...consider whether [abortion] is even an option, make decisions, and think critically about pregnancy.”<sup>200</sup> These barriers are reflected in the abortion rate among incarcerated pregnant people: around 4 percent, compared to roughly 18 percent in the general population.<sup>201</sup>

Some states have responded by codifying abortion protections into law. In 2019, Illinois enacted a statutory protection for abortion as a fundamental right, which includes people in custody; the state Supreme Court recognized the right under its constitution too.<sup>202</sup> In 2023, Illinois went a step farther. Its governor ordered the state Department of Corrections to make abortion care free for incarcerated people and reimburse those who previously paid for them.<sup>203</sup> Prior to *Roe*, only four states had laws on abortion for incarcerated people, including California, Maryland, Missouri and New Jersey.<sup>204</sup> In federal prisons, the Female Offender Manual states pregnant people decide whether they want to have an abortion. They should receive counseling to inform their decision, and health officials should arrange for the procedure.<sup>205</sup> The BOP pays for the procedure if the person’s life is in danger or the pregnancy is the result of rape or incest.<sup>206</sup> Corrections departments and facilities at the state and local levels may have internal policies regarding abortion too; although a few studies have found that jails in more than a dozen states lack written policies on abortion or have “vague” or “confusing” guidelines.<sup>207</sup>

U.S. Courts and international and national organizations have addressed the issue. Applying *Estelle v. Gamble*, the Third Circuit in *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro* stated that forced pregnancy inflicts medical and psychological harm, and categorically denying elective abortion absent a legitimate penological purpose can constitute deliberate indifference.<sup>208</sup> Other circuits have held that elective abortion is not per se a “serious medical need,” but acknowledge that case-specific circumstances can make it so.<sup>209</sup> Medical experts and organizations like the World Health Organization deem abortion care an essential health service.<sup>210</sup> WHO emphasizes that inadequate access to abortion forces people toward unsafe options or unwanted pregnancy, potentially causing severe health risks.<sup>211</sup> Additionally, ACOG recommends that carceral facilities provide abortions services, and AWOHNN says they should

provide referrals for abortion by request.<sup>212</sup> Sufrin also recommends that facilities provide referrals and clinical care that includes abortions.<sup>213</sup>

It is the position of WHO that a lack of “affordable, timely and respectful” abortion access poses substantial risks to an individual’s physical and mental health.<sup>214</sup> Risks from carrying a pregnancy to term are heightened for incarcerated individuals, as they may face higher rates of pregnancy-related complications and often inadequate prenatal care.<sup>215</sup>

## Chapter 4: Labor & Delivery

Giving birth comes with a variety of risks to both the birthing person and baby. Incarcerated people are typically transported to a hospital in the community to give birth. Speedy access to care is needed to reduce the risks of complications or worse outcomes. But incarcerated people must rely on corrections staff to access care. Birthing people face different restrictions that impact their birthing experience, including this “gatekeeping” of care by staff, shackling, the presence of prison staff, and limitations on support people.

### 4.1 Corrections Response to Labor & Delivery

Most incarcerated women give birth in hospitals. In a nongeneralizable sample of nine prisons and nine jails, all 18 facilities reported that pregnant women deliver at local hospitals.<sup>216</sup> As of 2019, 26 states had codified pre-existing arrangements for deliveries.<sup>217</sup> In the BJS survey of departments of corrections in all 50 states and the federal BOP, all jurisdictions reported they have a transportation plan in the event of a pregnancy emergency or labor.<sup>218</sup> Corrections staff act as “gatekeepers” to this care, tasked with assessing pregnant people for labor symptoms and deciding when to contact medical personnel.<sup>219</sup> Personal testimonies, news reports and numerous lawsuits against corrections agencies and staff highlight cases in which pregnant people in custody have faced substantial delays before receiving emergency care and experienced disrespect, neglect, and trauma during labor and delivery (See Box). Incarcerated women have reported that medical providers performed c-sections in Georgia<sup>220</sup> and inductions in Arizona without informed consent.<sup>221</sup>

International norms encourage birth in hospitals outside of prisons.<sup>222</sup> ACOG asserts that delivery must occur in a licensed hospital with facilities for high-risk pregnancies when available.<sup>223</sup> It says correctional officers do not need to be present in the hospital room during labor and delivery, with exceptions for safety. AWHONN says incarcerated women “should be safely transported to a licensed hospital for birth,” and opposes “nonmedically indicated inductions of labor or cesarean birth for incarcerated women for the convenience of health care providers or correctional staff.”<sup>224</sup> Dr. Carolyn Sufrin says that women showing signs or symptoms of labor should be quickly evaluated by a qualified health care professional, which may require transportation to an off-site provider.<sup>225</sup> Any facility that houses pregnant people should have an emergency delivery kit on-site and should train staff to use it, she recommends.

Delays in care can lead to complications or obstetric emergencies that can cause injury or even fetal or maternal death. While scheduling inductions and c-sections, with informed consent, may prevent emergencies, they can carry health risks for newborns and mothers, including infections, uterine rupture and bleeding.<sup>226</sup>

### **Incidents of Birth Trauma & Obstetric Violence in U.S. Jails and Prisons**

- A woman in an Alabama jail in 2021 gave birth unassisted in the shower; she was not taken to the hospital after her water broke and suffered “excruciating pain...and a life-threatening placental abruption.”<sup>227</sup> A lawsuit against the county, jail officials, medical contractors and employees was settled in 2025.
- A woman held in a Virginia county jail in 2021 sued the facility after she gave birth alone in an isolation cell.<sup>228</sup> She and the newborn were found in a pool of blood and taken to a hospital where the child was pronounced dead.
- A woman who was six-months pregnant went into labor in a New York jail in 2016.<sup>229</sup> She asked staff for help for two hours before being transported to the hospital. Officers stopped at Starbucks on the way, and her fetus ultimately died. The woman was awarded nearly \$500,000.

## 4.2 Doula & Support People

Pregnant people, especially those from marginalized groups or with higher risk for poor outcomes, can benefit from labor and birthing support, including better health outcomes and a more positive birth experience.<sup>230</sup> But many incarcerated women in the U.S. give birth alone, accompanied only by medical staff, or, in some cases, a corrections officer.<sup>231</sup> In a growing number of places, doulas provide a range of physical, emotional and educational support before, during, and after childbirth.<sup>232</sup> Doulas typically work outside of corrections and are granted access to jails, prisons, and the facilities where people give birth. At the federal level, the BOP established a doula training program for women in federal custody.<sup>233</sup> Only California, Colorado, New York, Minnesota, Oklahoma and Washington, by law, allow a person in custody to have a support person and/or doula during childbirth, as of November 2022.<sup>234</sup> In the BJS study of all 50 state correctional departments and the BOP, 35 percent reported they permit or provide doulas.<sup>235</sup> In a 2017 study of 53 jail facilities, very few allowed the baby’s father, a family member, or other support person at the birth.<sup>236</sup>

WHO recommends that pregnant people have a companion of their choice during labor and childbirth.<sup>237</sup> ACOG and Dr. Carolyn Sufrin note potential benefits of doula support for incarcerated individuals, highlighting its emotional benefits and improved obstetric outcomes.<sup>238</sup>

Limited studies show doula support has a positive impact on incarcerated women’s birth experiences and certain outcomes. Women in a Minnesota doula program reported “very high” satisfaction and “significantly fewer depressive symptoms [and] more confidence as parents.”<sup>239</sup> Women in a doula program at Cook County Jail in Chicago had lower rates of epidurals and c-sections than women delivering at the county hospital.<sup>240</sup>

To promote better birth experiences and health outcomes, some organizations offer one-on-one support and other enhanced perinatal support.

- *Alabama Prison Birth Project*

- *Baltimore Doula Project (MD)*
- *Doula Program at Rikers Island (NY)*
- *Giving Austin Labor Supports (TX)*
- *Michigan Prison Doula Initiative*
- *Minnesota Prison Doula Project*
- *Oregon Prison Birth Project*
- *Texas Jail Project*
- *Virginia Prison Birth Project*
- *Wisconsin Prison Birth Project*

<p>The <b>Minnesota Prison Doula Project</b> provides pregnancy and birth support to incarcerated people in Minnesota’s only state women’s prison and county correctional facilities. It offers doula care, counseling and group education to “to nurture healthy relationships and increase parenting confidence and skills.”<sup>241</sup></p>	<p>The <b>Helping Promote Birth Equity Through Community-Based Doula Care Program (HOPE)</b> offers free doula care to people in New York City. It recently expanded to offer care to those who are incarcerated. HOPE doulas provide support from the beginning of pregnancy to one year postpartum.<sup>242</sup></p>
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### 4.3 Shackling & the Use of Restraints

Shackling pregnant incarcerated people has become highly controversial in recent decades. It faces wide opposition domestically and around the globe. In the U.S., the First Step Act of 2018 restricts shackling in federal custody,<sup>243</sup> and 41 states restrict its use during labor and delivery.<sup>244</sup> Fifteen of those states restrict them from pregnancy through postpartum recovery. Yet shackling is still frequently used on pregnant people. Most laws have exceptions, and some protections only apply during labor and delivery while others cover the entire perinatal period. Nine states have no anti-shackling laws: Alaska, Iowa, Kansas, Michigan, Montana, North Dakota, South Dakota, Wisconsin, and Wyoming.<sup>245</sup> A 2017 study of 53 jail facilities around the U.S. found about 57 percent of facilities use restraints on women hours after childbirth.<sup>246</sup> Further, a 2019 study of more than 550 perinatal nurses, most (about 83 percent) reported shackles were used on their incarcerated patients sometimes to all of the time.<sup>247</sup>

International standards—the Bangkok Rules—declare restraints should never be used on women during labor, during childbirth, or immediately after.<sup>248</sup> ACOG guidelines go further, strongly advising against shackling throughout the entire perinatal period, except in exceptional circumstances and only using the least restrictive methods.<sup>249</sup> Restraints should never interfere with leg movements or restrict hands behind the back, prevent pregnant individuals from breaking a fall or lying on their side, or apply pressure to the abdomen, ACOG says. It asserts they should never be used during evaluation for labor or labor and delivery. AWHONN also opposes shackling for women who are pregnant or up to eight weeks postpartum.<sup>250</sup>

Shackling can pose a threat to those who are pregnant and/or giving birth.<sup>251</sup> There is increased risk of falling, coupled with a decreased opportunity to catch themselves in the event of a fall.<sup>252</sup> During tests and examinations, it can interfere with results and delay diagnosis of dangerous complications.<sup>253</sup> It also

interferes with labor and delivery, parent-baby bonding, and breastfeeding.<sup>254</sup> Women who have been shackled during birth report severe mental distress, depression and trauma.<sup>255</sup>

### **Other Care Programs & Policies for Incarcerated Pregnant People<sup>256</sup>**

- In Ohio, the Child Development Council of Franklin County, Inc. partnered with the local corrections center to provide case management to pregnant women in custody. Each week, a family service worker meets with the women to provide parenting education on topics like fetal development, maternal mental health, breastfeeding and more. They also share resources about housing and employment, as well as custody. The Council helps mothers find care for their child, either through kinship or foster care, and enrolls infants in Early Head Start.
- Central Missouri Community Action partners with a local prison to provide weekly visits, depression and nutritional screenings, and child and maternal health resources.
- In Arizona, the South Phoenix Healthy Start Initiative employs doulas and case managers to provide support to parents in jail, including pregnant women. They help coordinate care and provide health education and information about local resources.
- Fresno County funds a public health nurse and behavioral health workers to provide weekly pregnancy health education and substance use assessments at a local jail, as well as service referrals for post-release.

## Chapter 5: Postpartum Period

Typically defined as the six to eight weeks following birth, the postpartum period presents many physical and mental health challenges, during which comprehensive care is critical to the continued health of both mothers and infants.<sup>257</sup> Additionally, a child's lifetime is directly impacted by their experiences and their mother's experiences immediately following their birth. The bond between mother and infant are important parts of early development that can have lasting effects on a child's health as they grow. Ensuring the pair's early needs are met can be difficult in carceral settings because of the nature of incarceration itself.

### 5.1 Follow-Up Care

Across sources of policy and medical guidance, there is consensus on providing robust postpartum care. International legal standards provide that “the medical and nutritional needs of women prisoners who have recently given birth, but whose babies are not with them in prison, shall be included in treatment programmes,”<sup>258</sup> and that women's prisons must offer “special accommodation” for all postnatal care and treatment.<sup>259</sup> ACOG guidance stresses that postpartum care should begin immediately upon return from the hospital with early and frequent visits.<sup>260</sup> Medical experts concur that women returning to custody after childbirth must receive appropriate accommodations, like food and rest.<sup>261</sup>

### 5.2 Lactation, Breastfeeding, & Pumping Access

Incarcerated people experience many barriers to nursing after giving birth, causing mothers and infants to miss out on its health benefits. Lactation support –including educational information, supplies, counseling and more– is lacking across U.S. jails and prisons, leading to few women actually breastfeeding.<sup>262</sup> Only six states have laws requiring lactation or breastfeeding policies in carceral settings as of 2024.<sup>263</sup> The clearest barrier to nursing is when the child is separated from the incarcerated mother shortly after birth (see Section 5.4). In the select facilities where women are allowed to pump milk to send to their baby, the logistics of milk storage and delivery also create barriers to feeding.<sup>264</sup>

International legal standards say incarcerated women should not be discouraged from breastfeeding and accommodations should be made for those who do.<sup>265</sup> Medical experts promote breastfeeding too. ACOG “strongly supports breastfeeding” and calls it the preferred method of feeding for newborns and infants.<sup>266</sup> It asserts that incarcerated people who wish to breastfeed their child directly should be allowed to do so “when possible.” If not, they should be able to pump and express milk to be delivered to their child. Thus, ACOG recommends that carceral institutions should provide private spaces to pump, safe storage for expressed milk, and transportation of the milk to infants' caregivers. They should also educate women about lactation and ensure adequate nutrition for those who are breastfeeding, it concludes. AWHONN and NCCHC similarly support breastfeeding access and support.<sup>267</sup>

Breast milk and breastfeeding are greatly beneficial to both nursing parents and babies.<sup>268</sup> For the parent, breastfeeding helps with postpartum blood loss and reduces risks for postpartum depression, hypertension, Type 2 diabetes, rheumatoid arthritis, and breast, ovarian and thyroid cancers.<sup>269</sup> Breastmilk promotes infant development and brain and immune system growth.<sup>270</sup> Babies who were breastfed are less likely to experience sudden infant death syndrome (SIDS); have significantly lower rates of infections;

and have asthma, obesity, celiac disease, diabetes and other health conditions in infancy and later years in life.<sup>271</sup> Moreover, breastmilk and breastfeeding improves the mental health of babies.<sup>272</sup> Breastfeeding produces oxytocin, known as the “bonding hormone,” in both the mother and baby.<sup>273</sup> It influences the baby’s attachment to their maternal caregiver and stress levels and improves both the mother and child’s emotional well-being.<sup>274</sup>

Promising practices demonstrate feasibility and positive outcomes:

- In Oregon, Northwest Mothers Milk Bank’s Expression of Care program provides lactation support, provides supplies, and offers milk delivery for women enrolled in Coffee Creek Correctional Institution’s breastfeeding program.<sup>275</sup>
- The Alabama Prison Birth Project helped design a lactation room in Tutwiler Prison and supplies pumping equipment for moms separated from their babies.<sup>276</sup> The Birth Project picks up frozen milk and ships it to caregivers each week.<sup>277</sup>
- The Michigan Breastfeeding Network created a template policy for correctional facilities to provide lactation accommodation and support to incarcerated people, as well as a template letter to request judges consider someone’s breastfeeding needs during sentencing.<sup>278</sup>
- Lowell Correctional Institution in Florida offers a lactation program for prenatal and postpartum women.<sup>279</sup> It provides information about the benefits of pumping and equipment, like pumps, nursing pads and storage bags. The babies’ caregivers can pick up the milk at scheduled times. Women who participate live in specialized housing for up to a year after birth. The dormitory has private space for lactation and a kitchenette for cleaning pump parts.
- The Denver Sheriff’s Department in Colorado implemented a policy to support lactation for those detained in its city and county jails.<sup>280</sup> The department provides educational materials, breast pumps and supplies, and dedicated lactation space. It also freezes and stores the milk for three days for the children’s other caregiver to pick up.

The **Virginia Prison Birth Project** provides lactation support to incarcerated people at a state prison and county jail. Prior to birth, Birth Project doula offer prenatal education about nursing. Then, the doula visit the hospital to support new parents with latching and pumping before the person returns to prison. It ships and drives pumped milk to babies’ caregivers too.

Because lactation policies are often “inadequate,” its Founder and Program Director Sara Zia said, the doula often help the program participants wean and transition away from breastfeeding. “We have to have our [obstetrician] write a prescription to the kitchen to bring cabbage leaves into the infirmary, [so we can] use those cold cabbage leaves to help release the interstitial fluids and dry up their supply. We [also] give them some guidance on how to slow [milk production] down and eventually let it go, and then how to identify a clogged duct.”<sup>281</sup>

### 5.3 Postpartum Depression

After women give birth, they can experience postpartum depression (PPD). PPD can occur up to one year after birth—though it commonly starts about one to three weeks after—and can present “intense feelings of sadness, anxiety or despair.”<sup>282</sup> Experts predict that PPD is likely higher among incarcerated women than those in the community as they have various risk factors.<sup>283</sup> People are especially vulnerable during this postpartum period because of physical and emotional changes,<sup>284</sup> and experiences specific to incarceration and separation from their children can further exacerbate this.<sup>285</sup> PPD is treated with the support of medical professionals, and treatments may include antidepressants and/or therapy.<sup>286</sup>

Almost all 50 state departments of corrections and the federal BOP report providing depression screening during pregnancy and again postpartum.<sup>287</sup> Four state prison systems do not (Alabama, Iowa, Massachusetts, and Washington). It is unclear what is offered in jails across the country.<sup>288</sup>

International legal norms advise prison staff “to be sensitive” to women in the post-natal period and “ensure that the women are provided appropriate support.”<sup>289</sup> Medical experts address PPD explicitly. ACOG recommends universal screening for PPD after delivery, with timely access to treatment.<sup>290</sup> Dr. Sufrin recommends that correctional health care providers keep a close eye out for signs and symptoms of PPD and screen at least twice after delivery, around two weeks and six weeks.<sup>291</sup>

PPD directly undermines the health and well-being of mothers, contributing to extreme, persistent sadness, anxiety, fatigue and other symptoms that may impair daily functioning.<sup>292</sup> These symptoms are compounded in carceral settings, where women often lack support networks and adequate access to care.<sup>293</sup> Untreated PPD increases the risk of persistent depressive disorders and anxiety later in life.<sup>294</sup> Additionally, there is “substantial” evidence of the adverse effects of maternal depression on children from birth onward.<sup>295</sup>

### 5.4 Separation of Mother & Baby

When an incarcerated person gives birth to a child, separation typically occurs within 24 hours after delivery.<sup>296</sup> Only eight U.S. states legally guarantee incarcerated mothers at least 72 hours with their babies: Arizona, California, Kentucky, Massachusetts, Michigan, Mississippi, North Carolina, Texas, and Virginia.<sup>297</sup> Reliable national data on post-birth placements is scarce. It’s unknown where many babies go after separation.<sup>298</sup> The rest are usually placed in the care of relatives, typically grandparents. Some go to people who aren’t officially foster parents, and few go into the child welfare system.<sup>299</sup>

ACOG advises that maximum time for parent-infant bonding be afforded after birth, cautioning against expedited discharges for the convenience of the carceral facility.<sup>300</sup> ACOG and AWOHNN further recommend policies that promote continued contact, such as contact visits and coordination with caregivers to facilitate transport and breastfeeding.<sup>301</sup> International norms endorse alternatives to incarceration to avoid mother-baby separation altogether, and medical experts recognize the many benefits alternatives can provide.

This guidance is in response to the profound impacts of separation on both the birthing parent and baby. Separation after birth is the “most significant and devastating” mental health concern for incarcerated

pregnant women.<sup>302</sup> Mothers describe feeling “empty” and missing a piece of themselves<sup>303</sup> or experiencing “uncertainty, loss, and disenfranchised grief”—feelings that can contribute to depression, self-harm, or suicide.<sup>304</sup> Broader research shows that early mother-baby bonding has myriad benefits for babies, including sleep, hormone, temperature and breathing regulation, and is critical for physical and emotional development.<sup>305</sup> Inadequate bonding can have long-term consequences for the child, including secure attachment.<sup>306</sup> One study on babies who were separated from their incarcerated mothers shows they exhibited more anxious and depressive behaviors in their preschool years than children who lived in mother-baby units in prisons.<sup>307</sup>

Further, some mothers may never reunite with their infant following their incarceration, as they are at risk of experiencing a termination of parental rights (TPR). Under the federal Adoption and Safe Families Act (ASFA), states must generally file for TPR when a child has been in foster care for 15 of the last 22 months, unless “reasonable efforts” are made to reunify.<sup>308</sup> From 2006 to 2016, an estimated 32,000 parents who are incarcerated had their rights terminated; 5,000 parents lost their parental rights only because they were incarcerated.<sup>309</sup> Incarceration for any felony that results in the person’s child being in foster care is considered sufficient grounds for TPR in 26 states.<sup>310</sup> With the average sentence for incarcerated mothers at about 18 months, many risk losing their parental rights before reunification is possible.<sup>311</sup> Even those with shorter sentences may lose rights if they can’t complete a required case plan, which usually includes attending family court, visiting with their kids, and/or completing a treatment program; all of which are difficult to do behind bars.<sup>312</sup>

## 5.5 Alternatives to Separation

Given concerns about separating a new parent and their baby, alternatives to incarceration provide a favorable solution. A handful of U.S. jurisdictions have implemented policies and programs that seek to keep pairs together, in specialized units within carceral facilities, in other settings, or at home.<sup>315</sup>

Prison nursery programs permit eligible mothers to live with their newborns in custody for a defined period after birth, generally 18 months to three years.<sup>316</sup> As of 2023, only three states (New York, Ohio and West Virginia) had laws that allow prison nurseries;<sup>317</sup> but other states establish them through corrections policies. As of 2025, nine U.S. states have prison nursery programs,<sup>318</sup> the BOP offers two programs (one of which transfers some women in federal custody to Washington’s nursery; the other transfers women to residential reentry centers),<sup>319</sup> and just one known jail, at the Rose M. Singer facility in New York City,<sup>320</sup> has a nursery. Two residential nursery programs operate in Texas and California; the programs aren’t in prisons but they are still in supervised facilities.<sup>321</sup> Programs vary widely in eligibility, capacity, and admittance processes; they typically have strict criteria.<sup>322</sup> In 2023, of 665 prison births, only 86 mother–infant pairs were in state nursery programs at the end of the year.<sup>323</sup> (See Appendix A for more details about federal and state prison nursery programs.)

In many countries, nonprofits and community organizations support the creation and operation of prison nurseries, mother-baby units, and creches, as well as provide support to the women and children who reside in them.

CIC’s **Global Prison Nursery Network** brings together practitioners, researchers, and academics to advocate for the rights and well-being of children in prison with their caregivers.<sup>313</sup> GPNN partners include **Aangan Trust** and **India Vision Foundation**, **Clean Start Africa** and **Faraja Foundation** in Kenya, **Resinserta** in Mexico, **Terre des Hommes**, and more.<sup>314</sup>

Some states also have caregiver mitigation and diversion laws that require courts to consider the defendant's child in key decisions about their freedom; some apply to pregnant people.<sup>324</sup> Others allow and/or establish alternatives to incarceration for pregnant and postpartum people to help avoid parent-baby separation while also addressing the pair's other needs and keeping them in or near their community.<sup>325</sup> Non-custodial options may be considered or offered pretrial, during sentencing, or once the person is incarcerated. They may include electronic home monitoring, residential "halfway" houses, and other strategies.<sup>326</sup> For example, Minnesota's Healthy Start Act allows pregnant and postpartum women who are serving short sentences in state prison to be released conditionally for the duration of their pregnancy up to the first year after birth, at the discretion of the state's commissioner of corrections.<sup>327</sup> These programs usually offer additional support, like parenting education, life skills training, and/or access to social services. (See Appendices B and C for examples of domestic and global alternatives to separation for new parents and their babies.)

International law and U.S. medical organizations favor alternatives for pregnant people facing incarceration. The Bangkok Rules state: "[n]on-custodial sentences for pregnant women and women with dependent children shall be preferred where possible and appropriate, with custodial sentences being considered when the offence is serious or violent or the woman represents a continuing danger, and after taking into account the best interests of the child or children, while ensuring that appropriate provision has been made for the care of such children."<sup>328</sup> ACOG, AWHONN and other experts support community-based alternatives too.<sup>329</sup>

When incarceration is unavoidable, prison nurseries could help mitigate harms of separation by allowing mothers to care for their infants, fostering bonding, promoting healthy development, and supporting parenting skills.<sup>330</sup> Limited research suggests that alternatives "reduce intergenerational trauma, improve maternal self-image, promote secure attachment, encourage sustained breastfeeding, and may reduce rates of recidivism."<sup>331</sup>

Despite the promising benefits, prison nurseries and alternatives to incarceration face several common limitations and criticisms. Prisons may not be appropriate environments for newborns to reside with their parents, and the nature of incarceration and its institutional rules, like "zero-tolerance" policies for behavior, can inhibit their ability to parent.<sup>332</sup> Even non-custodial alternatives may exert some level of control and surveillance over parents, which can present significant challenges. For instance, electronic home monitoring or home arrest, while an alternative to traditional incarceration, can replicate carceral conditions and limit a parent's ability to care for and support their child.<sup>333</sup> Access to these programs is often limited by strict eligibility criteria, such as sentence length, crime severity, prior offenses, disciplinary records, or specific medical and mental health conditions.<sup>334</sup> This means that most pregnant and postpartum individuals who could benefit from these services do not have the opportunity to participate.<sup>335</sup> Many of these programs are also underfunded and underresourced, which limits their capacity and impact.<sup>336</sup> A significant evidence gap remains in the comprehensive documentation and evaluation of community-based alternatives, particularly regarding long-term outcomes for mothers, infants, and families, as well as their ultimate impact on recidivism.<sup>337</sup>

Nonetheless, there is a growing consensus among justice advocates for increased investment in non-custodial, community-based alternatives, especially for pregnant and postpartum people. This includes a

push for a fundamental shift in the criminal legal system from a punitive approach to one that is more rehabilitative, restorative, and holistic.<sup>338</sup>

## Conclusion

In this report, we summarize existing research and expert medical guidance related to perinatal care in U.S. prisons and jails. We encourage policymakers to utilize the research compiled here and beyond to inform policies, programs and funding. Ultimately, to be most effective and equitable, policies and programs should be informed by the lived experience of current and formerly incarcerated people.

For example, RestoreHER, an advocacy organization in Georgia founded by justice-involved women of color, have championed legislative change in states across the country. Its National Dignity Campaign seeks to ban shackling and solitary confinement for pregnant people and supports alternative sentences, among other reforms.<sup>339</sup> In Maryland, Reproductive Justice Inside evaluated conditions for pregnant people incarcerated and led to a law that required every facility in the state to have written policies on pregnancy care.<sup>340</sup> Its Model Pregnancy Policy Manual provides guidance about best practices for corrections administrators to utilize. In New York, the Birth Support Working Group –consisting of individuals who have experienced pregnancy in custody, reproductive justice and health care advocates, social workers and doulas, and medical professionals– held conversations with people who gave birth while incarcerated to learn about their experiences and what supports they think are needed to improve birth experiences in jails and prisons.<sup>341</sup> Its report *Born Inside: Birth Experiences During Incarceration & the Need for Doula Care*, launching at the Global Prison Nursery Network Symposium in October 2025, will offer detailed recommendations informed by first-hand experience.

## Appendix A: U.S. Federal & State Prison Nursery Programs

### Federal Prison Programs

Two prison nursery programs serve pregnant people in federal custody: the Mothers and Infants Nurturing Together (MINT) program and Washington’s Residential Parenting Program (RPP).<sup>342</sup> MINT is a community-based residential program that allows mothers and infants to stay together and bond for up to three months after birth.<sup>343</sup> Those who are accepted into MINT, during their last trimester, are transferred from their facility to one of five residential reentry centers, or halfway houses, around the U.S.<sup>344</sup>

Someone is eligible if they were pregnant upon entering custody, have less than five years left of their sentence, assume financial responsibility for their infant, and intend to retain custody of their child after release.<sup>345</sup>

Similarly, RPP supports cohabitation for mothers and children in the minimum-security unit of the Washington Corrections Center for Women (See *Washington* below).<sup>346</sup> The program is operated by the Washington Department of Corrections (WADOC) and is open to qualifying women in federal custody through an intergovernmental agreement between BOP and WADOC; however, most participants are in state custody.<sup>347</sup>

### Illinois

Illinois’ Moms and Babies Program accommodates certain pregnant women in a special wing of Decatur Correctional Center.<sup>348</sup> Only women who will become eligible for parole or release in less than two years are accepted.<sup>349</sup> The nursery can house up to eight mother and infant pairs for up to two years after the child is born.<sup>350</sup> The Moms and Babies Prison Nursery Program equips families with food stamps, medical insurance, parenting classes, and other support programs.<sup>351</sup> After release from the program, they’re connected to another program that continues support through home visits, case management, and more.<sup>352</sup>

### Indiana

In Indiana, the Officer Breann Leath Maternal and Child Health Unit (MCHU) houses up to ten mother and baby pairs in the Indiana Women’s Prison in Indianapolis.<sup>353</sup> Mothers can access this nursery if they have no history of violent or sexual offenses or child abuse or endangerment; finish their sentence within 26 months after their delivery date; pass specific standards of health; and fulfill other requirements.<sup>354</sup> Once in the program, mothers and infants can stay together until the baby reaches 18 months.<sup>355</sup> During this time at the MCHU, the program Mothers on the Rise supports mothers and prepares them for reentry through services such as therapists, community navigators, social workers, case managers, and legal assistance.<sup>356</sup>

### Missouri

Missouri’s legislature authorized a prison nursery in 2022, and it opened in February 2025 at the Women’s Eastern Reception, Diagnostic and Correctional Center in Vandalia.<sup>357</sup> It can hold 14 mothers. Women are eligible if they give birth in custody and have a release date within 18 months of their child’s birth; they cannot be convicted of certain violent felonies or sexual offenses.<sup>358</sup> After women are released from prison, they will continue to receive support from the program with baby supplies, employment help, housing and childcare.<sup>359</sup>

## **Nebraska**

Nebraska's Parenting Program was established in 1994 at the Nebraska Correctional Center for Women.<sup>360</sup> To qualify for one of the 15 available spots, women must have no more than 18 months until their release and no violent record or child abuse conviction.<sup>361</sup> Mothers can stay in the nursery with their babies for 18 months, though extensions can be authorized.<sup>362</sup>

## **New York**

In New York, Bedford Hills Correctional Facility can hold 25 women and their babies in a separate nursery wing, and sees about 40 pairs each year.<sup>363</sup> Mothers and infants can live together for 12 months or up to 18 months under certain circumstances.<sup>364</sup> Bedford Hills's nursery, run by the nonprofit Hour Children,<sup>365</sup> offers daycare, parenting classes, and other assistance to new mothers.<sup>366</sup> According to a study of one facility, mothers and babies who lived together in a prison nursery during the postpartum period were able to establish secure attachments in prison as they would outside detention.<sup>367</sup>

## **Ohio**

The Ohio Reformatory for Women coordinates the Achieving Baby Care Success (ABCS) Program for new mothers and their infants.<sup>368</sup> Mothers are eligible for the ABCS Program if their remaining sentence is less than 36 months and they have only been convicted of nonviolent offenses; babies experiencing neonatal abstinence syndrome are not able to participate.<sup>369</sup> Up to 24 mother-infant dyads can live in the nursery for up to 36 months.<sup>370</sup> The nursery provides child education and parenting courses.<sup>371</sup>

## **South Dakota**

The Mother-Infant Program in South Dakota Women's Prison accommodates pregnant women and women and their babies into the specialized housing unit.<sup>372</sup> There is no defined capacity for the unit.<sup>373</sup> Women are ineligible if they've committed certain violent offenses or crimes against children, and their parole or parole review date must be within 30 months of their child's birth in order to qualify.<sup>374</sup> Mothers must also pass mental and physical screenings and intend to care for the child upon release, though women who intend to enter a substance use treatment facility may be exempt.<sup>375</sup> They must participate in parenting classes or programs.<sup>376</sup>

## **Washington**

Washington Department of Correction's RPP can house 20 mother-baby pairs at the state prison in Gig Harbor.<sup>377</sup> It is open to both women in Washington state custody and in federal custody; they may be transferred there.<sup>378</sup> To be eligible for RPP, women must have been pregnant upon detention, have a release or house arrest date within 30 months of the child's birth, have no history of violence or child abuse and meet other considerations.<sup>379</sup> Mothers must participate in parenting programs and complete work and education while their children attend daycare provided by Early Head Start.<sup>380</sup>

## **West Virginia**

At West Virginia's Lakin Correctional Center, the Keeping Infant Development Successful (KIDS) program allows up to five women at a time to live with and care for their babies for up to 18 months.<sup>381</sup> Women can also move in while they're pregnant.<sup>382</sup> To be eligible, women must have a parole or release date within 18 months and they must meet strict requirements for entry, including no substance use.<sup>383</sup>

The pairs live in a shared mobile home on the prison property.<sup>384</sup> Babies participate in early education programs while living there.<sup>385</sup>

### **Residential Nursery Programs**

In California, pregnant women and mothers with young children can apply to serve the last 12 months of their sentence in a supervised facility outside of prison through the Community Participant Mother Program (CPMP).<sup>386</sup> Participants live on a “child-friendly” campus in Santa Fe Springs.<sup>387</sup> The program, run by the California Department of Corrections, offers beds to up to 24 women and 40 children; children under six are allowed to live with their parents.<sup>388</sup> Mothers can participate in therapy and substance abuse prevention, parenting, and educational programming,<sup>389</sup> and may go out into the community.<sup>390</sup> Children are enrolled in the local elementary school.<sup>391</sup>

In Texas, the Baby and Mother Bonding Initiative (BAMBI), established in 2010, is an out-of-prison nursery program run by the Texas Department of Criminal Justice and the University of Texas Medical Branch.<sup>392</sup> Participating mother-baby pairs live in the Santa Maria Hostel in Houston, one of the largest residential treatment and recovery facilities in the state.<sup>393</sup> They are still technically in state custody and their unit is gated and staffed with corrections workers; however the environment is more “supportive” and “nurturing” than prison, and the program offers comprehensive services, including child development education, infant first aid and CPR, nutrition classes, peer recovery, anger management, and family reunification sessions.<sup>394</sup> Women are eligible for the program if they have a prison sentence of less than 12 months, are designated a “minimal” security risk, haven’t committed certain violent or sex offenses, and other requirements.<sup>395</sup> Pregnant women are transferred to the facility in Galveston in their third trimester, and give birth at a nearby hospital.<sup>396</sup> They participate in prenatal classes prior to delivery.<sup>397</sup> At any time, 22 mothers and their newborns can stay in the facility for up to 12 months, with certain exceptions for longer stays.<sup>398</sup> The pairs are released together at the end of the mother’s sentence, with an individualized treatment plan for each.<sup>399</sup> Studies show the program has had some success in reducing recidivism among participants, and participants report exiting the program with improved parenting and life skills, as well as positive bonding experiences.<sup>400</sup>

## Appendix B: Alternatives to Incarceration for Pregnant & Postpartum People

### **California**

California allows pregnant women with a history of substance abuse to participate in a residential treatment program.<sup>401</sup> In Los Angeles County, through the county's Office of Diversion and Reentry Maternal Health Program, pregnant women with low-level offenses can be diverted from jail and remain in their community on probation for two to five years, with supportive services and housing.<sup>402</sup>

### **Colorado**

A new Colorado law establishes a "rebuttable presumption against detention" for pregnant women charged with nonviolent crimes, requiring courts to prove that there's a public safety risk before they are incarcerated.<sup>403</sup> Courts may give an alternative or deferred sentence, or a stay of execution.

### **Illinois**

Illinois allows electronic home monitoring as a condition for pretrial release for pregnant people.<sup>404</sup> The Children's Best Interest Act added pregnancy as a mitigating factor for courts to consider in sentencing.<sup>405</sup>

### **Maryland**

Maryland's governor can exercise executive clemency and grant a pregnant person parole, a reduced sentence, or release them to an alternative residential setting during their pregnancy; they must return to a facility "as soon as their health allows."<sup>406</sup>

### **Minnesota**

Minnesota's Healthy Start Act, enacted in 2021, allows the state's Commissioner of Corrections to conditionally release pregnant and postpartum women with short sentences into community alternatives, such as halfway houses.<sup>407</sup> They can be released from prison into the community to engage in a range of activities: prenatal or postnatal care programming, employment or seeking employment, vocational training, substance abuse or mental health treatment, educational programs, or parenting education.<sup>408</sup> Pregnant women and those who are up to eight months postpartum are eligible, and their sentence can't extend beyond their child's first birthday, with certain exceptions.<sup>409</sup> For example, one mother's seven-year sentence was delayed to allow her to care for her premature twins until their first birthday, after which she returned to prison.<sup>410</sup> In its first years, 2022 to 2024, 50 pregnant or postpartum people were screened for HSA release; 16 were released and one person was deemed eligible but declined to participate.<sup>411</sup> An evaluation of the HSA found opportunities for improvement, including changes to screening processes and eligibility criteria.<sup>412</sup>

### **Missouri**

Missouri offers "Alt-Care," outpatient, substance-use treatment and rehabilitation programs as an alternative to incarceration.<sup>413</sup> It can be imposed as a condition of probation or parole, including for people who are pregnant or a parent of a young child and charged with a drug-related offense. Participants receive "intensive, on-site supervision and collaborative treatment," at rehab facilities.

## **New Jersey**

In New Jersey, the wardens of correctional facilities can allow certain pregnant women and parents to enroll in residential drug treatment and mental health programs.<sup>414</sup>

## **New York**

In New York City, JusticeHome is an alternative to incarceration program that advocates for women and LGBTQIA+ people to remain at home.<sup>415</sup> The program provides court advocacy to reduce and dismiss charges, and offers case management and referrals for community programs, like housing support, counseling, and job training.<sup>416</sup>

## **Oklahoma**

In Oklahoma County, the non-profit ReMerge operates a pretrial diversion program for high-risk, high-needs mothers charged with non-violent felonies.<sup>417</sup> The program provides safe housing and comprehensive support, including food, clothing, transportation, mental and physical health care, employment help, and parenting development with ReMerge partners.<sup>418</sup> Although children do not reside with their mothers in this specific program, mothers are reunited with their children upon successful completion, which typically lasts two years and can result in the dismissal of charges.<sup>419</sup> Since 2011, 221 women with 555 minor children have successfully completed the program.<sup>420</sup>

## **Oregon**

In 2015, Oregon established a ten-year Family Sentencing Alternative Pilot Program (FSAPP) in five counties to provide intensive community supervision in lieu of imprisonment.<sup>421</sup> It became permanent in summer 2025.<sup>422</sup> Both pregnant people and parents of children are eligible. Participants must have a presumptive sentence of at least one year and can't be charged with certain crimes.<sup>423</sup> Defense attorneys and prosecutors recommend participants for the programs and probation officers complete assessments for judges to consider.<sup>424</sup> Participants must follow strict oversight plans that were developed for them.<sup>425</sup> Probation officers have more contact with those enrolled in FSAPP than traditional supervision and should connect participants to other support to meet their needs, like substance abuse treatment, parenting classes, and job training.<sup>426</sup> In its first ten years, almost 300 people with a collective 600 children participated, and participants had lower rates of recidivism, arrests and incarceration than single parents who went to prison and kids spent less time in foster care.<sup>427</sup>

## **Tennessee**

Pregnant people in Tennessee can be granted a temporary furlough up to six months for birth and bonding with their newborn.<sup>428</sup>

## **Washington**

In Washington, pregnant people are eligible for two alternatives geared towards parents: the Family and Offender Sentencing Alternative (FOSA) for those facing incarceration and the Community Parenting Alternative (CPA) for those who are already incarcerated.<sup>429</sup> The judicial sentencing alternative FOSA allows judges to waive a sentence and impose one year of community supervision and other conditions for treatment and programming for eligible pregnant people and parents.<sup>430</sup> Participants receive case management, counseling, and other services.<sup>431</sup> As of August 2024, nearly 460 people (73 percent of participants) had completed the FOSA program; very few have returned to prison.<sup>432</sup> Through the prison-

based CPA, the Department of Corrections may send eligible pregnant people and parents home on electronic monitoring for up to the last 18 months of their sentence.<sup>433</sup> More than 600 people (84 percent of participants) have completed the program; about 13 percent have returned to prison.<sup>434</sup>

### **Wisconsin**

In Madison, Wisconsin, the Department of Corrections refers certain pregnant and mothers of infants to ARC Maternal and Infant Program, a community-based residential treatment program run by the nonprofit ARC Community Services, Inc.<sup>435</sup> The ARC facility has 12 beds for pregnant women and mothers and their babies. Women receive parenting education and case management in addition to treatment.

## Appendix C: Examples of Alternatives in Other Countries

Around the globe, penal systems differ greatly—from size and infrastructure to ethos. Yet there is much to be learned from other countries’ policies and practices regarding pregnant and birthing people in prisons. Some offer prison nurseries or other arrangements to keep new parents and their newborns together in custody; others delay sentences or offer other options. Below, we highlight a few examples:

### **Argentina**

In the past 20 years, the population of women in Argentine prisons has increased by almost 200 percent.<sup>436</sup> As of 2009, judges may sentence mothers with children under five or those responsible for dependents with disabilities to serve their time on house arrest.<sup>437</sup> Most federal and provincial women’s facilities have dedicated mothers units too, allowing babies to live with their mother in custody.<sup>438</sup>

### **Armenia**

Less than 3 percent of the Armenian prison population were women, as of 2024.<sup>439</sup> The country’s criminal code lists pregnancy, childbirth, and caring for a child under 14 years as mitigating factors to be considered at sentencing.<sup>440</sup> Pregnant women or women with children under three can have their sentences deferred or even cancelled if their sentence is less than five years and if their offense is not considered an especially serious crime.<sup>441</sup>

### **Australia**

In 2024, Australia incarcerated about 3,400 women, or 7.7 percent of the prison population.<sup>442</sup> Pregnant women and mothers with newborns can live in mother-baby units in some Australian correctional facilities.<sup>443</sup>

### **Brazil**

Brazil has the third largest population of incarcerated people after the U.S. and China, and incarcerated nearly 54,000 women in 2024.<sup>444</sup> Brazilian law prescribes that pregnant people or mothers caring for children under 12 or people with disabilities should receive house arrest in lieu of pretrial detention. They must be considered nonviolent and have not harmed the child or person in their care.<sup>445</sup>

### **Canada**

Canada incarcerated about 2,300 women in 2021, 7 percent of the prison population.<sup>446</sup> Children have lived in Canadian prisons with their mothers for at least 150 years.<sup>447</sup> Today, young children can live with their mother in the country’s five federal facilities for women, as well as a healing lodge for incarcerated Indigenous women.<sup>448</sup> One known province offers a similar program in its jail.<sup>449</sup> Children under the age of five are eligible for full time residency, and those under seven are eligible for part-time visits on the weekends, holidays and during the summer.<sup>450</sup>

## **Colombia**

Women make up about six percent of the prison population in Colombia, with more than 6,000 behind bars.<sup>451</sup> Since women are typically the parent responsible for children, Colombia instituted in 2023 that women who are the head of their household and whose sentence is eight years or less are eligible for alternative sentencing, like community service, instead of detention.<sup>452</sup> Upon its implementation, President Gustavo Petro said this new law would allow 5,000 female inmates to be released from prison five days a week to care for their children.<sup>453</sup>

## **Costa Rica**

In 2023, about 800 women were incarcerated in Costa Rica, roughly 4.4 percent of the prison population.<sup>454</sup> Costa Rica's Code of Penal Procedure stipulates that for women in the last months of pregnancy and those with a child younger than three months, pretrial detention may be replaced with house arrest when detention would "endanger the life, health, or integrity of the mother, fetus, or child."<sup>455</sup> The Code also allows the penal sentence to be substituted with house arrest if a woman is the head of the household with a child under 12, a disabled dependent, or a seriously ill family member.<sup>456</sup> Alternative sentencing may also be granted if they have been the primary caregiver for a child and if there is no one else to care for said child.<sup>457</sup>

## **England & Wales**

About 3,500 women are jailed in England and Wales, about 4 percent of the prison population in 2025.<sup>458</sup> The National Health Service and Ministry of Justice classified all pregnancies in prison as "high-risk."<sup>459</sup> Pregnant women can apply to reside in a Mother and Baby Unit (MBU), a designated space for women and their children in six women's prisons around the country.<sup>460</sup> Babies can live with their mothers up to 18 months old.<sup>461</sup> Placement is decided on a case-by-case basis and the best interest of the child is priority.<sup>462</sup> In 2024, the country's independent Sentencing Council approved new guidelines that instructed judges to consider someone's pregnancy status during sentencing.<sup>463</sup> In April 2025, just before it was due to go into effect, the Sentencing Council suspended the new guidelines after facing government opposition.<sup>464</sup>

## **France**

In 2024, about 2,500 women were imprisoned in France, roughly 3.5 percent of the total prison population.<sup>465</sup> In more than half of France's 57 women's prisons, pregnant women and mothers can live in nurseries together.<sup>466</sup> Parents of young children with less than four years on their sentence and women who are more than 12 weeks pregnant can be conditionally released too.<sup>467</sup>

## **Georgia**

Georgia incarcerated about 475 women, almost 5 percent of the total prison population in 2025.<sup>468</sup> Georgia allows courts to postpone sentences for pregnant women after birth and up to one year; they are then enrolled in probation.<sup>469</sup> Children can also live with their mothers in prison for up to three years.<sup>470</sup>

## **Germany**

In Germany, about 5.6 percent of incarcerated people are women; 3,342 were in custody in 2024.<sup>471</sup> In more than half of the country's 16 federal states, newborns and young children can live in prison with their mothers.<sup>472</sup> Pairs live in specialized units called mother-baby units or homes. These arrangements

provide an alternative to separation after birth and allow time for bonding. However, there is no legal right to admission to these units in any state.<sup>473</sup>

### **India**

In 2023, more than 21,500 women were incarcerated in India, about 4 percent of the prison population.<sup>474</sup> The Supreme Court of India ruled in 2006 that female prisoners should be able to keep their children with them in custody until they reach the age of six.<sup>475</sup> Some prisons, through the work of nongovernmental organizations, have creches for the children.

### **Italy**

Until recently, Italian Criminal Code mandated deferral of imprisonment for pregnant women and mothers of children under age one.<sup>476</sup> A new provision, codified in April 2025, eliminated this automatic deferral, though judicial discretion can allow for it in some cases.<sup>477</sup>

### **Kazakhstan**

Kazakhstan incarcerates about 2,600 women, accounting for 8.2 percent of the prison population.<sup>478</sup> In Kazakhstan, judges may postpone the sentence of pregnant women and mothers with children under 14 if their sentences are less than five years for a non-violent crime.<sup>479</sup> The sentence can be deferred for one year or until the child turns 14, wherein the mother's behavior will be reviewed to determine if her sentence has been fulfilled.<sup>480</sup>

### **Kenya**

About 3,000 women were incarcerated in Kenya in 2023; that's about 4.7 percent of the prison population.<sup>481</sup> In Kenyan prisons, mothers who give birth while incarcerated can keep their babies with them until they are four years old.<sup>482</sup> Of the 43 correctional facilities that house women, about 10 have daycare centers and nurseries.<sup>483</sup>

### **Lithuania**

About 200 women were incarcerated in Lithuania in 2024, about 4.5 percent of the prison population.<sup>484</sup> There is a mother's home on the grounds of a women's prison in Lithuania where women can live with their children.<sup>485</sup> They may go out into the community for work and schooling.

### **Mexico**

In 2025, more than 15,500 women were incarcerated in Mexico, accounting for 6 percent of the prison population.<sup>486</sup> Incarcerated women who gave birth in custody and their newborns may reside together in a prison if facilities are available.<sup>487</sup>

### **Ukraine**

As of 2023, about 2,500 convicted women were in prison colonies in Ukraine, about 5.6 percent of the prison population.<sup>488</sup> Pregnant women who are sentenced to community service or prison labor can be released early.<sup>489</sup> Women who are sentenced to prison and are pregnant or gave birth while serving their sentence can have their sentences suspended too; they must meet certain requirements.<sup>490</sup> Ukraine also has baby homes in penal colonies where children under the age of three can live with their mothers.<sup>491</sup>

- <sup>1</sup> “Advocacy and Research on Reproductive Wellness of Incarcerated People,” Advocacy and Research on Reproductive Wellness of Incarcerated People, accessed September 25, 2025, <https://arrwip.org/>.
- <sup>2</sup> Jennifer G. Clarke and Eli Y. Adashi, “Perinatal Care for Incarcerated Patients: A 25-Year-Old Woman Pregnant in Jail,” *JAMA* (2011), doi:10.1001/jama.2011.125.
- <sup>3</sup> Carolyn Sufrin, *Pregnancy and Postpartum Care in Correctional Settings* (2018), <https://www.ncchc.org/wp-content/uploads/Pregnancy-and-Postpartum-Care-2018.pdf>.
- <sup>4</sup> Estelle v. Gamble, 429 U.S. 97, 106 (1976).
- <sup>5</sup> *Reproductive Health Care Legislation for Incarcerated People* (Advocacy and Research on Reproductive Wellness of Incarcerated People, August 2024), [https://arrwip.org/wp-content/uploads/2024/08/ARRWIP-Reproductive-Health-Laws-Table\\_Aug-2024-1.pdf](https://arrwip.org/wp-content/uploads/2024/08/ARRWIP-Reproductive-Health-Laws-Table_Aug-2024-1.pdf).
- <sup>6</sup> Rebecca J. Shlafer, Rachel R. Hardeman and Elizabeth A. Carlson, “Reproductive Justice for Incarcerated Mothers and Advocacy for Their Infants and Young Children,” *Infant Mental Health Journal* 40, no. 5 (2019) DOI: 10.1002/imhj.21810.
- <sup>7</sup> Summer Sherburne Hawkins, “Reproductive Health Care for Incarcerated Women in the Prenatal and Postpartum Periods,” *Journal of Obstetric, Gynecologic & Neonatal Nursing* 53, no. 3 (May 2024): 220–33, <https://doi.org/10.1016/j.jogn.2024.03.006>.
- <sup>8</sup> Emily Lupton Lupez, Steffie Woolhandler, David U. Himmelstein, et al., “Health, Access to Care, and Financial Barriers to Care Among People Incarcerated in US Prisons,” *JAMA Internal Medicine* 184, no. 10 (2024), doi:10.1001/jamainternmed.2024.3567.
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