COMMENT

Equitable Care for Pregnant Incarcerated Women: Infant Contact After Birth—A Human Right

By Christine Franco, Erika Mowers and Deborah Landis Lewis

The incarceration rate in the United States is the highest of any country in the world, with more than two million people currently imprisoned.[1] Mass incarceration is not unique to men—the nation also holds nearly a third of the world's incarcerated female population.[2] Overall, the total U.S. prison population has declined by 17% since 2009, however, this was driven by a decrease in male incarceration, while some states saw an increase in female incarceration.[3–5] The most recent estimates show that more than 223,000 women are incarcerated in jails and prisons in the United States, and an estimated 3–4% of these women* are pregnant on entry.[5–8]

Women's imprisonment is fraught with disparities and dangerous health care inequities, reflecting the structural racism and classism

within a system that disproportionately affects people of color. In 2018, Black women were incarcerated at twice the rate of White women.[3] Irrespective of incarceration status, the rate of pregnancy-related mortality among Black women is three times greater than that of White women, and women who are incarcerated during pregnancy may have increased risk of preterm birth and delivering infants with low birth weight.[9–11] Although data on pregnancy outcomes stratified by race and ethnicity in jails and prisons are limited, it is important to highlight existing inequities in the nation's carceral and health care systems.

While the 1976 Supreme Court case *Estelle v. Gamble* guaranteed the constitutional right to health care for all persons who are incarcerated, the quality of care—including prenatal care—varies widely.[12] In a survey of 19 state prisons across the country, 12 facilities did not have an on-site health care provider and many sites did not provide adequate nutrition to pregnant inmates.[13] A 2017 national survey of perinatal nurses highlighted that stigma against incarcerated people still exists and has the potential to impact the care they receive in a hospital.[14] Harmful practices that would be unimaginable for the general population persist in the hospital setting: Pregnant women continue to be shackled, often give birth in the presence of corrections officers but without the support of friends or family, and can be forcibly separated from their newborn immediately after birth.

As obstetric providers at a large community hospital affiliated with Michigan's single state prison for women, we strive to deliver the highest standards of care for all patients. Unfortunately, we have witnessed a system of harm and inequitable treatment that counters the oath we took as health care practitioners. As part of an ongoing retrospective maternal and neonatal outcomes study, we collected data on how often incarcerated mothers were denied contact with their newborns. We found that, between 2010 and 2019, more than 20% of the 240 incarcerated women who gave birth at our institution were forcibly separated from their newborns immediately after delivery for nonmedical reasons.[15] Individuals should not be stripped of their human rights simply because they are incarcerated. As reproductive health care practitioners, we believe it is our duty to advocate for our patients, especially the most vulnerable, and to let evidence, compassion and the principles of medical ethics guide our clinical decision making. In this commentary, we present evidence for the benefits of skin-to-skin contact and the harms of immediate separation after birth, and advocate for individual, local and systematic change to ensure this human right for pregnant women who are incarcerated.

Inconsistent and Biased Practice

Prenatal care in prison follows a general schema in which the majority of pregnancy care is provided at the prison, if there is a

qualified on-site health care practitioner. For high-risk pregnancies, obstetric emergencies or the onset of labor, patients are transferred from the prison to a community clinic or affiliated hospital for care. Mothers have a few days in the hospital, at most, to spend with their child after birth before they return to prison. Children are then placed with a family member, enter the foster care system or are placed for adoption. Prison-based nurseries exist, but are rare: Only eight states currently have prison nursery programs.[16] The pregnancy experience in jail is more fragmented than that in prison given the short-term nature and high turnover; however, women obtain on- and off-site prenatal care, and may be offered furlough for early release.[17]

Historically, prisons have been designed for men and do not account for the parental responsibilities and health care needs of women. Recommendations from scholars and activists call for prisons, which are inherently trauma-inducing institutions, to be more trauma-informed and gender-responsive.[18,19] Forcibly removing a newborn from their mother's presence directly counters efforts for such reform. Currently, there are no national standards of care regarding contact between incarcerated women and their newly born infants. Therefore, what is assumed to be best medical practice for the general population often does not translate into equitable care for those who are incarcerated. In the absence of national guidelines, individual hospitals and prisons, and even individual carceral

employees, are left to determine their own policies for infant contact. Although studies of immediate postpartum mother–newborn separation in the incarcerated population are not available, practitioners in the field report that practices range from immediate forced removal, to deliberate separation in the hospital with limited supervised contact, to full support of the mother–infant dyad with rooming-in and breastfeeding support.

Individual bias and institutional norms perpetuate stereotypes of incarcerated persons and propagate the idea of the "unworthiness" and "dangerousness" of an incarcerated mother.[20–22] Wardens, Departments of Corrections and hospital staff may internalize the belief that incarcerated women are more likely to harm their children. However, there are no documented cases of women who are incarcerated at the time of birth intentionally harming their newborns during the first days of life. While we recognize that neonaticide exists, the profile of women who commit this act is well described: those who have hidden, concealed or denied their pregnancy, do not engage in prenatal care and give birth alone outside of a hospital.[23] Furthermore, the majority of mothers who have killed their newborns have had no prior arrests.[23] Therefore, in the absence of any evidence, one cannot assume that pregnant women in jails or prisons are inherently more likely than others to hurt their newborns. Moreover, given the lack of privacy and the fact that routine pregnancy tests are performed on entry to prison,

incarcerated women are rarely able to hide a pregnancy and in any case are guaranteed some form of prenatal care. Finally, incarcerated individuals give birth within the "safe" space of a birth unit and are monitored by one or more corrections officers at all times throughout their hospital stay, making it highly unlikely that a patient would be able to harm their newborn.

Prohibition of infant contact based on a mother's history of involvement with Child Protective Services (CPS)—a practice documented in our ongoing study—is also problematic and inequitable. The child welfare system in the United States disproportionately impacts families of color, the result of structural racism both in U.S. society and within the welfare system.[24,25] If we use CPS case history to mandate immediate separation, we are further perpetuating the inequities currently engrained in our society. Furthermore, bias against pregnant incarcerated women is apparent because nonincarcerated pregnant women with a history of CPS involvement are not regularly policed in hospitals' labor and delivery units. Prior CPS history does not determine a mother's current capacity, and leveraging such history against a mother does not allow for personal rehabilitation. A blanket policy that separates an infant and mother because of the mother's prior actions is overtly punitive, not corrective or protective, and conveys that such women are second-class citizens undeserving of the basic human right of mother–infant contact. In the absence of cause or evidence to support

that a newborn is in immediate danger, forced separation is unjust and reflects conscious or subconscious bias against those who are imprisoned.

Benefits and Risks to the Infant

The premise that infant separation following birth confers safety for the neonate is further eroded by the evidence supporting the importance of the parent–child bond. The American Academy of Pediatrics, the American Academy of Family Physicians, the World Health Organization and UNICEF recommend skin-to-skin care and routine, unlimited contact between medically stable mothers and infants in the immediate postpartum period.[26–28] As far back as the 1970s, Klaus and colleagues proposed the importance of a pivotal period of time immediately following birth; during this "golden hour," the newborn shows behaviors such as the breast crawl if placed directly on the mother's chest.[29] This immediate and uninterrupted skin-to-skin contact facilitates bonding, breastfeeding and thermoregulation, and can even impact sleep–wake cycles.[29–31]

Newborns taken away from their mothers in these critical early hours are unable to obtain these important benefits, leading to more irritability, behavioral dysregulation and an inferior mother–infant bond compared with when infants receive direct skin-to-skin contact.[32] Furthermore, children of mothers who are incarcerated have shown increased difficulty with externalizing mental health

outcomes as they age, such as substance use and antisocial behaviors.[33] Moreover, Dowell and colleagues found an increase in mortality among infants whose mothers were incarcerated in the five years prior to, and within one year after, birth.[34] Given that these children are at risk for adverse childhood outcomes, it is critical for them to obtain every benefit they can under extremely difficult circumstances, which are outside of their control. It is unethical to withhold essential, protective, evidence-based care for a subset of the population when the standard of care is well established.

Benefits and Risks to the Mother

Not only is undisturbed skin-to-skin contact essential and healthy for the newborn, but there are positive benefits for the mother as well. Forced separation of mother and infant shortly after birth can be extremely distressing for new mothers and serves as a barrier to the bonding process.[35] This is especially concerning given that up to 70–80% of justice-involved pregnant women have depression, compared with just 8% of the general pregnant population.[36–39] When a mother has immediate skin-to-skin contact with her infant, she reports decreased symptoms of postpartum depression.[40] Additionally, infant contact after birth facilitates breastfeeding, which has been shown to increase oxytocin release, which in turn increases uterine contractions and decreases bleeding and risk of postpartum hemorrhage.[29] Even though many women will not

continue breastfeeding once they return to prison, these early experiences may still be beneficial and facilitate bonding over the long term.

The additional trauma endured by a mother when she is deemed a threat so severe that policy mandates that her child be taken away immediately after birth exacerbates the stigma and trauma that incarcerated women have already experienced. In a study by Karatzia et al., nine in 10 incarcerated females reported having experienced childhood and adult trauma, and more than half met the criteria for having posttraumatic stress disorder (PTSD).[41] The majority of individuals reported multiple traumas, including childhood neglect and emotional, sexual or physical abuse, among others.[41] It has also been shown that incarcerated women have an increased lifetime prevalence of PTSD—around 40%—compared with 6–9% in the general population.[42,43] In a space where clinicians are entrusted with protecting patients, the inhumane practice of immediate child separation needlessly contributes to women's lifetime trauma.

The Way Forward

Health care practitioners must continue working to create a health care system that treats all patients with compassion and respect, including mothers who experience incarceration and their newborn children. The work to be done must be directed at various levels of

intervention: national, state, local and individual.

Practitioners must obtain support from national organizations whose endorsement can translate into clinical and policy changes. Several organizations, including but not limited to the American College of Obstetricians and Gynecologists, the American Medical Association, the American Civil Liberties Union and the American Psychological Association, have issued policy or position statements on the harms of shackling pregnant women, and resulting standard best practice guidelines have been developed.[44–47] As of 2018, 22 states have passed anti-shackling legislation—regulations that address the use of handcuffs, leg irons and chains on those who are pregnant, although these laws vary in their scope.[48] We propose that similar position statements be issued clearly opposing the immediate separation of incarcerated mothers and their neonates for nonmedical reasons, with exceptions for the most extreme circumstances in which there is valid concern for newborn safety. We argue that in the absence of demonstrable, evidence-based cause, the forcible removal of newborn infants from their mothers' arms constitutes cruel and unusual punishment. Once awareness and support are established by these organizations, the ultimate goal would be state and federal policy addressing this practice.

It is equally important to engage at the local level. Hospitals, in collaboration with Department of Corrections staff, need to develop clear policies for patients who are incarcerated that are evidence-

based, humane and equitable, and that align with the best practices promoted for patients who are not incarcerated. Policies must support skin-to-skin care, rooming-in, the promotion of breastfeeding when desired, and uninhibited contact between mothers and infants in the critical time after birth. Incarcerated mothers and their children are already at increased risk for poor outcomes driven by structural racism and preincarceration factors; as health care practitioners, we must work to minimize trauma and care disparities in pregnancy and at birth. Any decision to deny infant contact should be made on a case-by-case basis after thorough evaluation by social workers, health care providers and correctional staff. We propose that this include a formal psychiatric assessment by a mental health professional with clear documentation of intent to harm, acknowledgments of the risks and benefits of denied contact for both individuals, and an ongoing treatment plan for women deemed to be at such high risk.

Finally, some of the most important work needs to be done on the individual level. First and foremost, health care practitioners must recognize, acknowledge and address biases, and become allies in the fair and equitable treatment of all patients. We must strive to better understand the lived experience of pregnant incarcerated women, both their preincarceration lives and their ongoing time behind bars. In all circumstances, we are professionally obligated to consider and apply the principles of medical ethics, including justice, autonomy,

beneficence and nonmaleficence. It is imperative that we acknowledge the multifaceted nature of this issue, which encompasses the violation of human rights, nuanced health care policy issues, and hospitals' and associated institutions' (e.g., Department of Health and Human Services, Department of Corrections) policy and protocol. We must understand that as silent observers we may be complicit in perpetuating inhumane practices. Each of us must educate ourselves regarding current local policies and practices, and make a concerted effort to try to change harmful practices. What may seem like a brief moment in time for mothers and newborns can have a lasting impact, one that may decisively change the trajectory of their lives.

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FOOTNOTE A:

*We acknowledge that not all pregnant and birthing individuals identify as women or mothers. The authors have chosen to use gendered language to remain consistent within the text and within the current body of literature.

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